No. 14-

IN THE
Supreme Court of the United States

BLUE CROSS BLUE SHIELD OF MICHIGAN,
Petitioner,

v.

HI-LEX CONTROLS, INC., HI-LEX AMERICA, INC., AND HI-LEX CORPORATION HEALTH AND WELFARE BENEFIT PLAN,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(21)(A), provides that an entity is a fiduciary—subject to ERISA's fiduciary obligations and remedial scheme—if the entity, *inter alia*, exercises "control" over the "assets" of an ERISA plan. The question presented under this provision by the decision below is:

Whether a service provider that contracts with an employer to provide services to an ERISA plan exercises "control" over "plan assets" when the service provider (1) contracts with the employer for compensation for services provided to the plan, and (2) elects to exercise its contractual right to receive that compensation, rather than waiving that right.

2. Section 406 of ERISA, 29 U.S.C. § 1106(b)(1), states that a fiduciary to an ERISA plan may not "deal with the assets of the plan in his own interest or for his own account." Section 408 of ERISA, 29 U.S.C. § 1108(c)(2), states that "[n]othing in section 1106 of this title shall be construed to prohibit any fiduciary from … receiving any reasonable compensation for services rendered … in the performance of his duties with the plan." The question presented under this provision by the decision below is:

Whether under the plain language of § 1108, a provider of services to an ERISA plan can be held to have violated § 1106(b) when it has received only "reasonable compensation" for its services.

PARTIES TO THE PROCEEDING

All parties to the proceeding are identified in the caption.

RULE 29.6 STATEMENT

Blue Cross Blue Shield of Michigan has no parent corporation and no publicly held company owns 10% or more of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Blue Cross Blue Shield of Michigan ("BCBSM") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in favor of respondents Hi-Lex Controls, Inc., Hi-Lex America, Inc., and Hi-Lex Health and Welfare Benefit Plan (collectively, "Hi-Lex").

OPINIONS BELOW

The opinion of the court of appeals is reported at 751 F.3d 740, and is reproduced in the appendix to this petition (Pet. App.) at 1a-21a. The opinion of the United States District Court for the Eastern District of Michigan granting partial summary judgment to respondents is unreported, and is reproduced at Pet. App. 109a-134a. The Corrected Findings of Fact and Conclusions of Law of the district court are unreported, and are reproduced at Pet. App. 33a-102a. The order of the district court excluding evidence as to BCBSM's reasonable compensation defense is unreported, and is reproduced at Pet. App. 103a-108a.

JURISDICTION

The court of appeals issued its decision on May 14, 2014. The court of appeals' jurisdiction was based on 28 U.S.C. § 1291. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 3 of ERISA, codified at 29 U.S.C. § 1002, provides in pertinent part:

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan

> to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets ….

29 U.S.C. § 1002(21)(A). The full text of § 3 has been reproduced at Pet. App. 135a-159a.

Section 406 of ERISA, codified at 29 U.S.C. § 1106, provides in pertinent part: "A fiduciary with respect to a plan shall not … deal with the assets of the plan in his own interest or for his own account." 29 U.S.C. § 1106(b)(1). The full text of § 406 has been reproduced at Pet. App. 159a-160a.

Section 408 of ERISA, codified at 29 U.S.C. § 1108, provides in pertinent part:

> Nothing in section 1106 of this title shall be construed to prohibit any fiduciary from … (2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full time pay from an employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred ….

29 U.S.C. § 1108(c)(2). The full text of § 408 has been reproduced at Pet. App. 160a-188a.

STATEMENT OF THE CASE

I. PRELIMINARY STATEMENT

This case arises from a dispute between an employer (respondent Hi-Lex) and petitioner BCBSM, a service provider that contracted to service Hi-Lex's self-funded employee health plan (the "Plan"). Unlike many ERISA cases, this case does not involve any allegation that benefit claims were mishandled or that any employee participants were harmed in any way. Instead, Hi-Lex claimed that BCBSM collected fees that were not specifically provided for in the parties' contract. While the case was pending in federal district court, the Michigan Court of Appeals held that the very same contract—a form contract that BCBSM has used in servicing hundreds of health plans—was valid and enforceable and explicitly authorized BCBSM to collect the precise fees at issue in this case.

The Sixth Circuit ignored the Michigan court's contract interpretation and held that the contract did not authorize BCBSM to collect those fees. Based on that conclusion, the court of appeals held that, for purposes of Hi-Lex's federal claim under ERISA, BCBSM's collection of the challenged fees was a "unilateral[]" exercise of unbounded "discretion" with respect to supposed "plan assets." Pet. App. 5a-6a. The court did not identify any source of federal law or specific objectives of ERISA that compelled it to read the contract differently than the Michigan state court had.

The Sixth Circuit's departure from standard contract interpretation—exemplified by the Michigan state court's decision—has extraordinary consequences. Because BCBSM collected fees supposedly not authorized by its contract, the Sixth Circuit held that BCBSM had exercised "control" over "plan as-

sets." That meant that BCBSM was unexpectedly converted into a plan "fiduciary" under ERISA, retroactively subject to a host of fiduciary duties. Moreover, the same supposedly unauthorized collection of fees that made BCBSM a fiduciary also amounted to a *per se* breach of BCBSM's newly-imposed fiduciary obligation not to engage in "self-dealing." That meant, in the Sixth Circuit's view, that Hi-Lex was entitled to full restitution of the disputed fees—without any consideration of whether those fees represented reasonable compensation for tens of millions of dollars of discounts that Hi-Lex had received through its access to BCBSM's provider network since 1994.

The Sixth Circuit's decision is a significant departure from decisions of the Second, Seventh, and Eighth Circuits, which have held in similar circumstances that a service provider's collection of fees permitted under a contract does not transform the service provider into an ERISA fiduciary. Only the Ninth Circuit has held that fiduciary liability can be imposed based on similar contractual terms. Moreover, as the Sixth Circuit acknowledged, its decision deepens a circuit split—with the Sixth Circuit joining the Third and Ninth Circuits, and the Second and Eighth Circuits on the other side—on the question whether, under 29 U.S.C. § 1108(c), a fiduciary engages in prohibited "self-dealing" when it collects no more than "reasonable compensation" from a plan.

Allowing the Sixth Circuit's decision to stand will have huge and immediate consequences. At a minimum, it will affect dozens of cases already pending against BCBSM, filed by employers that, like Hi-Lex, seek to enjoy a windfall of full restitution of fees for services that BCBSM duly provided over two decades. More broadly, and more importantly, the decision will upend the expectations of those who provide services

to employee benefit plans, including third-party administrators, actuaries, accountants, and others. Until now, service providers have understood that express contractual provisions authorizing their collection of fees for services provided to an ERISA plan could be relied upon to preclude or limit ERISA fiduciary status. As a result of the lower courts' unexplained rejection of the Michigan court's determination that the contract terms specifically authorized BCBSM to collect the fees at issue, that is no longer the case. The uncertainty created by the lower courts' new federal rule of contract construction will lead to a reduction in the supply of administrative and professional services available to ERISA plans and an increase in prices for those services that remain available, inevitably causing healthcare and other plan costs to rise. This Court's attention is needed to resolve the decisional conflicts among the circuits, to reaffirm the relevance of readily applicable state law to federal question cases, and to ensure the stability of ERISA plans going forward.

II. STATUTORY BACKGROUND

ERISA was enacted to "protect contractually defined benefits" provided through private employee benefit plans. *Mass. Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985). The statute's principal way of protecting benefits is to impose strict fiduciary obligations on those who control or manage benefit plans. "The statute provides that not only the persons named as fiduciaries by a benefit plan, see 29 U.S.C. § 1102(a), but also anyone else who exercises discretionary control or authority over the plan's management, administration, or assets, see § 1002(21)(A), is an ERISA 'fiduciary.'" *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 251 (1993).

Whether an entity acts as an ERISA fiduciary turns on the function the entity performs: As relevant here, the statute prescribes that "a person is a fiduciary with respect to a plan *to the extent* … he … exercises any authority or control respecting management or disposition of its assets." 29 U.S.C. § 1002(21)(A)(i) (emphasis added). Thus, for "every case charging breach of ERISA fiduciary duty," the "threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Pegram* v. *Herdrich*, 530 U.S. 211, 226 (2000).

When assessing fiduciary status, the Department of Labor has explained, "it is critical to distinguish between the ERISA plan itself (the administration of which by either the plan sponsor or an outside entity confers fiduciary status on an individual or other entity) and a provider of services to the plan (usually an independent entity not subject to ERISA's fiduciary duty standards)." Brief for United States as *Amicus Curiae* Supporting Petitioners at 9, *Pegram* v. *Herdrich*, 530 U.S. 211 (2000) (No. 98-1949). As the statute makes clear, the latter are fiduciaries only "to the extent" they exercise "control" over plan "assets." It is well recognized, as the lower courts here agreed, that "'mere custody'" of plan assets is insufficient to establish "control" for purposes of ERISA fiduciary status. Pet. App. 122a; *accord id.* at 5a. It is also well recognized that whether funds transmitted to a service provider constitute "plan assets" turns on "'ordinary notions of property rights.' Under this analysis, 'the assets of a welfare plan generally include any property, tangible or intangible, in which

the plan has a beneficial ownership interest.'" *Id.* at 7a-8a (citation omitted) (quoting U.S. Dep't of Labor, Advisory Op. No. 92-24A (Nov. 6, 1992), *available at* 1992 WL 337539, at *2).

A determination that an entity is an ERISA fiduciary carries with it significant obligations. "Fiduciaries are assigned a number of detailed duties and responsibilities, which include the proper management, administration, and investment of [plan] assets, the maintenance of proper records, the disclosure of specified information, and the avoidance of conflicts of interest." *Mertens*, 508 U.S. at 251-52 (internal quotation marks omitted; alteration in original). The statute "makes fiduciaries liable for breach of these duties, and specifies the remedies available against them: The fiduciary is personally liable for damages …, for restitution …, and for 'such other equitable or remedial relief as the court may deem appropriate,' including removal of the fiduciary." *Id.* at 252.

III. PROCEEDINGS BELOW

A. Factual Summary

Hi-Lex is an automotive supply company with approximately 1,300 employees, to whom Hi-Lex offers a Health and Welfare Benefit Plan. Hi-Lex self-funds benefits provided under the Plan, meaning that benefits are paid from Hi-Lex assets rather than through the purchase of insurance. BCBSM is a non-profit entity that contracts to provide services for companies and organizations in Michigan like Hi-Lex that provide self-funded health benefit plans for their employees. Pet. App. 2a.

Since 1991, BCBSM has contracted to process Hi-Lex employees' healthcare claims and to submit payments to healthcare providers for those claims. Under the parties' contract, Hi-Lex sent money to

BCBSM each week to cover its employees' estimated claims and to compensate BCBSM for its services. The contract provided that BCBSM's responsibilities were "limited to administrative services for the processing and payment of claims." 6th Cir. App'x 11. As the summary plan description[1] likewise explained to Hi-Lex employees, BCBSM would, "[w]ith [Hi-Lex's] approval," "review[] … claims and pay[] benefits from the money we [Hi-Lex] provide." *Id.* at 750. While a participant's "initial claim" would be submitted to BCBSM, Hi-Lex alone had discretion to consider and resolve any disputed claims. *Id.* at 752-53. The summary plan description further specified that "[b]enefit payments … are paid directly out of the general assets of the Company," and that "[t]here is no special fund or trust from which self-insured benefits are paid." *Id.* at 746.

The parties' contract also gave Hi-Lex access to discounts that BCBSM had negotiated with its network of providers—doctors and hospitals. Pet. App. 2a; *id.* at 38a. Thus, by working with BCBSM instead of paying providers directly, Hi-Lex was able to pay substantially less in total claims, and substantially less than Hi-Lex would have paid if it had engaged a different claims administrator. The parties' contract did not, however, entitle Hi-Lex to any particular discount.

Beginning in 1994, the parties' annual contracts expressly stated that BCBSM would collect a fee in order to cover the costs of maintaining its provider network. Pet. App. 123a; 6th Cir. App'x 10-11, 16. The fee was calculated as a percentage of the amount

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[1] The summary plan description is a document that ERISA requires be provided to participants in employee benefit plans. *See* 29 U.S.C. § 1024(b).

BCBSM paid to large acute-care hospitals—for example, 13.5 percent with a $35 cap in the most recent contract at issue. Specifically, the Administrative Services Contract ("ASC") between BCBSM and Hi-Lex stated that Hi-Lex would be required to pay—in addition to various other fees and costs—the "Amounts Billed." "Amounts Billed" was defined in the ASC as "the amount the Group owed in accordance with [BCBSM's] standard operating procedures for payment of Enrollees' claims." Pet. App. 123a; 6th Cir. App'x 10. The ASC further provided that BCBSM would collect a "Provider Network Fee" to pay for the "establishment, management and maintenance" of its provider network. 6th Cir. App'x 11. The contract then stated that "[t]he Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner" would be "reflected in the hospital claims cost contained in [the] Amounts Billed." *Id.* at 16. Thus, charges submitted by certain hospitals would be adjusted by both the amount of the discounts BCBSM had negotiated and BCBSM's access fee. Both the discount and the fee would be reflected in the "hospital claims cost" shown in the "Amounts Billed" to Hi-Lex.

Hi-Lex renewed its contract with BCBSM every year after 1994. After 2005, the contract became even more explicit by adding language—which appeared directly above the line for Hi-Lex's officer's signature—stating that "[a] portion of your hospital savings," which the contract labeled "the ASC Access Fee," "has been retained by BCBSM to cover costs associated with the establishment, management and maintenance of BCBSM's participating hospital, physician and other health provider networks." 6th Cir. App'x 35-36. The 2007 contract used similar lan-

guage, *id.* at 37-38, and BCBSM in that year began explicitly stating the dollar amount of the access fees it had collected in the previous year. See *id.* at 44 (specifying that Hi-Lex's payments to BCBSM included $562,760 in access fees in 2006). The annual contracts used similar terms until 2012, when Hi-Lex signed a new contract adopting a different method of calculating such fees. Pet. App. 48a.

B. State Court Litigation

The contract between BCBSM and Hi-Lex was a standard Administrative Services Contract that BCBSM used with other self-funded employer health plans, including various governmental entities. One of those governmental entities, Calhoun County, Michigan, filed a similar suit against BCBSM in Michigan state court.[2] *See Calhoun Cnty.* v. *Blue Cross Blue Shield Mich.*, 824 N.W.2d 202 (Mich. Ct. App. 2012), *leave to appeal denied*, 823 N.W.2d 603 (Mich. 2012). Calhoun County contended that BCBSM had breached the Administrative Services Contract and its state-law fiduciary duty by improperly collecting network access fees. In particular, Calhoun County contended that the contract did not authorize BCBSM to collect access fees because "the parties had not agreed to a price for the access fee and, even if they had, defendant unilaterally charged excessive fees in violation of the parties' agreement." *Id.* at 206.

The Michigan Court of Appeals rejected Calhoun County's claims as a matter of law. It held that the Administrative Services Contract "expressly provided for the collection of additional fees," and that "those

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[2] Because ERISA does not apply to governmental employee benefit plans, 29 U.S.C. § 1003(b)(1), Calhoun County could not bring suit under ERISA.

fees would be reflected in the hospital claims cost contained in 'Amounts Billed.'" *Id.* at 210-11. The court also rejected Calhoun County's argument that the contract was indefinite because it did not specify the precise amount of "access fees" BCBSM would collect. To the contrary, the court explained, the amount of access fees BCBSM collected was "readily ascertainable through defendant's standard operating procedures, and therefore plaintiff was obligated to pay the fee to which it agreed." *Id.* at 212.

For these reasons, the contract—which is materially identical to the contract between Hi-Lex and BCBSM—was sufficiently definite to authorize BCBSM to collect the disputed access fees. Likewise, BCBSM did not violate a fiduciary duty—if it had any—when it acted consistent with its contractual rights. *Id.* at 213. The Michigan Supreme Court declined to review the appellate court's decision. 823 N.W.2d 603. Subsequently, because it had held BCBSM's contract to be "unambiguous as a matter of law" in its *Calhoun County* decision, the Michigan Court of Appeals rejected similar claims in four more cases raising the same claims under the same form of contract. *Cnty. of Bay* v. *Blue Cross Blue Shield*, No. 307447, 2013 WL 6670894 (Mich. Ct. App. Dec. 17, 2013) (per curiam), *leave to appeal denied*, 846 N.W.2d 402 (Mich. 2014); *City of Battle Creek* v. *Blue Cross Blue Shield of Mich.*, No. 311872, 2014 WL 547613 (Mich. Ct. App. Feb. 11, 2014) (per curiam); *Blue Cross & Blue Shield of Mich.* v. *Genesee Cnty. Rd. Comm'n*, Nos. 305512, 313023, 2013 WL 2662806 (Mich. Ct. App. June 13, 2013) (per curiam), *leave to appeal denied*, 838 N.W.2d 554 (Mich. 2013); *Cnty. of Midland* v. *Blue Cross Blue Shield*, No. 303611, 2013 WL 2494983 (Mich. Ct. App. June 11, 2013) (per

curiam), *leave to appeal denied*, 838 N.W.2d 557 (Mich. 2013).

C. District Court Proceedings

The present suit was filed when Hi-Lex allegedly first discovered, after 17 years of signing contracts with BCBSM, that its contract, like Calhoun County's, provided that BCBSM would collect a fee in order to cover the cost of maintaining its provider network. Hi-Lex asserted claims under ERISA and state law. In connection with its ERISA claims, Hi-Lex alleged that the fees BCBSM collected represented Hi-Lex plan assets, and that the contract did not authorize BCBSM to collect them. According to Hi-Lex, the absence of contractual authorization transformed BCBSM into a fiduciary and made collection of the fees "unilateral"—*i.e.*, "self-dealing" prohibited by ERISA. The remedy Hi-Lex sought was a full refund of all fees paid back to 1994 with interest and without any off-set for the many millions of dollars in provider discounts Hi-Lex had obtained through its contract with BCBSM.

The district court granted Hi-Lex partial summary judgment, finding that BCBSM was an ERISA fiduciary because it exercised "control" over Hi-Lex's "plan assets." In the court's words:

> The [Administrative Services Contract] does not set forth a dollar amount for the Disputed Fee, nor does it set forth a method by which the Disputed Fee is calculated. In short, it grants Blue Cross discretion to determine the amount of the Disputed Fee, and the record reflects that Blue Cross did just that.

Pet. App. 124a.

The court recognized that in *Calhoun County*, the Michigan court had held that "the amount of the Disputed Fee was 'reasonably ascertainable,'" Pet. App. 116a (quoting *Calhoun Cnty.*, 824 N.W.2d at 212), and had rejected an argument that BCBSM "unilaterally charg[ed] the Disputed Fees," *id.* at 114a. But the district court declined to give any weight to the Michigan court's interpretation of the contract because "*Calhoun County* was not an ERISA case." *Id.* at 116a-117a. The district court separately held that the fees BCBSM collected were "plan assets," because BCBSM "could 'earmark the funds' that Hi-Lex … allocated to the plans." *Id.* at 127a-128a.

Thus, the court determined that BCBSM was a fiduciary because it exercised "discretion" to unilaterally determine its own fees for network maintenance, then collected them from "plan assets." This same conclusion led the court to hold that BCBSM had violated ERISA's prohibition on self-dealing: "Blue Cross determined its own administrative fee and collected it from plan assets. Plaintiffs need establish nothing more to prove a violation of Section 1106(b)(1)." Pet. App. 131a. The court held that BCBSM was not entitled to assert as a defense that the fees it collected were "reasonable compensation" permitted under § 1108(c)(2). *Id.* at 103a-108a.

The court found disputes of material fact as to BCBSM's liability for breach of the duty of loyalty under 29 U.S.C. § 1104(a)(1), as well as its statute of limitations defense. Pet. App. 132a-134a. The case proceeded to a bench trial on those issues, both of which the court decided in favor of Hi-Lex. *Id.* at 33a-102a. The court awarded Hi-Lex a refund of all disputed fees collected by BCBSM between 1994 and 2011—more than $5 million—without any offset for the millions of dollars in provider discounts Hi-Lex

received as a result of its access to BCBSM's provider network. *Id.* at 96a, 100a.

D. Sixth Circuit Decision

The Sixth Circuit affirmed in all respects. Like the district court, but in striking contrast to the court of appeals in *Calhoun County* and the four other Michigan Court of Appeals decisions following it, the Sixth Circuit held that BCBSM's actions were *not* authorized under the terms of the Administrative Services Contract, and thus *did* constitute a breach of fiduciary duty under ERISA. It first held that BCBSM was a fiduciary under ERISA, 29 U.S.C. § 1002(21)(A), because BCBSM supposedly exercised "control" over "plan assets." The court acknowledged the well-recognized principle that "simple adherence to a contract's term giving a party 'the unilateral right to retain funds as compensation' does not give rise to fiduciary status." Pet. App. 5a. But it held that BCBSM's collection of the fees was an exercise of "control" because the fees were supposedly "discretionarily imposed." *Id.* at 6a. The court found such discretion even though it recognized that the fees BCBSM collected were "part of the standard pricing arrangement for the company's entire ASC line of business," *id.*, and even though from 2007 through 2011 Hi-Lex had been specifically informed of the total amount of fees BCBSM had collected for network maintenance. It found that the fees were "discretionarily imposed" because BCBSM had, on occasion, waived its contractual right to collect such fees from other customers. *Id.* ("[T]he imposition of the Disputed Fees was not universal.… [T]he Disputed Fees were sometimes waived entirely for certain self-funded customers."). In other words, the fact that BCBSM, like any party to any contract, could choose not to exercise all of its contract rights in par-

ticular circumstances gave rise to a fiduciary relationship. The court simply ignored the Michigan Court of Appeals' holding in *Calhoun County* that the contract set forth a "reasonably ascertainable" amount of fees that BCBSM was authorized to collect.

Second, the court held that the fees BCBSM collected were "plan assets"—*i.e.* property in which the Plan held a beneficial interest, rather than contract payments giving rise to a contract right. Pet. App. 7a-9a. This was so even though BCBSM had contracted only with Hi-Lex—not the Plan. And it was so despite Hi-Lex's express statements in Plan documents that "[b]enefit payments" under the Plan were "paid directly out of the general assets of the Company," and that there is "'no special fund or trust from which self-insured benefits are paid." 6th Cir. App'x 746.[3] The court reached this result because, even though the summary plan description provided that Hi-Lex had authority to establish all eligibility rules for the plan and to make all final claim determinations, the plan documents made "clear that enrollees must make their initial benefit claims to BCBSM, which has both the funds and the discretion to pay claims." Pet. App. 8a. The court thus held that the relevant documents created an "understanding that BCBSM in its role as TPA [third-party administrator] would be holding funds to pay the healthcare expenses of Plan beneficiaries." *Id.* at 8a-9a.

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[3] In 2002, several years into the parties' contractual relationship, Hi-Lex began requiring its employees to make contributions to the Plan. Employee contributions, however, represented only a small fraction of the total funds Hi-Lex sent to BCBSM, and only after 2002. Thus, as the Sixth Circuit recognized, the "pertinent question" in this case is "whether the *employer* contributions that Hi-Lex sent to BCBSM must also be considered plan assets." Pet. App. 7a.

Finally, the court held that by collecting fees as authorized by the contract, BCBSM had engaged in "self-dealing" and breached its fiduciary duty under 29 U.S.C. § 1106(b)(1). Pet. App. 17a-18a. The court affirmed the district court's order that BCBSM repay in full the disputed fees—without regard to whether those fees were reasonable compensation for network access services BCBSM provided to Hi-Lex (services that Hi-Lex continues to purchase from BCBSM today). In particular, BCBSM was not permitted to retain any portion of the fees as "reasonable compensation" under 29 U.S.C. § 1108, even though that provision expressly states that payments for "reasonable compensation" are "not prohibited by section 1106." *Id.* The court recognized that, with this decision, it joined the Third and Ninth Circuits in splitting from the Eighth Circuit's decision in *Harley* v. *Minnesota Mining & Manufacturing Co.*, 284 F.3d 901, 908-09 (8th Cir. 2002). Pet. App. 18a.

