UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

WESCO, INC., WESCO, INC. CAFETERIA PLAN AND EMPLOYEE BENEFIT PLAN, FRANKENMUTH BAVARIAN INN, INC., FRANKENMUTH BAVARIAN INN, INC. EMPLOYEE HEALTH BENEFIT PLAN & TRUST, OPUS PACKAGING GROUP INC., and OPUS PACKAGING GROUP HEALTH INSURANCE PLAN, on behalf of themselves and a class of all others similarly situated,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 2:25-cv-11712

Hon. Susan K. DeClercq

Magistrate Judge: David R. Grand

CLASS ACTION

PLAINTIFFS' RESPONSE TO DEFENDANT'S MOTION TO TRANSFER CASE

TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases **Page(s)**

Rules

Statutes

CONCISE STATEMENT OF THE ISSUES PRESENTED

1. Whether the Court should transfer venue to the Federal District Court for the Western District of Michigan when the "First-to-File Rule" is inapplicable due to the different parties, issues, and claims at issue in *Tiara Yachts, Inc. v. BCBSM*, No. 1:22-cv-00603 (W.D. Mich. July 1, 2022).

Plaintiffs Answer: No

BCBSM Answers: Yes

2. Whether the Court should overrule Plaintiffs' choice of venue and transfer this case to the Federal District Court for the Western District of Michigan when: (A) BCBSM is headquartered in the Eastern District of Michigan, (B) BCBSM routinely litigates ERISA cases in the Eastern District of Michigan, (C) BCBSM's relevant evidence and witnesses are located in the Eastern District of Michigan, and (D) the convenience and relative means of the parties favors venue in the Eastern District of Michigan.

Plaintiffs Answer: No

BCBSM Answers: Yes

CONTROLLING OR MOST APPROPRIATE AUTHORITY

28 U.S.C. § 1404(a), and the authorities cited in the brief below.

I. INTRODUCTION

BCBSM—headquartered in Detroit and represented by attorneys from Farmington Hills, New York City, and Washington, D.C.—should not be permitted to transfer this case *away* from a Southeast Michigan federal court. Its motion is an attempt to forum shop. Based on this Court's decisions in prior ERISA cases about BCBSM's unlawful fees collected from self-funded customers—particularly, *Hi-Lex Controls, Inc. v. BCBSM*—BCBSM perceives this Court as unfavorable; and because a Western District of Michigan judge initially dismissed Tiara Yachts' Complaint on the pleadings (subsequently reversed by the Sixth Circuit), BCBSM believes it will fare better there. BCBSM's attempt to forum shop should be denied.

BCBSM primarily predicates its forum shopping on the "first to file" rule, which is inapplicable. Indeed, the very case BCBSM contends was filed "first" involves a different party advancing additional, separate claims against BCBSM: *Tiara Yachts v. BCBSM*, Case No. 1:22-cv-00603 (W.D. Mich. July 1, 2022) (hereinafter, "*Tiara Yachts*"). Mtn. to Transfer (ECF No. 20, PageID.114-15). Tiara Yachts is not part of the class in this case. Attempting to pigeonhole this case into the first-to-file rule, BCBSM omits key facts and misrepresents others that show this action and *Tiara Yachts* should continue separately. BCBSM ignores the dozens of ERISA cases regarding its fees that it has routinely litigated in the Eastern District and fails to explain how transfer would possibly promote the interests of justice.

BCBSM's alternative demand for transfer under the guise of "convenience" (pursuant to 28 U.S.C. § 1404(a)) fares no better. Plaintiffs are entitled to deference in selecting a venue, and BCBSM is at home in the Eastern District: it is headquartered in the Eastern District, its high-level officers are in the Eastern District, its witnesses and evidence are in the Eastern District, and its counsel are in the Eastern District (or out-of-state). The Western District is not more convenient. This case is exactly where it belongs. BCBSM's motion should be denied.

II. RELEVANT BACKGROUND

As a result of widespread self-dealing, breaches of fiduciary duty, and violations of ERISA perpetrated by BCBSM through its "Shared Savings Program" (the "SSP"), the present case is a class action seeking to remedy those actionable harms. Amended Compl., ¶¶ 1-5, ECF No. 23, PageID.250-51). The SSP represents BCBSM's concocted, nefarious scheme to leverage its role as claims administrator to increase its bottom dollar. *Id.* As BCBSM used its administrative services contracts ("ASCs") to unilaterally subject all self-funded benefit plans to its SSP, *id.*, ¶ 4, the Class Representatives (Wesco, Bavarian Inn, and Opus) seek to represent "All Self-Funded Plans and their Plan Sponsors from whom BCBSM has collected any SSP fees," excluding "(1) BCBSM and any entities in which BCBSM has a controlling interest; and (2) Self-funded Plans and their Plan Sponsors that have

pending or resolved litigation against BCBSM related to BCBSM's SSP fees." *id.*, ¶¶ 147, 150 (PageID.283-84) (collectively, "Plaintiffs").

Many employers sponsor self-funded employee benefits plans to cover the healthcare needs of their employees. *See e.g.*, *id.*, ¶¶ 15, 22, 29 (PageID.253-55). Under this structure, the employer funds the benefits plan directly and pays its employees' medical bills according to the plan's terms, rather than buying health insurance to cover employee health care claims. *Id.*, ¶ 20 (PageID.253). These plans are employee welfare benefit plans governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq. Id.*, ¶¶ 1, 16, 23, 30 (PageID.250, 253-55). Because employers are typically not in the healthcare business, they contract with a third-party to administer plan claims. *Id.*, ¶ 41 (PageID.257). All three Plaintiffs contracted with BCBSM to serve as their employee benefit plan's claims administrator, memorialized by their respective ASCs (which BCBSM drafted). *Id.*; *see also id.*, ¶¶ 54-57 (PageID.260-61).

Unbeknownst to Plaintiffs, BCBSM implemented a scheme (the SSP) by which BCBSM—under the deceptive portrayal to Plaintiffs as a "savings" and "cost-containment" program—siphons off plan's assets as a reward for "catching" its own administrative errors. *Id.*, ¶¶ 6, 7 (PageID.251). Indeed, BCBSM's SSP allows BCBSM to recover up to 30% of what it purportedly "recovers" or "prevents" from being paid on a second-pass review, *after BCBSM allowed that improper charge to*

pass through initially. Id. In short, the more mistakes BCBSM makes, the more errors it can "catch" and pays itself a "fee" for doing so. *Id.*, ¶¶ 8-10 (PageID.251-52). As an ERISA fiduciary, BCBSM is obligated to avoid processing these improper claims in the first place and was, further, expressly disallowed from self-dealing. *Id.*, ¶¶ 9-11 (PageID.252). This action seeks disgorgement of BCBSM's ill-gotten gains and recovery of Plaintiffs losses. *Id.*, ¶ 12.

Why is BCBSM forum shopping? Considering this Court's decisions in prior ERISA cases regarding BCBSM's unlawful fees collected from self-funded customers—e.g., *Hi-Lex Controls, Inc. v. BCBSM*—BCBSM views this Court as unfavorable. The Western District of Michigan, in contrast, is more appealing after a judge there initially dismissed Tiara Yachts' Complaint on the pleadings. **Exhibit A**. That decision was reversed by the Sixth Circuit, *Tiara Yachts, Inc. v. BCBSM*, 138 F.4th 457, 473 (6th Cir. 2025), but BCBSM thinks it will fare better there.

BCBSM's attempt to pigeonhole its forum shopping into the first-to-file rule belies its litigation strategy. The *Tiara Yachts* plaintiff is plainly excluded from Plaintiffs' Class, and that lawsuit involves a broader subset of ERISA violations perpetrated by BCBSM with respect to Tiara Yacht's *individual* Plan. **Exhibit B**, *Tiara Yachts v. BCBSM Complaint*. Any factual overlap between the two suits is immaterial, as Tiara Yachts has no obligation to advance its claims under a class (even if it did fit in Plaintiffs' Class as defined). Far from promoting judicial

economy or the interest of the parties, if granted, BCBSM's motion would stall this proceeding. BCBSM has litigated dozens of ERISA actions in this district, *see infra* n. 2; its headquarters is less than a mile from the Courthouse; and Plaintiffs' selection of venue is presumed correct. BCBSM's motion to transfer should be denied.

III. LAW AND ARGUMENT

A. THE FIRST-TO-FILE RULE DOES NOT APPLY.

"[T]he first-filed rule is not a strict rule[,] . . . [and] [d]istrict courts have the discretion to dispense with the [rule] where equity so demands." *Certified Restoration Dry Cleaning Network, LLC v. Tenke Corp.*, 511 F.3d 535, 551 (6th Cir. 2007) (internal citation omitted). To decide whether this rule applies, courts weigh three non-dispositive factors, including: "(1) the chronology of events, (2) the similarity of the parties involved, and (3) the similarity of the issues or claims at stake." *Baatz v. Columbia Gas Transmission, LLC*, 814 F.3d 785, 789 (6th Cir. 2016). However, even if all three factors are met, the court must still "determine whether any equitable considerations, such as evidence of inequitable conduct, bad faith, anticipatory suits, [or] forum shopping, merit not applying the first-to-file rule in a particular case." *Id.* (internal citation and quotation omitted). This rule's application is limited to duplicative proceedings with "nearly identical parties and issues[.]" *Zide Sport Shop of Ohio, Inc. v. Ed Tobergte Assocs., Inc.*, 16 F. App'x

433, 437 (6th Cir. 2001). It is "within the discretion of the district court to decline to apply the first-to-file rule." *Baatz*, 814 F.3d at 793.

1. The Chronology of Events.

Tiara Yachts, Inc. v. BCBSM, No. 1:22-cv-00603 (W.D. Mich. July 1, 2022) was filed before the present action, but the relevant chronology of events should include the numerous other ERISA suits filed against BCBSM over the past decade.[1] BCBSM ignores *dozens* of prior ERISA fee cases that have been filed by Plaintiffs' counsel and defended by BCBSM in the Eastern District.[2] BCBSM's attempt to

[1] Additionally, even though BCBSM only focuses on this case and *Tiara Yachts*, the two cases are in the exact same posture (BCBSM having yet to answer the complaint and, instead, arguing for dismissal).

[2] *See e.g.*, *Comau LLC v. BCBSM*, Case No. 2:19-12623 (E.D. Mich. Sep. 6, 2019); *Passage Ways Travel Serv., Inc. v. BCBSM*, Case No. 4:19-cv-11707 (E.D. Mich. Jun. 7, 2019); *Blinds and Designs, Inc. v. BCBSM*, Case No. 2:19-cv-11123 (E.D. Mich. Apr. 17, 2019); *Oak Point Partners, LLC v. BCBSM*, Case No. 2:19-cv-10662 (E.D. Mich. Mar. 5, 2019); *Chippewa-Luce-Mackinac Cmty. Action Hum. Res. Auth., Inc. v. BCBSM*, Case No. 2:19-cv-10507 (E.D. Mich. Feb. 19, 2019); *Textron Inc. v. BCBSM*, Case No. 2:18-cv-137999 (E.D. Mich. Dec. 7, 2018); *Brooks Kushman P.C. v. BCBSM*, Case No. 2:17-cv-14052 (E.D. Mich. Dec. 15, 2017); *ThyssenKrupp Materials NA, Inc. v. BCBSM*, Case No. 2:17-cv-12653 (E.D. Mich. Aug. 11, 2017); *Phillips Serv. Indus., Inc. v. BCBSM*, Case No. 2:17-cv-12652 (E.D. Mich. Aug. 11, 2017); *Gardner White Furniture Co., Inc. v. BCBSM*, Case No. 2:17-cv-12651 (E.D. Mich. Aug. 11, 2017); *N-K Mfg. Tech., LLC v. BCBSM*, Case No. 2:17-cv-12650 (E.D. Mich. Aug. 11, 2017); *Mayco Int'l, LLC v. BCBSM*, Case No. 2:17-cv-12649 (E.D. Mich. Aug. 11, 2017); *Hillsdale Coll. v. BCBSM*, Case No. 2:17-cv-12648 (E.D. Mich. Aug. 11, 2017); *Imlach Movers, Inc. v. BCBSM*, Case No. 2:17-cv-12645 (E.D. Mich. Aug. 11, 2017); *Oakland Stamping, LLC v. BCBSM*, Case No. 2:17-cv-12638 (E.D. Mich. Aug. 11, 2017); *Auto Club Ins. Ass'n v. BCBSM*, Case No. 2:17-cv-12640 (E.D. Mich. Aug. 11, 2017); *L.E. Jones Co., LLC v. BCBSM*,