REASONS FOR GRANTING THE PETITION

I. THE SIXTH CIRCUIT'S CONCLUSION THAT BCBSM IS AN ERISA FIDUCIARY IS CONTRARY TO DECISIONS OF OTHER CIRCUITS AND OF THIS COURT.

Before the district court's decision below, the Michigan Court of Appeals held that under standard, state law contract principles, BCBSM's Administrative Services Contract is valid and definite, providing for contractual compensation to BCBSM that is "readily ascertainable" in amount. *Supra,* p. 10-12. The district court declined to follow any part of that decision—not because ERISA's language or policy required a different result, but because "*Calhoun County* was not an ERISA case. It involved state law contract and tort claims, and was decided under state

common law." Pet. App. 116a. The Sixth Circuit simply ignored the Michigan state court's interpretation of the contract altogether. It held—without regard to *Calhoun County*'s judgment to the contrary—that the disputed fees "were discretionarily imposed" on the theory that BCBSM could have "waived" its right to fees, and thus did something more than exercise its express contractual right to collect the fees. *Id.* at 6a.

The lower courts' disregard for the Michigan court's interpretation of the contract marks a departure from this Court's instructions. To be sure, evaluation of plaintiffs' ERISA claim is a matter of federal, not state, law. Nonetheless, this Court has consistently explained that federal courts should not disregard "readily applicable" state law that could appropriately fill the "interstices" of federal law. *Kamen* v. *Kemper Fin. Servs., Inc.*, 500 U.S. 90, 97-98 (1991). Instead, "federal courts should incorporate state law as the federal rule of decision, unless application of the particular state law in question would frustrate specific objectives of the federal programs." *Id.* at 98 (internal quotation marks and alterations omitted). See also *O'Melveny & Myers* v. *FDIC*, 512 U.S. 79, 87 (1994) ("[C]ases in which judicial creation of a special federal rule would be justified …. are … 'few and restricted'…. Our cases uniformly require the existence of [a significant conflict between some federal policy or interest and the use of state law] for recognition of a federal rule of decision."); *Atherton* v. *FDIC*, 519 U.S. 213, 218-19 (1997); *Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 507 (1988).

Had the Sixth Circuit followed this approach, it would have had to explain why ERISA required it to depart from the Michigan court's interpretation of the Administrative Services Contract. The Sixth Circuit

failed to do so. Nor could it. There is neither any authority interpreting ERISA nor any objective of ERISA that supports the Sixth Circuit's conclusion that the supposed "discretion" to waive a contractual right to fees causes the exercise of that right to amount to "control" of "plan assets" under § 3 of ERISA. As matters stand, BCBSM's collection of fees has been held to be (1) an exercise of express contractual authority to collect compensation provided for under the terms of its Administrative Services Contract with Michigan governmental employers, and (2) under *the very same terms* in contracts with private employers, a unilateral act of "self-dealing" with "plan assets." ERISA does not compel either such an absurd result or such disregard for state law.

The Sixth Circuit also departed from the decisions of multiple other circuits in assessing what constitutes "control" of "plan assets" under 29 U.S.C. § 1002(21)(A)(i). Unlike the Sixth Circuit here, the Second, Third, and Seventh Circuits all have held that when a contract expressly authorizes a third-party administrator to earn a fee, the third-party administrator's election to retain some or all of the compensation that the contract permits does not represent "control" of "plan assets." See, *e.g.*, *Leimkuehler* v. *Am. United Life Ins. Co.*, 713 F.3d 905, 912-13 (7th Cir. 2013) (service provider to a 401(k) plan is not a fiduciary as a result of electing to retain revenue-sharing fees that the contract permits it to retain), *cert. denied*, 134 S. Ct. 1280 (2014); *Renfro* v. *Unisys Corp.,* 671 F.3d 314, 324 (3d Cir. 2011) (entity is not a fiduciary as a result of application of a negotiated fee structure; service provider "'does not act as a fiduciary with respect to the terms in the service agreement'"); *Hecker* v. *Deere & Co.*, 556 F.3d 575, 584 (7th Cir. 2009) (retaining revenue-sharing

fees as allowed by contract is not controlling plan assets); *Harris Trust & Sav. Bank* v. *John Hancock Mut. Life. Ins. Co.*, 302 F.3d 18, 31 (2d Cir. 2002) (entity was not an ERISA fiduciary as a result of retaining "agreed-upon compensation" even though that compensation was "more lucrative" than the plan trustee "expected at the time of contracting"). In none of these cases did the court follow the theory adopted by the Sixth Circuit here—*i.e.*, that contractual terms authorizing a third-party administrator to collect fees should be ignored in the ERISA fiduciary analysis because the third-party administrator could exercise "discretion" to waive its contractual right to those fees.

Perhaps most obvious is the conflict between the Sixth Circuit's decision here and the Seventh Circuit's decision in *Chicago District Council of Carpenters Welfare Fund* v. *Caremark, Inc.*, 474 F.3d 463 (7th Cir. 2007) ("*Carpenters*"). There, as here, Carpenters contracted with Caremark to process benefit claims and to gain access to Caremark's network of providers, which provided pharmaceuticals at a discount to participants in Carpenters' plan. *Id.* at 466-67. The contract provided that Carpenters would obtain a fixed amount of the discounts that Caremark negotiated, and Carpenters "apparently believed that the percentage discounts" provided for in the contract included "*all* of the savings that Caremark could negotiate with retailers." *Id.* at 474. Carpenters therefore argued that Caremark's retention of a portion of those savings made Caremark an ERISA fiduciary. The Seventh Circuit disagreed:

> [N]othing in the contracts required Caremark to pass along all of the savings.... Caremark was always free to … negotiate a higher price with Carpenters than Caremark paid for the drugs.

> Except for a modest dispensing fee, that is how Caremark made its money. It was to Carpenters' benefit to deal with Caremark rather than dealing directly with the retailers. Caremark had many clients and could use this volume to negotiate better prices with the retailers than a single client could negotiate. Caremark could then pass some of those savings on to clients like Carpenters and still make money by keeping the difference for itself.

Id. Accordingly, when Caremark retained a share of the discounts for itself as permitted under the contract, it did not act as a fiduciary, much less breach any fiduciary duty. *Id.* at 475.

Carpenters is directly contrary to this case. Like Carpenters, Hi-Lex knew the total sum it paid BCBSM in exchange for BCBSM's services and access to BCBSM's provider network. Like Carpenters, Hi-Lex did not receive the benefit of the full amount of BCBSM's provider discounts, but instead paid BCBSM a fee to cover the cost of maintaining its provider network—as was permitted under the terms of the contract, which, like the *Carpenters* contract, did not obligate BCBSM to pass through all provider discounts to Hi-Lex without any fee offset. Indeed, this case is even clearer than *Carpenters*, in that from 2007 through 2011, Hi-Lex was specifically informed of the precise amount BCBSM had collected as a network access fee—yet the Sixth Circuit *still* concluded that those fees must be returned to Hi-Lex. As with Caremark, the only "discretion" BCBSM exercised was the supposed "discretion" not to waive its contractual right to compensation, but instead to exercise its contractual rights, paying beneficiary claims in exchange for compensation on the terms set by

contract. Just as Caremark was not a fiduciary, neither is BCBSM.

The Sixth Circuit also deepened a circuit split in holding that BCBSM's performance of bargained-for administrative functions—here, making *initial* claim determinations pursuant to eligibility rules established by Hi-Lex—gave rise to fiduciary duties. According to the Sixth Circuit, because plan participants were told to "make their initial benefit claims to BCBSM," and because BCBSM actually processed claims by paying providers with funds "'earmark[ed]'" for payment of Hi-Lex employees' claims, BCBSM exercised control over "plan assets." Pet. App. 8a-10a.

The Second and Seventh Circuits have rejected precisely this interpretation. *See Faber* v. *Metro. Life Ins. Co.*, 648 F.3d 98, 105 (2d Cir. 2011) (holding that establishing and administering beneficiary accounts "in the manner contemplated by" plan documents does not implicate control over plan assets); *Finkel* v. *Romanowicz*, 577 F.3d 79, 86-87 (2d Cir. 2009) (same); *Harris Trust & Sav. Bank* v. *Provident Life & Acc. Ins. Co.*, 57 F.3d 608, 613 (7th Cir. 1995) (same). So too has the Department of Labor. See 29 C.F.R. § 2509.75-8 (Question D-2) (stating that service providers "who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform … administrative functions," such as " "[p]rocessing of claims," and "[m]aking recommendations to others," are not plan fiduciaries).[4]

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[4] The Department of Labor filed an *amicus* brief in support of Hi-Lex in the Sixth Circuit, taking the position that "[t]he employer contributions that Hi-Lex forwarded to Blue Cross were also plan assets as they were earmarked for the payment of plan benefits." Brief of the Sec'y of Labor, Thomas E. Perez, as *Amicus Curiae* in Support of Appellees at 25. That statement, however, directly contradicted the Department's previous and re-

Only the Ninth Circuit has held—like the Sixth Circuit here—that a third-party administrator that makes initial decisions as to payment of health care claims according to plan rules is a fiduciary even where the employer has sole authority to make final decisions. *See IT Corp.* v. *Gen. Am. Life Ins. Co.*, 107 F.3d 1415, 1420-21 (9th Cir. 1997) (third-party administrator was a plan fiduciary even though "the contract require[d] it to refer disputed cases back to" the contracting employer).[5]

And the Sixth Circuit likewise parted company with the Second, Seventh, and Eighth Circuits by holding that the fees BCBSM collected were "plan assets." Those courts have held that plan participants have no beneficial ownership interest in a service provider's bargained-for compensation. Instead, plan participants have only the ownership rights specified in the contract. Thus, in *Carpenters*, Caremark had a contractual "duty to pay rebates [Caremark obtained from drug manufacturers] to Carpenters." 474 F.3d at 476 n.6. That did not mean, however, that the rebates Caremark obtained were "plan assets"; to the contrary, the rebates were

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cently stated opinion that "in the absence of any other actions or representations by an employer which manifest an intent to contribute assets to a plan," merely earmarking funds by "establish[ing] … an account in the name of the employer to be used exclusively in administering the plan would not create" plan assets. U.S. Dep't of Labor Adv. Op. 2013-03A, at 2 n.2 (July 3, 2013).

[5] Notably, Hi-Lex does not challenge BCBSM's actions in processing Plan beneficiaries' claims. The Sixth Circuit's decision that BCBSM's claims-processing role gave rise to fiduciary duties is thus inconsistent with this Court's holding in *Pegram* that the "threshold question" in any ERISA claim is whether the defendant "was acting as a fiduciary … *when taking the action subject to complaint*." 530 U.S. at 226 (emphasis added).

Caremark's assets—and Carpenters simply held a contractual right to payment. *Id.* Likewise here, Hi-Lex had a contractual right to performance by BCBSM in exchange for the fees—but nothing in the contract created any ownership interest for Plan participants in those fees.

Similarly, in *Tussey* v. *ABB, Inc.*, 746 F.3d 327, 339-40 (8th Cir. 2014), the Eighth Circuit held that a plan had no ownership interest in "float income"—*i.e.*, interest earned on overnight investment—from funds that the plan's service provider had a right to retain and disburse after fully performing its obligation to credit plan participants' investment accounts as directed. Likewise, in *Faber*, the Second Circuit explained that funds transmitted to a third-party administrator and credited to participants' accounts as directed were not plan assets. 648 F.3d at 106. Instead, "under ordinary notions of property rights," the relationship between the third-party administrator and plan participants was that between a debtor and creditor—"a relationship fundamentally different from an ERISA fiduciary relationship with its panoply of discretionary authority and responsibility." *Id.*

In sum, the Sixth Circuit's reading of the contract would not support a finding of fiduciary status in the Second, Third, Seventh, or Eighth Circuits. Each of those courts has applied contractual terms as written in determining whether a service provider performs the functions of an ERISA fiduciary. If a service provider does no more than collect contractually authorized compensation, or exercise contractually defined authority, then that service provider does not perform a fiduciary function. Thus, those courts would not hold that exercising so-called "discretion" to collect contractually authorized fees amounts to exercising "control" of "plan assets." Only the Ninth Circuit

agrees with the Sixth Circuit's reading of ERISA's fiduciary definition. Both courts are mistaken, and in any event, an entity's status as a fiduciary should not be determined by geography. Only this Court can resolve that problem.

II. THE SIXTH CIRCUIT'S DECISION DEEPENS AN ACKNOWLEDGED CIRCUIT SPLIT ON THE MEANING OF 29 U.S.C. § 1108.

The impact of the Sixth Circuit's decision is magnified because of its holding that BCBSM must refund all the fees it collected without regard for whether those fees are "reasonable compensation" for services BCBSM actually rendered. As the Sixth Circuit acknowledged, its decision deepened an existing circuit split on the question whether ERISA permits plans to enjoy such windfalls. Pet. App. 18a (recognizing disagreement with the Eighth Circuit).

The Sixth Circuit held that, by supposedly collecting the fees "unilaterally," BCBSM violated § 1106(b)(1). That statute provides that an ERISA plan fiduciary "shall not … deal with the assets of the plan in his own interest or for his own account." However, § 1108 provides that "[n]othing in section 1106 of this title shall be construed to prohibit any fiduciary from … receiving any reasonable compensation for services rendered … in the performance of his duties with the plan." 29 U.S.C. § 1108(c)(2). By its plain language, then, § 1108(c)(2) expressly limits the scope of § 1106's prohibitions, providing that § 1106 *does not prohibit* a fiduciary's receipt of reasonable compensation from an ERISA plan for services rendered to the plan.

This straightforward reading of the statutory text has been adopted by both the Eighth and Second Cir-

cuits. In *Harley* v. *Minnesota Mining & Manufacturing Co.*, 284 F.3d 901 (8th Cir. 2002), the Eighth Circuit considered the same question presented here—whether a party charged with a violation of § 1106(b)(1) could assert a reasonable compensation defense under § 1108(c)(2). The Eighth Circuit held that "the plain language of § 1108(c)(2) sensibly insulates the fiduciary from liability if the compensation paid was reasonable." *Id.* at 908-09. The court rejected the plaintiffs' argument that a Department of Labor regulation, 29 C.F.R. § 2550.408c-2(a), compelled a different conclusion, because the plaintiffs' reading of that regulation "conflict[ed] with an unambiguous statute." 284 F.3d at 909. Moreover, the court explained, the legislative history did not support a narrower interpretation of § 1108(c)(2). *Id.* The Second Circuit has likewise explained that "[b]y its express language," § 1108(c)(2) exempts from § 1106's prohibitions a fiduciary's receipt of reasonable compensation for "services rendered to a plan and paid for by a plan." *Lowen* v. *Tower Asset Mgmt., Inc.*, 829 F.2d 1209, 1216 & n.4 (2d Cir. 1987).[6]

Without analyzing or even reciting the statutory text, the Sixth Circuit stated that "the majority of courts that have examined this statutory interpretation issue have held that § 1108 applies only to transactions under § 1106(a), not § 1106(b)." Pet. App. 18a (citing *Nat'l Sec. Sys., Inc.* v. *Iola*, 700 F.3d 65, 93-96 (3d Cir. 2012), *cert. denied sub nom. Barrett*

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[6] The Second Circuit held that the reasonable compensation defense did not apply to the circumstances before it because the fiduciary had received fees not from a plan, but from "companies in which the Plans' assets are invested." 829 F.2d at 1216. Here, however, the lower courts held that BCBSM's supposed "self-dealing" involved compensation received from "plan assets."

v. *Universal Mailing Ser*v., *Inc.*, 133 S. Ct. 1812 (2013); *Patelco Credit Union* v. *Sahni*, 262 F.3d 897, 910-11 (9th Cir. 2001); and several district court cases). The court "decline[d] BCBSM's invitation" to apply § 1108(c)'s reasonable compensation defense to § 1106(b). *Id.*

While the Sixth Circuit did not undertake any statutory analysis, the Third and Ninth Circuit opinions it relied on both focused on language in § 1106(a). *Nat'l Sec. Sys.*, 700 F.3d at 94-95; *Patelco*, 262 F.3d at 910. That subsection prohibits certain transactions between an ERISA plan and a "party in interest," but includes a prefatory clause stating that its prohibitions apply "[e]xcept as provided in section 1108 of this title." Section 1106(b), which addresses transactions between a plan and a fiduciary, has no such cross-reference to § 1108. Thus, the Third and Ninth Circuits stated, "by prefacing [§ 1106(a)], but not [§ 1106(b)], with a qualification, Congress tempered [§ 1106(a)] transactions, but not [§ 1106(b)] transactions, with [§ 1108] exemptions." *Nat'l Sec. Sys.*, 700 F.3d at 95; *Patelco*, 262 F.3d at 910. Similarly, the Department of Labor has interpreted § 1108(c)(2) only as "clarify[ing] what constitutes reasonable compensation" paid "by a plan to a party in interest for services rendered to the plan," 29 C.F.R. § 2550.408c-2(a)—and not as providing "an independently operative reasonable-compensation exception" to § 1106(b)'s prohibition on transactions between a plan and a fiduciary. *Nat'l Sec. Sys.*, 700 F.3d at 96.[7]

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[7] The Third Circuit in *National Security Systems* ultimately concluded that the statutory language was ambiguous, and deferred to the Department of Labor's interpretation as "a reasonable construction of the statute insofar as it relates to the [§ 1106(b)] prohibited transactions." 700 F.3d at 96.

The conclusion that § 1108(c)'s reasonable compensation defense applies only to the transactions addressed in § 1106(a), and not to those addressed in § 1106(b), cannot be reconciled with the statutory text. Section 1108(c) unambiguously states that "*[n]othing* in section 1106"—that is, neither § 1106(a) nor § 1106(b)—"shall be construed to prohibit any fiduciary from … receiving any reasonable compensation for services rendered." 29 U.S.C. § 1108(c)(2) (emphasis added). It would be strange indeed to read this text in § 1108, which deals specifically with liability for transactions between a plan and a fiduciary, not to apply to § 1106(b), which also deals specifically with transactions between a plan and a fiduciary. Moreover, contrary to the Third and Ninth Circuits, reading § 1108(c) according to its plain terms does not require ignoring the prefatory clause in § 1106(a). Section 1106(a) prohibits particular categories of transactions between a plan and party in interest—such as "lending of money or other extension of credit"—with the exception of the specific transactions allowed by § 1108. *Id.* § 1106(a)(1). Section 1108(b) identifies particular transactions that *are* permitted. *E.g.*, *id.* § 1108(b)(1) (authorizing "[a]ny loans made by the plan to parties in interest who are participants or beneficiaries of the plans if such loans" satisfy designated criteria). Thus, the prefatory clause in § 1106(a) makes unambiguous that that subsection's prohibitions of specified categories of transactions are subject to the carve-outs from those prohibited categories in § 1108.

What is more, other subsections of § 1108 make express reference to both § 1106(a) and (b). *See id.* § 1108(a), (b)(19). This demonstrates two things. First, the Sixth Circuit was wrong to conclude that "§ 1108 applies only to transactions under § 1106(a),

not § 1106(b)." Pet. App. 18a. In fact, on its face, § 1108 applies to both subsections. Second, it makes clear that Congress was fully capable of limiting § 1108's application to individual subsections of § 1106 when it chose to do so. Therefore, there is no reason to read § 1108(c)'s unambiguous text—"[n]othing in section 1106"—to mean "nothing in section 1106(a)."

By adopting the Third and Ninth Circuits' erroneous reading of § 1108(c), the Sixth Circuit deepened the now longstanding circuit split on this critical issue. Moreover, it turned ERISA into a source of potentially immense windfalls for plaintiffs. See, *e.g.*, *Henry* v. *Champlain Enters., Inc.*, 445 F.3d 610, 624 (2d Cir. 2006) (Sotomayor, J.) ("The aim of ERISA is to make the plaintiffs whole, but not to give them a windfall.") (internal quotation marks omitted).

This case is a perfect example of such an unintended windfall. Hi-Lex's claim was that it was unaware that BCBSM had been collecting a network access fee and that BCBSM breached a fiduciary duty by doing so. After 2007, as the lower courts held, Hi-Lex was indisputably aware that BCBSM was, under the contract, collecting those fees, as well as the precise dollar amount of the fees. Even so, *Hi-Lex continued to contract with BCBSM and to pay the network maintenance fees*, and does so to this day. In other words, Hi-Lex chose, in the exercise of its fiduciary duty as plan sponsor, to continue contracting for BCBSM's services even when Hi-Lex was fully aware that BCBSM was collecting access fees as compensation for those services. Hi-Lex's action refutes any notion that Hi-Lex—much less the Plan or its participants—suffered harm by paying those fees in prior years, or that those fees did not represent reasonable compensation for the services BCBSM provided.

The lower courts' award of a full refund of all fees from the years at issue thus is a massive windfall for Hi-Lex. If the Sixth Circuit's decision is permitted to stand, it may well lead to equally unsupportable windfalls for the dozens of other plaintiffs who have filed identical suits against BCBSM—as well as in future suits against BCBSM and other service providers across the nation.

III. IF ALLOWED TO STAND, THE SIXTH CIRCUIT'S DECISION WILL HAVE BROAD, IMMEDIATE, AND HARMFUL IMPACTS.

As shown above, this Court's review is warranted to address multiple disputes among the federal courts of appeals concerning the proper interpretation of ERISA. Moreover, review *in this case* is essential to avoid both a tidal wave of litigation and the inevitable cost increases that will result for healthcare and other benefit plans.

Most immediately, the outcome of this case will have huge effects across Michigan, where BCBSM has entered into materially identical contracts with several hundred employers. Indeed, if allowed to stand, the Sixth Circuit's decision here may well be binding in a host of cases already filed against BCBSM. See *Bandit Indus., Inc.* v. *Blue Cross & Blue Shield of Mich.*, No. 4:13-cv-12922, 2013 WL 5651444, at *1 (E.D. Mich. Oct. 15, 2013) (noting that, as of October 2013, there had been "over thirty nearly identical cases" filed in the Eastern District of Michigan); Chad Halcom, *Hidden-Fees Ruling Against Blues Opens Door to Lawsuits Under Stay*, Crain's Detroit Bus. (May 18, 2014) ("It's 'game on' once more for 35 self-insured businesses looking to recoup alleged hidden fees in past reimbursements to

Blue Cross Blue Shield of Michigan").[8] Multiple lawsuits have been filed since the Sixth Circuit's decision, and even more are sure to follow—particularly in light of the Sixth Circuit's conclusion that Hi-Lex was entitled to an extended, six-year statute of limitations under ERISA's "fraud or concealment" exception. Pet. App. 13a-14a; *see also DM Cos.* v. *Blue Cross & Blue Shield of Mich.*, No. 2:14-cv-13079-DPH-MJH (E.D. Mich. complaint filed Aug. 8, 2014); *Alma Prods. I, Inc.* v. *Blue Cross & Blue Shield of Mich.*, No. 2:14-cv-13066-RHC-RSW (E.D. Mich. complaint filed Aug. 7, 2014); *Kent Cos.* v. *Blue Cross & Blue Shield of Mich.*, No. 2:14-cv-13070-GCS-DRG (E.D. Mich. complaint filed Aug. 7, 2014); *Master Automatic Mach. Co.* v. *Blue Cross & Blue Shield of Mich.*, No. 4:14-cv-12542-LVP-DRG (E.D. Mich. complaint filed June 27, 2014); *Automatic Spring Prods. Corp.* v. *Blue Cross & Blue Shield of Mich.*, No. 5:14-cv-12545-JEL-PJK (E.D. Mich. complaint filed June 27, 2014).

More broadly, the Sixth Circuit's disregard for the express, bargained-for limitations on BCBSM's authority and obligations in the controlling documents—contractual terms that have been repeatedly enforced by the Michigan courts—threatens to wreak havoc. It eliminates any prospect that a

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[8] The decision has been extensively covered in the legal and regional press. *See, e.g.*, Megan Stride, *Blue Cross Hit with $5M Judgment in Hidden Fees Case*, Law360 (May 24, 2013); Pete Daly, *Varnum Wins $5.1 M Fees Case Against BCBSM*, Grand Rapids Bus. J. (May 31, 2013); Steve Flores, *Circuit Court Upholds Breach of Fiduciary Duty Determination Against Third Party Administrator of Self-Insured Health Plan*, Lexology (May 23, 2014); Cynthia Price, *Sixth Circuit Court of Appeals Upholds Varnum Win in Precedent-Setting Case*, Legal News (May 23, 2014); Jim Harger, *Blue Cross Blue Shield of Michigan Loses Appeal of $6.1M Fraud Judgment*, mlive (May 15, 2014).

service provider can bargain for and rely on contractual terms that place fiduciary obligations on the employer, and not the service provider. Under the Sixth Circuit's decision, a service provider may be deemed a fiduciary whenever it: (1) collects bargained-for compensation, even pursuant to an express contract that has been held valid and definite as a matter of state law; (2) makes initial claim determinations, even where the employer establishes eligibility rules and retains the authority to make final determinations; or (3) receives compensation from an employer, even where the employer has specified that the compensation is paid from the employer's general assets rather than plan funds.

Each of these is a common practice of service providers to ERISA-governed plans, and none has previously been understood to create fiduciary obligations. The Sixth Circuit's expansion of fiduciary obligations for third-party administrators—irrespective of what the controlling documents state—is a dramatic departure from current practice, as the cases discussed above and a host of other authorities attest. *See, e.g.*, U.S. Dep't of Labor, *Understanding Your Fiduciary Responsibilities Under A Group Health Plan* 1 n.1, 2 (May 2013) ("If a plan is self-funded (paid from the employer's general assets), those funds are not plan assets …"; "a third party administrator … who performs solely ministerial tasks is not a fiduciary"), *available at* http://www.dol.gov/ebsa/pdf/ghpfiduciaryresponsibilities.pdf; *Pharm. Care Mgmt. Ass'n* v. *Rowe*, 429 F.3d 294, 298, 301 (1st Cir. 2005) (per curiam) (pharmaceutical benefit managers, which "serve as intermediaries between pharmaceutical manufacturers and pharmacies on the one hand … and health benefit providers

[such as self-insured entities] on the other," do not "act[] as fiduciaries under ERISA").

The uncertainty engendered by the Sixth Circuit's decision will inevitably lead to reduced supply and increased costs as service providers are exposed to an increased risk that contractual terms and business practices thought to avoid ERISA fiduciary status will later be deemed ineffective. This Court has recognized as much, noting that with ERISA, "Congress sought to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Conkright* v. *Frommert*, 559 U.S. 506, 516-17 (2010) (internal quotation marks omitted; alterations in original); *see also Beddall* v. *State Street Bank & Trust Co.*, 137 F.3d 12, 21 (1st Cir. 1998) ("ERISA's somewhat narrow fiduciary provisions are designed to avoid … incremental costs" associated with expanding fiduciary status unexpectedly). Only this Court's prompt review can prevent these unfortunate and unwarranted outcomes.

CONCLUSION

For the foregoing reasons, the petition for a writ for certiorari should be granted.

Respectfully submitted,

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August 12, 2014

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS,
SIXTH CIRCUIT.

Nos. 13-1773, 13-1859
Argued: March 19, 2014

HI-LEX CONTROLS, INC.,
HI-LEX AMERICA, INC., AND HI-LEX CORPORATION
HEALTH AND WELFARE BENEFIT PLAN,

Plaintiffs-Appellees / Cross-Appellants,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant-Appellant / Cross-Appellee.

Decided and Filed: May 14, 2014

OPINION

BEFORE: KEITH, SILER, and ROGERS, *Circuit Judges*.

SILER, *Circuit Judge*.

The Hi-Lex corporation, on behalf of itself and the Hi-Lex Health & Welfare Plan, filed suit in 2011 alleging that Blue Cross Blue Shield of Michigan (BCBSM) breached its fiduciary duty under the Employee Retirement Income Security Act of 1974 (ERISA) by inflating hospital claims with hidden surcharges in order to retain additional administrative compensation. The district court granted summary

judgment to Hi-Lex on the issue of whether BCBSM functioned as an ERISA fiduciary and whether BCBSM's actions amounted to self-dealing. A bench trial followed in which the district court found that Hi-Lex's claims were not time-barred and that BCBSM had violated ERISA's general fiduciary obligations under 29 U.S.C. § 1104(a). The district court also awarded pre- and post-judgment interest. We AFFIRM.

I.

Hi-Lex is an automotive supply company with approximately 1,300 employees. BCBSM is non-profit entity regulated by the state of Michigan that contracts to serve as a third-party administrator (TPA) for companies and organizations that self-fund their health benefit plans.

Since 1991, BCBSM has been the contracted TPA for Hi-Lex's Health and Welfare Benefit Plan (Health Plan). The terms under which BCBSM served as the Health Plan's TPA are set forth in two Administrative Services Contracts (ASCs) the parties entered into in 1991 and 2002, respectively. The parties renewed those terms each year from 1991 to 2011 by executing a "Schedule A" document.

Under the ASCs, BCBSM agreed to process health-care claims for Hi-Lex's employees and grant those employees access to BCBSM's provider networks. In exchange for its services, BCBSM received compensation in the form of an "administrative fee"—an amount set forth in the Schedule A on a per employee, per month basis.

In 1993, BCBSM implemented a new system whereby it would retain additional revenue by adding certain mark-ups to hospital claims paid by its ASC

clients. These fees were charged in addition to the "administrative fee" that BCBSM collected from Hi-Lex under a separate portion of the ASC. Thus, regardless of the amount BCBSM was required to pay a hospital for a given service, it reported a higher amount that was then paid by the self-insured client. The difference between the amount billed to the client and the amount paid to the hospital was retained by BCBSM. This new system was termed "Retention Reallocation."

The fees involved in this new system have been termed "Disputed Fees" by the district court. They include:

A. Charges for access to the Blue Cross participating provider and hospital network (Provider Network Fee);

B. Contribution to the Blue Cross contingency reserve (contingency/risk fee);

C. Other Than Group subsidy (OTG fee); and

D. a retiree surcharge.

Hi-Lex asserts that it was unaware of the existence of the Disputed Fees until 2011, when BCBSM disclosed to the company in a letter the existence of the fees and described them as "administrative compensation."

Following the disclosure, Hi-Lex sued BCBSM, alleging violations of ERISA as well as various state law claims. The district court dismissed the company's state law claims as preempted, but granted Hi-Lex summary judgment on its claim that BCBSM functioned as an ERISA fiduciary and that BCBSM had violated ERISA by self-dealing. Furthermore, after a nine-day bench trial, the district court ruled that

BCBSM had violated its general fiduciary duty under § 1104(a) and that Hi-Lex's claims were not time-barred. The court awarded Hi-Lex $5,111,431 in damages and prejudgment interest in the amount of $914,241.

BCBSM asserts that the district court erred by (1) finding the company was an ERISA fiduciary, (2) ruling that BCBSM had breached its fiduciary duty under ERISA § 1104(a), (3) holding that BCBSM had conducted "self-dealing" in violation of ERISA § 1106(b)(1), and concluding that Hi-Lex's claims were not time-barred. Hi-Lex cross-appealed, arguing that the district court abused its discretion by ordering an insufficient prejudgment interest award.

II.

We review a district court's summary judgment rulings de novo. *Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Mich.*, 722 F.3d 861, 865 (6th Cir.2013) (*Pipefitters IV*). The same standard applies when this court reviews "a district court's determination regarding ERISA-fiduciary status." *McLemore v. Regions Bank*, 682 F.3d 414, 422 (6th Cir.2012). After a bench trial, a court's legal conclusions are reviewed de novo while its factual findings are reviewed for clear error. *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 448 (6th Cir.2002).

III.

A. BCBSM's ERISA Fiduciary Status

A threshold issue in this case is whether BCBSM functioned as an ERISA fiduciary for Hi-Lex's Health Plan. In relevant part, ERISA provides that

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

29 U.S.C. § 1002(21)(A) (emphasis added). The term *person* is defined broadly to include a corporation such as BCBSM. *Id*. § 1002(9). In *Briscoe v. Fine*, we found this statute "impose[d] fiduciary duties not only on those entities that exercise *discretionary* control over the disposition of plan assets, but also impose[d] such duties on entities or companies that exercise '*any* authority or control' over the covered assets." 444 F.3d 478, 490–91 (6th Cir.2006). Applying that standard, we recently held that BCBSM functioned as an ERISA fiduciary when it served as a TPA for a separate client under the same ASC terms at issue here. *See Pipefitters IV*, 722 F.3d at 865–67. In that case, we found that BCBSM functioned as an ERISA fiduciary with respect to hidden OTG fees that it unilaterally added to hospital claims subsequently paid by the Pipefitters Fund. *Id*. at 866–67.

BCBSM argues that the decisions in *McLemore*, 682 F.3d at 422–24, and *Seaway Food Town, Inc. v. Med. Mut. of Ohio*, 347 F.3d 610, 616–19 (6th Cir.2003), support its right to collect fees per the terms of its contract with Hi-Lex. In *Seaway*, however, we qualified our holding by noting that while simple adherence to a contract's term giving a party "the unilateral right to retain funds as compensation" does not give rise to fiduciary status, a "term [that] authorizes [a] party to exercise discretion with respect

to that right" does. 347 F.3d at 619. Acknowledging this, BCBSM argues that it exercised no discretion with respect to the Disputed Fees because they were part of the standard pricing arrangement for the company's entire ASC line of business. The record, though, supports a finding that the imposition of the Disputed Fees was not universal. The district court cited an email in which BCBSM's underwriting manager, Cindy Garofali, acknowledged that individual underwriters for BCBSM had the "flexibility to determine" how and when access fees were charged to self-funded ASC clients. Moreover, Garofali admitted during testimony at trial that the Disputed Fees were sometimes waived entirely for certain self-funded customers. *See also Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Mich*., 213 Fed.Appx. 473, 475 (6th Cir.2007) (*Pipefitters I*) (noting that self-insured clients were not always required to pay the Disputed Fees). The district court did not err in finding that the Disputed Fees were discretionarily imposed.[1]

BCBSM also attempts to distinguish this case from *Pipefitters IV* by arguing that the funds which paid the Disputed Fees were Hi-Lex's corporate assets, not "plan assets" subject to ERISA protections. In *Pipefitters IV*, corporate funds from several employ-ers were first pooled together in a trust account, the Pipefitters Fund, which then remitted funds to BCBSM in its capacity as a TPA. In this case, the funds Hi-Lex sent to BCBSM in its role as TPA came

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[1] Counsel for BCBSM acknowledged as much during oral argument in *Pipefitters IV*. "But Your Honor, again, I really need to stress, getting caught up in the *Hi–Lex* case I think is a mistake because the fees are totally different. It's not . . . that . . . those are about fees where there is discretion." Oral Argument at 22:28, *Pipefitters IV*, 722 F.3d 861 (6th Cir.2013).

not from a formal trust account, but from a combination of the company's general funds and Hi-Lex employee contributions.

Department of Labor regulations state that employee contributions constitute plan assets under ERISA once they are "segregated from the employer's general assets." 29 C.F.R. § 2510.3-102(a)(1). Thus, the health care contributions deducted from Hi-Lex employees' paychecks and sent to BCBSM to pay claims and administrative costs qualify as plan assets.[2] *See* U.S. Dep't of Labor, Advisory Op. No. 92–24A, 1992 WL 337539, *2 (Nov. 6, 1992) (AO 92–24A) ("all amounts that a participant pays to or has withheld by an employer for purposes of obtaining benefits under a plan will constitute plan assets"); *see also United States v. Grizzle*, 933 F.2d 943, 946–47 (11th Cir.1991) (finding that plan assets may be composed of employee contributions even before their delivery to the plan). BCBSM correctly notes, though, that employee contributions represented only a fraction of the funds it received from Hi-Lex and those contributions first began in 2003—several years after the Disputed Fee compensation system was initiated. The pertinent question, then, is whether the *employer* contributions that Hi-Lex sent to BCBSM must also be considered plan assets.

"[T]he assets of an employee benefit plan generally are to be identified on the basis of ordinary notions of property rights." AO 92–24A at *2. Under this analysis, "the assets of a welfare plan generally

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[2] BCBSM's contention that it lacked notice of any employee contributions in the funds it received from Hi–Lex is not supported by the record. The Summary Plan Description (SPD) states that Hi–Lex and its employees "share the cost of participating in the Plan."

include any property, tangible or intangible, in which the plan has a beneficial ownership interest." *Id*. Making the plan assets' determination "therefore requires consideration of any contract or other legal instrument involving the plan, as well as the actions and representations of the parties involved." *Id*. Furthermore, the "drawing benefit checks on a TPA account, as opposed to an employer account, may suggest to participants that there is an independent source of funds securing payment of their benefits under the plan." *Id*.

In this case, the Summary Plan Description (SPD)—which ERISA requires to be distributed to plan participants[3]—establishes that Hi-Lex's intention was to place plan assets for its self-funded Health Plan with BCBSM in its capacity as TPA. The SPD specifically notes that Hi-Lex "is not [a] direct payor of any benefits" and "no special fund or trust" exists from which self-insured benefits are paid.[4] Instead, the SPD states that a TPA (designated later in the document as BCBSM) has been hired, and it "reviews [plan participant's] claims and pays benefits from the money we provide." Moreover, although the SPD gives final claims determination to Hi-Lex, the document makes clear that enrollees must make their initial benefit claims to BCBSM, which has both the funds and the discretion to pay claims.[5] The language in the ASC does nothing to alter the understanding that BCBSM in its role as TPA would be holding

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[3] *See* 29 U.S.C. § 1024(b).

[4] ERISA permits this arrangement. *See* 29 U.S.C. § 1103(b).

[5] BCBSM maintained exclusive check-writing authority over the Comerica Bank account into which Hi–Lex's funds were wired as mandated by the Schedule A.

funds to pay the healthcare expenses of Plan beneficiaries—a group the ASC terms "enrollees."[6] Indeed, the quarterly statements received by Hi-Lex show that the funds it sent to BCBSM were, predictably, spent covering the health expenses and administrative costs of plan beneficiaries.

While BCBSM attempts to characterize its arrangement with Hi-Lex as a service agreement between two companies—with no thought toward ERISA and its protections—that argument is unavailing. The SPD contains an entire section disclosing plan beneficiaries' rights under ERISA, including the right to sue "the fiduciaries" (plural) if they "misuse the Plan's money." If BCBSM's interpretation of the parties' arrangement were accurate, there would only be a single fiduciary, Hi-Lex, the named Plan Administrator. Additionally, although the ASC lacks any specific reference to plan assets, it does recognize that BCBSM may have certain responsibilities "under ERISA" that it cannot contract around.[7] Furthermore, in practice, BCBSM annually submitted data to Hi-Lex especially designed for use on the company's ERISA-mandated DOL 5500 forms.[8] Collectively, these "actions and representations" establish that BCBSM, Hi-Lex and the company's employees all

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[6] Although the ASC was made between the "Group" (Hi–Lex) and BCBSM, its provisions regarding health claims processing and payment correlate with those found in the SPD.

[7] A fiduciary is established under ERISA by a party's functional role and that responsibility cannot be abrogated by contract. *See Mertens v. Hewitt Assocs*., 508 U.S. 248, 262, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993); *Briscoe*, 444 F.3d at 492.

[8] The Form 5500 Series is required by the Department of Labor to fulfill certain reporting requirements under ERISA's Titles I and IV.

understood that BCBSM would be holding ERISA-regulated funds to pay the health expenses and administrative costs of enrollees in the Hi-Lex Health Plan. As a result, Hi-Lex's Plan beneficiaries had a reasonable expectation of a "beneficial ownership interest" in the funds held by BCBSM.

BCBSM makes much of the fact that neither it nor Hi-Lex had a separate bank account set aside exclusively for the funds intended to pay enrollee health expenses. BCBSM cannot, however, cite any case law requiring such an arrangement for the existence of ERISA plan assets. Our court has found that plan assets can exist when a company directly funds an ERISA plan from its corporate assets and the contracted TPA holds those funds in a general account. *See Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031, 1036 (6th Cir.1993) (finding that Blue Cross was a fiduciary "because [it] could earmark the funds that Libbey-Owens-Ford allocated to the plan").

Finally, trust law, which BCBSM acknowledges should guide the court in its fiduciary analysis, favors Hi-Lex's position.

> When one person transfers funds to another, it depends on the manifested intention of the parties whether the relationship created is that of trust or debt. If the intention is that the money shall be kept or used as a separate fund for the benefit of the payor or *one or more third persons*, a trust is created.

Restatement (Third) of Trusts § 5 cmt. k (2003) (emphasis added); *see also Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 110–11, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) (noting the value of trust law in

interpreting ERISA's responsibility provisions). Thus, while a formal trust was never created in this case, 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. ERISA's Statute of Limitations

A separate threshold issue in this case involves ERISA's statute of limitations for actions brought under 29 U.S.C. §§ 1104(a) and 1106(b). "[T]he statute requires that a claim be brought within three years of the date the plaintiff first obtained 'actual knowledge' of the breach or violation forming the basis for the claim." *Cataldo v. U.S. Steel Corp*., 676 F.3d 542, 548 (6th Cir.2012). "'Actual knowledge' means 'knowledge of the underlying conduct giving rise to the alleged violation,' rather than 'knowledge that the underlying conduct violates ERISA.'" *Id.* (quoting *Wright v. Heyne,* 349 F.3d 321, 331 (6th Cir.2003)). However, the statute provides an exception for a case involving "fraud or concealment," extending the filing period to a date no later than six years after the time of discovery of the violation. *See id*.; 29 U.S.C. § 1113.

In this case, the district court found that Hi-Lex obtained knowledge of the Disputed Fees in August 2007[9]—a finding the company does not dispute. Since Hi-Lex filed suit in June 2011, it must avail itself of

[9] The district court held that Hi–Lex should have discovered the Disputed Fees when a "Value of Blue" pie chart that depicted the charges was presented to the company as part of an annual settlement meeting with BCBSM on August 21, 2007.

ERISA's "fraud or concealment" exception or its action is time-barred. BCBSM asserts that the district court erred by not finding that Hi-Lex had actual knowledge of the Disputed Fees before August 2007 or, alternatively, that the company's failure to exercise due diligence led to its lack of knowledge regarding the fees.

1. Timeframe for Actual Knowledge

There is no evidence in the record that any ASC signed before 2002 contained language pertaining to the Disputed Fees. The Schedule As from 1995 to 2002 contained a single sentence that BCBSM contends relates to the Disputed Fees: "Your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate." This statement, however, did not appear in the "Administrative Charge" section of the document where other recurring expenses related to BCBSM's compensation are located. It also omitted the critical fact that the Disputed Fees would be retained by BCBSM as additional compensation and not paid to hospitals.

In 2002, language was added to the ASC that BCBSM contends further explains the Disputed Fees:

> The Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in Amounts Billed.

This language, though, is similarly opaque and misleading. *See Pipefitters IV*, 722 F.3d at 867. The phrase "ordered by the State Insurance Commissioner" is not accurate because the Insurance Commissioner neither ordered BCBSM customers to pay these fees

nor had the authority to do so. Additionally, because the phrase "Amounts Billed" is defined in the ASC to mean "the amount [Hi-Lex] owes in accordance with BCBSM's standard operating procedures *for payment of Enrollees' claims*," this term provides no notice that BCBSM will be retaining additional administrative compensation from these charges.[10] Furthermore, even to the extent that the contract documents provide some hint about additional fees, those documents describe only what *might* happen in the future. Every year, however, Hi–Lex received DOL 5500 certification sheets from BCBSM which purported to show the administrative compensation that BCBSM was *actually* receiving. The 5500 Forms, though, indicated that BCBSM was not retaining any administrative compensation beyond that clearly delineated in the ASC and Schedule As.[11] The district court did not err in finding that Hi-Lex gained knowledge of the Disputed Fees beginning in August 2007.

2. Fraud or Concealment Exception

Unless ERISA's "fraud or concealment" exception applies, Hi-Lex's action is time-barred because it was

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[10] Language in a Schedule A from 2006 did note that "[a] portion of [Hi–Lex's] hospital savings has been retained by BCBSM" to cover provider network costs. However, even assuming that language provided actual knowledge to Hi–Lex, it did so within the 6–year statute of limitations period under ERISA's "fraud or concealment" exception.

[11] In the certifications provided by BCBSM to help prepare DOL 5500s, the Disputed Fees were included on the line for "Claims Paid." The "Administration" section that should have included all administrative fees listed only those fees disclosed by BCBSM. Lines for "Other Expenses" and "Risk and Contingency" were either marked zero or not applicable each year.

filed in June 2011, more than three years after the company acquired knowledge of the Disputed Fees. Other circuit courts have split when interpreting the scope of the fraud or concealment exception. Compare *Larson v. Northrop Corp.*, 21 F.3d 1164, 1174 (D.C.Cir.1994) (finding that § 1113 requires a defendant to have actively engaged in concealment), with *Caputo v. Pfizer, Inc.*, 267 F.3d 181, 192–93 (2d Cir.2001) (holding that the fraud or concealment provision applies to actions for breach of fiduciary duty in which the underlying action itself sounds in fraud). We have not yet taken a position on these two competing interpretations. *See Cataldo*, 676 F.3d at 548–51 (noting that an "open question" exists in the Sixth Circuit on the scope of the fraud or concealment exception). To resolve this case, though, it remains unnecessary for us to take sides because, as the district court found, BCBSM breached its fiduciary duty by committing fraud and then acting to conceal that fraud.

BCBSM committed fraud by knowingly misrepresenting and omitting information about the Disputed Fees in contract documents. Specifically, the ASC, the Schedule As, the monthly claims reports, and the quarterly and annual settlements all misled Hi–Lex into believing that the disclosed administrative fees and charges were the only form of compensation that BCBSM retained for itself.

BCBSM also "engaged in a course of conduct designed to conceal evidence of [its] alleged wrong-doing." *Larson*, 21 F.3d at 1172. After rumors emerged that BCBSM had "hidden fees" in the early 2000s, representatives from BCBSM told various insurance brokers that customers got 100% of the hospital discounts and that "Blue Cross does not hold anything

back." BCBSM made similar assurances to Hi-Lex, stating in an annual renewal document, "Your BCBSM Administrative Fee is all-inclusive." BCBSM also gave a misleading response to a Request for Proposal (RFP) issued by Hi-Lex by denying that it charged "Access Fees." This response helped sustain the illusion that BCBSM was more cost-competitive than other TPAs who responded to the RFP. Finally, the Form 5500 certification sheets that BCBSM provided to Hi-Lex every year concealed the additional administrative compensation that was being taken in the form of the Disputed Fees.

3. Due Diligence

A common requirement of both the *Caputo* and *Larson* standards for determining "fraud or concealment," is that an ERISA plaintiff's failure to discover a fiduciary violation must not have been attributable to a lack of due diligence on his part. *See Larson*, 21 F.3d at 1172 (finding that plaintiffs must not have been on notice about evidence of a fiduciary breach, "despite their exercise of diligence"); *Caputo*, 267 F.3d at 192–93 (holding that "plaintiffs' action [was] timely because it was brought within six years of when, with due diligence, they should have discovered the fraud").

BCBSM argues that Hi-Lex failed to exercise due diligence because the company's finance officials, Thomas Welsh and John Flack, did not thoroughly read the 2002 ASC or the annual Schedule A renewal documents. While that assertion is accurate, it represents an incomplete picture of the actions of those officials. The district court found that "Welsh carefully reviewed all financial reports from BCBSM" and maintained that "financial data in a master spreadsheet." Moreover, after a healthcare consultant, hired by Hi-Lex, raised a question about ambiguous

language in the Schedule A, "Welsh diligently followed up with BCBSM, only to never get a response." Later, Hi-Lex's RFP specifically asked TPAs whether they charged any "Network Access/Management Fees" or "Other Fees" and BCBSM answered "N/A." Hi-Lex officials reasonably relied on their consultant who interpreted that response to mean there were no Disputed Fees in addition to BCBSM's disclosed Administrative Fees. When Flack assumed the CFO role from Welsh, he continued to review the monthly claims reports from BCBSM and record the data into the master spreadsheet. As before, though, none of those reports gave any indication that claims included administrative fees paid to BCBSM. The district court did not err in finding that Hi-Lex acted with diligence in reviewing the administrative costs of its health plan until BCBSM presented its Value of Blue Report in August 2007.