Case No. 2:17-cv-12635 (E.D. Mich. Aug. 11, 2017); *Lear Corp. v. BCBSM*, Case No. 4:17-cv-12634 (E.D. Mich. Aug. 11, 2017); *Optimal Comput. Aided Eng'g v. BCBSM*, Case No. 2:17-cv-12633 (E.D. Mich. Aug. 11, 2017); *Healthsource Saginaw, Inc. v. BCBSM*, Case No. 1:17-cv-12632 (E.D. Mich. Aug. 11, 2017); *Artiflex Mfg., LLC. v. BCBSM*, Case No. 2:17-cv-12616 (E.D. Mich. Aug. 10, 2017); *Williams Chevrolet, Inc. v. BCBSM*, Case No. 2:17-cv-12606 (E.D. Mich. Aug. 9, 2017); *Plastomer Corp. v. BCBSM*, Case No. 2:17-cv-12605 (E.D. Mich. Aug. 9, 2017); *Gen. Die Casting Co. v. BCBSM*, Case No. 2:17-cv-12604 (E.D. Mich. Aug. 9, 2017); *Wendricks Truss, Inc. v. BCBSM*, Case No. 2:17-cv-12603 (E.D. Mich. Aug. 9, 2017); *W & P Mgmt. LLC v. BCBSM*, Case No. 4:17-cv-12602 (E.D. Mich. Aug. 9, 2017); *Trans-Matic Mfg. Co. v. BCBSM*, Case No. 2:17-cv-12601 (E.D. Mich. Aug. 9, 2017); *Ross Educ., LLC v. BCBSM*, Case No. 2:17-cv-12600 (E.D. Mich. Aug. 9, 2017); *Ritsema Assoc. v. BCBSM*, Case No. 2:17-cv-12596 (E.D. Mich. Aug. 9, 2017); *Rhema Holdings, LLC v. BCBSM*, Case No. 2:17-cv-12595 (E.D. Mich. Aug. 9, 2017); *Unified Brands, Inc. v. BCBSM*, Case No. 1:17-cv-12594 (E.D. Mich. Aug. 9, 2017); *Husky Envelope Prod. v. BCBSM*, Case No. 2:17-cv-12592 (E.D. Mich. Aug. 9, 2017); *Bruinsma ex. rel. Fuel Sys., Inc. v. BCBSM*, Case No. 2:17-cv-12585 (E.D. Mich. Aug. 9, 2017); *Decorative Panels Int'l, Inc. v. BCBSM*, Case No. 1:17-cv-12584 (E.D. Mich. Aug. 9, 2017); *Anchor Lamina Am., Inc. v. BCBSM*, Case No. 2:17-cv-12583 (E.D. Mich. Aug. 9, 2017); *Delta Faucet Co. v. BCBSM*, Case No. 2:17-cv-12582 (E.D. Mich. Aug. 9, 2017); *Ajax Paving Indus., Inc. v. BCBSM*, Case No. 2:17-cv-12581 (E.D. Mich. Aug. 9, 2017); *Pontiac Coil, Inc. v. BCBSM*, Case No. 2:17-cv-11561 (E.D. Mich. May 16, 2017); *G & R Felpausch Co. v. BCBSM*, Case No. 2:17-cv-10691 (E.D. Mich. Mar. 6, 2017); *Bruinsma ex rel. Hastings Mfg. Co. v. BCBSM*, Case No. 2:17-cv-10135 (E.D. Mich. Jan. 16, 2017); *Heartland Emp. Serv., LLC. v. BCBSM*, Case No. 2:16-cv-14486 (E.D. Mich. Dec. 29, 2016); *Fitness Mgmt. Corp. v. BCBSM*, Case No. 4:16-cv-14004 (E.D. Mich. Nov. 10, 2016); *Burton Indus., Inc. v. BCBSM*, Case No. 4:16-cv-13819 (E.D. Mich. Oct. 27, 2016); *Loeks Theatres, Inc. v. BCBSM*, Case No. 4:16-cv-13554 (E.D. Mich. Oct. 4, 2016); *Warren Indus., Inc. v. BCBSM*, Case No. 4:16-cv-13183 (E.D. Mich. Sept. 2, 2016); *FIAMM Tech., LLC v. BCBSM*, Case No. 2:16-cv-13182 (E.D. Mich. Sept. 2, 2016); *Barker Mfg. Co. v. BCBSM*, Case No. 5:16-cv-13132 (E.D. Mich. Aug. 30, 2016); *Sur-Flo Plastics and Eng'g, Inc. v. Blue Cross Blue Shield of Michigan*, Case no. 5:16-cv-12958 (E.D. Mich. Aug. 15, 2016); *Comau LLC v. BCBSM*, Case No. 2:16-cv-12870 (E.D. Mich. Aug. 5, 2016); *Atlas Tool, Inc. v. BCBSM*, Case No. 2:16-cv-12488 (E.D. Mich. Jul. 1, 2016).

cherry-pick two cases out of this history of litigation—when, if anything, *Tiara Yachts* in the Western District is the outlier—is a seriously disingenuous representation of the chronology of ERISA fee litigation against BCBSM in the Eastern District. In no way, shape, or form is *Tiara Yachts* the "first" case redressing ERISA fee violations perpetrated by BCBSM. Indeed, *each* of these prior cases, *supra* n. 2, involved allegations that BCBSM violated ERISA, and at no point during *any* of these cases has BCBSM sought to transfer venue to the Western District. Instead, each case was commenced and concluded in the Eastern District.

BCBSM misstates the chronology of events. The "first" case here is not *Tiara Yachts* at all, but any number of other, independent ERISA cases that have all taken place in the Eastern District of Michigan. *See supra* n. 2. Taken altogether, the chronology of events disfavors application of the first-to-file rule.

2. The Similarity of the Parties Involved.

The first-to-file rule only applies "when the parties in the two actions substantially overlap[.]" *Baatz*, 814 F.3d at 790 (internal citations and quotations omitted); *see also Certified Restoration*, 511 F.3d at 551 (requiring "nearly identical parties"). On this factor, BCBSM's motion dispositively fails.

Plaintiffs in the present action seek to represent a class consisting of "All Self-Funded Plans and their Plan Sponsors from whom BCBSM has collected any SSP fees." Amended Compl., ¶ 147 (ECF No. 23, PageID.283). "Excluded from the

Class are: (1) BCBSM and any entities in which BCBSM has a controlling interest; and (2) Self-funded Plans and their Plan Sponsors that have pending or resolved litigation against BCBSM related to BCBSM's SSP fees." *Id.*, ¶ 150 (PageID.284). In its separate action, Tiara Yachts has advanced its own, individual claims against BCBSM for misconduct solely with respect to its self-funded plan, in part involving BCBSM's SSP fees. **Exhibit B**. Accordingly, Tiara Yachts has pending litigation that does not fall within the putative class definition set forth by Plaintiffs. The two cases involve separate and dissimilar parties, making application of the first-to-file rule inappropriate.

Arguing that the parties are "nearly identical," BCBSM nevertheless maintains that "Tiara Yachts . . . would be a member of the putative class on whose behalf the Wesco Plaintiffs bring their claims (unless one of the exclusions applies)" (ECF No. 20, PageID.116). Not only is this assertion incorrect, as Tiara Yachts is excluded from the present class due to its pending claim against BCBSM related to BCBSM's SSP fees, but it directly contradicts BCBSM's own representations to the court in *Tiara Yachts*. Indeed, BCBSM has represented to that court that Tiara Yachts' claims should be dismissed, as Tiara Yachts purportedly signed a release which should resolve the ongoing litigation. **Exhibit C**, p. 4. Even if *Tiara Yachts* was somehow no longer pending litigation, BCBSM's contention that Tiara Yachts has signed a purported release—and that BCBSM is accordingly entitled to

dispositive relief—means that the claim has ostensibly been "resolved" and is therefore excluded from the present class definition. In either case, Tiara Yachts does not fall within the Class. The parties are thus dissimilar and should not be transferred to the Western District.

Regardless, the mere prospect of belonging to another proceeding's class is insufficient to find similarity of the parties under the first to file rule. *See Cheslek v. Encore Cap. Grp., Inc.*, No. 1:16-CV-1183, 2017 WL 7362749, at *1 (W.D. Mich. Feb. 3, 2017) ("As for the second factor, unless and until the *Newman* class is certified by the Eastern District of Michigan, Plaintiff is not a party to that case merely by virtue of being within the putative class."). Indeed, BCBSM's own motion relies on case law that holds as much. *Baatz v. Columbia Gas Transmission, LLC*, 814 F.3d 785, 790 (6th Cir. 2016) ("[Plaintiffs] are correct that, unless and until the [ ] class is certified by the Southern District of Ohio, they are not parties to that case merely by virtue of being within the putative class."). Here, the Class has not yet been certified and, therefore, Tiara Yachts—even if it did fall under the Class as defined—has no interest in the present dispute. Of course, it is also entirely possible that Tiara Yachts would exercise its right to opt out of the class and pursue its own, independent claims. BCBSM therefore fails to demonstrate any "nearly identical" parties under the second factor. *Certified Restoration*, 511 F.3d at 551.

3. The Similarity of the Issues or Claims.

As with the first two first-to-file factors, the third factor is also not met. "The third factor to evaluate in the first-to-file rule is the similarity of the issues or claims at stake." *Baatz*, 814 F.3d at 791. The issues in the two proceedings "need [to] substantially overlap", "be materially on all fours," and "have such an identity that a determination in one action leaves little or nothing to be determined in the other." *Heyman v. Lincoln Nat'l Life Ins. Co.*, 781 F. App'x 463, 477 (6th Cir. 2019) (internal citation and quotation omitted).

BCBSM argues this factor is met because both plaintiffs "assert similar claims based on BCBSM's administration of the SSP," and "Wesco Plaintiffs acknowledge this similarity by citing and referencing the Sixth Circuit's *Tiara Yachts* decision throughout their complaint and contend that it is preclusive on multiple issues." Mtn. to Transfer (ECF No. 20, PageID.117). That is wrong.

First, under BCBSM's flawed logic, any federal challenge to the administration of BCBSM's SSP necessarily must be transferred to the Western District for adjudication. Not only is this impracticable, but it also directly conflicts with the Supreme Court's repeated recognition that "[t]he plaintiff is 'the master of the complaint,' and therefore controls much about her suit." *Royal Canin U. S. A., Inc. v. Wullschleger*, 604 U.S. 22, 35 (2025) (quoting *Caterpillar Inc. v. Williams*, 482 U.S. 386, 398-99 (1987)). As master of its complaint, a plaintiff may select

venue, and BCBSM's assertion that the earlier filing of *Tiara Yachts* somehow thwarts unrelated, separate plaintiffs from bringing claims in different federal courts is wrong. In effect, BCBSM argues for necessary joinder of Plaintiffs and their claims with *Tiara Yachts*—something that BCBSM has never raised nor would be able to raise successfully. *See* Fed. R. Civ. P. 19.

Second, *Tiara Yachts'* claims involve a variety of separate BCBSM breaches of fiduciary duties not present in this case. In addition to self-dealing related to the SSP, *Tiara Yachts* also challenges BCBSM's failure to properly process Tiara Yachts' claims, BCBSM's overpayment of claims on behalf of Tiara Yachts' self-funded plan, BCBSM's refusal to provide Tiara Yachts with its full set of claims data, and errors in BCBSM's processing of claims from out-of-state providers relative to Tiara Yachts. *See generally* **Exhibit B**. There is minimal overlap between *those* claims (which are intrinsically specific to Tiara Yachts) and Plaintiffs' present claims dealing with the BCBSM's unlawful retention of SSP fees class-wide. Accordingly, resolution of either case would not "leave[ ] little or nothing to be determined" in the other, as required for a finding of substantial similarity between claims. *Heyman*, 781 F. App'x at 477. BCBSM's broadly painted picture of both cases involving SSP allegations fails to explain how a judgment in either case would fully resolve all the claims in the other case—*because it would not*.

Finally, BCBSM's argument that Plaintiffs' citations to *Tiara Yachts v. BCBSM*, 138 F.4th 457 (6th Cir. 2025), is somehow demonstrative of the similarity of the claims is unfounded. The Sixth Circuit's published decision in *Tiara Yachts* is binding on this Court, as is any other Sixth Circuit opinion. *See e.g.*, *Hall v. Eichenlaub*, 559 F. Supp. 2d 777, 782 (E.D. Mich. 2008) ("[A] district court is bound by the decisions of the Circuit Court of Appeals in which it sits."). BCBSM's manipulation of this fact to contend that "it is easy to imagine the Wesco Plaintiffs and Tiara Yachts seeking to use rulings in one case to advance the interests of the other" is baseless because that doesn't mean the cases have *all* the same or similar claims. (ECF No. 20, PageID. 117). Further, citation of case law by a party in other cases is not a factor considered under the first to file rule. BCBSM has failed to establish that the claims in both cases are "substantially overlap[ping]", "materially on all fours" and "have such an identity that a determination in one action leaves little or nothing to be determined in the other." *Heyman*, 781 F. App'x at 477.

4. Equitable Considerations.

None of the first-to-file factors apply here. And the first to file rule should also independently not be applied given equitable considerations. BCBSM is a Southeast Michigan-headquartered company represented by a Southeast Michigan law firm arguing that a Southeast Michigan federal court is somehow an improper venue. This confounding position is even more astonishing when considering the

extensive list of ERISA cases regarding BCBSM's fees prosecuted by Plaintiffs' counsel against BCBSM that have proceeded in the Eastern District over the past decade. *See supra* n. 2. The availability of witnesses, discovery, and judicial efficiency are best served in the Eastern District. Indeed, at least one class representative and numerous putative class members have only ever dealt or transacted business with BCBSM in the Eastern District of Michigan. BCBSM cannot reasonably assert—while defending hundreds of lawsuits in the Eastern District and being headquartered within walking distance of the courthouse—that venue in the Eastern District is improper. It is abundantly clear that BCBSM's motion is a bad faith attempt to forum shop and forestall Plaintiffs' claims.

This is demonstrated further by BCBSM's conspicuous omission that Wesco currently has *another* action pending against BCBSM ***in the Eastern District***—*Wesco Inc., et al., v. BCBSM*, No. 2:24-cv-12986 (E.D. Mich. Nov. 11, 2024) (Hood, J.)—in which BCBSM has not objected to venue. "Courts have repeatedly warned that the first-to-file rule 'is not a mandate directing wooden application of the rule without regard to extraordinary circumstances, inequitable conduct, bad faith, or forum shopping." *Baatz*, 814 F.3d at 792 (quoting *E.E.O.C. v. Univ. of Pennsylvania*, 850 F.2d 969, 972 (3d Cir. 1998), *aff'd*, 493 U.S. 182 (1990)). Here, BCBSM's bad faith attempt to forum shop dictate maintaining venue here.

Further, BCBSM currently has a second pending motion to dismiss in *Tiara Yachts* and has represented that if that motion should fail, it will file a motion for judgment on the pleadings. **Exhibit C**, p. 4. Likewise, four days after filing this Motion to Transfer, BCBSM (represented by the same counsel) filed a Motion to Stay Discovery in *Tiara Yachts*, arguing that discovery should be stayed or limited because it believes BCBSM is somehow entitled to dispositive relief in that case. *Id.* ("Plaintiff [Tiara Yachts], upon receipt of the final settlement payment, executed a separate **release** in addition to the one included in the parties' contract. . . . If BCBSM's Motion to Dismiss is denied, BCBSM intends to pursue a motion for judgment on the pleadings under Federal Rule of Civil Procedure 12(c) based on, among other things, this **release**.") (emphasis added). BCBSM clearly does not believe that Tiara Yachts has any tenable causes of action and does not intend on adjudicating those claims on the merits. In fact, BCBSM's most recent motion to stay discovery directly conflicts with its representation that transfer would serve "the interests of judicial efficiency and [ ] avoid duplicative discovery and the risk of inconsistent decisions." Mtn. to Transfer (ECF No. 20, PageID.112).

Altogether, BCBSM's motion to transfer is not in the interests of the parties, judicial economy, or the expedient disposition of claims—it is quite the opposite, and only serves to demonstrate BCBSM's ongoing delay and bad faith. Application of the first-to-file rule is therefore inappropriate.

B. BCBSM IS NOT ENTITLED TO TRANSFER UNDER 28 U.S.C. § 1404(A).

BCBSM's request to transfer venue under § 1404(a) is meritless too. "For the convenience of parties and witnesses, in the interest of justice, a district court may transfer any civil action to any other district or division where it might have been brought[.]" 28 U.S.C. § 1404(a). "[U]nless the balance is strongly in favor of the defendant, ***the plaintiff's choice of forum should rarely be disturbed***." *Dowling v. Richardson-Merrell, Inc.*, 727 F.2d 608, 612 (6th Cir. 1984) (emphasis added) (internal citation and quotation omitted); *see also Grand Kensington, LLC v. Burger King Corp.*, 81 F. Supp. 2d 834, 836 (E.D. Mich. 2000) ("[A] court should give deference to a plaintiff's choice of venue.") (internal citation and quotation omitted). Courts consider nine factors when deciding whether to transfer venue:

> (1) the convenience of the witnesses; (2) the location of relevant documents and relative ease of access to sources of proof; (3) the convenience of the parties; (4) the locus of operative facts; (5) the availability of process to compel the attendance of unwilling witnesses; (6) the relative means of the parties; (7) the forum's familiarity with the governing law; (8) the weight accorded the plaintiff's choice of forum; and (9) trial efficiency and the interests of justice, based on the totality of the circumstances.