Moreover, if Hi-Lex had not acted diligently, the Supreme Court has held that when a "discovery of the facts constituting the violation" provision exists in a statute of limitations, courts must also examine whether "a hypothetical reasonably diligent plaintiff would have discovered [those facts]." *Merck & Co. v. Reynolds*, 559 U.S. 633, 646–47, 130 S.Ct. 1784, 176 L.Ed.2d 582 (2010). The district court correctly found that such a company would not have discovered the Disputed Fees until August 2007.

The contract documents (ASC and Schedule As until 2006) fail to reference or explain the Disputed Fees in a way that a reasonable reader would understand that those fees involved additional compensation for BCBSM. Indeed, BCBSM's own account manager, Sandy Ham, who read and signed multiple Schedule As from 1999 to 2005, testified that she did not

understand anything about the Disputed Fees, including their existence. Additionally, six insurance brokers, who had years of experience working with self-funded customers, testified at trial that they had no understanding of the fees until 2007 when BCBSM began disclosing more information. If health industry experts and BCBSM's account manager—who was tasked with explaining contract documents to customers—did not understand that the Disputed Fees were being authorized by contract documents, then a "reasonably diligent" CFO could not be expected to know about them. Besides the contract documents, BCBSM made discovery of its Disputed Fee practice more difficult for a hypothetical diligent customer by not separately accounting for those fees in its monthly, quarterly, and annual claims reports or in the information sheets it provided to help customers prepare DOL 5500 Forms. Finally, according to BCBSM's own survey of its self-insured customers, a substantial majority—83%—did not know the Disputed Fees were being charged.

The claims in this case did not violate ERISA's statute of limitations because Hi-Lex can validly invoke the extended six-year period permitted by the fraud or concealment exception.

IV.

A. § 1106(b)(1)

A fiduciary with respect to an ERISA plan "shall not deal with the assets of the plan in his own interest or for his own account." 29 U.S.C. § 1106(b)(1). As interpreted by this court, that statute contains an "absolute bar against self-dealing." *Brock v. Hendershott*, 840 F.2d 339, 341 (6th Cir.1988). Because this case involves the same ASC, same

defendant, and same allegations, our decision in *Pipefitters IV* controls with respect to the § 1106(b)(1) claim. *See Pipefitters IV*, 722 F.3d at 868 (holding that BCBSM's use of fees it discretionarily charged "for its own account" is "exactly the sort of self-dealing that ERISA prohibits fiduciaries from engaging in").

BCBSM argues it is entitled to present a "reasonable compensation" defense under 29 U.S.C. §§ 1108(b)(2) and (c)(2). In support, it cites *Harley v. Minn. Mining & Mfg. Co*., 284 F.3d 901, 908–09 (8th Cir.2002). However, the majority of courts that have examined this statutory interpretation issue have held that § 1108 applies only to transactions under § 1106(a), not § 1106(b). *See, e.g., Nat'l Sec. Sys., Inc. v. Iola*, 700 F.3d 65, 93–96 (3d Cir.2012); *Patelco Credit Union v. Sahni*, 262 F.3d 897, 910–11 (9th Cir.2001); *Chao v. Linder*, 421 F.Supp.2d 1129, 1135–36 (N.D.Ill.2006); *LaScala v. Scrufari*, 96 F.Supp.2d 233, 238 (W.D.N.Y.2000); *Daniels v. Nat'l Emp. Benefit Servs., Inc*., 858 F.Supp. 684, 693 (N.D.Ohio 1994); *Donovan v. Daugherty*, 550 F.Supp. 390, 404 n. 3 (S.D.Ala.1982); *Gilliam v. Edwards*, 492 F.Supp. 1255, 1262 (D.N.J.1980); *Marshall v. Kelly*, 465 F.Supp. 341, 353 (W.D.Okla.1978). The Department of Labor agrees with these courts. *See* 29 C.F.R. § 2550.408b–2(a)(3) (ERISA "section 408(b)(2) does not contain an exemption from acts described in section 406(b)(1)"). We decline BCBSM's invitation to apply the reasonable compensation provisions found in §§ 1108(b)(2) and (c)(2) to the self-dealing restriction in § 1106(b)(1).

B. § 1104(a)

ERISA imposes three broad duties on qualified fiduciaries: (1) the duty of loyalty, (2) the prudent person fiduciary obligation, and (3) the exclusive

benefit rule. *Pirelli Armstrong Tire Corp*., 305 F.3d at 448–49. Collectively, these duties serve the goal of ensuring that ERISA fiduciaries act "solely in the interest of [plan] participants and beneficiaries." 29 U.S.C. § 1104(a)(1). Our analysis of the § 1104(a) claim in *Pipefitters IV* is again determinative for this case. *See* 722 F.3d at 867–69. There, as here, when a "fiduciary uses a plan's funds for its own purposes, . . . such a fiduciary is liable under § 1104(a)(1) and § 1106(b)(1)." *Id*. at 868 (citing *Guyan Int'l, Inc. v. Prof'l Benefits Adm'rs, Inc*., 689 F.3d 793, 798–99 (6th Cir.2012)).

V.

After ruling for the plaintiffs in this case, the district court awarded prejudgment interest in accordance with 28 U.S.C. § 1961. Although ERISA does not require a prejudgment interest award to prevailing plaintiffs, this court has "long recognized that the district court may do so at its discretion in accordance with general equitable principles." *Caffey v. Unum Life Ins. Co*., 302 F.3d 576, 585 (6th Cir.2002) (quoting *Ford v. Uniroyal Pension Plan*, 154 F.3d 613, 616 (6th Cir.1998)).

Hi-Lex asserts that the district court abused its discretion in two respects: (1) the court failed to make specific findings of fact with respect to its decision regarding prejudgment interest, and (2) the § 1961 interest calculation undercompensates Hi-Lex for the lost interest value of the Disputed Fees.

Hi-Lex, through its expert, Neil Steinkamp, was the only party to offer testimony regarding prejudgment interest. BCBSM relies on its critique of Steinkamp's analysis, noting that he produced no evidence to support his conclusion that Hi-Lex would have in-

vested the savings from the Disputed Fees in corporate bonds. The district court's relevant factual finding was that Steinkamp's prejudgment interest rate computation would overcompensate Hi-Lex for its loss. Moreover, Hi-Lex's contention that *Drennan v. Gen. Motors Corp*., 977 F.2d 246 (6th Cir.1992), requires reversal on this point is incorrect. That case stands for the proposition that a district court errs by not making findings of fact when deciding whether to award discretionary prejudgment interest. The issue here is whether the court made sufficient findings with respect to its prejudgment interest calculation.

In *Schumacher v. AK Steel Corp. Ret. Accumulation Pension Plan*, we held that

> [a] proper determination of pre-judgment interest involves a consideration of various case-specific factors and competing interests to achieve a just result. While we have upheld awards of pre-judgment interest calculated pursuant to 28 U.S.C. § 1961, a mechanical application of the rate *at the time of the award* amounts to an abuse of discretion.

711 F.3d 675, 686 (6th Cir.2013) (emphasis added). The *Schumacher* court found that a district court's use of a single rate—0.12%—calculated at the time of the award under § 1961 represented an abuse of discretion.

In this case, however, the district court did not use a single rate in calculating the prejudgment interest. Instead, the court utilized a blended rate for each of the 17 years during which the Disputed Fees were charged—a range from 6.13% to 0.14%. Thus, on the $5,111,431 damages award, the district court calculated the prejudgment interest at $914,241. Because

the district court avoided a mechanical application of § 1961, it did not abuse its discretion in calculating the prejudgment interest award.

VI.

For the foregoing reasons, we AFFIRM the judgment of the district court.

APPENDIX B

UNITED STATES DISTRICT COURT,
E.D. MICHIGAN,
SOUTHERN DIVISION

No. 11–12557

HI–LEX CONTROLS INCORPORATED,
HI–LEX AMERICA, INCORPORATED AND
HI–LEX CORPORATION HEALTH AND WELFARE PLAN,

Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Defendant.

ORDER GRANTING IN PART AND DENYING
IN PART PLAINTIFFS' MOTION
TO AMEND JUDGMENT (DOC. 249)

July 17, 2013

VICTORIA A. ROBERTS, *District Judge*.

I. INTRODUCTION AND BACKGROUND

This case is one of several concerning Disputed Fees which Defendant allocated to itself as third-party administrator for employee health benefit plans.

After a bench trial on May 23, 2013, the Court entered Corrected Findings of Fact and Conclusions

of Law and judgment in favor of Plaintiffs, finding Defendant liable for violations of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*, and awarding Plaintiffs $5,111,431 in damages. This amount reflects the Disputed Fees which Defendant allocated to itself since it began collecting them in May 1, 1994, until the date of judgment. The Court ruled that Plaintiffs are also entitled to prejudgment interest, which must be calculated under 28 U.S.C. § 1961.

Before the Court is Plaintiffs' Motion to Amend Judgment to Include Amount of Pre–Judgment Interest Award under Federal Rule of Civil Procedure 59(e). The motion is *GRANTED IN PART* and *DENIED IN PART*. The Court awards Plaintiffs pre-judgment interest, but adopts a different method to calculate it under § 1961.

II. ANALYSIS

Although ERISA does not mandate the award of prejudgment interest to prevailing parties, the Court may award it at its discretion according to general equitable principles." *Ford v. Uniroyal Pension Plan*, 154 F.3d 613, 616 (6th Cir.1998). Similarly, the determination of the pre-judgment interest rate for an ERISA benefits award lies within the Court's discretion. See *id*. at 619. The interest award should not be punitive or excessive; instead, the goal is to place Plaintiffs in the position they would have been but for Defendant's wrongdoing, and to compensate them for the lost interest value of money wrongfully withheld. *Id*. at 618.

The Sixth Circuit and other courts uphold awards of pre-judgment interest calculated under the federal post-judgment statute, 28 U.S.C. § 1961. *Rybarczyk v.*

TRW, Inc., 235 F.3d 975, 986 (6th Cir.2000) (citing *Ford*, 154 F.3d at 619 and *Algie v. RCA Global Communications, Inc.*, 60 F.3d 956, 960 (2nd Cir.1995)). Section 1961 provides:

> (a) Interest shall be allowed on any money judgment in a civil case recovered in a district court. . . . Such interest shall be calculated . . . at a rate equal to the weekly average 1–year constant maturity Treasury yield, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the date of the judgment . . . .
>
> (b) Interest shall be . . . compounded annually.

28 U.S.C. § 1961.

Plaintiffs ask the Court to calculate prejudgment interest under § 1961 by: (1) using a blended interest rate which averages the 1–year United States Treasury Bill rate over the relevant 17–year period in which the Disputed Fees were collected; (2) applying the blended rate to the amount of Disputed Fees in each Administrative Service Contract ("ASC") year; and (3) compounding interest annually.

Defendant does not dispute that Plaintiffs calculated the 17–year blended rate correctly. In addition, Defendant concedes that a prejudgment interest calculation under § 1961 is determined at the discretion of the Court, the use of the blended rate is common practice in ERISA cases, and authority supports compounding interest annually. But, Defendant says that the Court should make a determination which would reflect an award that is remedial and compensatory rather than punitive, according to principles guiding prejudgment interest awards under ERISA.

Defendant objects to Plaintiffs' overall calculation method, saying it would overcompensate because:

> (A) Plaintiffs' use of Disputed Fee amounts for each ASC year rather than on a weekly basis reflects Plaintiffs' incorrect assumption that they did not have the benefit of funds not yet collected throughout the year, given that the Disputed Fees were transferred weekly; and
>
> (B) Plaintiffs' use of a 17–year blended rate allegedly is grossly inaccurate given the long period of time being averaged and the significant variations in the treasury rate for the specific weekly periods in which the Disputed Fees were transferred to Defendant.

Defendant also says that Plaintiffs' calculation is faulty because it does not use the "stream of benefits model," in which pre-judgment interest is calculated for each period for which damages accrued, as opposed to a "simple interest method" in which pre-judgment interest is determined by applying the interest rate to the whole damages award. *See Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 585–86 (6th Cir.2002). Although Plaintiffs did apply the 17–year blended rate on an ASC fiscal year basis and do not seek to use a simple interest method, Defendant says the interest rate should apply on a *weekly* basis because the Disputed Fees were transferred every week.

Defendant presents three alternative calculations:

> (1) Individualized fiscal year blended rate applied on a weekly basis:
>
> (i) Averaging the actual weekly rates in each ASC year to come up with a blended rate for each ASC year;

(ii) Dividing the amount of Disputed Fees in an ASC year to come up with the average amount of Disputed Fees transferred per week in that ASC year;

(iii) Applying the blended rate from an ASC year to each weekly period in that ASC year; and

(iv) Compounding interest annually.

(2) Individualized ASC year blended rate applied on an ASC year basis:

(i) Averaging the actual weekly rates in each fiscal year to come up with a blended rate for each ASC year;

(ii) Applying the blended rate from an ASC year to the amount of Disputed Fees in that ASC year; and

(iv) Compounding interest annually.

(3) Actual weekly rate applied on a weekly basis:

(i) Identifying the actual rate for each week in the 17–year period;

(ii) Dividing the amount of Disputed Fees in each ASC year to come up with the average amount of Disputed Fees transferred per week in that ASC year;

(iii) Applying the actual rate from a week to the amount of Disputed Fees transferred in that week; and

(iv) Compounding interest annually.

Based on the foregoing, the Court identifies two issues:

(A) Whether the interest rate should be calculated using the stream of benefits method, and whether the Court should apply the interest rate on either an ASC year or weekly basis; and

(B) Whether the applicable interest rate under § 1961 should be: (i) a single blended rate for the entire 17–year period; (ii) a blended rate for each ASC year based on the average of actual weekly treasury rates for that ASC year; or (iii) the actual interest rate for each week throughout the 17–year period.

A. The Interest Rate Should Be Calculated Based On the Stream of Benefits Model and Applied on an ASC Year Basis

Although Plaintiffs do not contest that Disputed Fees were taken on a weekly basis, they say their calculation—based on an annual rather than weekly basis—meets the stream of benefits model because the focus of this litigation and the evidence in it has been Disputed Fees in each ASC year. Plaintiffs concede that application of the interest rate on weekly periods—obtained from averaging the per-week amount in each ASC year—would have "little practical effect" on their current calculation, but they say it would be speculative because there is no evidence in the record of the amount of Disputed Fees which Defendant took in any given week.

The Sixth Circuit prefers the use of the stream of benefits model over the simple interest model to calculate ERISA prejudgment interest in order to preclude overcompensatory awards. *See Caffey*, 302 F.3d at 585–86 (affirming a calculation of interest due on each monthly payment of disability benefits

beginning with the date that each payment was due; a simple interest model would overcompensate the plaintiff for the delayed payment by awarding her interest on individual benefits payments before they were due to her); *see also Rabuck v. Hartford Life & Acc. Ins. Co.*, 522 F.Supp.2d 844 (W.D.Mich.2007); *Crider v. Highmark Life Ins. Co*., 458 F.Supp.2d 487 (W.D.Mich.2006); *Krupp v. Metro. Life Ins. Co*., 174 F.Supp.2d 545 (E.D.Mich.2001).

Accordingly, the Court will not apply the simple interest model; it will use a calculation based on the stream of benefits model to adequately compensate Plaintiffs and preclude a punitive award. *See Caffey*, 302 F.3d at 585–86; *Ford*, 154 F.3d at 618.

Although Plaintiffs agreed to transfer funds to Defendant weekly under the ASC, (Joint Trial Exhibit 1 at 8–9), equitable principles guiding ERISA prejudgment interest awards favor basing the Court's calculation on an ASC yearly basis.

First, the actual amount of Disputed Fees transferred per week is unknown and an average estimate would be speculative. Defendant argued in its Post–Trial Proposed Findings of Fact and Conclusions of Law that Plaintiffs wired to Defendant "at regular intervals" pre-determined amounts, which included Disputed Fees. (Doc. 242 at Page ID 15184). But, even assuming that all transfers were indeed made weekly, the actual amounts of Disputed Fees within each transfer—and whether each transfer included Disputed Fees—was not established and remains unclear. A calculation based on uncertain amounts of Disputed Fees may lead to speculative values against the remedial, non-punitive purposes of ERISA prejudgment interest awards.

In addition, this litigation has focused on the *actual* amount of Disputed Fees per ASC year. The parties stipulated in the Joint Final Pre–Trial Order to the amount of Disputed Fees in each ASC year from 2002 to 2011. (Doc. 240 at Page ID 15097). And, the Court accepted the damages report of Plaintiffs' expert based on Disputed Fees per ASC year. (Doc. 246 at ¶ 261).

For these reasons, the period for a prejudgment interest calculation based on the stream of benefits model should be an ASC year; this would prevent a calculation which relies on speculative, unforeseen estimates of Disputed Fees, and would preclude an overcompensatory award under the simple interest model.

B. The Court Will Use a Blended Rate for Each ASC Year Based on the Average of Actual Weekly Treasury Rates for that ASC Year

"[I]n situations involving complicated calculations of a stream of payments occurring over a long period of time where the interest rates are not static, an average or blended rate may be used in calculating the accrued prejudgment interest [under § 1961]." *Brooking v. Hartford Life & Acc. Ins. Co.*, No. 04–95–KSF, 2007 WL 781333, at *4 (E.D.Ky. Mar.12, 2007) (citing *Ford*, 154 F.3d at 619); *see also Caffey*, 302 F.3d at 585–86; *Shreve v. Aetna Life Ins. Co.*, No. 05–72444, 2007 WL 201053, at *8 (E.D.Mich. Jan.24, 2007); *Smith v. Bayer Corp. Long Term Disability Plan*, No. 3:04–CV–128, 2006 WL 3053472, at *3 (E.D.Tenn. Oct.26, 2006).

Defendant concedes that courts typically use a blended rate rather than actual rates, but says the Court should incorporate an approach to further a remedial pre-judgment interest award because using

a single blended rate for the entire 17–year period results in a grossly-inflated measure of Plaintiffs' lost time and value of their money.

The Court declines to apply the actual weekly rates, consistent with other courts in this Circuit favoring the use of blended rates under § 1961, and because ASC years are the relevant periods for a calculation based on the stream of benefits model in this case, as stated above.

The Court will apply a blended interest rate. At issue is whether the use of a blended rate for the entire 17–year period may lead to a grossly-inflated and inequitable pre-judgment interest award.

Plaintiffs do not direct the Court to authority which compels it to use a single blended rate for the entire 17 years. Their sole argument in favor of a single 17–year blended rate is that it has precedential support in *Caffey*, *Ford*, and most district court decisions in the Sixth Circuit. However, the cases upon which Plaintiffs rely deal with denials of disability payments over periods much shorter than in this case, most of them approximately three years. The Court does not find them helpful, and declines to use a single 17–year blended interest rate. *See, e.g., Caffey*, 302 F.3d 576 (single blended rate for a period between 1990–1999); *O'Callaghan v. SPX Corp*., No. 09–10196, 2010 WL 259052 (E.D.Mich. Jan. 20, 2010) (single blended rate for a period between 2007–2010); *Shreve v. Aetna Life Ins. Co*., No. 05–72444, 2007 WL 201053 (E.D.Mich. Jan.24, 2007) (single blended rate for a period between 2004–2007); *Nat'l Bank & Trust Co. v. Webb*, No. 1:04CV789, 2006 WL 1966591 (S.D.Ohio July 11, 2006) (single blended rate for a period between 2003–2006). Considering the particular long period of damages and the wide variations in the 1–year

Treasury Bill rate over 17 years, the use of a single 17–year blended interest rate may lead to a grossly-inaccurate and, thus, inequitable prejudgment interest award.

The Court exercises its discretion to promote a remedial award which would not be punitive, *see Ford*, 154 F.3d at 616–19, and finds that a blended rate for each ASC year based on the average of actual weekly treasury rates for that ASC year would be a better approximation to the interest rate existing at the times Plaintiffs paid Disputed Fees to Defendant. *See, e.g., Perrin v. Hartford Life Ins. C*o., No. 06–182–JBC, 2008 WL 2705451 (E.D.Ky. July 7, 2008) (applying yearly blended rates in a three-year damages period); *Brooking v. Hartford Life & Acc. Ins. Co.,* No. 04–95–KSF, 2007 WL 781333, at *4 (E.D.Ky. Mar.12, 2007) (same). The use of blended rates per ASC year would allow for appropriate compensation to Plaintiffs for the lost interest value of money wrongfully withheld, and put them in the position they would have been in but for Defendant's wrongdoing. This approach will prevent a punitive award.

III. CONCLUSION

Plaintiffs' motion is GRANTED IN PART and DENIED IN PART. The Court awards Plaintiffs prejudgment interest, but adopts a different method to calculate it under § 1961:

(1) Using a blended rate for each ASC year based on the average of actual weekly treasury rates for that ASC year;

(2) Applying the ASC year blended rates to the corresponding ASC year based on a stream of benefits model, for a period between May 1, 1994, to May 23, 2013; and

(3) compounding interest annually.

To assist the Court in framing an appropriate amended judgment, the parties are directed to file a stipulated amount based on the Court's method by *July 30, 2013*, or notify the Court if they are unable to do so. The Court will then do the calculation and amenvbd [sic] the judgment accordingly.

IT IS ORDERED.

APPENDIX C

UNITED STATES DISTRICT COURT,
E.D. MICHIGAN

No. 11–12557

HI–LEX CONTROLS INCORPORATED,
HI–LEX AMERICA, INCORPORATED AND
HI–LEX CORPORATION HEALTH AND WELFARE PLAN,

Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Defendant.

CORRECTED FINDINGS OF FACT AND CONCLUSIONS OF LAW

May 23, 2013

VICTORIA A. ROBERTS, *District Judge*.

I. INTRODUCTION

This is an action for alleged violations of the Employee Retirement Income Security Act of 1974 ("ERISA"). Plaintiffs filed suit on June 13, 2011. It is one in a series involving Administrative Service Contracts ("ASC") with Blue Cross and Blue Shield of Michigan ("BCBSM") for claims administration services and network access for self-funded employee health benefit plans. Under the ASCs, BCBSM serves as third-party administrator for Plaintiffs' employee health benefit plans. It processes and pays employee health claims; provides access to its network of physicians, hospitals, pharmacies, etc. for covered employees; and negotiates with hospitals and health care providers throughout the state. Plaintiffs reimburse BCBSM for claims paid on their behalf.

This case concerns certain fees that BCBSM allocated to itself as additional compensation ("Disputed Fees"). In essence, Plaintiffs argue that they did not know about the Disputed Fees until recently, and that BCBSM employed different ways to hide them. BCBSM says that it did not breach any duties in collecting the disputed fees because they were fully disclosed and Plaintiffs agreed to pay them.

Plaintiffs allege violations of § 1104(a)—breach of fiduciary duty (Count One)—and § 1106(b)—self dealing (Count Two)—under ERISA.

On September 7, 2012, the Court issued an order addressing the parties' cross-motions for summary judgment. The Court found that BCBSM is a fiduciary under ERISA, that the Disputed Fees were paid from plan funds, and that relief is available to Plaintiffs under ERISA.

The Court granted summary judgment to Plaintiffs on Count Two—ERISA prohibited transaction (self-dealing)—finding that BCBSM committed a *per se* breach of Section 1106(b)(1) when it allocated Disputed Fees to itself. The Court held that the self-dealing claim would proceed to trial on damages. It also held that Count One—ERISA breach of fiduciary duty—would proceed to trial because several issues of material fact remained regarding whether BCBSM breached its fiduciary duty.

In its September 7, 2012 ruling, the Court found genuine issues of fact related to BCBSM's statute of limitations defense. It recognized that resolution of the statute of limitations was necessary to determine the extent of BCBSM's liability under Count II, and the extent of its liability, if any, under Count I. The applicable statute of limitations also governs the amount of damages Plaintiffs would be able to collect from BCBSM.

BCBSM filed a second motion for summary judgment grounded on a statute of limitations affirmative defense. The Court denied it on April 17, 2013; it held numerous issues of material fact had to be decided before the Court could determine the appropriate statute of limitations.

The Court conducted a bench trial. It began on April 23, 2013 and continued for nine non-consecutive days, ending on May 8, 2013.

II. FINDINGS OF FACT

A. PLAINTIFFS RETAIN BCBSM TO ADMINISTER THEIR SELF-FUNDED HEALTH BENEFIT PLAN

1. Since at least 1991, BCBSM has served as the third party administrator of Plaintiffs' self-insured

employee benefit plan, the Hi–Lex Corporation Health and Welfare Benefit Plan (the "Plan"). (Stipulated Fact ("SF") 2).