Amphion, Inc. v. Buckeye Elec. Co., 285 F. Supp. 2d 943, 947 (E.D. Mich. 2003) (internal citation and quotation omitted).

BCBSM bears the burden of demonstrating "fairness and practicality strongly favor the forum to which transfer is sought." *Thomas v. Home Depot U.S.A., Inc.*,

131 F. Supp. 2d 934, 936 (E.D. Mich 2001) (quoting *Rowe v. Chrysler Corp.*, 520 F. Supp 15, 16 (E.D. Mich 1981)). "Mere assertions or speculation, without evidence, are insufficient to meet this burden." *IFL Grp. Inc. v. World Wide Flight Serv., Inc.*, 306 F. Supp. 2d 709, 714 (E.D. Mich. 2004). "[U]nless the balance is strongly in favor of the defendant, the plaintiff's choice of forum should rarely be disturbed." *Reese v. CNH Am. LLC*, 574 F.3d 315, 320 (6th Cir. 2009) (internal citation omitted). Critically, "[m]erely shifting the inconvenience from one party to another does not meet Defendant's burden." *B.E. Tech., LLC v. Groupon, Inc.*, 957 F. Supp. 2d 939, 943 (W.D. Tenn. 2013) (internal citation and quotation omitted).

For the following reasons, BCBSM falls far short of meeting its burden. In fact, in all the years Plaintiffs' counsel has litigated ERISA claims against BCBSM, *supra* n. 2, it is aware of only one instance in which BCBSM sought transfer to the Western District under § 1404(a)—*Grand Traverse Band of Ottawa and Chippewa Indians, and Its Employee Welfare Plan v. BCBSM*, Case No. 14-cv-11349 (E.D. Mich. March 1, 2014). This Court, after reviewing the pleadings and hearing oral argument, ***denied BCBSM's motion***. **Exhibit D**. That same result is warranted here.

1. The Evidentiary Factors Favor Venue in the Eastern District.

Each of the evidentiary factors independently favors this case continuing in the Eastern District. The crux of this case is that BCBSM engaged in impermissible self-dealing through administration of its Shared Savings Program ("SSP") in

violation of ERISA. Amended Compl., ¶¶ 1-12 (ECF No. 23, PageID.250-52). Although the ERISA violations undoubtedly impacted self-funded insurers who engaged BCBSM as its claims' administrator throughout the state, BCBSM's scheme necessarily originated in the Eastern District with BCBSM's high-level employees. The relevant documents and witnesses are therefore in the Eastern District.

In considering which venue is most convenient for material witnesses, "the location of key witnesses is more important than the location of a larger number of less important witnesses." *Crestmark Fin. Corp. v. Omo Sci., Energey & Tech., Inc.*, No. 10-11795, 2010 WL 3702371, at *4 (E.D. Mich. Sept. 16, 2010) (citing *Thomas*, 131 F. Supp. 2d at 937). "Because this factor is so important, parties should provide each witnesses' name and an outline of the material testimony each witness will provide." *Id.* BCBSM fails to discuss *any* specific witnesses, let alone identify what testimony may be provided. For this alone, BCBSM fails to meet its burden. *Id.*

Plaintiffs expect most testimony in this case to come from BCBSM's own current and former employees, the majority of whom work and reside in Southeast Michigan. A non-exhaustive list of such individuals, all located in the Eastern District, is as follows:

EMPLOYEE	POSITION AT BCBS	WORK LOCATION
Marcia Varner	Director, Payment Integrity Operations	Detroit
Paul Ozdarski	Manager, Payment Integrity / recently promoted to Director	Detroit Area
Dianne Malmgren	Manager – Benefit Administration	Detroit
Robert Hopper	Director of Account Services	Detroit

EMPLOYEE	POSITION AT BCBS	WORK LOCATION
Lori Shannon	Former VP Commercial Market Sales	Detroit
Dennis Wegner	Former Key Account Manager	Detroit
David R. Malik	Regional Manager – National Accounts	Detroit
Kimberly Jones Schneider	Director of Payment Integrity Operations and Recoveries	Detroit
Teresa Henry	Data Analyst	Detroit/Hybrid
Allyson Rogers	Director – Payment Integrity Strategy & Operations	Detroit
Marisa Martini	Senior Business Systems Analyst – Payment Integrity Strategy & Operations	Detroit
Jeff Baker	Director – Payment Integrity	Detroit
David Dawson	Director – Payment Integrity	Remote
Zizi Hamawi	Operations Analyst – Payment Integrity	Detroit
Donna Swantek	Manager – Payment Integrity	Detroit
Ronnie Adams	Manager – Payment Integrity	Detroit/Hybrid

These witnesses, who are identified on BCBSM's documents related to its SSP, would testify to BCBSM's intent behind establishing the SSP, its policies related to the SSP, and its SSP fees. Accordingly, BCBSM's argument that a witness may have to travel from Western Michigan to the Eastern District to testify is wrong and is insufficient to demonstrate inconvenience regardless. *See Amphion*, 285 F. Supp. 2d at 947 ("Defendants have not described any particular inconveniences associated with this forum. Although presumably some travel may be required between the districts, the distance between the Southern District of Ohio and the Eastern District of Michigan is not great, particularly in light of modern transportation methods.").

To the extent any witnesses are unwilling to testify, this Court has authority to compel attendance that the Western District does not. As BCBSM notes, Rule 45 provides, "A subpoena may command a person to attend a trial, hearing, or

deposition only as follows: (A) within 100 miles of where the person resides, is employed, or regularly transacts business in person. . . ." Fed R. Civ. P. 45(c)(1)(A). The witnesses Plaintiffs anticipate will testify are in Southeast Michigan (within one hundred miles of the Court). Thus, this Court could compel their attendance to testify should they be unwilling. *Id.* However, the Western District (over one hundred miles from Southeast Michigan) would lack this ability. Notably, BCBSM has not identified any witness who would be unwilling to attend proceedings in the Eastern District, conceding this point. *Performance Contracting, Inc. v. DynaSteel Corp.*, No. 12-10165, 2012 WL 1666394, at *7 (E.D. Mich. May 9, 2012) ("Because Defendants have not identified any witness who resides outside of the 100-mile subpoena limit of this Court and who is unwilling to incur the burden of traveling to Michigan to testify, they have not met their burden of demonstrating that this favor weighs in favor of transferring the case[.]").

Lastly, most of the relevant documents and exhibits anticipated by Plaintiffs are within the care, custody, and control of BCBSM. *See e.g.*, Amended Compl., ¶ 152 (ECF No. 23, PageID.284) ("The putative class members' identities are readily ascertainable from BCBSM's records within its control."). These documents include BCBSM's SSP policies, SSP reports, customer lists, and internal communications involving implementation and administration of the SSP. BCBSM's headquarters, in-house counsel, and present counsel (locations where these records likely exist)

are all located in the Eastern District. And, in the event BCBSM claims the evidence is kept digitally, that similarly weighs against transfer. *Wayne County Employees' Ret. Sys. v. MGIC Inv. Corp.*, 604 F. Supp. 2d 969, 976 (E.D. Mich. 2009) (collecting cases). Each evidentiary factor weighs against transfer to the Western District.

2. The Convenience and Relative Means of the Parties Favors Venue in the Eastern District.

BCBSM is headquartered in Southeast Michigan, as is its in-house counsel and trial counsel. BCBSM cannot genuinely argue that the Eastern District is an inconvenient forum to litigate in. In fact, it routinely does so without objection. *See supra* n. 2.

BCBSM nevertheless claims "[t]ransferring this action to the Western District of Michigan would be more convenient for Wesco employees because it is headquartered there. . . . It would be similarly convenient for BCBSM employees, given that (i) BCBSM has offices in Grand Rapids and (ii) employees at BCBSM . . . are already subject to potential involvement through the Tiara Yachts case." Mtn. to Transfer (ECF No. 20, PageID.121). Each of these positions presents inherently flawed reasoning. On one hand, BCBSM argues the Western District is more convenient for Wesco because it is headquartered there, even though it is of no inconvenience to Plaintiff Wesco to litigate in the venue it selected. In fact, Wesco has another action currently pending in the Eastern District against BCBSM. *See Wesco Inc., et al., v. BCBSM*, No. 2:24-cv-12986 (E.D. Mich. Nov. 11, 2024) (Hood,

J.). Then, BCBSM—*conveniently omitting that it is headquartered and has the vast majority of its employees located in the Eastern District*—states that the Western District would similarly be more convenient for BCBSM. Wesco's counsel frequently litigates in the Eastern District and has local offices in Birmingham, Novi, and Ann Arbor.[3] Thus, the convenience of the parties favors the Eastern District.

This position is reinforced by the relative means of the parties. BCBSM is Michigan's largest insurance company that generates tens of millions of dollars in profits each year. Amended Compl., ¶¶ 35-40 (ECF No. 23, PageID.256-57). Its wealth and ability to litigate regardless of forum bolsters that Plaintiffs' choice of venue should control. Transferring venue would do nothing to protect BCBSM "against the risk that a plaintiff will select an unfair or inconvenient place of trial." *Gen. Motors*, 705 F. Supp. 2d at 752. These factors weigh against transfer.

3. The Eastern District is Familiar with BCBSM's ERISA Violations and Can Efficiently Hear the Present Case.

This Court has previously adjudicated dozens of ERISA claims against BCBSM. *Supra* n. 2. BCBSM's position that, "the familiarity of the *Tiara Yachts* court with the factual allegations will allow it to move the proceedings along more efficiently" omits that *Tiara Yachts* and this case are at the exact same procedural

[3] Moreover, Plaintiff Bavarian Inn has exclusively only dealt with BCBSM in the Eastern District of Michigan.

posture (despite this case being filed approximately three years later). The Western District erroneously granted BCBSM's motion to dismiss, which was unanimously reversed by the Sixth Circuit, and recently remanded to the Western District for further proceedings in May 2025. *Tiara Yachts*, 138 F.4th at 473. Rather than answer the complaint, BCBSM has re-filed a second motion to dismiss that is currently pending in that court. Accordingly, the Western District has no more understanding of the allegations in Tiara Yachts' Complaint than does this Court with respect to Plaintiffs' Complaint. Regardless, *Tiara Yachts* involves additional, separate claims raising separate issues, making any familiarity in *Tiara Yachts* of no value. There is no "risk of inconsistent rulings," as BCBSM posits. (ECF No. 22, PageID.122). The actions are separate and will continue as such through judgment.

Regarding trial efficiency, keeping the actions separate is the best course of action. BCBSM notes that the time intervals from filing to disposition are roughly the same in the Eastern District and Western District. *Id.* (PageID.123). This alone undercuts BCBSM's request for transfer on efficiency, and, in any event, BCBSM's actions show it wants anything *but* efficiency. While requesting this Court transfer Plaintiffs' case to the Western District (due to *Tiara Yachts* currently pending there), BCBSM has maintained that it is insistent on delaying and stalling that case. *See* **Exhibit C**, p. 4. ("If BCBSM's Motion to Dismiss is denied, BCBSM intends to pursue a motion for judgment on the pleadings under Federal Rule of Civil

Procedure 12(c)[.]"). BCBSM has no intention of adjudicating the merits of *Tiara Yachts*, instead filing a motion to dismiss and to stay discovery and threatening a motion for judgment on the pleadings after that. Submitting Plaintiffs to the procedural and dilatory morass BCBSM is creating in *Tiara Yachts* would only frustrate Plaintiffs ability to advance their own claims. Thus, these factors weigh against transfer.

4. Plaintiffs' Choice of Forum Should Not be Disturbed.

Plaintiffs are the masters of their complaint and can control much of their suit, including venue. *See Royal Canin U. S. A., Inc.*, 604 U.S. at 35. "One of the most significant factors in considering whether venue should be transferred is the plaintiff's choice of forum." *Steelcase Inc. v. Smart Techs. Inc.*, 336 F. Supp. 2d 714, 720 (W.D. Mich. 2004). Plaintiffs' selection of the Eastern District as its chosen venue is "entitled to substantial consideration in balancing the § 1404(a) factors." *Id.*

Instead of giving deference to Plaintiffs' chosen venue, BCBSM somehow faults Plaintiffs for bringing this lawsuit against BCBSM in BCBSM's home forum. There is no contention that venue is improper here—only that, for ostensible convenience or otherwise, judicial economy is better served in the Western District. BCBSM has wholly failed to provide substantive reasons in favor of transfer, and, accordingly, Plaintiffs' choice of forum should be given controlling weight. Clearly, BCBSM's cursory discussion of the "factors" and misrepresentations fail to meet its

burden of showing that fairness and practicality "strongly favor the forum to which transfer is sought." *Thomas*, 131 F. Supp. at 941.

"When a defendant moves to change the forum, he must overcome the presumption that the plaintiff has chosen the proper forum." *Grand Kensington*, 81 F. Supp. 2d at 836 (internal citation and quotation omitted). Given BCBSM attempts to omit facts to pigeonhole this matter into the first to file rule and otherwise misrepresent the convenience of the Eastern District, BCBSM has failed to overcome this presumption. *See id.* BCBSM—a Southeast Michigan-based company with Southeast Michigan-based counsel—should litigate this matter in Southeast Michigan, in Plaintiff's chosen venue of the Eastern District of Michigan.

IV. CONCLUSION

Based on the foregoing, Plaintiffs respectfully request that the Court deny BCBSM's Motion to Transfer Case.

Respectfully submitted,

Dated: July 28, 2025

By: */s/ Aaron M. Phelps*

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CERTIFICATE OF SERVICE

I certify that on July 28, 2025, I electronically filed this document with the Clerk of the Court using the ECF system, which will send notification of the filing to all ECF filing participants.

By: */s/ Aaron M. Phelps*
Aaron M. Phelps (P64790)

EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TIARA YACHTS, INC.,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

_____/

CASE No. 1:22-cv-603

HON. ROBERT J. JONKER

ORDER

INTRODUCTION

In 2006, Tiara Yachts, Inc. ("Tiara Yachts") contracted with Blue Cross Blue Shield of Michigan ("BCBSM") to process claims and otherwise administer its self-insured employee health benefit plan. The two companies did business together under a series of Administrative Services Contracts ("ASCs") until Tiara Yachts terminated the contractual relationship at the end of December 2018. During the contractual relationship, BCBSM reviewed the healthcare claims submitted by Tiara Yachts' beneficiaries and paid those claims.