2. The terms under which BCBSM served as the Plan's third-party administrator are set forth in the parties' 1991 and 2002 ASCs. (SF 3).

3. The parties renewed the ASCs each year from 1991 through 2011 by executing a Schedule A document (the "Schedule As"). (SF 3). The ASCs and Schedule As are boilerplate documents created by BCBSM and used by BCBSM for the vast majority of its self-insured ASC customers. *Id.*

4. The Court admitted into evidence as joint exhibits, the 2002 ASC and a number of the Schedule As. Neither party can locate the 1991 ASC and certain Schedule As, but the parties crafted a stipulation concerning the relevant aspects of the Schedule As. (SF 4).

5. Pursuant to the ASCs and Schedule As, BCBSM administered the health care claims on behalf of the Plan from the Plan's assets. (SF 5).

6. The Plan's assets were pre-supplied by Plaintiffs; BCBSM wired funds to a BCBSM bank account. (Joint Trial Exhibit ("JTE") 1 at 8–9). That bank account and the Plan assets held in that account were under BCBSM's sole control.

7. The monies Plaintiffs provided to BCBSM also included employee contributions to their health care coverage under the Plan.

8. In exchange for its services to the Plan, BCBSM received an administrative fee in a per employee, per month amount set forth in the Schedule As ("Administrative Fee"). (JTE 2–11).

B. BEFORE 1993: BCBSM UNDER PRESSURE TO INCREASE REVENUE; CUSTOMERS BALK WHEN BCBSM IMPLEMENTS NEW FEES

9. In 1987 and 1988, BCBSM was in poor financial shape. (Testimony of John Paul Austin, BCBSM's former chief actuary ("Austin Test.")).

10. To regain financial stability, BCBSM started charging various fees of its self-funded customers such as Plaintiffs: the "Plan–Wide Viability Surcharge," "Other Than Group Subsidy," and "Group Retiree Surcharge." (*See id.*; JTE 80 at 276, ¶ 1).

11. BCBSM received "tremendous complaints from customers" in response to the new fees. (Austin Test.) This stemmed, in part, from the fact that "[t]he billing of these amounts to customers was an add-on to the bill, *highlighted for all to see* ...." (JTE 80 at 276, ¶ 2) (emphasis added).

12. BCBSM was unable to convince customers that the subsidies were fair:

> *The advent of self-funding as an alternative to insured programs has highlighted administrative fees as a cost and a concern to customers purchasing a BCBSM ASC plan. Citing BCBSM's high costs, many customers have complained and have threatened to leave if relief was not provided*. Indeed, some customers have cancelled BCBSM coverage for this reason. Many arguments have been presented to customers dissatisfied with our administrative costs. The costs of managing a network of hospitals and doctors as large as the Blue network, focusing on total costs and not just the small percentage reflective of administrative costs and the wide range of services provided by

> BCBSM have all been used at various stages to address case specific concerns. *These arguments have been met with moderate success*.

(JTE 80 at 277, ¶ 1) (emphasis added).

13. The charges were so unpopular that, in 1989 alone, BCBSM lost 225,000 members. (Austin Test.).

14. Many other customers refused to pay the fees. Mr. Austin confirmed that roughly half of these "add-on" fees were *not* being paid; it was BCBSM's policy not to sue customers. (*Id*.)

15. BCBSM was under enormous financial pressure. (Austin Test.).

16. According to BCBSM, these fees made it a "challenge to maintain customer relationships." (JTE 80 at 276, ¶ 2). By disclosing the fees, BCBSM was "its own worst enemy." (*Id*.)

C. 1993–94: BCBSM PLANS TO CHANGE ITS DISCLOSURES

17. In 1993, BCBSM Executives suggested replacing the fees it disclosed with a "hidden" administrative fee buried in marked-up hospital claims. (*See id*.; Austin Test.).

18. The decision was made for this pricing arrangement to become effective for customers with their first renewal after October, 1993. The renewal was selected as the effective date for each group because that is when the group would sign a new Schedule A, which was revised to make Disputed Fees a contractual obligation. (JTE 81 at 219–220).

19. This solution offered several advantages to BCBSM:

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

(JTE 80 at 3, ¶ 2) (emphasis added).

22. BCBSM's senior management approved this proposal, known as "Retention Reallocation." (Austin Test.). It went into effect in October, 1993. (*Id*.)

23. Because the events pertinent to this lawsuit occurred over a time period of more than two decades, the terminology relevant to the dispute changed over time. The term "Disputed Fees" is synonymous with the terms "Retention Reallocation Fees" and "Access Fees."

24. However, the Access Fee terminology used to describe "Disputed Fees" is different from "Access Fee" as defined in the ASC. The ASC, Article VI, Section B is labeled "Access Fee," and is unrelated to the "Access Fee" which is subject to this litigation. In the ASC, "Access Fee" is explained as:

> If an access fee is charged by the Host Plan, the amount of the fee may be up to (10) percent of

> the negotiated savings obtained by the Host Plan from its providers but not to exceed Two Thousand ($2,000) Dollars. Access fees will be charged only if the Host Plan's arrangements with its participating providers prohibit billing the Enrollee for amounts in excess of the negotiated rate. However, providers may bill for deductibles and/or copayments.

(JTE 1 at 13).

24. The Disputed Fees have the following components:

a. A charge for access to the Blue Cross participating provider and hospital networks (also described as "provider network access" and "Provider Network Fee");

b. A contribution to the Blue Cross contingency reserve (also described as "contingency" and "contingency/risk");

c. Other Than Group, or OTG subsidy;

d. Retiree surcharge (only for certain employers); and

e. Plan–Wide Viability, or PWV surcharge.

Items (c) and (d), and (e) are often referred to generally as "other subsidies" or "subsidies and surcharges." Item (e) has been set at zero since 1991 and so is not relevant to this case. (Austin test.; testimony of Cindy Garofali, BCBSM's manager in underwriting ("Garofali test."); Defendant's Trial Exhibit ("DTE") 1005 at 235).

26 [sic]. The term "retention" refers to money BCBSM retains, as opposed to money used to pay medical claims. (Testimony of Paula Brawdy, former BCBSM Regional Sales Manager ("Brawdy Test.").

27. BCBSM continued to charge the "Other Than Group Subsidy" and "Retiree Surcharge." Austin Test. The "Retiree Surcharge" was assessed to customers who did not cover retirees health care, *id*.; Hi–Lex never covered retirees. (Testimony of John Flack, Hi–Lex's Director of Finance ("Flack Test.")).

28. After 1993, whenever BCBSM used the term "Hospital Claims" in contract documents, it intended that the term have the following components:

a. Charge for provider network access;

b. Contribution to contingency reserve;

c. OTG subsidy;

d. Retiree surcharge; and

e. PWV surcharge (0 since '91)

29. The Post–1993 components under the heading "Hospital Claims" in contract documents are collectively referred to in this litigation as "Disputed Fees."

30. The term "Retention Reallocation" refers to the new pricing arrangement developed and implemented by BCBSM in 1993; then, Disputed Fees became part of the calculation for amounts to be billed for Hospital Claims. (JTE 80).

31. The Retention Reallocation fees were decided unilaterally by BCBSM; cost accountants and actuaries decided what expenses BCBSM wanted to recoup through the Disputed Fees. They then decided how much Hospital Claims had to be marked up to reach

that goal. The percentages used to determine the fees are referred to as "Factors". (James Patrick Bobak Deposition, BCBSM's senior underwriting analyst, at 14:4–12; Austin Test.).

32. The Disputed Fees Factors were not reported to customers, but were known to BCBSM in advance of customer renewals. (Austin Test.; Plaintiffs' Trial Exhibit ("PTE") 580).

33. Internal documents from BCBSM confirm that BCBSM had complete discretion to determine the amount of the Disputed Fees, as well as which of its customers paid them. (PTE 561, Garofali Email ("[I]ndividual underwriters will have the flexibility to determine how we charge ... access fee on group"); PTE 562, Ken Krisan, BCBSM's senior underwriter, Email (explaining that trust funds have a unique arrangement)).

34. Under Ms. Garofali's oversight, the following strategy was developed in 1993 to educate groups about the new pricing arrangement:

a. Revised Schedule A included a new disclosure: "Effective with your current renewal, your hospital claims cost will reflect certain charges for provider network access, contingency, and other subsidies as appropriate." (JTE 81 at 220; testimony of Ken Krisan ("Krisan Test.")).

b. A tri-fold color brochure entitled "A new pricing arrangement" was created for the customer. (DTE 1008). This brochure was to be left with the customer at a meeting where the new pricing arrangement was explained. (Garofali Test.). The brochure identifies certain components of the Disputed Fee and explains that as a result of the new pricing arrangement, the

fixed Administrative Fee would go down and the hospital differential would also decrease. (DTE 1008).

D. 1994–PRESENT: BCBSM EMPLOYS ARTIFICES TO HIDE THE DISPUTED FEES

35. Following the implementation of "retention reallocation," BCBSM went to great lengths to ensure that the Disputed Fees were not disclosed to the customer.

1. Monthly Claims Reports

36. On a monthly basis, BCBSM provided Hi–Lex with detailed claims reports for every claim incurred. (Flack Test.)

37. Hi–Lex relied on this claims data, reviewed it, and incorporated it (manually in earlier years) into a master spreadsheet used for budgeting and internal auditing purposes. (Thomas Welsh Deposition, Hi–Lex's former Director of Finance, at 203:18–204:15; Flack Test.; PTE 594).

38. The claims data did not mention Disputed Fees; the Disputed Fees paid to BCBSM were actually included in the Hospital Claims numbers provided. (Austin Test.; Krisan Test.; Flack Test.).

2. Quarterly Settlements

39. BCBSM sent the Plaintiffs quarterly reports containing details about the plan's performance. (JTE 23–51). The parties do not have every quarterly settlement statement, but have stipulated to the content of them. (JTE 77).

40. The quarterly reports did not show customers the amount of Disputed Fees collected for each

quarter, nor did they identify under what category or heading they were included. (Austin Test.; Testimony of Sophia Quinn ("Quinn Test."); Chris Winkler Deposition at 105:2–20).

41. In reality, the amount of Disputed Fees was added to the facility or hospital charges and altogether reported as Hospital Claims. (*Id*.)

42. This made it appear to customers, like Plaintiffs, that the savings from using BCBSM as its administrator were smaller than they truly were.

43. The amount of Disputed Fees was included in the line for "TOTAL CLAIMS EXPENSE." (Austin Test.; Quinn Test.)

44. This made it appear to customers, like Plaintiffs, that the claims paid to providers were higher than they truly were.

45. The amount of Disputed Fees also was excluded from the line for "TOTAL ADMINISTRATIVE FEE EXPENSE." (*Id*.)

46. This made it seem to customers that they were paying less Administrative Fees than they, in fact, paid.

47. Only beginning in April, 2011 did BCBSM refer to the Disputed Fees as "administrative compensation." (PTE 581). It was in a responsive letter from BCBSM to Plaintiffs.

48. Before then, BCBSM, through the quarterly settlements, represented to Plaintiffs that plan assets were only being used to pay: (1) actual claims, (2) disclosed Administrative Fees, and (3) stop loss premiums.

49. BCBSM had the technical capability to provide quarterly reports which specified the amount paid in the various subsidies and surcharges. (Austin Test.; Krisan Test.). BCBSM did make other projections that it shared with Plaintiffs.

50. BCBSM knew these reports were false when it gave them to Plaintiffs, and gave them to Plaintiffs with the intent to deceive them. (Austin Test.; Winkler Deposition at 87:2–14; Quinn Test.).

3. Renewal Documents

51. In addition to the quarterly reports, BCBSM provided claims information at the time of renewal.

52. The first page purported to show claims amounts "passed on" to Hi–Lex by BCBSM. This promoted the belief that claims reports related to actual claims and nothing else.

53. Additionally, the "Benefit and Savings Review Summary" was given in two formats. (JTE 52–63).

54. Both formats showed amounts for either "Approved Charges and Payments" or "Amounts Billed" which consisted of actual claims plus the Disputed Fees. Similarly, both formats showed either the "Hospital Savings" or "Provider Reimbursement Savings" that were reduced by the Disputed Fees. (Austin Test.)

55. BCBSM provided misleading claim information in the "Provider Contract Savings" report supplied with each renewal. (JTE 52–63).

56. Those reports indicated amounts for "BCBSM Provider Savings" and "Total BCBSM Payments." The savings number, however, was not the full savings, but rather the savings reduced by the Disputed Fees; correspondingly, the "Total BCBSM Payments" were

not the total payments actually paid by BCBSM, but rather that amount plus the Disputed Fees kept by BCBSM. (Austin Test.)

57. BCBSM also represented in the Renewals that its "Administrative Fee is all-inclusive." (JTE 52 at 819). That was not true; BCBSM also charged the Disputed Fees, a second form of administrative compensation, but not described as such before 2011.

58. BCBSM knew these reports were false when it gave them to Plaintiffs and gave them to Plaintiffs with the intent to deceive them.

59. In later years, BCBSM inserted an asterisk with misleading language into a claims projection. (JTE 58). These were not reviewed by Mr. Flack because BCBSM's claims projections were notoriously unreliable and Mr. Flack made his own projections. (Flack Test.).

4. Annual Settlements

60. Roughly six months after the close of each plan year, BCBSM sent self-funded customers an annual settlement statement. The annual reports did not show customers the amount of Disputed Fees collected for each year, but they did show other fees collected. There was an "Administrative Fee Settlement," a "POS Incentive Fee Settlement," and a "Stop Loss Premium Settlement." But there was no "Disputed Fees / Retention Reallocation Fees Settlement." (JTE 12–22).

61. In some years, the amount of Disputed Fees was included (but not identified) on the line for "ACTUAL CLAIMS PAID BY BCBSM: FACILITY" in the "Stop Loss Premium Settlement." This was false and misleading because the Disputed Fees were

compensation to BCBSM, not "Claims Paid by BCBSM."

62. The amount of Disputed Fees was not included in the "Administrative Fee Settlement" either. This was false and misleading because the Disputed Fees were "administrative compensation." (PTE 581).

63. According to BCBSM's own underwriter, Chris Winkler:

> Q. And this heading A. [of the annual settlement] . . . refers to claims paid by BCBSM, correct?
>
> A. Correct.
>
> Q. And the access fee is not a claim that is paid by BCBSM, correct?
>
> A. Correct. * * *
>
> Q. So the number provided by Blue Cross on the annual settlement for actual claims paid overstates what the actual claims paid to providers by Blue Cross was?
>
> Q. Correct?
>
> A. The number of actual claims paid includes the access fee. *So, yes, it would be overstating true cost of claim.*

(Winkler Deposition at 85:1–10, 19–25; 86:1–4, 13–21) (emphasis added).

64. Reviewing this report, a reader could not determine whether Disputed Fees were charged, or in what amount. (*Id*. at 106:5–8).

65. BCBSM knew these reports were false when it gave them to Plaintiffs and gave them to Plaintiffs with the intent to deceive.

5. Form 5500 Certifications

66. At or around the time that BCBSM sent its annual settlements to the Plaintiffs, BCBSM also provided a completed certification for the preparation of Form 5500 Schedule A, which is filed with the U.S. Department of Labor. (Austin Test.; Winkler Deposition at 10:22–11:4; Flack Test.).

67. Forms 5500 were developed by the Department of Labor, the Internal Revenue Service, and the Pension Benefit Guaranty Corporation to satisfy annual reporting requirements under ERISA's Titles I and IV and under the IRS Code. They are "intended to assure that employee benefit plans are operated and managed in accordance with certain prescribed standards and that participants and beneficiaries, as well as regulators, are provided or have access to sufficient information to protect the rights and benefits of participants and beneficiaries under employee benefit plans." (Annual Return/Report 5500 Series Forms and Instructions, United States Department of Labor, http://www.dol.gov/ebsa/5500 main.html (last visited May 17, 2013)).

68. The Form 5500 certifications did not show customers the amount of Disputed Fees collected for each year. Rather, the amount of Disputed Fees was added to the amount of claims paid to providers and included in the line for "CLAIMS PAID." (JTE 15 at 032); Winkler Deposition at 95:21–25.

69. The amount of Disputed Fees should have but was not reported in the lines for "ADMINISTRATION," "OTHER EXPENSES (MANDATED SUBSIDY)," "RISK AND CONTINGENCY," "OTHER RETENTION (LATE FEE, STOP LOSS PREMIUM),

or "TOTAL RETENTION INCLUDING STOP LOSS PREMIUM ." (JTE 12–22).

70. The line for "ADMINISTRATION" included only the disclosed Administrative Fees, not the Disputed Fees. (Austin Test.; Winkler Deposition at 96:1–5).

71. The lines for "OTHER EXPENSES (MANDATED SUBSIDY)" and "RISK AND CONTINGENCY" were either a zero (0) or "not applicable" in each year. (JTE 12–22). The Disputed Fees included charges for subsidy and risk/contingency. (PTE 592; Austin Test.; Winkler Deposition at 92:19–93:1, 94:6–16). The line for "OTHER RETENTION" included only a customer's stop loss premium and applicable late fees. (JTE 12–22).

72. A reader reviewing this report could not determine whether Disputed Fees were charged, or in what amount. (Winkler Deposition at 106:9–21).

73. The Form 5500 certifications were false and misleading because (1) the amount reported as claims was over-stated, (2) the amount reported as Administrative Fee was under-stated, and (3) the subsidies and risk/contingencies that were collected by BCBSM as part of the Disputed Fees were reported as zero or "not applicable." (Winkler Deposition at 95:14–96:15, 94:6–16).

74. Hi–Lex was misled into believing that BCBSM was paid less in Administrative Fees than it actually retained, because of the Disputed Fees. (Flack Test.).

75. To the extent BCBSM claims that contract documents gave Plaintiffs notice of what it *might* do in the future, the Form 5500 certifications were understood by Plaintiffs to show what BCBSM was

actually doing: not charging additional administrative fees.

76. BCBSM knew the Form 5500 Certifications were false when it gave them to Plaintiffs, and gave them to Plaintiffs with the intent to deceive them.

E. 1999 AND AFTER: THE NEW FEES WERE A SECRET EVEN TO BCBSM EMPLOYEES

77. Sandy Ham became a BCBSM account representative in 1999, and began handling the Hi–Lex account in 1999. She testified that the training she received included several references to and an explanation of Disputed Fees. (DTE 1186 at 2625, 2642). Ms. Ham was able to identify her handwriting on her personal copy of the 1999 training presentation. She noted that Disputed Fees are a "small charge when your people access our providers to enjoy the discounts." (DTE 1186 at 2642; testimony of Sandy Ham ("Ham Test.")).

78. However, Ms. Ham's deposition testimony—taken before trial and read at trial—was unequivocal:

> Q. When you started in 1999, did you, fairly early on, learn about access fees?
>
> A. Not that I recall.
>
> Q. Was it 2005 when you first learned about access fees?
>
> A. Yes.
>
> * * *
>
> Q. Am I correct in understanding that the first time you learned about access fees was in connection with training that was done in 2005?

A. Correct.

Q. For example, you could have heard about access fees from a colleague and then coincidentally, at some later date in the same year, been trained about access fees. But if I'm understanding you, you're saying, I learned about access fees because I had training about access fees?

A. Correct.

(Sandy Ham Deposition at 19).

79. Ms. Ham's lack of knowledge explains, in part, why according to a BCBSM commissioned survey, *none* of her customers knew about the Disputed Fees as of 2007. (PTE 524–527).

80. Ms. Ham was still confused as late as 2009, when she described the Disputed Fees as something "the provider [meaning the hospital, not the self-funded group] pays . . . based on the experience of the group." (PTE 535).

81. Given the foregoing, it is not reasonable to: (1) conclude that Plaintiffs would have obtained any meaningful information about the Disputed Fees from their own BCBSM account executive, or (2) expect Plaintiffs to have learned about the Disputed Fees from the same documents that Ms. Ham reviewed, signed, but did not understand.

F. EARLY 2000S; RUMORS OF DISPUTED FEES EMERGE, BUT BCBSM DENIES THE EXISTENCE OF DISPUTED FEES

82. In the early 2000s, Todd Stacy of ASR, a BCBSM competitor, told certain brokers that BCBSM had "hidden fees." (Wally Martyniek Deposition at 20:9–21:15). According to one broker, Wally Martyniek,

those rumors led him to call a face-to-face meeting with BCBSM sales manager, Steve Hartnett. Mr. Hartnett denied the existence of Disputed Fees. (*Id*. at 40:2–15). Mr. Hartnett said that BCBSM self-funded customers get 100% of the hospital discounts:

> Q. What did you say at that face-to-face meeting?
>
> A. I said at the meeting that the reason that we're here is that I want to hear it from Steve Hartnett . . . an employee [of BCBSM], that basically what Todd Stacy is saying about the access fee is not correct, because you had told me that it wasn't correct, but I wanted him to tell the client, I didn't want it coming from me.
>
> Q. What did Steve say?
>
> A. Steve said that there was no—that the hospital discount is the full discount that the client gets, that Blue Cross does not hold anything back.

(*Id*. at 40:2–15).

83. Jeffery Liggett also attended the meeting with Mr. Martyniek and corroborated this BCBSM representation. (Stipulation of Counsel on May 7, 2013).

84. Mr. Martyniek's experience mirrored that of an unrelated broker, David Young. Young recounted a presentation made by BCBSM, at which BCBSM falsely represented that it passed on 100% of the provider discounts to customers:

> A. I said, I hear out in the market that you don't pass along one hundred percent of your discounts, and I said, can you respond to that? And the response back was, that's not true, we

absolutely pass one hundred percent of our discounts.

Q. Who said that?

A. Steve Hartnett.

(Dave Young Deposition at 53 line 1–6).

85. BCBSM told Mr. Young that its Administrative Fee was "all inclusive" as well. (*Id*. at 81:15–22).

86. Similarly, an internal BCBSM report acknowledged that BCBSM "traditionally markets the Administrative Fees as all inclusive." (PTE 529).

87. BCBSM management described the Administrative Fees as "all inclusive:"

- "We have used the term "all-inclusive" when describing our Administrative Fee." (PTE 545: 2007 Ken Krisan Email).
- "Contributions to reserves, the Medicare subsidy and claims processing are part of this Administrative Fee." (PTE 533: 2008 Kathleen McNeill Email).

88. BCBSM made similar misrepresentations to Hi–Lex in annual renewal documents. (JTE 52 at M00819: Hi–Lex ASC Renewal ("Your BCBSM Administrative Fee is all-inclusive.")).

89. Brokers understood BCBSM's Administrative Fee to be "all-inclusive," including Denise Sherwood, a former BCBSM employee and then later a broker with Spectrum Benefits and Aon. She testified:

A. All I know is Blue Cross's admin fee was comprehensive, everything was included in it.

Q. What's your basis for saying that?

A. Just experience. That's how Blue Cross marketed itself.

(Sherwood Deposition at 107:8–13).

90. BCBSM's representations to brokers and its description of its Administrative Fee as "all-inclusive" were false and misleading. BCBSM secretly charged a second fee—Disputed Fees—in exchange for its services.

G. 2003: BCBSM INITIALLY IGNORES HI–LEX'S INQUIRY ABOUT THE DISPUTED FEES AND THEN COVERS UP THEIR EXISTENCE

91. In 2003, Hi–Lex hired health care consultant Marsh to review its benefit plan. This was a review of benefits, not of claims payments or monies paid to BCBSM. (PTE 503; testimony of Christine Warren ("Warren Test.").

92. One of Marsh's employees, Dave Mamuscia, noted the ambiguous language in paragraph 11 of the Schedule A and suggested "the Blues should demonstrate how this works. . . ." (JTE 83 at 557).

93. Paragraph 11 states: "Your Hospital Claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate." (JTE 2–4).

94. Mr. Mamuscia's reference to paragraph 11 was mentioned in a single paragraph of a larger six-page memo. (JTE 63 at 557–562).

95. The memo also came less than a month before Hi–Lex had to renew the ASC with BCBSM. With no other alternative claims administrators available, Hi–Lex's renewal was a foregone conclusion, regardless of

what paragraph 11 meant. (Welsh Deposition at 168:16–170:1; Warren Test.).