Four years after ending the contractual relationship, Tiara Yachts filed this action alleging that BCBSM breached its ERISA fiduciary duties in processing some claims. The claim is not that BCBSM short-changed beneficiaries or providers, or that it wrongfully kept money for itself that should have been used to pay claims. Rather, Tiara Yachts says BCBSM paid providers more for some claims that it should have. Even here the claim is not that BCBSM paid more than the providers actually charged, but rather that the provider should have charged less and BCBSM

should have known that. Tiara Yachts also claims that BCBSM may not have maintained sufficient data to review its past work under the contractual relationship, and that BCBSM ultimately developed a premium servicing program that would have rewarded BCBSM for catching mistakes it should not have made in the first place, allegedly in violation of ERISA.

All this sounds more like an ordinary contract dispute than an ERISA fiduciary duty case. Tiara Yachts wants money back in its own coffers based on what it says was poor performance by BCBSM under the contract. A win for Tiara Yachts here does not augment the resources of any ERISA plan—indeed, the Plan itself is not even a party and Tiara Yachts is not asking in its Complaint for anything on behalf of the Plan itself. A win for Tiara Yachts here does nothing to provide beneficiaries or providers with more health benefits or payments for services than they have already received. All a win for Tiara Yachts does here is take money from BCBSM and put it in Tiara Yachts' own accounts based on claims that BCBSM performed poorly under the contract of the parties.

That's a matter of contract, not fiduciary duty, and Tiara Yachts had remedies under the ASCs to audit BCBSM's work along the way and recover any improper payments. But rather than avail itself of those mechanisms, or file a contract claim for breach of the ASCs, Tiara Yachts filed this action alleging ERISA violations. BCBSM moves to dismiss because Tiara Yachts' allegations do not demonstrate that BCBSM was functioning as a fiduciary for purposes of ERISA on the challenged conduct. The Court agrees that the allegations set out by Tiara Yachts do not set out an ERISA fiduciary claim. Stripped to essentials, 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. If ultimately established, that may state a claim for breach of contract, not ERISA fiduciary duty.

FACTUAL BACKGROUND

1. The Contractual Relationship

Tiara Yachts offered a self-funded health benefits plan to its employees and their dependents. (Compl. ¶¶ 1, 15-17, ECF No. 1, PageID.1-3).[1] A self-funded plan is one in which the company self-insures the healthcare claims of its employees instead of purchasing an insurance policy from a third party. The company contracts with an administrator to process and pay the claims in exchange for a fee. (*Id.* at ¶ 12). To that end, Tiara Yachts, beginning with its predecessor S2 Yachts, Inc., contracted with BCBSM starting in 2006 to provide administrative services for the plan it sponsored. (*Id.* at ¶ 15).

The parties signed a series of ASCs under which BCBSM served as the plan administrator for the Tiara Yachts sponsored plan. Under the ASCs, Tiara Yachts paid BCBSM a monthly administrative fee, and in exchange BCBSM reviewed claims submitted by plan beneficiaries and processed and paid those claims using the plan's assets. (*Id.* at ¶¶ 18-21). The ASCs included terms, including time limits, that governed any dispute over payments that BCBSM paid to providers out of plan funds. For example, the ASC for the 2016 calendar year provided that Tiara Yachts (or "Group" for purposes of the agreement) was to "notify BCBSM in writing of any Claim that Group disputes within 60 days of Group's access to a paid Claims listing." (2016 ASC, Art. II § D (ECF No. 12-2, PageID.142).[2] The ASC went on to specify that Tiara Yachts could audit

[1] In this, Tiara Yachts qualifies as the plan sponsor. The Plan itself is not a party to this action.

[2] The ASC is attached as an exhibit to the defense brief, it was not included as part of the Complaint. The Complaint, however, makes express references to the ASCs (*see, e.g.*, Compl. ¶¶ 17-18). Accordingly the Court may consider the ASCs without converting the motion to one of summary judgment. *See Weinder v. Klais & Co., Inc.,* 108 F.3d 86, 89 (6th Cir. 1997) (quoting

the claims incurred under the contract at its own expense. (Id. at Art. II § G, ECF No. 12-2, PageID.144). However, these audits were to occur no more than "once every twelve months" and would not include claims "from previously audited periods or Claims paid prior to the last 24 months." (*Id*). The time limitation appears to be due, in part, because of the expressed acknowledgment that claims with incurred dates over two years old were more costly to retrieve than more recent claims. (*Id.*). The parties renewed the ASCs each year until 2018, when Tiara Yachts ended the relationship. (Compl. ¶ 17).

2. The Claims

In this action, Tiara Yachts alleges that BCBSM paid too much out of Plan funds for certain claims it processed during the contractual relationship. The allegations in Tiara Yachts' Complaint largely stem from a complaint made by a former BCBSM employee about how BCBSM, in general, would process certain claims related to self-funded plans. It's not clear, even to Tiara Yachts, whether any of its beneficiaries' claims were affected. But Tiara Yachts says it believes they were. Tiara Yachts identifies areas in which BCBSM allegedly engaged in misconduct: 1) overpayment of claims using standard programming called "flip logic;" (2) deficiencies in handling claims data; and (3) development of a Shared Savings Program that allegedly constitutes a prohibited transaction under ERISA.

A. "Flip Logic"

Tiara Yachts first contends that BCBSM maintained an internal policy known as "flip logic" that allegedly resulted in the payment of too much money to certain providers. (Compl. ¶¶ 48-49). The payments were not more than the provider billed, but were at rates higher than the

Venture Assocs. Corp. v. Zenith Data Sys. Corp., 987 F.2 429, 431 (7th Cir. 1993) ("[D]ocuments that a defendant attaches to a motion to dismiss are considered part of the pleadings if they are referred to in the plaintiff's complaint and are central to [the plaintiff's] claim.")).

provider should have billed, and BCBSM should have known. In particular, when beneficiaries of the Tiara Yachts' sponsored plan visited healthcare providers that were participating providers who had agreed to accept lower negotiated rates, the beneficiaries would sometimes also receive services from associated providers that were not participating providers with BCBSM-negotiated rates. These services often related to things like lab work, and x-rays, though Tiara Yachts asserts it also extended to hospital stays and office visits. When claims from these non-participating providers were submitted to BCBSM, Tiara Yachts alleges BCBSM would then "flip" the non-participating provider claims to process the claims at rates actually charged, rather than the lower BCBSM-negotiated rate for participating providers. (Compl. ¶¶ 48-51). The end result, Tiara Yachts asserts, was that BCBSM would pay whatever the non-participating provider charged, often at much higher rates than those available from participating providers. Tiara Yachts argues it should have been paying for these claims at a lower rate. (*Id.* at ¶ 54).[3]

B. Claims Data

Another category of alleged misconduct identified by Tiara Yachts is BCBSM's handling of claims data. Here Tiara Yachts argues BCBSM made improper payments on claims that were submitted with various flaws or deficiencies in the claims. These deficiencies include missing provider information, missing payee information, rolled-up financials, financials that do not reconcile, claims showing as rejected but still paid, missing fields, or fields affected by "flip logic."

[3] BCBSM does not disagree that "flip logic" was a part of the programming that BCBSM used to process certain claims from providers, though it disputes some of the characterizations that Tiara Yachts makes about the programming based the materials attached to Tiara Yachts' Complaint. (ECF No. 1-4, PageID.41). Moreover, it asserts there is good reason for the program. It uses "flip logic" to pay the full amount of the claim regardless of whether the claim is from a participating provider at lower rates, or a non-participating provider at higher rates. This allows BCBSM to avoid balance billing Plan beneficiaries for the higher charges. And this, in turn, ensures timely and uninterrupted healthcare for the beneficiaries. To the extent there are any factual disputes here, the Court accepts as true the allegations in the Complaint for purposes of deciding the motion.

(Compl. ¶ 93). All this, Tiara Yachts asserts, rendered it difficult, if not impossible, to determine after the fact whether claims were properly paid. Tiara Yachts further alleges that BCBSM should not have allowed claims that contain the various deficiencies described.

Tiara Yachts does not allege that any of these deficiencies were actually present in claims that BCBSM paid out of its sponsored plan assets. Nor does it identify a specific claim it argues was improperly paid. Rather, it asserts that BCBSM has exclusive control over claims data that amounts to a tool that BCBSM can utilize to conceal misconduct. (Compl. ¶ 91). Based on the former employee's complaint about general practices and customers other than Tiara Yachts, Tiara Yachts argues these are errors that were regularly made to customers like Tiara Yachts, and therefore must be out there, waiting to be discovered. (*Id.* at ¶ 108).

C. Shared Savings Plan

The third category of errors identified by Tiara Yachts relates to a Shared Savings Program maintained by BCBSM beginning in the 2018 calendar year. Tiara Yachts was only a part of the program for the last year of the contractual relationship, and there is no claim the Program resulted in any direct impact to Tiara Yachts. Even so, Tiara Yachts argues that the program constituted a prohibited transaction under ERISA. (Compl. ¶ 71). As set out in an FAQ document attached to Tiara Yachts' Complaint, the Shared Savings Program either avoided or recovered savings for BCBSM customers with BCBSM retaining or "sharing" a portion of the savings. (ECF No. 1-6, PageID.52). BCBSM worked with two third-party vendors to help run the program. (Compl. ¶¶ 73, 77). Under the program, for any improper payments avoided or recovered, BCBSM retained thirty percent of the saved funds as its share. (*Id.* at ¶ 83). Tiara Yachts agreed to this term in the 2018 Amendment to the ASC (ECF No. 12-4, PageID.158) and Schedule to the 2018 ASC. (ECF No. 12-5, PageID.161).

Tiara Yachts maintains that participation in the Shared Savings Plan for self-insured customers like itself was required. (Compl. ¶ 81). It further contends the Shared Savings Plan created a perverse incentive for BCBSM under which 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." (Compl. ¶ 84). There is no allegation that BCBSM recovered or avoided any such funds for Tiara Yachts or that BCBSM itself retained any such funds, nor is there any allegation that BCBSM had exclusive or unilateral control over the program.

PROCEDURAL HISTORY

Tiara Yachts filed this action on July 1, 2022. (ECF No. 1). The Complaint contains two counts: Count I asserts a claim for breach of fiduciary duty under ERISA based on the flip logic and claims data flaws as alleged. Count II asserts an ERISA claim of engaging in a prohibited transaction, namely the Shared Savings Program. (ECF No. 1).

On August 25, 2022, BCBSM moved to dismiss under FED. R. CIV. P. 8, 9(b) and 12(b)(6). In the main, BCBSM argues that this is nothing more than a contractual dispute and that Tiara Yachts has failed to state a claim under ERISA. (ECF No. 11). Tiara Yachts filed a response in opposition to the motion (ECF No. 16) and BCBSM has replied. (ECF No. 18). The Court heard argument on the motion on November 15, 2022, and thereafter took the matter under advisement. The matter is ready for decision.

LEGAL STANDARDS

Rule 8(a)(2) of the Federal Rules of Civil Procedure requires only a "short and plain statement" of a claim designed to "give the defendant fair notice" of the claim against him. *Conley v. Gibson*, 355 U.S. 41, 47 (1957). But the Supreme Court has clarified that to meet that standard

and survive a Rule 12(b)(6) motion to dismiss, a complaint must allege sufficient facts to "raise a right to relief above the speculative level." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007). *Twombly* did not change the notice-pleading standard; "detailed factual allegations" are still not necessary, but the Supreme Court did hold that a plaintiff's complaint must contain "more than labels and conclusions." *Id.* In so holding, the Court took a step away from the long-standing "no set of facts" standard established by *Conley*. *Conley*, 355 U.S. at 45-46 ("[A] complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief."). Indeed, the Court found that "*Conley*'s 'no set of facts' language had been questioned, criticized, and explained away" such that "this famous observation had earned its retirement." *Twombly*, 550 U.S. at 563.

Accordingly, in considering a motion to dismiss under Rule 12(b)(6), the court construes the complaint in the light most favorable to the plaintiff; accepts as true the plaintiff's factual allegations; and determines whether the complaint "contain[s] sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (internal quotation and citation omitted). "A claim has facial plausibility when the plaintiff pleads factual conduct that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* If "the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint . . . has not show[n] that the pleader is entitled to relief.'" *Iqbal*, 556 U.S. at 679 (quoting FED. R. CIV. P. 8(a)(2)).

The more rigorous pleading standards of Rule 9(b) apply to a plaintiff's claims based on fraud. Under Rule 9(b), "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." To allege fraud with particularity, a plaintiff must, at a minimum, "allege the time, place, and content of the alleged misrepresentation on which her

or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud." *United States ex. rel. Bledsoe v. Cmty. Health Sys., Inc.*, 342 F.3d 634, 643 (6th Cir. 2003) (internal quotation marks omitted).

DISCUSSION

1. Tiara Yachts' Complaints Are About BCBSM as a Contractor, Not a Fiduciary.

"A threshold issue" in cases like this, is whether BCBSM "functioned as an ERISA fiduciary." *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751 F.3d 740, 744 (6th Cir. 2014). ERISA provides that:

> a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan *or* exercises any authority or control respecting management or disposition of its assets, ... or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Id. (quoting 29 U.S.C. § 1002(21)(A).

The complained of actions within Tiara Yachts' Complaint alleging that BCBSM acted as a fiduciary fail to survive Rule 12 scrutiny. This is, at bottom a contractual dispute. Tiara Yachts and BCBSM agreed via the ASCs that BCBSM would process and pay out of Plan funds those claims submitted by providers. There is no dispute that BCBSM in fact did that. Tiara Yachts' core complaint is that BCBSM paid out more than it should have on some claims, particularly for non-participating providers that had not pre-negotiated rates with BCBSM as part of its regular "flip logic" system. But this complaint is plainly covered by the contractual duties of the ASCs, and the provisions within them for auditing and disputing overpayments in claims processing. *See* 2016 ASC, Art. II §§ D, G (ECF No. 12-2, PageID.142). Tiara Yachts' allegations regarding claims processing, claims data, and the Shared Savings Program fail to state a claim of breach of fiduciary duty and, if actionable at all, are fully matters of contract.

A. Flip Logic and Claims Processing

Tiara Yachts' complaints about flip logic and claims processing challenge decisions BCBSM made as a contractor, not a fiduciary. Tiara Yachts recognizes BCBSM paid actual claims at the actual rates charged by actual providers for services actually provided to Plan beneficiaries. Tiara Yachts does not assert that BCBSM retained Plan funds for itself that it should have paid; rather it simply complains that BCBSM paid some of the providers too much. Furthermore, the specific things Tiara Yachts complains about—flip logic, upcoding or unbundling claims, improper coding, etc.—are all a systemwide BCBSM method for paying providers, not some individual exercise of discretion. And Tiara Yachts' Complaint is clear that its complaints are part of overarching business dealings. In fact, Tiara Yachts' explanation for having no specific examples to show the Court now, but being confident it will find them later, depends on these being systemwide BCBSM practices. These are not ERISA fiduciary duty violations, but simply complaints about BCBSM as a contractor. *See DeLuca v. Blue Cross Blue Shield of Michigan*, 628 F.3d 743, 747 (6th Cir. 2010) ("We conclude . . . that BCBSM was not acting as a fiduciary when it negotiated the challenged rate changes, principally because those business dealings were not directly associated with the benefits plan at issue here but were generally applicable to a broad range of health-care consumers.").

Tiara Yachts disputes that *DeLuca* applies. It says it is not challenging BCBSM's negotiation of rates with providers, but rather it is challenging how BCBSM administered the Tiara Yachts' sponsored plan. *See id.* ("[I]n determining liability for an alleged breach of fiduciary in an ERISA case, the courts 'must examine the conduct at issue to determine whether it constitutes 'management' or 'administration' of *the plan*, giving rise to fiduciary concerns, or merely a business decision that has an effect on an ERISA plan not subject to fiduciary standards.") (quoting

Hunter v. Caliber Sys., Inc., 220 F.3d 702, 718 (6th Cir. 2000) (emphasis in *DeLuca*)). As an example, Tiara Yachts contends it is not contesting the negotiation BCBSM had with providers on the rate it would pay for applying a bandage, but rather is challenging an administrative decision that BCBSM allegedly made to process "up-coded" claims that charged an exorbitant amount for applying the bandage. (ECF No. 16, PageID.197-198). Tiara Yachts points to *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751 F.3d 740 (6th Cir. 2014) and *Pipefitters Loc. 636 Ins. Fund v. Blue cross Blue Shield of Michigan*, 722 F.3d 861, 867 (6th Cir. 2013) for the assertion that the Sixth Circuit has already decided that BCBSM acts as an ERISA fiduciary when administering self-funded plans.

Yet, "[t]he Supreme court has recognized that ERISA 'defines 'fiduciary' not in terms of formal trusteeship, but in *functional* terms of control and authority over [a] plan.'" *DeLuca*, 628 F.3d at 747 (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993)) (emphasis and brackets in *Deluca*). Accordingly, "in determining liability for an alleged breach of fiduciary duty in an ERISA case, the courts 'must examine the conduct at issue to determine whether it constitutes 'management' or 'administration' of *the plan* giving rise to fiduciary concerns, or merely a business decision that has an effect on an ERISA plan not subject to fiduciary standards." *Id.* (quoting *Hunter v. Caliber Sys., Inc.*, 220 F.3d 702 (718) (6th Cir. 2000) (emphasis in *DeLuca*). Here, the system-wide business decisions that Tiara Yachts identifies plainly fall into the latter category. As Tiara Yachts' own allegations recognize, it's the way BCBSM ran its overall claims processing operation, not specific decisions made about the Tiara Yachts' sponsored Plan in particular, that are at the root of the claimed problems. The Court thus determines that Tiara Yachts has not stated a *Twombly*-plausible claim that BCBSM acted as a fiduciary with respect to

the claims processing complaints at issue here. The remedy for any mistake BCBSM made is in contract.

Beyond that, the Complaint is sparse on alleged facts that would make up a fiduciary duty and breach. Tiara Yachts suggests there is a possibility that BCBSM's claims processing system meant that it processed Tiara Yachts' claims with improper codes or clinical edits, but it has not identified any actual claim that BCBSM paid out that suffers from these alleged deficiencies. This is too speculative a basis on which to proceed, and it again relies on an alleged systemic business practice, not a discrete discretionary call. Principles of *Twombly* and *Iqbal* require more for a viable fiduciary duty claim.

B. Claims Data

The same result follows with respect to the Tiara Yachts' claims regarding claims data. As BCBSM points out, Tiara Yachts' complaint here is largely based on conjecture. It asserts, for example, that "Tiara Yachts' claim data should reflect all information necessary to ascertain whether a claim was properly processed and/or paid. To the extent it does not, BCBSM's failure to collect and/or maintain such data would itself be a breach of fiduciary duty." (Compl. ¶ 92, ECF No. 1, PageID.13). The Complaint then proceeds to explain what the data deficiencies "may" include, such as missing provider and payee information, claims that are altogether missing, or claims that have financials that do not reconcile. (*Id.* at ¶ 93).

These assertions fail to meet Rule 8's pleading requirements and the "sufficient facts" necessary to survive a Rule 12(b)(6) motion under *Twombly*. "The ability to plead hypothetically is not so broad as to allow a plaintiff to sue for a hypothetical injury[.]" § 1282 *Alternative and Hypothetical Pleading*, 5 FED. PRAC. & PROC. CIV. § 1282 (4th ed.). Yet this is what Tiara Yacht's Complaint does here. Quoting from circuit caselaw, Tiara Yachts contends *Twombly* and *Iqbal*'s

"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.]'" *Ohio Pub. Emps. Ret. Sys. v. Fed. Home Loan Mortg. Corp.*, 830 F.3d 376, 383 (6th Cir. 2016) (quoting *Twombly*, 550 U.S. at 556). It further says that ERISA complaints must be read with some leniency, since "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). Moreover, according to Tiara Yachts, BCBSM maintains exclusive control over Tiara Yachts' claims data. Relying on cases like *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), it asserts it need not specifically identify the allegedly fraudulent claims prior to discovery.

Grp. 1 Auto., however, demonstrates the differences between ERISA claims that will survive *Twombly* scrutiny and those, like this one, that do not. In *Grp. 1 Auto*, the plaintiff alleged that several indicia of fraudulent or unjustified claims appeared in some of the claims submitted to the administrator. The complaint alleged that the administrator "failed to account for one or more of these characteristics that appeared in many claims" that the administrator paid on behalf of the plaintiff. *Grp. 1 Auto., Inc.*, 2020 WL 8299592, at *3. The Complaint here makes no such assertion. It does not allege, even at a broad level, that there were data deficiencies in the claims processed by BCBSM. Rather, it depends on claims and accusations about BCBSM practices generally, and other BCBSM customers. This is not enough to pass muster under *Twombly* and *Iqbal*.

C. Shared Savings Program

Finally, the Court concludes that BCBSM was not functioning as a fiduciary with respect to the Shared Savings Program. As an initial matter, the parties dispute whether Tiara Yachts must meet the heightened Rule 9(b) pleading standard with respect to this claim. Tiara Yachts says it does not. It contends that this argument has previously been rejected in *Comau LLC v. BCBSM*, No. 19-CV-1263, 2020 WL 7024683 (E.D. Mich. Nov. 30, 2020), where the district court concluded the plaintiff's claim that BCBSM paid inflated healthcare claims on the plaintiff's behalf did not sound in fraud. *Comau* however, did not deal with the Shared Savings Program. Here, the essential claim is that the more BCBSM mismanaged its claim processing, the more money BCBSM stood to recover. In other words, the Complaint alleges that BCBSM developed a scheme by which it intentionally paid inflated claims so that, through the Shared Savings Program, it could skim off a portion under the label of "savings." The Court agrees with BCBSM that this allegation does sound in fraud, and thus Rule 9(b) properly applies.

But whether under Rule 9 or Rule 8, the allegations in Tiara Yachts' Complaint fail to state a viable claim that BCBSM was functioning as a fiduciary here and instead are simple contractual complaints. The ASCs provided that BCBS could retain a contractually fixed percentage of 30% of recovered third-party payments as an administrative fee. In *Seaway Food Town, Inc. v. Med. Mut. Of Ohio*, 347 F.3d 610, 619 (6th Cir. 2003), the circuit held that "where parties enter into a contract term at arm's length and where the term confers on one party the unilateral right to retain funds as compensation for services rendered with respect to an ERISA plan, that party's adherence to the term does not give rise to ERISA fiduciary status unless the term authorizes the party to exercise discretion with respect to that right." The contractually agreed to Shared Savings

Program by BCBSM does not give to rise a fiduciary status because, like in *Seaway Food Town*, there was no BCBSM discretion in administrating the program.

Tiara Yachts insists there was discretion in administrating the program, but these arguments are unavailing. For one thing, the allegations within the Complaint make clear that BCBSM did not act unilaterally. Rather, the Complaint details that the Shared Savings Program contemplates four services and the pleading goes on to describe how the first, second, and fourth services are performed by third party vendors. (Compl. ¶¶ 73-77). BCBSM can hardly be acting unilaterally under such an arrangement. Nevertheless, Tiara Yachts contends BCBSM did retain discretion sufficient to distinguish *Seaway* and to bring this case closer to those cases, like *Hi-Lex*, that have found fiduciary acts. It points to the front end of claims processing, and argues that BCBSM had unilateral control and discretion in a system in which it could knowingly pay improper claims, correct the claim, and then correct a recovery fee. The Court disagrees. There is no assertion within the Complaint that this happened to Tiara Yachts, or that claims processing and data deficiencies were tied in any way to the Shared Savings Program. This does not survive Rule 9, nor does it survive Rule 8.

2. ERISA Does Not Provide a Pathway for the Recovery Tiara Yachts Seeks

Even if Tiara Yachts' Complaint did allege fiduciary acts, the ERISA statute does not provide a pathway for Tiara Yachts to recover on the alleged overpayments because the funds were paid out to providers and do not relate to funds that BCBSM allegedly retained from Plan funds.

A. Section 1132(a)(3)

Section 1132(a)(3) provides that a civil action may be brought under ERISA—

> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress

> such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

Tiara Yachts cannot recover under this section for any overpayments under a straightforward reading of the statute.

In *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002), the Supreme Court made clear that "equitable relief" in Section 1132(a)(3) "must mean *something* less than *all* relief." (citing *Mertens v. Hewitt Associates*, 508 U.S. 248, 258 n.8 (1993)) (emphasis in *Great-West*). Relief under the section, then, "must refer to 'those categories of relief that were *typically* available in equity." *Id.* (citing *Mertens*, 508 U.S. at 256). The Supreme Court explained that relief in equity contemplates funds remaining in the possession of the defendant. *See id.* ("a plaintiff could seek restitution *in equity* . . . where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession."). This is not the case here. The complaint is that BCBSM paid out too much money out of plan funds, not that it retained any funds in its claim processing. There is no fund of Plan money sitting out there for potential disgorgement.

Nevertheless, Tiara Yachts responds that monetary relief is available under Section 1132(a)(3) based on the Supreme Court case *CIGNA Corp. v. Amara*, 563 U.S. 421, 441 (2011). It says that in an ERISA claim against a fiduciary, a plaintiff may obtain "make whole" monetary compensation. The portion of *Amara* that Tiara Yachts relies on is dicta. *See Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 375 n.4 (6th Cir. 2015). And it is inapplicable to this case in any event, because the remedy that Tiara Yachts seeks is not the surcharge that was at issue in *Amara*. In *Amara*, the order at issue required payments to be paid out to beneficiaries according to a reformed plan. This was, the Supreme Court found, consistent with surcharge. But this case is not a case (like those cited by Tiara) where a case is brought by a plan beneficiary against a fiduciary.

The beneficiaries here would not be made whole by the relief sought. They are already whole, and obtained the healthcare coverage they were owed. What Tiara Yachts wants is money back in its own accounts from its former contract partner, BCBSM. Thus the Court determines that Tiara Yachts cannot recover any monetary relief under Section 1132(a)(3) arising out of its claims for overpayments in claims processing.

Nor is any other relief available to Tiara Yachts under this statute because the parties' contractual relationship has ended and thus there is not pathway for prospective relief.

B. 1132(a)(2)

Next BCBSM argues that Tiara Yachts—which is the Plan sponsor and not the Plan itself—cannot recover under Section 1132(a)(2). The Court agrees. Section 1132(a)(2) provides that a civil action may be brought

> by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

Id. Section 1109, in turn, goes on to provide that a fiduciary may be held "personally liable to make good to *such plan* any losses *to the plan* resulting from" a breach of fiduciary duty. 29 U.S.C. § 1109(a). Here, Tiara Yachts cannot recover because Section 1109 authorizes suits for relief to be awarded to an ERISA plan, and so a plan sponsor, like Tiara Yachts, cannot recover on its own behalf under Section 1109.

Tiara Yachts says it can recover under the reasoning of two cases, *Borroughs Corp. v. Blue Cross Blue Shield*, 2012 WL 3887438 (E.D. Mich. 2012) and *Guyan Int'l v. Professional Benefits Administrators, Inc.*, 689 F.3d 793 (Aug. 20, 2012). But as BCBSM persuasively demonstrates in reply, the complaints in both cases demonstrated that the sponsor, or other entity plaintiff, sought recovery on behalf of the plan. In *Guyan* for example, the plaintiffs' complaint expressly stated that action was brought on behalf of each plaintiff's respective plan. *Guyan*, 689 F.3d at 800. This

is not the case here. The Complaint expressly seeks relief for Tiara Yachts, the employer, and not the Plan. Accordingly, the Court concludes that Tiara Yachts cannot recover under this provision either.

3. Time Bar

Finally, BCBSM independently argues that the claims in this case are time barred. Tiara Yachts disagrees. In light of the Court's other rulings, it is not presently necessary to address these issues.

CONCLUSION

Tiara Yachts self-funds an ERISA health plan for its employees. It hired BCBSM to process and pay the claims under a series of contracts. BCBSM did that for a dozen years until Tiara Yachts ended the arrangement in 2018. Tiara Yachts now challenges, for the first time, the business system BCBSM used to process and pay those claims. It did not complain during the life of the contracts or use the contractual audit procedure to check on things along the way. Tiara Yachts says it did not have to do that because these claims amount to breaches of ERISA fiduciary duties. The Court does not agree, but even if it did, the Court would have to dismiss this action because any fiduciary duty recovery must flow to the Plan, not to the Plan sponsor. Yet the Plan is not even a party here and all a win for Tiara Yachts would do is shift money from one contracting party to the other. That is the function of a contract claim, not an ERISA fiduciary duty lawsuit.

ACCORDINGLY, IT IS ORDERED that BCBSM's Motion to Dismiss (ECF No. 11) is **GRANTED.** This case is **DISMISSED.**

Dated: February 27, 2023

/s/ Robert J. Jonker
ROBERT J. JONKER
UNITED STATES DISTRICT JUDGE

EXHIBIT B

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 _____

COMPLAINT

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

NATURE OF ACTION

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

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

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

PARTIES, JURISDICTION AND VENUE

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

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

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

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

GENERAL ALLEGATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. <u>CLAIMS ASSOCIATED WITH OUT-OF-STATE PROVIDERS.</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. BCBSM Further Conceals Its Misconduct By Gatekeeping Information Necessary To Identify Improper Charges.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNT I
Breach of Fiduciary Duty – ERISA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNT II
Engaging in Prohibited Transactions

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

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

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

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

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

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

PRAYER FOR RELIEF

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

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

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

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

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

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

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

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

Respectfully submitted,

VARNUM LLP
Attorneys for Plaintiff

Dated: July 1, 2022

By: */s/ Aaron M. Phelps*

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19294942.4

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TIARA YACHTS, INC.,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

INDEX OF EXHIBITS TO COMPLAINT

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

EXHIBIT A

Message

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

Redacted - Attorney Work Product

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

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

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

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

Rod

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

Meeting recap is below:

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

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

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

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

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

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

2. Impacted group customers should be made aware, educated and their concurrence be documented.
3. Provider outreach to curtail the behavior.