96. Hi–Lex CFO, Tom Welsh, signed the May 1, 2003 Schedule A without any revision to the Disputed Fee disclosure. (JTE 3–4; per the stipulation in JTE 77 at ¶ 2, JTE 4 at 2 is the same as the missing page 2 of JTE 3).

97. Mr. Welsh forwarded Mr. Mamuscia's memo to BCBSM, which garnered this response, memorialized in an email written by a BCBSM sales manager:

> Dave Mamucia [sic] wants disclosure, or a more detailed explanation regarding line 11 of the Schedule A. That is 'your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate. *You had warned us that this question was coming*. We did tell the account that there is retention reallocation that reduces the net hospital discount. We do not want to respond with an inappropriate answer and would like support from your area as to what exactly we can say. *We realize that Marsh is going to share our answer with all their consultants and we want to give a well measured response*. Please provide us with underwriting's suggestion to this question.

(JTE 84: 2003 Dave Gay Email) (emphasis added).

98. BCBSM's reaction to Marsh's request for information demonstrates that it knew that neither Plaintiffs nor their consultant knew about Disputed Fees, and that disclosure of the fees would damage its business.

99. BCBSM did not adequately respond to Mamuscia's inquiry, prompting Marsh to email: "You haven't answered our question." (JTE 86).

100. Mr. Welsh forwarded Marsh's comment to BCBSM's account executive, Deborah Dickson; she does not remember responding. (Testimony of Deborah Dickson ("Dickson Test.")). The emails indicate that she would visit Hi–Lex in the next couple days, but Ms. Dickson's meeting notes reflect no conversation about Disputed Fees. (*Id.*; JTE 90–95).

101. Ms. Dickson does not recall discussing the memo with anyone, including anyone at Hi–Lex. (Dickson Test.).

102. Mr. Welsh denies being told about Disputed Fees. (Welsh Deposition at 163:1–164:8; PTE 603).

103. Ms. Dickson confirmed at trial that she could not recall a single instance when she provided Hi–Lex with any information about Disputed Fees, and her practice when meeting with Mr. Welsh was to review any changes in the quarterly or annual settlements from the prior year. (Dickson Test.). Ms. Dickson testified that she never received training on how to tell customers about Disputed Fees. (*Id.*)

104. According to Ms. Dickson, Mr. Welsh was a "financially savvy" CFO who was interested in the cost of the health plan. (*Id.*) He regularly negotiated over the disclosed Administrative Fees charged by BCBSM. (*Id.*)

105. BCBSM's own client profile reflects that Mr. Welsh was "close on numbers" and kept his own claims spreadsheet. (JTE 87).

106. Ms. Dickson admitted at trial that she never explained to Mr. Welsh that the "claims" reported in

the quarterly settlements included Disputed Fees, despite having four meetings a year with him. (Dickson Test.).

107. Mr. Welsh was adamant that he had no knowledge of the Disputed Fees:

> Q. Did you ever have any understanding that the administrative services contract between Blue Cross and either Borroughs or Hi–Lex allowed Blue Cross to mark up hospital claims?
>
> A. No.
>
> Q. Did you ever have any understanding that the amounts reported by Blue Cross as claims were anything other than actual claims paid to health care providers?
>
> A. No.
>
> * * *
>
> Q. Did you understand paragraph 11 [of the Schedule A] to refer at all to administrative compensation that was going to be retained by Blue Cross in addition to the base admin. fee on the first page?
>
> A. *No, because the way I read that and I read it today it still seems like it's hospital costs. It doesn't say anything about being paid to Blue Cross Blue Shield*.

(Welsh Deposition at 183:16–184:2, 186:20–187:4) (emphasis added).

108. In the fall of 2003, Marsh put out a Request for Proposal ("RFP") on Hi–Lex's behalf for its Plan. (PTE 505; Warren Test.). BCBSM was asked to respond to the RFP by September 15, 2003. (PTE 505 at 322).

109. The RFP specifically asked BCBSM to identify any "network access/management fees." (JTE 97 at 93). Indeed, Christine Warren testified that the purpose of page M00093 of the RFP was to understand the costs of the programs offered by the recipients of that RFP. (Warren Test.).

110. Generally speaking, "Access Fees" are not uncommon in the industry because many third-party claims administrators lack their own network; they lease one that causes them to incur access fees. (Warren Test.). BCBSM, however, owns its own network, and as one broker confirmed, BCBSM was thus presumed not to have such fees. (Sherwood Deposition at 16:15–17:18).

111. BCBSM responded to the Marsh RFP in September by denying there were Access Fees. (PTE 505 at 392) (responding that network access fees were "N/A" and that there were no other fees); Warren Test; Garofali Test. (testifying about PTE 505 and explaining that BCBSM personnel were "discouraged" from providing any information if nothing was requested)).

112. BCBSM's RFP response was false and misleading, and created the illusion that BCBSM was more cost competitive than the other third party administrators who responded to the RFP. In fact, Ms. Dickson testified that the completed bid form RFP response was not correct. (Dickson Test.).

113. Marsh took the false information provided by BCBSM and incorporated it into its marketing results summary on October 10, 2003. (PTE 507 at 261). In that summary, Marsh compares four potential claims administrators. With respect to BCBSM reports, the

summary says, "access fees included in administration fee." (*Id*.)

114. Marsh's description of "access fees" as "included in administrative fee" was false. The access fees (Disputed Fees) were in addition to the Administrative Fee. Marsh, an expert in the field of self-insured health plans, was misled by BCBSM's response to the RFP.

115. Ms. Warren delivered her marketing results summary to Hi–Lex. (Warren Test.).

116. BCBSM intentionally misrepresented to Plaintiffs and Marsh that there were no Disputed Fees charged. This misrepresentation was material, and relied upon by Plaintiffs to their detriment.

117. BCBSM argues on one hand that the RFP response is not from it, but on the other hand that the RFP is correct because BCBSM did not charge the Disputed Fees on a "per employee per month" ("PEPM") basis. That argument is unavailing for two reasons: (1) the RFP asked whether there were any Access Fees, and, if so, asked that they be expressed on a PEPM basis, and (2) if BCBSM was not going to express the Access Fees on a PEPM basis, it should have explained how it did express them, just as BCBSM did in a similar RFP response six years later. (PTE 506).

118. Making BCBSM's argument all the more implausible is the fact that it regularly expressed Disputed Fees on a PEPM basis. (PTE 564–568).

119. BCBSM's misrepresentation that it did not charge separate access fees had the effect of dramatically understating the administrative costs associated with its proposal. According to page 18 of the

RFP summary prepared by Marsh, (PTE 507 at 263), BCBSM was the second lowest cost bidder, with a total Administrative Fee expense of $505,068. If, however, BCBSM had disclosed that it was going to charge $460,698, in Disputed Fees in 2004 (stipulated in Joint Final Pre–Trial Order), then it would have been the most expensive bidder at *$965,766*, with the next lowest cost bidder at $532,192. (*Id.*)

H. 2003–2007: BCBSM DEBATES WHETHER TO DISCLOSE THE DISPUTED FEES FOR FIVE YEARS AND THEN DECIDES NOT TO

120. Starting around 2003, a few BCBSM executives raised concerns about the lack of disclosure surrounding Disputed Fees, which according to former BCBSM Regional Sales Manager Paula Brawdy, led to an internal debate about what to do. (Brawdy Test.).

121. This debate was sparked by the City of Grand Rapids in 2004, which discovered the Disputed Fees and demanded disclosure. BCBSM ultimately developed Schedule A language that disclosed Disputed Fees in detail for the City, but refused to include this disclosure in other contracts. (PTE 512; Brawdy Test.).

122. A snapshot of this debate was captured in a 2004 email from Michael O'Neil to Ms. Garofali. Mr. O'Neil explained, "If we want to counter that perception [that we hide fees] and retain our credibility, we must be willing to disclose all our fees and stand behind them." (PTE 513).

123. Ms. Brawdy explained that she favored disclosing the amount of the Disputed Fees, but Mr. Austin and the new business sales staff did not want to do so because the Administrative Fees would be too high and BCBSM could not compete. (Brawdy

Test.). This was because self-funded customers were focused on their fixed costs, namely the amount of the Administrative Fee. (*Id*.)

124. Ultimately, BCBSM rejected Ms. Brawdy's position.

125. BCBSM's true intentions are shown by the evolution of a proposed renewal exhibit that starts with a numeric disclosure of the Disputed Fees and is watered down over time to the point where all line items for Disputed Fees and any monetary reference are removed. (PTE 508–510).

126. BCBSM senior underwriter, Ken Krisan, was in charge of the strategy for "disclosing" the Disputed Fees without customers noticing. Mr. Krisan's emails confirm that actual disclosure of the Disputed Fees was not BCBSM's intent:

- "I think there is a need [to] *downplay* this [Disputed Fees] with respect to the outside world . . . [corporate communications] may be helpful in developing some internal training materials or job aids that puts the proper 'spin' on what we want to say." (PTE 538: 2007 Email to Greg Mays) (emphasis added).
- "We want to keep this a little on the *understated* side so we don't want to include this in any mass communications. *In many cases this is not going to [be] good news*." (PTE 540: 2007 Email to Kathleen McNeill) (emphasis added).
- In referring to the "Talking Points" memo, "because we want to *downplay* the release of this information, it was decided that Agents and Customers should not receive any written

materials." (PTE 543: 2007 Email to Kathleen McNeill) (emphasis added).

- "The Access Fee portion of the discussion is intended to be *downplayed* to the customer. . . . There is no plan to provide anything to customers or agents on this topic." (PTE 546: 2007 Email to Karen Butterfield) (emphasis added).
- "We want to stay away from identifying what is in the fee." (PTE 550: 2007 Email to Kathleen McNeill)

131. On August 21, 2007, Ms. Ham presented the 2006 annual settlement to Hi–Lex representatives John Flack, Mitch Freeman, and Liza Walling. (Ham Test.; DTE 1189). Ms. Ham presented the 2006 "Value of Blue" pie chart and pointed out to Mr. Flack a portion entitled "Access Fee," as well as the notation at the bottom of the chart showing the Disputed Fees as a percentage of total cost. (Ham Test.; JTE 17).

132. The Value of Blue charts were only provided at the time of annual settlement. This is significant because annual settlement occurs approximately six months after a plan year closes.

I. 2006–2007: BCBSM'S OWN INVESTIGATION CONCLUDED THAT HI–LEX (AND MOST OTHER CUSTOMERS) DID NOT KNOW ABOUT THE DISPUTED FEES

133. In connection with the anticipated release of the Value of Blue, BCBSM undertook an investigation to determine which customers would be surprised to learn that they had paid the Disputed Fees the year before. (PTE 524–527).

134. The investigations resulted in detailed spreadsheets that identified whether BCBSM's customers, or their brokers, knew about the Disputed Fees. (*Id*.)

135. Hi–Lex is identified in at least four different spreadsheets, the latest of which was from December 14, 2007. Each one indicates that Hi–Lex did not know about the Disputed Fees. (PTE 527). They also indicated that Hi–Lex could not have been informed about the Disputed Fees through a broker because Hi–Lex did not have a broker. (*Id*.)

136.The results of BCBSM's formal investigation were consistent with anecdotal accounts from BCBSM employees:

- "The [Value of Blue] report will identify the ASC Access Fee which for most groups is something new." (PTE 542: 2007 Ken Krisan Email).
- "[N]ot all ASC groups are aware of BCBSM's Retention Reallocation Policy." (PTE 544: 2007 Kenneth Bluhm Email).
- "I know many of the smaller [groups] aren't aware [of access fees]." (PTE 532: 2007 James Bobak Email).
- "I agree that there is overwhelming confusion on access fees internally (and externally)." (PTE 537: 2009 Christine Farah Email).
- "[I]t is not certain [some accounts] were aware of the access fees when entering into the arrangement." (PTE 536: 2010 Ken Krisan Email).

J. THE MISLEADING CONTRACT DOCUMENTS DID NOT DISCLOSE THE DISPUTED FEES

137. BCBSM has not produced an ASC signed before 2002, nor did it offer any evidence that such an ASC would have contained any language that would have allowed it to charge the Disputed Fees.

1. The Schedule As Are Misleading

138. The parties stipulated that the 1994 Schedule A to the ASC would have been the same as the 1994 Borroughs Corporation ("Borroughs") Schedule A. (JTE 77 at ¶ 2). That Schedule A does not contain language related to Disputed Fees. (JTE 64).

139. The parties stipulated that the 1995–2000 and 2002 Schedule As would have been the same as the Borroughs Schedule As for the same years. (JTE 77 at ¶ 2). The Borroughs Schedule As contain a single sentence on the second page that reads: "Your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate." (JTE 65–70).

140. This sentence is false and misleading, and did not disclose the Disputed Fees:

- The Schedule As have a heading entitled "Administrative Charge." It was under this heading that BCBSM's administrative compensation was to be disclosed. Hi–Lex expected all fees paid to BCBSM to be included in this section of the Schedule As. The Disputed Fees were "administrative compensation", (PTE 581), and were not noted under "Administrative Charge."
- The sentence omits the critical fact—that Plaintiffs would pay these fees as additional administrative compensation to BCBSM. Just the opposite, the language stated that the

> identified items would be "reflected" in the "hospital claims cost." "Hospital claims cost" is the cost paid *to* hospitals for services rendered. Thus, the "disclosure" represented that the amounts "ordered by the Insurance Commissioner" would be *paid to* the hospitals. In reality, the fees were *not* included in the claims paid to the hospitals—they were additional administrative compensation *retained by BCBSM*.

141. BCBSM recognized that its contracts were confusing and that its "customers probably don't completely understand the Access Fees." (PTE 516: 2004 Jack Gray Email).

2. The 2002 ASC Was Misleading

142. BCBSM did change the ASC language in 2002, but it, too, was misleading:

> The Provider Network Fee, contingency, and any cost transfer subsidies or sur-charges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in Amounts Billed.

143. The ASC contains a heading called "Financial Responsibilities," under which it says the customer will "pay BCBSM the total of the following amounts. . . ." The "following amounts" are then identified in a *numbered list* of specific obligations (*e.g.*, administrative fees, late fees, and interest). *Not one of the nine enumerated obligations includes Plaintiffs paying Disputed Fees*. By not including Disputed Fees in the enumerated list of financial obligations of the customer, BCBSM effectively represented that the Hidden Fees were NOT something to be paid by the customer to BCBSM.

(Burgoon Deposition at 36:12–37:17) (emphasis added).

144. The "disclosure" represented the fees as "ordered by the State Insurance Commissioner." This was a misrepresentation in three respects: (1) it is untrue; the Insurance Commissioner never ordered any BCBSM customers to pay these fees,[1] nor would the Insurance Commissioner have had that authority in the first place;[2] (2) by characterizing the fees as something "ordered" by state government, BCBSM represented that these were NOT any kind of com-

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[1] BCBSM offered a 1992 Order of the Michigan Insurance Commissioner as its only evidence of this alleged obligation. (DTE 1002). But the Order contains no such requirement. On the contrary, in the Order, the Insurance Commissioner advised BCBSM to *pursue collection* of any *contractually agreed-upon* payments to meet the OTG Subsidy. (*Id*. ¶¶ 106–108). Nothing in that Order tells BCBSM that it must collect an OTG Subsidy Fee, in what amount it should collect the Fee, or from whom it should collect the Fee. Further, this alleged obligation rings hollow, as BCBSM did not uniformly levy or collect OTG Subsidy Fees from its customers. (Garofali Test.) (Trust Funds were not charged OTG). Moreover, there was no contractual agreement to pay OTG.

[2] Any such order by the Insurance Commissioner would have been preempted by ERISA. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a); *see also Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); *Ingersoll–Rand Co. v. McClendon*, 498 U.S. 133, 138, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). That includes state laws that "(1) mandate employee benefit structures or their administration . . . or (3) bind employer or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself." *Briscoe v. Fine*, 444 F.3d 478, 497 (6th Cir.2006). Such an order by the Insurance Commissioner, regulating BCBSM's ERISA customers, would fall into both of these categories.

pensation for it, but rather some kind of fee imposed by the State. As it turned out, these Disputed Fees were kept by BCBSM as additional administrative compensation, (*Id*. at 39:22–40:22); and (3) BCBSM recently disavowed any claim that it was ordered to collect the OTG subsidy from Plaintiffs in a brief to the Sixth Circuit. See *Response in Opposition to Leave to File Amicus Brief, Pipefitters Local 636 v. BCBSM*, No. 12–2265, Doc. 6111635985, at 15–17 (6th Cir. March 27, 2013).

145. This language also refers to "Amounts Billed." "Amounts Billed" is defined as "the amount the Group owes in accordance with BCBSM's standard operating procedures *for payment of Enrollees' claims."* (JTE 1 at 1) (emphasis added). The definition of "Amounts Billed" does not include fees paid to BCBSM.

146. The ASC, at Art. IV, B1 "Scheduled Payments," identifies seven payments to be made pursuant to the Schedule A. None of the seven includes the Disputed Fees. Further, by itemizing payments "listed in Schedule A," BCBSM represented that there were no other payments, and consequently, Plaintiffs would not have understood the language in the Schedule A to refer to more Administrative Fees.

K. PLAINTIFFS LACKED KNOWLEDGE OF THE DISPUTED FEES UNTIL 2007

147. CBSM alleges that Plaintiffs were told about BCBSM's plan to charge the Disputed Fees in a meeting between former BCBSM account manager, Ron Crofoot, and former Hi–Lex CFO, Tony Schultz, in 1994. Mr. Crofoot's account of his conversation with Mr. Schultz cannot be believed for several reasons:

- The entire point of the Disputed Fees, according to BCBSM's own internal memo, was to obtain

additional administrative compensation without customers knowing or, in BCBSM's own words—to charge fees that were "no longer visible to the customer." Since BCBSM just established a plan to charge hidden fees, it stretches credulity to think BCBSM would then tell its customers about that plan.

- BCBSM acknowledged that charging the Disputed Fees required a change in the ASC. Mr. Crofoot does not allege any amendments or modifications to the ASC were ever discussed, and testified at trial that he "did not have a lot of detail [about the Disputed Fees], frankly." (Crofoot Test.). If Mr. Crofoot had actually explained the Disputed Fees as a change to the way BCBSM was compensated, a conversation about contract terms would necessarily have followed.
- Mr. Crofoot carried a pre-printed form with him to confirm he had a conversation with Mr. Schultz. The existence of this form suggests BCBSM knew it may need "cover" sometime in the future about whether it verbally disclosed the Disputed Fees. That creates a strong inference that BCBSM knew what it was doing was subject to disagreement or challenge at some point in the future; if the fees were fully disclosed and agreed to as BCBSM contends, then there would have been no concern about future disagreements. Indeed, Cindy Garofali testified that she never saw anything like these forms in her 10 years before the Disputed Fees, and never in the 20 years since. (Garofali Test.).
- The timing of the alleged meeting is suspect. BCBSM began charging Hi–Lex the Disputed

Fees on May 1, 1994. (SF 6). The 1994 Schedule A did not contain language related to the Disputed Fees. (JTE 64, 77). The alleged meeting with Mr. Crofoot did not happen until August 1994. This four month gap demonstrates that BCBSM intended to obtain the Disputed Fees without Plaintiffs' consent.

- Mr. Schultz denies that the Disputed Fees were explained to him. (Testimony of Tony Schultz ("Schultz Test.)). Mr. Schultz testified that he is a detail-oriented person and focused on the financial aspects of the Plan. (*Id*.) Mr. Schultz says he would never have agreed to the Disputed Fees and, in fact, would have objected to them. He also would have required that the Disputed Fees be memorialized in a contract amendment.

148. Even if Mr. Crofoot's testimony is accepted at face value, he apparently represented to Mr. Schultz that the "new pricing arrangement" would be "revenue neutral." That was false. According to Mr. Austin the whole point of "Retention Reallocation" was to get BCBSM out of financial trouble (i.e., more revenue). (Austin Test.).

149. BCBSM does not allege any further mention of the Disputed Fees by its representatives until almost ten years later—in 2003. BCBSM alleges that Hi–Lex was told about the Disputed Fees in 2003. The evidence does not support BCBSM:

- Plaintiffs' consultant, Marsh, raised a question about paragraph 11 of the Schedule A. Marsh's inquiry, buried in a single paragraph of a six-page memo (which itself was one of at least three other exhibits), was forwarded to BCBSM.

BCBSM's reaction to the email revealed its great concern over discovery of Disputed Fees and potential disclosure by Marsh to other consultants and customers. There is no evidence that BCBSM ever disclosed the Disputed Fees in response to these email inquiries. (Paragraphs 84–94; JTE 86).

- Shortly after this above email exchange, Plaintiffs issued a formal RFP to BCBSM that asked for disclosure of any "network access/ management fees." BCBSM responded by indicating there were none. This response was interpreted by Marsh to mean Access Fees, if any, were included in the disclosed Administrative Fee. BCBSM's response was false and misled both Plaintiffs and their consultant, Marsh. (Paragraphs 108–119; JTE 97 at 093).

1. Plaintiffs Exercised Due Diligence Until 2007

150. Mr. Welsh carefully reviewed all financial reports from BCBSM and included the financial data in a master spreadsheet. (Welsh Deposition at 203:18–204:15). None of those reports gave any indication that claims included administrative fees paid to BCBSM. (Winkler Deposition at 45:6–25).

151. Hi–Lex hired a consultant, Marsh, to review its plan. When Marsh raised a question about paragraph 11, Mr. Welsh diligently followed up with BCBSM, only to never get a response. (Welsh Deposition at 165:7–166:14; JTE 86).

152. Shortly thereafter, Hi–Lex, through Marsh, issued an RFP that expressly asked whether BCBSM charged Disputed Fees. (JTE 97). BCBSM answered "N/A." (PTE 505). Hi–Lex's expert interpreted BCBSM's

response to mean there were no Disputed Fees in addition to the disclosed Administrative Fee. (PTE 507). Hi–Lex was reasonable in relying on its expert.

153. When John Flack took over as CFO, he continued his predecessors' practices of carefully reviewing all financial reports provided by BCBSM. (Flack Test.). He also continued keeping the master spreadsheet of every single claim handled by BCBSM. (*Id*.) Again, none of these reports indicated there was a problem.

154. When John Flack took over as CFO, he had no reason to question the long-standing relationship between Hi–Lex and BCBSM. Hi–Lex had already asked about Disputed Fees through the RFP and had been told they were not applicable. The contract documents remained identical for several years, giving Mr. Flack no reason to question BCBSM.

a. Plaintiffs Did Not Have a Broker During Any Relevant Time Period

155. From 1994 until 2003, it is undisputed that Plaintiffs did not have an insurance broker or "agent of record." In 2003, Hi–Lex retained Marsh to conduct a health benefit review. (PTE 503). This was a limited scope project and Hi–Lex did not retain Marsh to be its "agent of record." (Warren Test.).

2. A Hypothetically Diligent Company Would Not Have Discovered the Disputed Fees until 2007.

156. Even if the Court concluded that Plaintiffs were not diligent—despite having carefully and fully reviewed every financial report from BCBSM—that does not end the inquiry. The question remains whether a reasonably diligent company in Hi–Lex's

position would have discovered that BCBSM was taking a greater Administrative Fee than it reported, more than six years before Plaintiffs filed suit:

- No one could tell from the monthly claims reports, quarterly reports, annual settlements and Form 5500 certifications that BCBSM kept part of the money reported as claims for itself. (Winkler Deposition at 45:6–25).
- Mr. Flack was fully justified in not reading the boilerplate of the Schedule As, given the longstanding relationship between the parties and his understanding of the program based on his own historic involvement. Even if he had read the contracts, it would not have made a difference:
    a) The contract documents are misleading. (Part III, Section J).
    b) BCBSM's own account manager, Sandy Ham, read and signed numerous Schedule As over a six year period (1999 to 2005) and testified she did not understand anything about the Disputed Fees (including their existence). (Part III, Section E; Ham Test.). If BCBSM's trained account managers—charged with explaining the Schedule As to Hi–Lex—did not understand the contracts, then a "reasonably diligent" CFO could not be expected to understand them to authorize the Disputed Fees.
    c) Not only did BCBSM's own employees not understand the contracts; neither did any of the six brokers who testified at trial. As noted more fully below, all

brokers (each with years of experience dealing with BCBSM self-funded customers), testified that they had no understanding of these fees until around 2007/2008 (or in some cases after that). A "reasonably diligent" CFO cannot be expected to understand the contracts better than industry experts.