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

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

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

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

N

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

Team:

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

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

Thanks.

Rod

From: Malik, David R.
Sent: Tuesday, September 12, 2017 11:50 AM
To: Begosa, Rod <RBe osa BCBSM.com>
Subject: FW: UTC Labs
Importance: High

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

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

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

David,

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

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

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

Dennis J. Wegner
Account Manager, Key & Large Group Business
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd, Detroit MI 48226 I Mail Code 517D I 313.448.8095 Direct I 586.839.8621 Cell I 866.264.4050 Fax
dwegner@bcbsrn.com

EXHIBIT B

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

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

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

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

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

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

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

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

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

EXHIBIT C

Message

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

Importance: High

All —

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

Background

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

ntly have the capability for providers outside of Michigan.

Issue(s)

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

In 2016, BCBSM processed 30,000 non-par claims at charge when Host pricing was available. The sum of those charges was $30.5M and resulted in a payment amount of $26.7M. With the application of the Host plan pricing, the total allowed amount for these claims would have been $7.1M; a potential savings of $23.OM in benefit costs.

Who Is Impacted?

- BlueCard transactions initiated by non-par providers for 201 customer groups on NASCO Classic with exception of Auto.

- MOS processing is not impacted at large, unless a group made a request for exception processing by means of MOS mod/rider. MOS default logic is to pay "Host allowed."

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

What Has Been Suggested?

1. **Short Term Solution:** Make a global change to discontinue the logic and pay at Host allowed, except for global selection - no choice services. Also allow group customers to opt out on the individual basis, ensuring they fully understand possible consequences, including BCBSM limitation in preventing abusive provider behavior.

2. **Long Term Solution:** implement SBP 18642 BlueCard Non-par Payment that would introduce a robust select criteria for if/when they wish to pay at charge in benefits (currently undergoing feasibility review and estimation). A key business requirement is that the necessary controls are put in place to curtail potential provider fraud and abuse in addition to leveraging host plan allowed amounts.

In counsel with the OGC,1 **Redacted - Attorney-Client Privilege** **Redacted - Attorney-Client Privilege**

4. Provider outreach to curtail the behavior,

5. Member outreach for education.

Business Readiness/What We Need Answers For

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

What Risks Do We Need To Address?

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

R.crb-

Rob Hopper
Director, Group Customer Activation
Group Customer Advocate and Performance

Health Plan Business
Blue Cross Blue Shield of Michigan
Office: 313.448.2339
Mobile: 586.863.6002
Download our mobile app

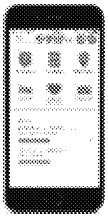


EXHIBIT D

STATE OF MICHIGAN

IN THE WAYNE COUNTY CIRCUIT COURT

DENNIS WEGNER,

Plaintiff

Case No. 2019 - - CD
Hon.

-vs-

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

/

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

/

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

VERIFIED COMPLAINT

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

Jurisdiction and Parties

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

2. Plaintiff Dennis Wegner is a resident of Macomb County.

3. Defendant Blue Cross Blue Shield of Michigan is a Michigan corporation doing business in Wayne County, Michigan.

4. The events giving rise to this cause of action occurred in Wayne County, Michigan.

5. The amount in controversy exceeds $25,000, exclusive of interest, costs, and attorney fees.

Background Facts

6. Plaintiff was an account manager with Defendant corporation for the past 18 years. Plaintiff managed insurance accounts for a number of companies.

7. During his employment a customer alerted Defendant regarding a significant medical claim in excess of $250,000.

8. Plaintiff researched the complaint and discovered that a medical provider was taking advantage of Defendant's claims processing system and overcharging significantly for routine medical testing.

9. By way of example, the medical provider was billing between $5,000 - $15,000 for routine urinalysis that actually costs $10.00 or less.

10. Defendant paid the total amounts billed by the medical provider and charged the customer the amounts billed.

11. Shocked to learn that this customer was being overbilled, Plaintiff conducted additional research and discovered a pattern with other medical providers and over a two-year period Defendant paid over $600,000 for over-charged procedures.

12. Upon bringing Plaintiff to Defendant's attention and with the customer's knowledge of the overbilling, Defendant ultimately did reimburse that customer for the total amount of overbilling, an amount in excess of $600,000.00 for that one customer.

13. Plaintiff was concerned that other customers had been likewise overbilled and forced to pay excess medical fees as a result of Defendant's failure to appropriately oversee the claims.

14. Plaintiff began researching claims and billings for two of his other customers and found similar issues totaling $125,000 and $75,000.

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

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

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

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

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

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

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

Count I:
Violation of Michigan Whistleblowers' Protection Act

22. Plaintiff incorporates by reference paragraphs 1 through 21.

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

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

25. The actions of Defendant were intentional.

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

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

Count II:
Michigan Bullard-Plawecki Employee Right -to -Know-Act

26. Plaintiff incorporates by reference paragraphs 1 through 25.

27. Pursuant to the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501 Plaintiff is entitled to a copy of any information contained in his personnel record.

28. Plaintiff requested his employee file pursuant to the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501 on November 29, 2018.

28. At no time since Plaintiff's request on November 29, 2018, Defendant did not provide Plaintiff an opportunity to review his personnel record.

29. At no time since Plaintiff's request on November 29, 2018, Defendant did not mail Plaintiff his personnel record.

30. Defendant willfully and knowingly violated the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501.

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

a. statutory damages in whatever amount he is found to be entitled;

b. compensatory damages in whatever amount he is found to be entitled;

c. exemplary damages in whatever amount he is found to be entitled

d. judgment for lost wages, past and future, in whatever amount he is found to be entitled

e. an award for the value of lost fringe and pension benefits, past and future

f. an award of interest, costs, and reasonable attorney fees

g. whatever other equitable relief appears appropriate at the time of final judgment

DEMAND FOR JURY TRIAL

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

Respectfully submitted,

Dated: February 5, 2019

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

VERIFICATION

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

Dennis J. Wegner

Dennis Wegner

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

NOTARY PUBLIC
Acting in the County of Oakland

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

EXHIBIT E

ASC Shared Savings | Internal Sales FAQs

SHARED SAVINGS OVERVIEW

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

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

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

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

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

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

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

When will this start for ASC customers?
This new model will start upon renewal with January 1, 2018 effective dates and upon renewal thereafter.

PAYMENT INTEGRITY PACKAGE

What programs is Blue Cross including in the shared savings model?
Initially, Blue Cross is offering a **Payment Integrity** package within the shared savings pricing model.

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

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

What is different about Pre-pay Forensic Bill Review vs. what is already being offered to ASC customers today?
Today, Blue Cross reviews claims prior to payment as part of the base administration fee for self-funded groups, but not itemized provider bills. The high dollar edit reviews we currently perform post payment focus on pricing accuracy rather than billing accuracy.

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

Does Pre-pay Forensic Bill Review include behavioral health?
Yes, for inpatient facilities only.

Since Pre-pay Forensic Bill Review is all about avoidance vs. recovery, how does my customer get the procedure detail?
We are currently working on an inquiry process to handle these requests from your customers.

2. Advanced Payment Analytics. What does it entail?
Advanced Payment Analytics offers advanced data mining capabilities to identify claim overpayments not previously detected and recover the overpayment from providers after payment is rendered. These services will be performed by a 3rd party vendor called Cotiviti.

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

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

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

What is the dollar threshold for Advanced Payment Analytics?
There is no dollar threshold. Cotiviti will review all charges, regardless of dollar amount.

If a customer stays opted in, effective 1/1/18, will Cotiviti review claims prior to this date?
Yes. Reviews will go back 18 — 24 months, retroactive to 1/1/18.

Are pharmacy claims included in Advanced Payment Analytics?
Not now, but this feature is under future consideration.

3. **Subrogation. What does it entail?**
Subrogation involves the detection and recovery of 3rd-party liability claims where a 3rd party is accountable for the expense. Blue Cross currently performs these services in-house today, but is making investments to enhance the program moving forward.

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

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

What is different about Provider Credit Balance Recovery vs. what is already being offered to ASC customers today?
Blue Cross currently performs several post-pay claims review services for ASC customers in Michigan.

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

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

Will Blue Cross be using outside vendors to perform these additional services?
Yes. Blue Cross will be employing the services of outside vendors to deliver incremental value to customers.

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

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

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

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

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

Will this change result in a reduction of administrative fees for ASC customers?
No. The Payment Integrity package represents incremental value to ASC customers for the services offered. There will be no adjustments to the administration fee as a direct result of a group moving to the package.

From a member perspective, what happens if a member has already paid a provider (e.g. member with a high-deductible plan with HSA), and it is determined through these additional reviews that the provider made an error?
Similar to any situation where a provider has overbilled and so forth, the provider would then be responsible for crediting the patient's account or issue a refund check to the member.

ADMINISTRATION

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

Since some of the services offered within the Payment Integrity package are already included in the base admin fee today (e.g. Subrogation), but wouldn't there be an adjustment to the admin fee?
Blue Cross is making these changes to align with what is already happening in the self-funded market. Even considering the changes being made, Blue Cross remains very competitive from a total cost standpoint with our customers. By shifting very focused services to a different pricing model, this helps to ensure Blue Cross can innovate and amplify the savings we deliver to our customers.

Why isn't Blue Cross reducing our admin expense since subrogation will no longer be covered under the ASC agreement?
Blue Cross is focused on introducing new and enhanced programs that will directly bring quantifiable cost savings to our ASC customers.

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

ASC Shared Savings | Internal Sales FAQs

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

Are customers required to participate in all 4 of the services that are part of the Payment Integrity package?
Yes. The Payment Integrity package is offered as a `package,' meaning that it is an all-in deal. The underlying services included in the package cannot be offered in a piecemealed fashion.

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

Is it mandatory for customers to participate?
Yes. To ensure our group customers don't miss out on the value, Blue Cross will automatically opt ASC group customers into the Payment Integrity package.

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

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

How are customers with multi-year contracts to be handled?
ASC customers will have the option of joining the Payment Integrity package now or at the specified contract renewal time.

ASC Shared Savings | Internal Sales FAQs

INVOICING AND REPORTING

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

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

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

How will my customers know they're getting value out of this program?
Each month, Blue Cross will generate detailed reporting to outline costs that were avoided or recovered through the services offered within the Payment Integrity package.

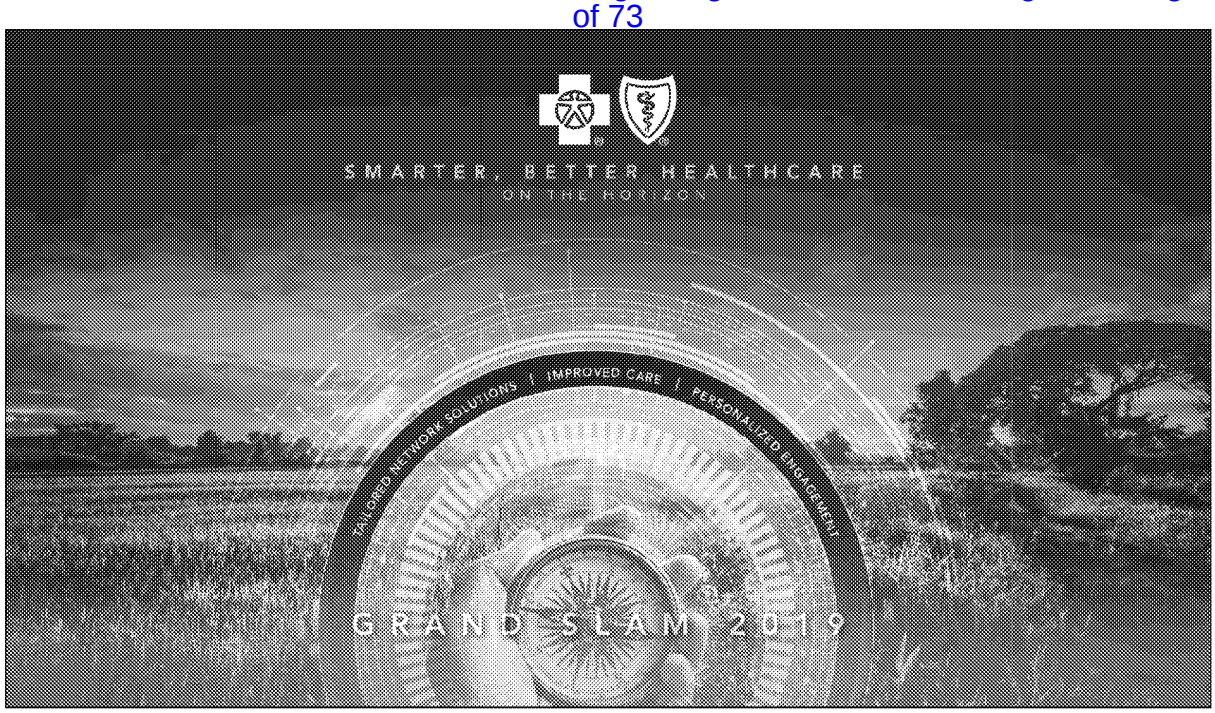
COMMUNICATING THIS TO CUSTOMERS

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

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

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

EXHIBIT F


SMARTER, BETTER HEALTHCARE
ON THE HORIZON
TAILORED NETWORK SOLUTIONS | IMPROVED CARE | PERSONALIZED ENGAGEMENT
GRAND SLAM 2019

Payment Integrity: Ensuring the Accuracy of Claims

Marcia Varner
Director, Payment integfity Operations

Paul Ozdarski
Manager, Payment In€egrity Unit

Jennifer Kuhar
Finess Systems Analyst, Payment it tegrii Operations

Payment integrity program overview

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

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

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

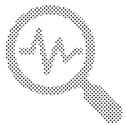
Base savings programs included in administrative *fee:*

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

Payment integrity program overview

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

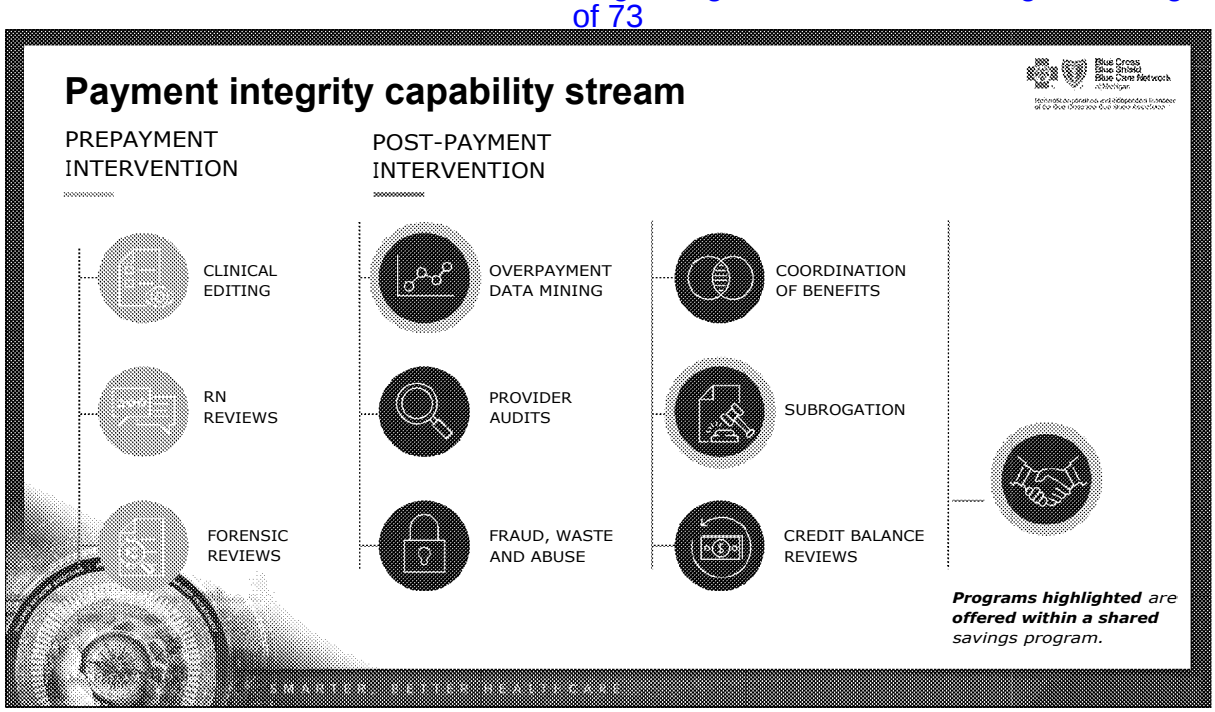
This is a risk-free value proposition as customers will not be charged unless savings are delivered under these programs.

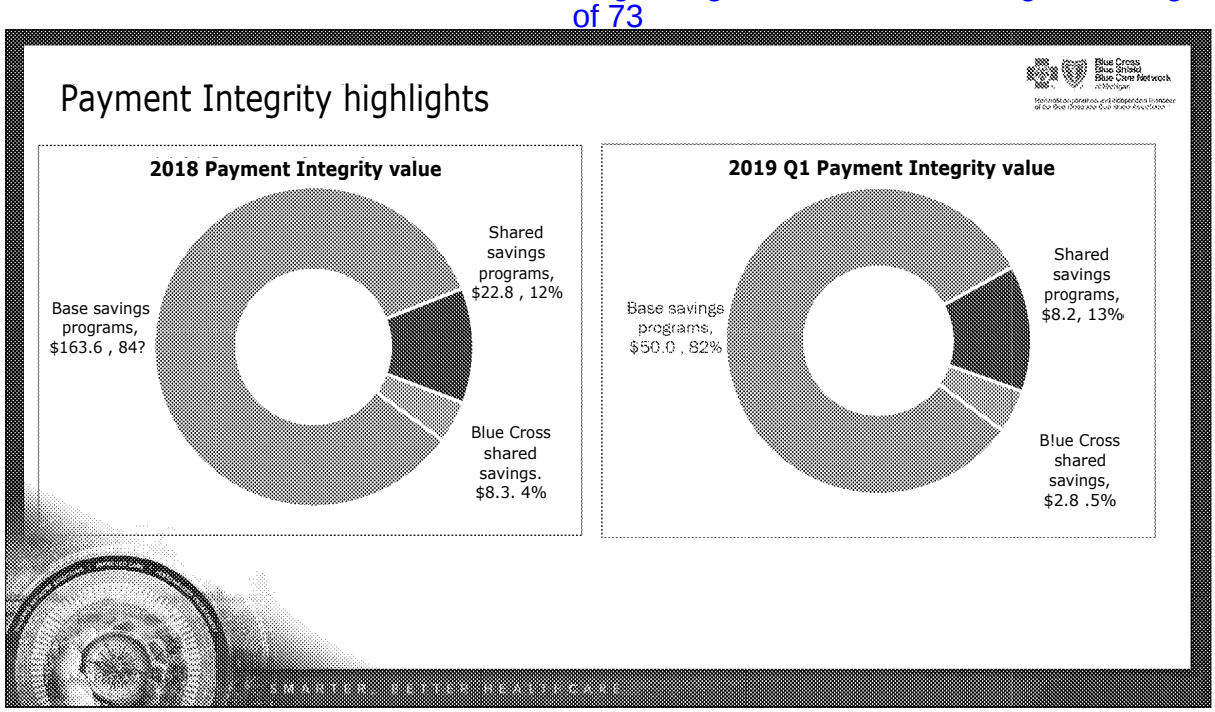


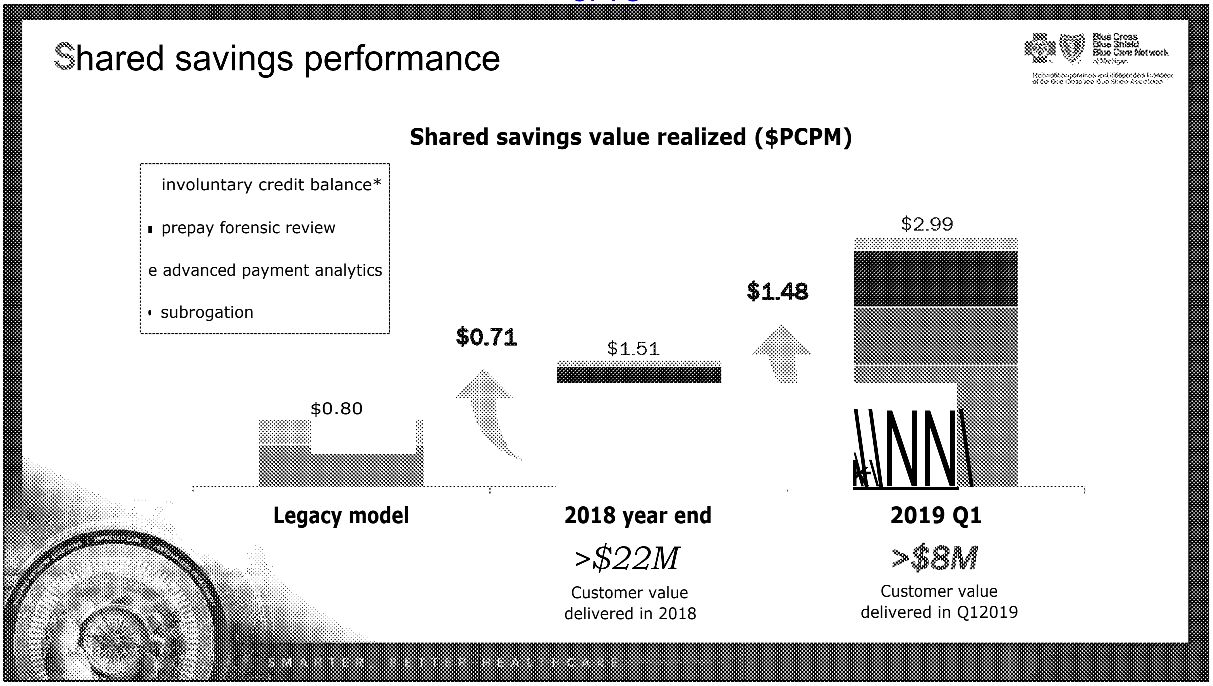
Slimed savings programs include:

- Prepay forensic review
- Advanced payment a na lytics
- Involuntary credit balance
- Subrogation

SMARTER. BETTER. HEALTHCARE.

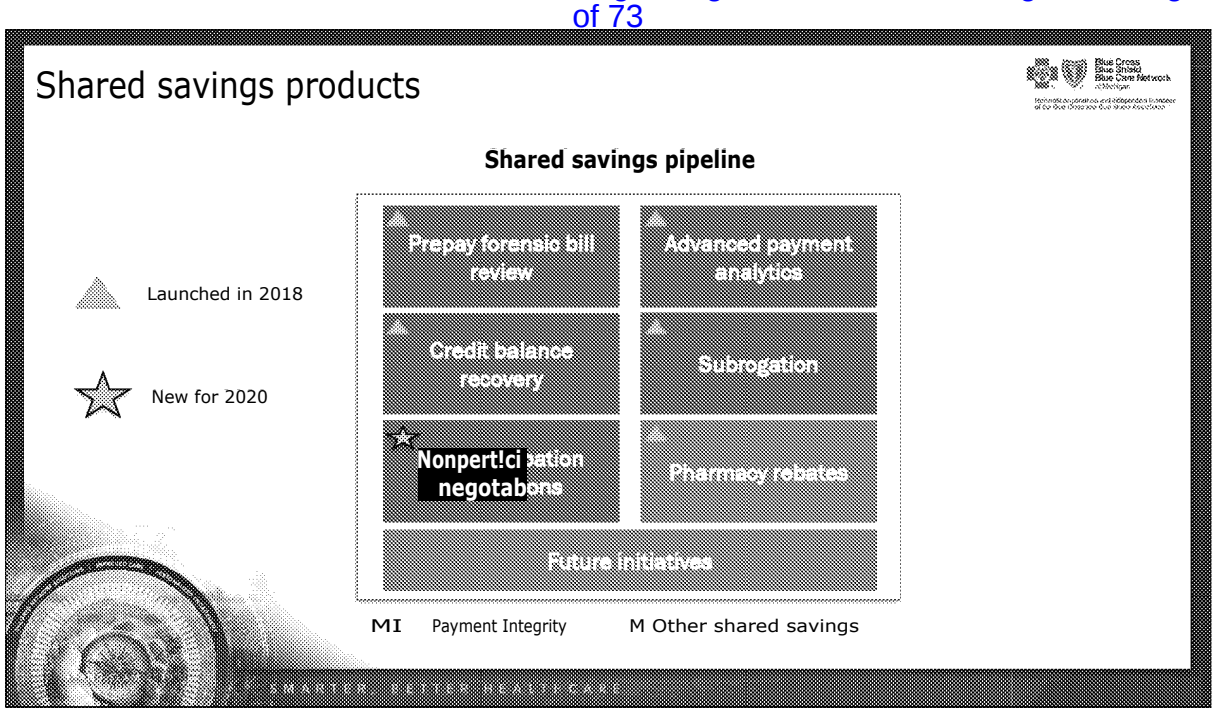

Payment integrity capability stream
PREPAYMENT INTERVENTION
POST-PAYMENT INTERVENTION
CLINICAL EDITING
RN REVIEWS
FORENSIC REVIEWS
OVERPAYMENT DATA MINING
PROVIDER AUDITS
FRAUD, WASTE AND ABUSE
COORDINATION OF BENEFITS
SUBROGATION
CREDIT BALANCE REVIEWS
Programs highlighted are offered within a shared savings program.

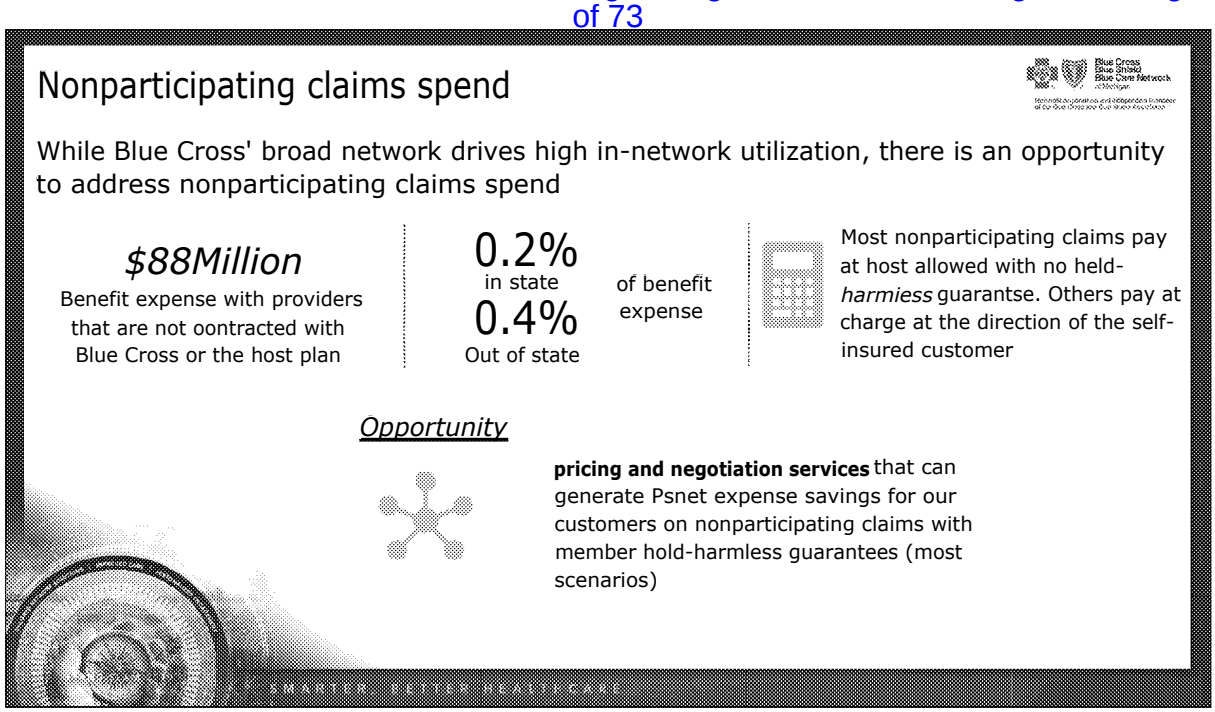

Payment Integrity highlights
2018 Payment Integrity value
Base savings programs, $163.6 , 84?
Shared savings programs, $22.8 , 12%
Blue Cross shared savings. $8.3. 4%
2019 Q1 Payment Integrity value
Base savings programs, $50.0 , 82%
Shared savings programs, $8.2, 13%
Blue Cross shared savings, $2.8 .5%



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

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


Shared savings products
Shared savings pipeline
Launched in 2018
New for 2020
Prepay forensic bill review
Advanced payment analytics
Credit balance recovery
Subrogation
Nonpert!ci ation negotabons
Pharmacy rebates
Future initiatives
MI Payment Integrity
M Other shared savings



BCBSM's customers incur approximately $88M annually in benefit expense with providers that are not contracted with BCBSM or the Host plan.
This represents 0.2% of total benefit expense for customers in-state and 0.4% out-of-state.
Most non-par claims pay at host allowed with no hold harmless guarantee while some pay at charge at the direction of the self-insured customer.
MultiPlan delivers pricing and negotiation services that can generate benefit expense savings, via cost avoidance, for our customers on non-par claims with member hold harmless guarantees (most scenarios).
MultiPlan is the dominant market leader; clients include 9 of the top 10 U.S. health insurers and 9+ BCBS Plans.
Starting in 2020, self-insured customers will have the option to activate MultiPlan's services in a shared savings arrangement to further minimize non-par benefit expense.

itipian services: Augmenting our industry ending ciaims
proving practices

Blue Cross Blue Shield Blue Care Network of Michigan

.I Multi an.