L. WITH THE EXERCISE OF DUE DILIGENCE, PLAINTIFFS SHOULD HAVE BEEN ON SUFFICIENT NOTICE OF THE DISPUTED FEES IN 2007, THROUGH THE VALUE OF BLUE CHART

157. Beginning in 2007, BCBSM produced yearly Value of Blue charts. [JTE 17–22].

158. In June, 2007, Plaintiffs received a 2006 annual settlement from Blue Cross that included the new "Value of Blue" report. This report disclosed the precise dollar amount of Disputed Fees paid in 2006. (JTE 18 at 2304).

159. The Value of Blue pie chart was developed in response to customer requests that BCBSM report the precise dollar amount of Disputed Fees. (Krisan Test.). The pie chart format was selected to show the customer the relationship between what it paid and the savings it received, hence the title "Value of Blue." (*Id*.) It took several years to finalize the Value of Blue format after a decision was made to develop such a report. (*Id*.)

160. Sales staff received training on the Value of Blue report in 2005. (*Id*.; DTE 1015 at 259, 1010).

161. On August 21, 2007, Ms. Ham presented the 2006 annual settlement to Hi–Lex representatives

John Flack, Mitch Freeman, and Liza Walling. (Ham Test.; DTE 1189). Ms. Ham specifically recalled presenting at that meeting the parts of the 2006 Value of Blue pie chart in a clockwise direction, and that she pointed out to Mr. Flack the portion entitled "Access Fee," as well as the notation at the bottom of the chart showing the Disputed Fees as a percentage of total cost. (Ham Test.; JTE 17).

162. This Value of the Blue chart disclosed the precise amount of Disputed Fees paid in 2006. (JTE 17; SF 7).

163. Mr. Flack explained that he did not read the Value of Blue pie charts because they were "pictorial graphs." (Flack Test.).

164. No one at Blue Cross ever told Mr. Flack not to read the Value of Blue pie charts. To the contrary, Sandy Ham presented each and every page of the renewal packets to Mr. Flack and testified that she walked him through each "slice" on the Value of Blue pie charts. (Ham Test.).

165. Mr. Flack testified that if he had read the Disputed Fee disclosure in the renewal packets, (JTE 58–63), projections disclosures, and the Schedule A disclosures, he would have been "aware" of the Disputed Fee pricing arrangement and would have "asked questions" and "taken action" in response to those disclosures. (Flack Test.).

166. The Value of Blue chart was a sufficient change from other documents and an adequate disclosure of the Disputed Fees that BCBSM was charging. But, it only disclosed the fees for the prior year and is irrelevant to notice of Disputed Fees charged prior to 2006.

167. BCBSM has provided Value of Blue charts to Plaintiffs continuously since 2007.

M. PLAINTIFFS ARE ENTITLED TO DAMAGES

168. Plaintiffs are entitled to restitution in the amount of all Disputed Fees paid, beginning in 1994 to 2011.

169. The parties have stipulated that the Disputed Fees charged by BCBSM to Plaintiffs from 2002–2011 were $4,035,134. (SF 7).

170. BCBSM has not produced any data to establish what the Disputed Fees were for years 1994 through 2001.

171. Plaintiffs' damages expert, Neil Steinkamp, calculated estimated Disputed Fees using claims data and other documents provided by BCBSM or otherwise historically maintained by Hi–Lex. Using this data and Disputed Fee factors provided by BCBSM, Mr. Steinkamp estimates the Disputed Fees for years 1994 through 2001 to be $1,076,297. The estimates provided by Mr. Steinkamp are the result of reliable principles and methods and were accurately calculated. BCBSM failed to offer contrary evidence or otherwise dispute Mr. Steinkamp's estimates. Accordingly, the Court accepts Mr. Steinkamp's estimate of $1,076,297 as a fair, reasonable, and accurate approximation of the Disputed Fees for 1994 through 2001. (PTE 582).

172. Plaintiffs are entitled to total damages in the amount of $5,111,431.

173. Plaintiffs are entitled to recovery of prejudgement interest, to compensate them fully for the loss of the Disputed Fees. Prejudgment interest shall

be calculated pursuant to the rate under 28 U.S.C. § 1961.

174. Plaintiffs are entitled to post-judgment interest, calculated under 28 U.S.C. § 1961.

III. CONCLUSIONS OF LAW

A. BCBSM IS AN ERISA FIDUCIARY (PREVIOUSLY DECIDED IN 9/7/2012 SUMMARY JUDGMENT ORDER)

175. ERISA provides that a third-party administrator of an employee benefit plan is a fiduciary when it exercises any authority or control over the disposition of plan assets:

> "[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan *or exercises any authority or control respecting management or disposition of its assets*, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan."

Summary Judgment Order [Doc. 112] at 10 (quoting 29 U.S.C. § 1002(21)(A) (emphasis added).

176. Thus, under § 1002(21)(A), "any person or entity that exercises control over the assets of an ERISA-covered plan, *including third-party administrators*, acquires fiduciary status with regard to the control of those assets." *Briscoe v. Fine*, 444 F.3d 478, 494 (6th Cir.2006) (emphasis added).

177. "The Sixth Circuit employs a 'functional test' to determine fiduciary status." Summary Judgment Order, at 10 (citing *Briscoe*, 444 F.3d at 486).

178. "The relevant question is 'whether an entity is a fiduciary with respect to the particular activity in question.'" *Id*. (quoting *Guyan Int'l Inc. v. Prof'l Benefits Adm'rs, Inc*., 689 F.3d 793, 797 (6th Cir.2012).

179. "The Sixth Circuit holds that a third-party administrator such as Blue Cross 'becomes an ERISA fiduciary when it exercises 'practical control over an ERISA plan's money.'" *Id*. (quoting *Guyan*, 689 F.3d at 798).

180. Funds deposited by an employer with a third-party administrator of a self-funded employee benefits plan are "plan assets" under ERISA. Summary Judgment Order, at 17 (citing *Libbey–Owens–Ford Co. v. Blue Cross & Blue Shield Mutual of Ohio*, 982 F.2d 1031 (6th Cir.1993) and *Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Mich*., 654 F.3d 618, 626 (6th Cir.2011); *see also Briscoe*, 444 F.3d 478.

181. "BCBSM was a fiduciary when it allocated the Disputed Fee from plan assets itself. By accepting regular deposits from Plaintiffs for the purpose of paying health claims, Blue Cross exercised 'practical control over an ERISA plan's money.'" Summary Judgment Order, at 12 (citing *Guyan*, 689 F.3d at 798).

182. BCBSM was also a fiduciary because it exercised discretion over Plaintiff's Plan Assets when it determined the amount of any fees it would allocate to itself. Summary Judgment Order, at 14; *see also Charters v. John Hancock Life Ins. Co*., 583 F.Supp.2d 189, 197 (D.Mass.2008).

B. BCBSM VIOLATED ITS FIDUCIARY OBLIGATIONS (COUNT I)

183. "ERISA is a 'comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans.'" Summary Judgment Order, at 9 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983)).

184. It was "designed to 'protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Akers v. Palmer*, 71 F.3d 226, 229 (6th Cir.1995) (quoting 29 U.S.C. § 1001(b)).

185. ERISA accomplishes its purposes by imposing "strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries.'" *Id*. at 229 (quoting *Berlin*, 858 F.2d at 1162).

186. Indeed, "the crucible of congressional concern was misuse and mismanagement of plan assets by plan administrators and . . . ERISA was designed to prevent these abuses in the future." *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 n. 8, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985).

187. "Fiduciaries are assigned a number of detailed duties and responsibilities, which include 'the proper management, administration, and investment of plan assets, the maintenance of proper records, the disclosure of specified information, and the avoidance of conflicts of interest.'" *Mertens v. Hewitt Assocs*., 508 U.S. 248, 251–52, 113 S.Ct. 2063, 124 L.Ed.2d 161

(1993) (quoting *Mass. Mut. Life Ins*., 473 U.S. at 142–43 and citing 29 U.S.C. § 1104(a)).

188. "Clearly, the duties charged to an ERISA fiduciary are 'the highest known to the law.'" *Chao v. Hall Holding Co*., 285 F.3d 415, 426 (6th Cir.2002) (quoting *Howard v. Shay*, 100 F.3d 1484, 1488 (9th Cir.1996)); *see also* Summary Judgment Order, at 9.

189. ERISA fiduciaries owe the Plan, the participants, and beneficiaries an undivided duty of loyalty under 29 U.S.C. § 1104(a) (1).

190. The duty "requires that 'all decisions regarding an ERISA plan must be made with an eye single to the interests of the participants and beneficiaries.'" *Krohn v. Huron Mem'l Hosp*., 173 F.3d 542, 547 (6th Cir.1999) (quoting *Berlin v. Mich. Bell Tel. Co*., 858 F.2d 1154, 1162 (6th Cir.1988)).

191. It encompasses a number of obligations, including the duty to avoid giving "misleading or inaccurate information," *Varity Corp. v. Howe*, 516 U.S. 489, 506, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996), and to "inform when the trustee knows that its silence might be harmful," *Krohn*, 173 F.3d at 551.

192. "[A] fiduciary may not materially mislead those to whom the duties of loyalty and prudence . . . are owed." *Berlin*, 858 F.2d at 1163; *see also Varity*, 516 U.S. at 506 ("lying is inconsistent with the duty of loyalty owed by all fiduciaries and codified in [Section 1104(a)(1)] of ERISA").

193. A fiduciary breaches its duty of loyalty by providing misleading information regarding the costs of its services. *Gregg v. Transp. Workers of Am. Int'l*, 343 F.3d 833, 844 (6th Cir.2003); *Frulla v.*

CRA Holdings, *Inc.*, 596 F.Supp.2d 275, 284–86 (D.Conn.2009).

194. An ERISA fiduciary has a duty under § 1104(a)(1) to disclose information to the principal about its compensation. *See Krohn*, 173 F.3d at 547 ("The duty to inform . . . entails . . . an affirmative duty to inform when the trustee knows that silence might be harmful.").

195. BCBSM violated its duty under § 1104(a)(1) to avoid supplying the Plaintiffs with misleading or inaccurate information about its administration of the self-funded ERISA plans. It did this by supplying false and misleading information to Plaintiffs about the nature and extent of the Disputed Fees. *Gregg*, 343 F.3d at 844; *Berlin*, 858 F.2d at 1163; *Frulla*, 596 F.Supp.2d at 284–86.

196. BCBSM also violated its fiduciary duty under § 1104(a)(1) to disclose information to the Plaintiffs about its compensation, which necessarily included information about the Disputed Fees, even if Hi–Lex did not make a specific request for information. *See Krohn*, 173 F.3d at 547.

197. BCBSM knew that Plaintiffs were required to file Form 5500s to the Department of Labor, and BCBSM was required under ERISA to provide the necessary information to Plaintiffs, so that Plaintiffs could supply accurate information to the DOL. 29 U.S.C. §§ 1021, 1023; 29 C.F.R. § 2520.103–4; 29 C.F.R. § 2520.103–5.

198. BCBSM violated its fiduciary duty under ERISA by supplying false information in Form 5500s to Plaintiffs. *See Frulla*, 596 F.Supp.2d at 288.

C. BCBSM VIOLATED ERISA'S PROHIBITION OF SELF–DEALING (COUNT II) (PREVIOUSLY DECIDED IN 9/7/2012 SUMMARY JUDGMENT ORDER)

199. A third-party administrator engages in self-dealing when it marks up insurance premiums when charging expenses to an ERISA plan. Summary Judgment Order, at 20 (citing *Patelco Credit Union v. Sahni*, 262 F.3d 897, 911 (9th Cir.2001)).

200. A fiduciary also engages in self-dealing by "determin[ing] his own administrative fees and collect[ing] them himself from the Plan's funds, in violation of § 1106(b)(1)." *Patelco*, 262 F.3d at 911; *see also* Summary Judgment Order, at 20.

201. BCBSM determined its own administrative fees by acting unilaterally with respect to the Disputed Fee; this type of self-dealing is a *per se* breach of Section 1106(b)(1). *See* Summary Judgment Order, at 21.

D. PLAINTIFFS TIMELY FILED THEIR ERISA CLAIMS (STATUTE OF LIMITATIONS)

202. The statute of limitations for ERISA claims under § 1104(a) and § 1106(b) is set forth in 29 U.S.C. § 1113:

§ 1113. Limitation of actions

No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—

(1) six years after (A) the date of the last action which constituted a part of the breach or violation,

> or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
>
> (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
>
> *except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation*.

29 U.S.C. § 1113 (emphasis added).

203. Under § 1113, if the case involves "fraud or concealment," then the limitations periods set forth in Subsections 1 and 2 will not apply. In that case, the limitations period is "six years after the date of discovery of such breach or violation." *Id*.

1. Neither The Standard Six–Year Limitations Period Nor The Three–Year Limitations Period for "Actual Knowledge" Applies

204. A claim for a fiduciary breach or violation as claimed here will be time barred upon the earlier expiration of two alternative time periods. One period expires six years from the last act constituting a part of the breach or violation; the other is for a period of three years from the earliest date on which the Plaintiff had actual knowledge of the breach or violation. 29 U.S.C. § 1113.

205. That a claim is time barred under 29 USC § 1113 is an affirmative defense; BCBSM raises it and has the burden of proof. *Blanton v. Anzalone*, 760 F.2d 989, 991–92 (9th Cir.1985).

206. BCBSM does not argue that the "standard" six year statute of limitations is in play here, only to say

that "Even under a six year limitations period; Plaintiffs' claims were time barred in either 2000 or 2009." (Defendant's Proposed Conclusions of Law, ¶ 8). Hence, the Court focuses on BCBSM's actual knowledge argument.

207. In interpreting and applying § 1113, courts refer to the broad remedial purposes of ERISA; they express the view that "A fiduciary who violates the trust placed in him by the plan will not easily find protection from a time bar." *Useden v. Acker*, 734 F.Supp. 978, 979–80 (S.D.Fla.1989), 947 F.2d 1563 (11th Cir.1991), cert. denied, 508 U.S. 959, 113 S.Ct. 2927, 124 L.Ed.2d 678 (1993).

208. In keeping with the broad remedial purpose of ERISA, the standard six year limitations period provides potential litigants with a long period of time from commission of a breach or violation, in which to file suit. However, to prevent litigants from unreasonably delaying the filing of suit once they have knowledge of the facts underlying their claims, § 1113 provides that a fiduciary claim will be time barred if it is not filed within three years after Plaintiff has actual knowledge of the breach or violation, even if the six year period has yet to expire. 29 U.S.C. § 1113(2).

209. As outlined above, the preponderance of the evidence shows that Hi–Lex:

> (1) Did not have actual knowledge of the breach or violation until *August 21, 2007*, when the Value of Blue chart was presented by Ms. Ham to Hi–Lex representatives. So-called disclosures made by Mr. Crofoot in 1994 did not give Plaintiff's actual knowledge of Disputed fees. Nor did the audit and RFP process in 2003.

(2) So-called disclosures made in the 2002 ASC, 1995 through 2008 Schedule As, and the renewal packages for 2006 through 2008, did not unambiguously disclose the Disputed Fees.

210. The relevant "actual knowledge" "required to trigger the statute of limitations under 29 USC § 1113(2) is knowledge of the facts or transaction that constituted the alleged violations; it is not necessary that the Plaintiff also have actual knowledge that the facts establish a cognizable legal claim under ERISA in order to trigger the running of the statute." *Wright v. Heyne*, 349 F.3d 321, 330 (6th Cir.2003); *Bishop v. Lucent Techs, Inc*., 520 F.3d 516, 519–20 (6th Cir.2008).

211. While the failure to read plan documents will not shield Plaintiffs from actual knowledge of the documents terms, *Brown v. Owens Corning Inv. Review Comm*., 622 F.3d 564, 571 (6th Cir.2010), the documents that BCBSM say Plaintiffs should have read and which would have given them so called actual knowledge, failed to set forth Disputed Fees as an Administrative Fee, or in a manner which would have caused Plaintiffs to question the Disputed Fees. Further, the documents BCBSM relies upon do not clearly set forth the essential facts of the transaction or conduct which constitutes BCBSM's breach of duty. BCBSM's breach was supplying false, misleading, and inaccurate information to Plaintiffs about the nature and extent Disputed Fees, (*see* Part IV, Sections B and C). The manner in which the contract documents were written did not disclose all material facts necessary to understand that BCBS breached its duty or otherwise violated the statute.

212. As the Eleventh Circuit held and the Sixth Circuit recognized, it is not enough that an ERISA

Plaintiff "notice that something was awry; he must have had knowledge of the actual breach of duty upon which he sues." *Brock v. Nellis*, 809 F.2d 753 (11th Cir.), cert. dismissed, 483 U.S. 1057, 108 S.Ct. 33, 97 L.Ed.2d 821 (1987); *see Rogers v. Millan*, 902 F.2d 34 (6th Cir.1990).

213. Based on the foregoing, the Court finds that BCBSM failed to meet its burden to prove that Plaintiffs gained actual knowledge of the Disputed Fees in 1994, 2002, 2003, or from 1995 up to August 21, 2007.

2. The Six–Year Discovery Rule for "Fraud or Concealment" Applies and Allows Plaintiffs to Recover Damages From 1994 Through 2011

a. The applicable standard for the application of "Fraud or Concealment" is an open question in the Sixth Circuit

214. Under ERISA § 1113, neither the expiration of six years from the last act constituting a fiduciary breach or violation, nor three years from actual knowledge of the breach or violation, will bar a claim where fraud or concealment is proven. 29 U.S.C. § 1113.

215. In the case of fraud or concealment, § 1113 gives a plaintiff six years after the date of discovery of the breach to file suit. *Id*.

216. Accordingly, Hi–Lex can preserve any claims that might otherwise be time barred under the normal three year limitations period, if it can show that BCBS engaged in conduct that constitutes fraud or concealment.

217. In a claim of breach of fiduciary duty based on fraud or concealment, the Circuits are not unanimous

on what the elements are for such a cause of action; there are two approaches on this issue.

218. First, various Circuits hold that the "fraud or concealment" language cannot be read literally, and that the cause of action incorporates the federal concealment rule, or the "fraudulent concealment" doctrine.

219. The concealment rule was established by the Supreme Court in *Bailey v. Glover*, 21 Wall. 342, 88 U.S. 342, 22 L.Ed. 636 (1874). It grew from equitable estoppel principles, and provides that when a defendant's wrongdoing "has been concealed, or is of such character as to conceal itself, the statute [of limitations] does not begin to run" until the plaintiff discovers the wrongful acts. *See id*. at 349–50.

220. Thus, to invoke the "fraud or concealment" limitations period, the Circuits that rely upon the concealment rule require that a plaintiff—in addition to alleging a breach of fiduciary duty (based on fraud or anything else)—must prove that the defendant committed either: (1) a self-concealing act, i.e., an act that has the effect of concealing the breach from the Plaintiff; (or) "active concealment"—an act distinct from and subsequent to breach, intended to conceal it. *See Kurz v. Philadelphia Elec. Co.*, 96 F.3d 1544, 1552 (3d Cir.1996); *J. Geils Band Employee Benefit Plan v. Smith Barney*, 76 F.3d 1245, 1252 (1st Cir.1996); *Barker v. American Mobil Power Corp*., 64 F.3d 1397, 1401–02 (9th Cir.1995); *Larson v. Northrop Corp*., 21 F.3d 1164, 1172–1173 (D.C.Cir.1994); *Radiology Ctr. v. Stifel Nicolaus & Co*., 919 F.2d 1216, 1220 (7th Cir.1990); *Schaefer v. Arkansas Med. Soc'y*, 853 F.2d 1487, 1491–1492 (8th Cir.1988).

221. A different approach in applying the "fraud or concealment" limitations period has been articulated in *Caputo v. Pfizer*, 267 F.3d 181 (2d Cir.2001). It does not require a plaintiff to prove fraudulent concealment. The Second Circuit declined to follow its sister Circuits on this issue, holding that "[t]he six-year statute of limitations should be applied to cases in which a fiduciary: (1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce [a plaintiff] to act to his detriment; *or* (2) engaged in acts to hinder the discovery of a breach of fiduciary duty." *Id*. at 190 (emphasis in original).

222. *Caputo* breaks from the other Circuits for three reasons.

a. "[T]he genesis of this uniformly adopted theory is a footnote in a district court opinion that cites no legal support for the proposition." *Id*. at 189 (explaining that "The First, Third, Seventh, Ninth, and D.C. Circuits all cite the Eighth Circuit decision in *Schaefer*, 853 F.2d at 1491–1492, which, in turn, relied on *Foltz v. U.S. News & World Report, Inc*., 663 F.Supp. 1494, 1537 n. 66 (D.D.C.1987) (noting that 'any claim under ERISA § 502(a)(3) may [. . .] be tolled under the fraudulent concealment doctrine incorporated in section 413, 29 U.S.C. § 1113.')").

b. "[T]he 'fraud or concealment' provision does not 'toll' the otherwise applicable six-or three-year statute of limitations established in § 413(1) or (2); rather, it prescribes a separate statute of limitations of six years from the date of discovery." *Id*.

c. "[P]rinciples of statutory interpretation counsel strongly against merging" the terms "fraud" and

"concealment," and each term should be given "independent significance" pursuant to their definitions and the provision's legislative history. *See id*. at 189–90.

223. BCBSM argues that the Court should follow the First, Third, Seventh, Eighth, Ninth, and D.C. Circuits, and directs the Court to *Larson v. Northrop*, 21 F.3d 1164 (D.C.Cir.1994), which held that that a plaintiff invoking the special fraud limitations period must prove that the defendant engaged in actual, fraudulent concealment. *See id*. at 1172–74.

224. In addition, BCBSM claims that this Court is bound to apply the majority of the Circuits' approach because *Brown v. Owens Corning Inv. Review Committee*, 622 F.3d 564 (6th Circuit 2010)—a Sixth Circuit case—allegedly mandates it because *Brown* quoted *Larson*.

225. The language to which BCBSM directs the Court's attention in *Brown* is: "ERISA's fraud exception to the statute of limitations 'requires the plaintiffs to show (1) that defendants engaged in a course of conduct designed to conceal evidence of their alleged wrong-doing and that (2) [the plaintiffs] were not on actual or constructive notice of that evidence, (3) despite their exercise of diligence." *Brown*, 622 F.3d at 573 (quoting *Larson*, 21 F.3d at 1172) (alteration in original).

226. However, a more recent Sixth Circuit case, *Cataldo v. U.S. Steel Corp*., 676 F.3d 542 (6th Cir.2012), held that "whether a six-year limitations period applies in instances where the claim is based upon fraud and there are no allegations of separate conduct undertaken by the fiduciary to hide the fraud is an open question" in the Sixth Circuit. *Id*. at 550.

227. *Cataldo* held that *Brown* was dictum to the extent that it purported "to set forth the entire set of circumstances in which [the six year statute of limitations] can apply." *Cataldo* stated this because it believed the Sixth Circuit did not have to consider—for the ultimate holding in *Brown*—"whether a claim of fraud, by itself, would be subject to the six-year period because plaintiffs never pressed such a claim; they claimed . . . *non-fraudulent* breach of fiduciary duty." *Id*. at 550–51.

228. *Cataldo* went on to find the *Caputo* approach persuasive. *Id.* ("[T]he Second Circuit has provided a persuasive contrary interpretation." (citing *Caputo* 267 F.3d at 188–190)). However, the *Cataldo* court did not pronounce it as Sixth Circuit authority because it was not necessary to the holding in *Cataldo*; the court found that the plaintiffs failed to plead fraud sufficiently, and concluded that any discussion on that issue would have been dictum. *Cataldo*, 676 F.3d at 550–51 ("[W]e assume, but do not decide, that a claim of fiduciary fraud not involving separate acts of concealment is subject to a six-year limitations period that begins to run when the plaintiff discovered or with due diligence should have discovered the fraud.").