Market-leading vendor

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

* Incremental service not included in the PCPM admin" fee

Nonparticipation pricing and negotiation

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

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MultiPlan services available in 2020

Market positioning

- Enhanced service that provides additional controls on claims spend
- Delivered by MultiPlan, the industry leader in nonparticipating pricing and negotiations
- Offered as optional stand-alone program (not integrated into 2018 Payment Integrity bundle)
- Available to ASC customers on renewal starting in **2020**

Value (estimated) summary

- Program is estimated to generate up to $0.53 PCPM in savings (book of business) with ASC customers retaining 70% of the value created
- Value calculated as total reduction in original claim allowed amount (inclusive of member cost-sharing)
- Value will depend on nonparticipating pricing approach and utilization, host decisions and MultiPlan success rate

Program scope

- Using MdUp€an's negotiation services as well as their clinical and benchmarking tools.
- Applies to commerc€al claims; in state and out of state (BlueCard)
- All claim types are in scope, both facility and professional
- Claims from network PPO and Traditional network providers excluded

Terms and conditions

- Program terms will be disclosed in Schedule A
- Renewals will assume customers will opt in, while providing an Opt out process
- ASC customers will retain 70% of value and Blue Cross will retain 30%
- Transparent monthly value reporting is provided, consistent with the Payment Integrity bundle

Key takeaways

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

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

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

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

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

EXHIBIT C

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

TIARA YACHTS, INC., Plaintiff, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No.: 1:22-cv-603 Judge: Hon. Robert J. Jonker Magistrate Judge: Ray Kent

DEFENDANT'S BRIEF IN SUPPORT OF ITS MOTION TO
STAY DISCOVERY PENDING RESOLUTION OF ITS MOTION TO DISMISS

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

Cases

Other Authorities

INTRODUCTION AND BACKGROUND

Plaintiff Tiara Yachts, Inc. sponsors a self-insured employee benefit healthcare plan (the "Plan"). In 2006 Blue Cross Blue Shield of Michigan ("BCBSM") and Plaintiff entered into an Administrative Services Contract ("ASC") under which BCBSM processed claims submitted by health care providers for services rendered to Plaintiff's self-insured employee benefit plan (the "Plan"). ECF No. 1, PageID.1, 3 ¶¶ 1, 15, 17–18. Plaintiff alleges that BCBSM engaged in prohibited conduct under ERISA while processing those claims and asserts two causes of action: first, that BCBSM is a fiduciary under ERISA and breached its fiduciary duties to Plaintiff, and second, that BCBSM engaged in prohibited transactions under ERISA. *Id.* at PageID.18-21 ¶¶ 105–15.

Following reversal of a separate motion to dismiss by the Sixth Circuit, BCBSM moved to dismiss, raising arguments for dismissal that had been raised previously but were not addressed by this Court or the Sixth Circuit. *See generally* ECF No. 66. BCBSM's motion argues that (i) the Complaint fails to plead breaches of fiduciary duty or prohibited transactions under ERISA, and (ii) Plaintiff's claims are time-barred. *See* ECF No. 66, PageID.1108-1113.

Before BCBSM filed its recent Motion to Dismiss, the Court entered an order setting an August 11, 2025 scheduling conference under Federal Rule of Civil Procedure 16. ECF No. 64, PageID.1092. But discovery at this stage would be wasteful if the Court were to dismiss the Complaint in its entirety, and disposition of the Motion to Dismiss (even if not granted in its entirety) would streamline the case and discovery significantly. BCBSM thus requests that the Court adjourn the Rule 16 scheduling conference currently scheduled for August 11 and stay discovery until the Court resolves the Motion to Dismiss or, alternatively, limit discovery to the case-dispositive issue of whether Plaintiff has already released its claims against BCBSM.

ARGUMENT

I. The Court Should Stay Discovery Pending Resolution of the Motion to Dismiss.

"'Trial courts have broad discretion and inherent power to stay discovery until preliminary questions that may dispose of the case are determined.'" *Otworth v. Fifth Third Bank*, No. 1:19-cv-55, 2020 WL 13546491, at *1 (W.D. Mich. Jan. 27, 2020) (quoting *Hahn v. Star Bank*, 190 F.3d 708, 719 (6th Cir. 1999)); *see* Fed. R. Civ. P. 26(c). The Supreme Court recently encouraged "district courts [to] use existing tools . . . to screen out meritless [ERISA] claims before discovery." *Cunningham v. Cornell Univ.*, 145 S. Ct. 1020, 1032 (2025). Similarly, the Sixth Circuit recognizes that "[l]imitations on pretrial discovery are appropriate where claims may be dismissed 'based on legal determinations that could not have been altered by any further discovery.'" *Gettings v. Bldg. Laborers Local 310 Fringe Benefits Fund*, 349 F.3d 300, 304 (6th Cir. 2003) (quoting *Muzquiz v. W.A. Foote Mem'l Hosp., Inc.*, 70 F.3d 422, 430 (6th Cir. 1995)).

As one court in this district has noted, "[a] stay of discovery pending the determination of a dispositive motion is an eminently logical means to prevent wasting the time and effort of all concerned, and to make the most efficient use of judicial resources." *Otworth*, 2020 WL 13546491, at *1 (quoting *Chavous v. Dist. of Columbia Fin. Resp. & Mgmt. Assistance Auth.*, 201 F.R.D. 1, 2 (D.D.C. 2001)). Another court in this district similarly observed that "[t]he purpose of a motion to dismiss for failure to state a claim is 'to enable defendants to challenge the legal sufficiency of complaints without subjecting themselves to discovery.'" *Fedorova v. Foley*, No. 1:22-cv-991, 2023 WL 3379957, at *1 (W.D. Mich. May 11, 2023) (quoting *Yuhasz v. Brush Wellman, Inc.*, 341 F.3d 559, 566 (6th Cir. 2003)).

BCBSM's pending Motion to Dismiss is case dispositive and, even if not granted in its entirety, would substantially narrow any remaining claims. For example, the Motion to Dismiss argues that Plaintiff's claims are time-barred under ERISA's three-year statute of limitations. *See*

ECF No. 66, PageID.1111-1113. As discussed in the Motion to Dismiss, this statute of limitations argument would dispose of all of Plaintiff's claims. *Id*. Similarly, the motion argues that the Complaint has not pled any actionable breaches or prohibited transactions with respect to the Plan. The Court may dismiss the case in its entirety independently on that basis as well.

But even if the Court held that the case was subject to ERISA's six-year statute of repose, as the Motion to Dismiss argues in the alternative, that holding would cut the relevant time period in half and thus narrow the scope of discovery.

The Motion to Dismiss also argues that Plaintiff's claims should be partially dismissed to the extent they are based on alleged claims processing errors because such errors cannot establish a breach of fiduciary duty claim. *Id*. at PageID.1111. If this argument is successful, it would also limit the scope of any remaining claims and corresponding discovery.

Engaging in discovery before the Court addresses BCBSM's arguments would thus "contravene the very purpose of Rule 12." *Fedorova*, 2023 WL 3379957, at *1. By contrast, deferring discovery until the Court rules on the Motion to Dismiss would not prejudice Plaintiff. A stay would only briefly defer discovery, and no plausible risk exists that a deferred discovery process would impede Plaintiff's access to sources of information if the Court were to find that any of Plaintiff's claims survive BCBSM's motion. Rather, staying discovery pending adjudication of BCBSM's motion would preserve the Court's and parties' resources and ensure that any discovery proceeds in respect of legally sufficient claims.

II. In the Alternative, the Court Should Limit the Scope of Discovery.

Should the Court find that a complete stay of discovery is inappropriate, the Court should limit the scope of discovery to the issue of whether Plaintiff released its claims against BCBSM. *See* Fed. R. Civ. P. 26(c)(1)(D) (providing courts with the discretion to "limit[] the scope of disclosure or discovery to certain matters" "to protect a party . . . from . . . undue burden or

expense"). Under Article IV § B.6 of their operative contract, the parties agreed that a final settlement payment between them would release "any and all" of Plaintiff's claims against BCBSM, whether known or unknown. *See* ECF No. 12-2, PageID.150 ("The payment to Group or to BCBSM as provided in the immediately preceding sentence shall fully and finally settle, release, and discharge each party from any and all claims that are known, unknown, liquidated, non-liquidated, incurred-but-not-reported, adjustments, recoupments, receivables, recoveries, rebates, hospital settlements, and other sums of money due and owing between the parties and arising under this Contract."). Additionally, Plaintiff, upon receipt of the final settlement payment, executed a separate release in addition to the one included in the parties' contract. *See* Exhibit A ("This mutual final settlement is made among BCBSM, Group and the group health plan and fully and finally settles, releases and discharges each party from any and all claims that are known, unknown, liquidated, non-liquidated, incurred-but-not-reported (IBNR), adjustments, recoupments, receivables, recoveries, rebates, hospital settlements, and other sums of money due and owing between the parties and arising under the administrative services contract and arrangement.").

If BCBSM's Motion to Dismiss is denied, BCBSM intends to pursue a motion for judgment on the pleadings under Federal Rule of Civil Procedure 12(c) based on, among other things, this release. Although BCBSM does not believe any discovery is needed to adjudicate arguments based on the release, it respectfully submits that any discovery should be limited to that issue if the Court does not stay discovery in full. Such an approach would ensure that both parties' and the Court's resources are tailored to a question that could put an early end to this litigation. *See, e.g.*, *Cunningham*, 145 S. Ct. at 1032 ("district courts retain discretionary authority to expedite or limit

discovery as necessary to mitigate unnecessary costs" to the extent ERISA "claims . . . do proceed past the motion to dismiss stage").

CONCLUSION

For these reasons, BCBSM respectfully asks the Court to adjourn the Rule 16 conference and stay discovery or, alternatively, limit discovery pending resolution of BCBSM's Motion to Dismiss.

Dated: July 18, 2025

Respectfully submitted,

ALLEN OVERY SHEARMAN STERLING US LLP

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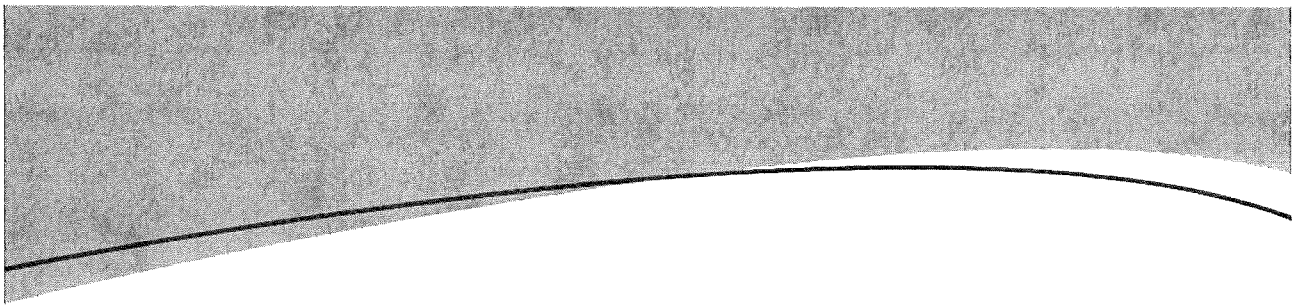
Attorneys for Defendant

EXHIBIT A



This mutual final settlement is made among BCBSM, Group and the group health plan and fully and finally settles, releases and discharges each party from any and all claims that are known, unknown, liquidated, non-liquidated, incurred-but-not-reported (IBNR), adjustments, recoupments, receivables, recoveries, rebates, hospital settlements, and other sums of money due and owing between the parties and arising under the administrative services contract and arrangement.

BCBSM 08-Apr-2021

Whitney Briggs W. Mich Sales

Date 4/16/21

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

S2 Yachts

Sign Ed Walsh

Print Ed Walsh

Title Vice President Finance

Date 4/16/21

EXHIBIT D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Grand Traverse Band of Ottawa and Chippewa Indians, and Its Employee Welfare Plan,

Plaintiffs,

Case No. 14-cv-11349
Hon. Judith E. Levy
Mag. Judge Mona K. Majzoub

v.

Blue Cross and Blue Shield of Michigan,

Defendant.

_____/

ORDER DENYING MOTION TO TRANSFER VENUE [15]

For the reasons stated on the record at the hearing held on October 2, 2014, the Court hereby denies defendant's motion to transfer venue. (Dkt. 15.)

IT IS SO ORDERED.

Dated: October 3, 2014
Ann Arbor, Michigan

s/Judith E. Levy
JUDITH E. LEVY
United States District Judge

CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing document was served upon counsel of record and any unrepresented parties via the Court's ECF System to their respective email or First Class U.S. mail addresses disclosed on the Notice of Electronic Filing on October 3, 2014.

s/Felicia M. Moses
FELICIA M. MOSES
Case Manager

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

WESCO, INC., WESCO, INC. CAFETERIA PLAN AND EMPLOYEE BENEFIT PLAN, FRANKENMUTH BAVARIAN INN, INC., FRANKENMUTH BAVARIAN INN, INC. EMPLOYEE HEALTH BENEFIT PLAN & TRUST, OPUS PACKAGING GROUP INC., and OPUS PACKAGING GROUP HEALTH INSURANCE PLAN, on behalf of themselves and a class of all others similarly situated,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 2:25-cv-11712

Hon. Susan K. DeClercq

Magistrate Judge: David R. Grand

INDEX OF EXHIBITS

Exhibit	Description
A	Order Granting BCBSM's Motion to Dismiss
B	Tiara Yachts, Inc. v. BCBSM Complaint (case no. 1:22-cv-603)
C	BCBSM's Brief in Support of its Motion to Stay Discovery Pending Resolution of its Motion to Dismiss (Tiara Yachts, Inc. v. BCBSM)
D	Order Denying BCBSM's Motion to Transfer Venue