229. Accordingly, neither *Brown* nor *Cataldo* binds this Court on the applicable statute of limitations.

230. The Court concludes that—pursuant to *Cataldo*—if the Sixth Circuit adopted a standard on this issue, it would follow the *Caputo* approach for the same reasons that *Caputo* rejected its sister Circuits' approach: (1) "fraud" and "concealment" are used in the disjunctive in the statute; (2) the "fraud or concealment" provision has its own statute of limitations running from the date of discovery, and is not intended to toll another statute of limitations; and

(3) the majority of Circuits relied upon a district court decision which erroneously merged the term "fraud" and "concealment" to require an ERISA plaintiff to prove "fraudulent concealment" in a breach of duty claim before the plaintiff could reap the benefit of the longer statute of limitations.

231. In addition, several judges in this district have either used the *Caputo* standard for analyzing the fraud or concealment exception in § 1113 or cited it with approval. *See, e.g., East Jordan Plastics, Inc. v. Blue Cross & Blue Shield of Mich*., No. 12–cv–15621, Dkt. No. 27, at Page ID 937 (E.D.Mich. May 3, 2013) (applying *Caputo*); *McGuire v. Metro. Life Ins. Co*., 899 F.Supp.2d 645, 659 (E.D.Mich.2012) (citing *Caputo* with approval).

232. Nonetheless, the Court finds that whether the burden on Plaintiffs is to prove simple "fraud" or "fraudulent concealment" is of no moment; Plaintiffs satisfy their burden under either *Caputo* or the various other Circuits.

b. Plaintiffs Prove BCBSM Engaged in Fraudulent Conduct

233. *Caputo* allows the application of the "fraud or concealment" limitations period under § 1113 when, in relevant part, a defendant: "(1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce [a plaintiff] to act to his detriment." 267 F.3d at 190.

234. Furthermore, under *Frulla v. CRA Holdings Inc.*, 596 F.Supp.2d 275 (D.Conn.2009), a plan administrator is guilty of fraud under § 1113 if it made "knowing omissions of material facts" that "misled plan participants" into believing facts that were not true. *Id*. at 288. Frulla involved ERISA claims under

§ 1104(a) that "in the course of administering the Plan . . ., defendants engaged in actions that violated their fiduciary duties, failed to disclose material information to Plan participants, and concealed material information from them." *Id*. at 278.

235. The Court finds the rule in *Caputo* and the holding in *Frulla* applicable to whether BCBSM engaged in fraud for the purpose of § 1113.

236. Plaintiffs prove that BCBSM engaged in knowing misrepresentations and omissions of Disputed Fees in the contract documents, which misled Plaintiffs into thinking that the disclosed Administrative Fees were the only compensation that BCBSM retained. (*See* Part III, Sections D–J).

237. To comply with the particularity requirement of Federal Rule of Civil Procedure 9(b), "[w]ith regard to misrepresentations, a plaintiff must identify the time, place, speaker, and content of the alleged misrepresentations." *Frulla*, 596 F.Supp.2d at 288 (citing *Caputo*, 267 F.3d at 191). "With regard to omissions, a plaintiff must detail the omissions made, state the person responsible for the failure to speak, provide the context in which the omissions were made, and explain how the omissions deceived the plaintiff." *Id.* (citing *Eternity Global Master Fund Ltd. v. Morgan Guar. Trust Co. of N.Y.*, 375 F.3d 168, 187 (2d Cir.2004)). Plaintiffs met these requirements at trial, and BCBSM waived the particularity requirements under Rule 9(b). (*See* Paragraph 238).

238. BCBSM argues that Plaintiffs did not sufficiently plead fraud (or fraudulent concealment) under Rule 9(b), and should be foreclosed from trying these issues now. This argument is unavailing. BCBSM's main defense at trial was based on an

absence of fraud. "When an issue not raised by the pleadings is tried by the parties' express or implied consent, it must be treated in all respects as if raised in the pleadings. A party may move—at any time, even after judgment—to amend the pleadings to conform them to the evidence and to raise an unpleaded issue. But failure to amend does not affect the result of the trial of that issue." Fed.R.Civ.P. 15(b)(2).

239. "When a 'discovery rule' [such as that in § 113] applies, the statute of limitations begins to run from the date on which the plaintiff discovers, or with due diligence reasonably should have discovered, that he has suffered an injury." *Frulla*, 596 F.Supp.2d at 289; *see Caputo*, 267 F.3d at 190 ("[T]he final version of the statute adopted a six-year term and a discovery rule (i.e., the limitations period begins to run when the employee discovers or with due diligence should have discovered the breach). . . .").

240. When "discovery" is used in a statute, courts typically interpret the word to refer not only to actual discovery, but also to the hypothetical discovery of facts a reasonably diligent plaintiff would know. *Merck & Co., Inc. v. Reynolds*, 559 U.S. 633, 130 S.Ct. 1784, 1794, 176 L.Ed.2d 582 (2010).

241. Plaintiffs did not discover BCBSM's fraud until August 21, 2007. (*See* Part III, Section K).

242. Plaintiffs did not discover BCBSM's fraud until August 21, 2007, through their own exercise of due diligence. Importantly, a hypothetical diligent company would not have discovered BCBSM's fraud until August 21, 2007. (*See* Part III, Section K).

243. Accordingly, Plaintiffs had until August 21, 2013 to file their suit. Their claims are timely, and they are entitled to damages from 1994 through 2011.

c. Plaintiffs Prove BCBSM Engaged in Fraudulent Concealment

244. To rely on the "fraud or concealment" limitations period under *Larson*, Plaintiffs must show: (1) that BCBSM engaged in a course of conduct designed to conceal evidence of their alleged wrongdoing and that (2) Plaintiffs were not on actual or constructive notice of that evidence, despite (3) their exercise of diligence. *Larson*, 21 F.3d at 1172.

245. Under *Larson*, Plaintiffs must—in addition to proving a breach of fiduciary duty based on a failure to disclose—show that BCBSM engaged in a "course of conduct designed to conceal evidence of [BCBSM's] wrongdoing." *Id*. at 1172. "'There must be actual concealment—i.e., some trick or contrivance intended to exclude suspicion and prevent inquiry.'" *Id*. at 1173 (quoting *Martin v. Consultants & Administrators, Inc*., 966 F.2d 1078, 1095 (7th Cir.1992)).

246. Plaintiffs prove that BCBSM actively concealed their knowing misrepresentations and omissions in the contract documents in order to allay Plaintiffs' suspicion and prevent inquiry into Disputed Fees. (*See* Part III, Sections D–J).

247. Plaintiffs were not on actual or constructive notice of the evidence of BCBSM's wrongdoing until August 21, 2007. (*See* Part III, Section K).

248. Plaintiffs exercised due diligence until August 21, 2007. (*See* Part III, Section K).

249. Accordingly, Plaintiffs had until August 21, 2013 to file their suit. Their claims are timely, and they are entitled to damages from 1994 through 2011.

E. BCBSM CANNOT ESTABLISH A STATUTE OF LIMITATIONS DEFENSE BASED ON ALLEGED IMPUTED KNOWLEDGE FROM MARSH

1. BCBSM may not seek to impute knowledge in order to shield its ERISA violations.

250. The Court has found "that agency law is applicable in the context of ERISA, and adopt[ed] the imputed knowledge doctrine and its exception." (April 19, 2013 Order on Motions in Limine (Doc No. 235) ("Order on Motions in Limine")).

251. Thus, "[t]he rule imputing an agent's knowledge to the principal is designed to protect only those who exercise good faith, and is not intended to serve as a shield for unfair dealing by the third person." *Id*. (quoting 3 Am.Jur.2d Agency § 284); *see also, e.g., First Ala. Bank v. First State Ins. Co*., 899 F.2d 1045, 1060 n.8 (11th Cir.1990) (acknowledging the "universally accepted" rule); *Mut. Life Ins. Co. v. Hilton–Green*, 241 U.S. 613, 623, 36 S.Ct. 676, 60 L.Ed. 1202 (1916) ("The rule [of imputation] is intended to protect those who exercise good faith, and not as a shield for unfair dealing"); *Armstrong v. Ashley*, 204 U.S. 272, 283, 27 S.Ct. 270, 51 L.Ed. 482 (1907) (explaining that the rule of imputation applied because defendants did not have any connection with the agents' frauds); B*ass v. Equitable Life Assurance Soc'y of the U.S.*, 72 F. App'x 401, 404 (6th Cir. Aug.13, 2003).

252. "The Court interprets this doctrine to require the party invoking it to have acted in good faith." (Order on Motions in Limine).

253. "Defendant [BCBSM] has the burden to prove imputed knowledge and that it acted in good faith." (*Id*.)

254. Dave Mamuscia, who was not a subagent working with Hi–Lex in 2003, never testified at trial. There is no evidence as to what he knew about the Disputed Fees in 2003.

255. Accordingly, no knowledge regarding the Disputed Fees can be imputed to Hi–Lex.

256. BCBSM violated ERISA's prohibition against self-dealing and also breached its fiduciary duties. It also engaged in fraud and concealment to hide its violations from Plaintiffs. BCBSM exhibited bad faith that precludes imputation for the purpose of its statute of limitations defense or otherwise.

F. PLAINTIFFS ARE ENTITLED TO A RETURN OF THE DISPUTED FEES, WITH INTEREST

252. Under ERISA:

> [a] fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate . . . .

29 U.S.C. § 1109.

1. Damages

258. "Section 1109, in turn, makes any person found to be a fiduciary personally liable to the ERISA-covered plan for any damages caused by that person's breach of fiduciary duties." *Briscoe*, 444 F.3d at 486.

259. "[I]n measuring a loss, the burden of persuasion should be placed on the breaching fiduciary." *Sec'y of the U.S. Dep't of Labor v. Gilley*, 290 F.3d 827, 830 (6th Cir.2002).

260. Further, "to the extent that there is any ambiguity in determining the amount of loss in an ERISA action, the uncertainty should be resolved against the breaching fiduciary." *Id*.

261. The Court accepts the well-founded damage opinions set forth in Mr. Steinkamp's expert report (PTE 582 and 587) and awards the Plaintiffs the full amount of Disputed Fees, *$5,111,431*, pursuant to 29 U.S.C. § 1109.

2. Prejudgment Interest

262. There is no fixed interest rate for prejudgment interest under ERISA. Rather "the determination of the prejudgment interest rate [is] within the sound discretion of the district court." *Ford v. Uniroyal Pension Plan*, 154 F.3d 613, 619 (6th Cir.1998).

263. BCBSM offered no testimony—expert or otherwise—on this issue. Its critiques of Mr. Steinkamp's expert opinion (DTE 1240) fall flat in light of John Flack's testimony that BCBSM's attorneys' summary exhibit (DTE 1240) is entirely incorrect. Flack Test.

264. The goal of the district court in setting the rate should be to adhere to "ERISA's remedial goal of simply *placing the plaintiff in the position he or*

she would have occupied but for the defendant's wrongdoing." Id. at 618 (emphasis added).

265. Prejudgment interest should "compensate a beneficiary for the lost interest value of money wrongfully withheld from him or her." *Rybarczyk v. TRW, Inc.*, 235 F.3d 975, 985 (6th Cir.2000) (quoting *Ford*, 154 F.3d at 618).

266. "An award that fails to make the plaintiff whole due to an inadequate compensation for her lost use of money frustrates the purpose of ERISA's remedial scheme." *Schumacher v. AK Steel Corp. Ret. Accumulation Pension Plan*, 711 F.3d 675, 2013 WL 1235624, at *8 (6th Cir. Mar.28, 2013) (published, pagination forthcoming).

267. The Sixth Circuit has cited with approval, decisions that utilize expert testimony in determining the appropriate prejudgment interest rate under ERISA. *Rybarczyk*, 235 F.3d at 986 (citing *Katsaros v. Cody*, 744 F.2d 270, 281 (2d Cir.1984)).

268. Equity requires that Plaintiffs be awarded prejudgment interest dating back to the date the Disputed Fees were kept by BCBSM. *See Ford*, 154 F.3d at 618 ("awards at prejudgment interest . . . compensate a beneficiary for the lost interest value of money wrongfully withheld from him or her"); *Bricklayers' Pension Trust Fund v. Taiariol*, 671 F.2d 988 (6th Cir.1982) (awarding interest to ERISA-plan plaintiff).

269. Plaintiffs' damages expert, Neil Steinkamp, testified as to the interest rate which he believes would place Plaintiffs in the position they would have been in, had BCBSM not taken the Disputed Fees. (Steinkamp Test.) The Court does not accept the

interest rate set forth in Mr. Steinkamp's expert report.

270. The Court applies the interest rate under 28 U.S.C. § 1961, and awards Plaintiffs prejudgment interest under § 1967.

3. Post-judgment Interest

271. The Court awards Plaintiffs post judgment interest according to 28 U.S.C. § 1961.

4. Attorney Fees

272. The Court will entertain a petition for Attorney Fees.

IV. CONCLUSION

These are the Findings of Fact and Conclusions of Law. Judgment enters in the amount of *$5,111,431*, together with costs, interest, and attorney fees.

IT IS ORDERED.

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case Number: 11-12557

HI-LEX CONTROLS INCORPORATED, HI-LEX AMERICA, INCORPORATED AND HI-LEX CORPORATION HEALTH AND WELFARE PLAN,

Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Defendant.

Honorable Victoria A. Roberts

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consolidated with
Case Number: 11-12565

BORROUGHS CORPORATION AND BORROUGHS CORPORATION EMPLOYEE BENEFIT PLAN,

Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Defendant.

Honorable Victoria A. Roberts

ORDER GRANTING PLAINTIFFS' MOTIONS TO STRIKE EXPERT WITNESS

I. INTRODUCTION

This matter is before the Court on Plaintiffs' Motion to Strike Expert Witness John W. Bauerlein and Plaintiffs' Second Motion to Strike Defendant's Expert Witness John W. Bauerlein. The motions are fully briefed. Plaintiffs seek to preclude Defendant's introduction of expert testimony regarding certain claimed cost savings achieved by Plaintiff Hi-Lex.

The Court GRANTS Plaintiffs' motions.

II. BACKGROUND

These cases are two in a series involving Plaintiffs' Administrative Service Contracts ("ASC") with Defendant for claims administration services and network access for their self-funded employee health benefit plans. Under the ASCs, Defendant serves as third-party administrator for Plaintiffs' employee health benefit plans. It processes and pays employee health claims, provides access to its network for covered employees, and negotiates with hospitals and health care providers throughout the state. Plaintiffs reimburse Defendant for claims paid on their behalf.

These cases concern certain fees that Defendant allocated to itself as additional administrative compensation ("Disputed Fees"). In essence, Plaintiffs argue that they did not know about the disputed fees until recently and that Defendant employed different ways to hide them. Defendant says that it did not breach any duties in collecting the disputed fees because they were fully disclosed and Plaintiffs agreed to pay them.

On September 7, 2012, the Court issued an order addressing the parties' cross-motions for summary judgment. (Hi-Lex #112/ Borroughs #118). The Court found that Defendant is a fiduciary under ERISA, that the disputed fees were paid from plan funds, and that relief is available to Plaintiffs under ERISA.

The Court granted summary judgment to Plaintiffs on Count II, ERISA prohibited transaction, finding that Defendant committed a *per se* breach of Section 1106(b)(1) when it allocated itself the disputed fees; that claim will proceed to trial on damages. The Court also held that Count 1, ERISA breach of fiduciary duty under Section 1104(a)(1), will proceed to trial because several issues of material fact remain regarding whether Defendant breached its fiduciary duty by lying to or misleading Plaintiffs about the disputed fees.

These motions are to exclude expert testimony regarding savings attained by Plaintiff Hi-Lex by participating in Defendant's health benefit program. The Report prepared by Defendant's expert, John W. Bauerlein ("the Report"), includes a calculation of these alleged savings, done by comparing Defendant's contracted provider reimbursement to (a) provider billed charges and (b) estimated provider reimbursement levels for Defendant's competitors. The Report sets forth: (1) the amounts that healthcare providers billed and what they were allowed to charge; (2) what Plaintiff Hi-Lex saved by participating in Defendant's network; and (3) what Plaintiffs would have saved by participating in the best alternative network or competitor. It also includes the percentage that the disputed fees correspond to the Plaintiff Hi-Lex's savings. The crux of the Report is Mr. Bauerlein's opinion that such level of savings is reasonable and

that Defendant provides substantial claims cost savings, compared to the best alternative network.

Plaintiffs argue that the Court should strike the Report because:

(A) It is irrelevant pursuant to Federal Rule of Evidence 402 given that Mr. Bauerlein's opinions do not address any claims or defenses in Counts I and II;

(B) It fails to comply with Federal Rule of Civil Procedure 26(a)(2)(B)(ii) and should be stricken as a sanction under Federal Rule of Civil Procedure 37 because the expert did not provide the data of Plaintiffs' medical claims or his company's proprietary data with his report; and

(C) It is inadmissible under Federal Rule of Evidence 702 and fails to meet the reliability factors under *Daubert v. Merrell Dow Pharms*., 509 U.S. 579 (1993).

III. STANDARD OF REVIEW

District courts may rule on motions in limine under their authority to manage trials. The Court exercises its sound discretion when resolving questions of relevancy and admissibility of evidence at trial. *See United States v. Seago*, 930 F.2d 482, 494 (6th Cir. 1991).

IV. ANALYSIS

Federal Rule of Evidence 401 defines relevant evidence as including "evidence having any tendency to make the existence of a fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." Fed. R. Evid. 401. Under Federal Rule of Evidence 402, "evidence not relevant is inadmissible." Fed. R. Evid. 402.

Plaintiffs argue that Defendant's intended use of the Report to support a "cost-savings," "we were worth it"

defense based on reasonableness of arrangements and compensation under § 1108(b)(2) or (c)(2), does not apply to breaches of § 1104(a) and 1106(b); they say a § 1108 defense applies only to claims under § 1106(a). In support of their argument, Plaintiffs direct the Court to numerous decisions, including *Patelco Credit Union v. Sahni*, 262 F.3d 897 (9th Cir. 2001). Trial in this case involves only Plaintiffs' § 1104(a) claim, breach of fiduciary duty, and § 1106(b)(1) claim, damages for a prohibited transaction.

Defendant says that the exemptions under §§ 1108(b)(2) and (c)(2) are defenses to claims under all of § 1106 and the issue of reasonableness of such fees must be adjudicated in order to assess the extent of liability for Plaintiffs' § 1106(b)(1) claim. Defendant argues the Report provides a measure for assessing the reasonableness of the disputed fees. In support of its argument, Defendant directs the Court to *Harley v. Minnesota Mining & Manufacturing Co*., 284 F.3d 901 (8th Cir. 2002).

The Court is persuaded by the majority of decisions which hold that §§ 1108(b)(2) and (c)(2) do not apply to claims arising under either § 1104(a) or § 1106(b). *See Patelco*, 262 F.3d at 910-912; *Tibble v. Edison Int'l*, 639 F. Supp. 2d 1074, 1105 n.14 (C.D. Cal. 2009); *Chao v. Linder*, 421 F. Supp. 2d 1129, 1135-36 (N.D. Ill. 2006); *see also Nat'l Sec. Sys., Inc. v. Iola*, 10-4154, 2012 WL 5440113 at 20-23 (3d Cir. Nov. 8, 2012). Indeed, § 1108 "does not provide a safe harbor to fiduciaries who self-deal." *Patelco*, 262 F.3d at 911. Accordingly, use of the Report to assess the reasonableness of the disputed fees or for a "cost-savings" defense is inconsequential to Plaintiffs' claims. The Report is not relevant.

Defendant also argues that even if a § 1108 defense may not apply to a §1106(b) claim, evidence of a benefit received by Plaintiffs from the prohibited transactions and alleged breach of fiduciary duty is relevant to the measure of relief.

The Court need not reach the merits of this argument. Even assuming that Defendant's argument has merit, the Court believes that the Report merely purports to show that Plaintiff Hi-Lex obtained savings from participation in Defendant's network and that Defendant was Plaintiff Hi-Lex's best option. The expert's conclusions do not make it "more or less probable" that the prohibited transaction itself—the allocation of the disputed fees—conferred a benefit on the Plaintiffs.

V. CONCLUSION

Because the Court finds that the Report is not relevant, it need not address Plaintiffs' additional grounds for its exclusion.

Plaintiffs' motions are GRANTED.

IT IS ORDERED.

/s/ Victoria A. Roberts
Victoria A. Roberts
United States District Judge

Dated: December 5, 2012

APPENDIX E

UNITED STATES DISTRICT COURT
E.D. MICHIGAN
SOUTHERN DIVISION

Nos. 11–12565, 11–12557

BORROUGHS CORPORATION AND BORROUGHS CORPORATION EMPLOYEE BENEFIT PLAN,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant,

and

HI-LEX CONTROLS INCORPORATED, HI-LEX CORPORATION AND HI-LEX CORPORATION HEALTH AND WELFARE PLAN,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

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

Sept. 7, 2012

VICTORIA A. ROBERTS, *District Judge*.

I. INTRODUCTION

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

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

For the reasons that follow:

- Defendant's Motion for Summary Judgment is GRANTED IN PART and DENIED IN PART. The Court dismisses the state law claims (Counts IIIIX) with prejudice. Defendant's Motion is denied as to the ERISA claims (Counts I–II)
- Plaintiffs' Motion for Summary Judgment is GRANTED IN PART and DENIED IN PART. The Court grants summary judgment to Plaintiffs on Count II, ERISA prohibited transaction. The Court denies summary judgment to Plaintiffs on all other counts.

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

II. BACKGROUND

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

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

These cases are about certain fees that Blue Cross allocated to itself as additional administrative compensation. Plaintiffs refer to the disputed fees as "Hidden Fees"; Defendant refers to them as "Access Fees." The disputed fees, set forth in an unnumbered and untitled provision of Article III of the ASCs, include "The Provider Network Fee, contingency, and

any cost transfer subsidies or surcharges. . . .” According to that provision, these fees will be “reflected in the hospital claims cost contained in the Amounts Billed.”

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

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

In 1993, Blue Cross decided to hide the Disputed Fees by merging them with hospital claims on billing

statements. A 1993 document entitled Executive Summary, attached as Exhibit A to Plaintiffs' summary judgment brief, explains the plan. The Summary reads, in relevant part:

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

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

Plaintiffs say that from 1994 to present, Blue Cross employed a "bevy of artifices" to hide the fees. Indeed, on the various disclosures discussed in the pleadings

and reviewed by the Court, the Disputed Fees are not itemized. Plaintiffs say they did not learn about the Disputed Fees until 2011. Defendants, on the other hand, point to the contractual language in the ASCs and renewals to argue that the Disputed Fees were fully disclosed, that Plaintiffs agreed to payment of the Disputed Fees, and that, therefore, they did not breach any duties in collecting the fees.

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

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

III. STANDARD OF REVIEW

The Court will grant summary judgment if "the movant shows that there is no genuine dispute as

to any material fact and the movant is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(a); *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 250–57, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). When reviewing cross-motions for summary judgment, the court must assess each motion on its own merits. *Federal Ins. Co. v. Hartford Steam Boiler Insp. and Ins. Co.*, 415 F.3d 487, 493 (6th Cir.2005). "The standard of review for cross-motions for summary judgment does not differ from the standard applied when a motion is filed by only one party to the litigation." *Lee v. City of Columbus*, 636 F.3d 245, 249 (6th Cir.2011). "[T]he filing of cross-motions for summary judgment does not necessarily mean that an award of summary judgment is appropriate." *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust*, 410 F.3d 304, 309 (6th Cir.2005).

IV. ANALYSIS

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

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

The Court disagrees that *Calhoun County* is dispositive for two reasons: (1) the court in *Calhoun*

County did not address the precise issues before this Court; and (2) ERISA law is federal law; state rules of decision have no binding precedential effect.

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

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

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

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

B. Is This an ERISA Case?

ERISA is a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 90, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983). The duties ERISA imposes on fiduciaries

have been called "'the highest known to law.'" *Chao v. Hall Holding Co.*, 285 F.3d 415, 426 (6th Cir.2002) (quoting *Howard v. Shay*, 100 F.3d 1484, 1488 (9th Cir.1996)).

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

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

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

In relevant part, ERISA provides that "a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or

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

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

On at least two occasions the Sixth Circuit held that a third-party administrator of an employee health benefit plan was a fiduciary under ERISA. In *Guyan*, the plaintiffs entered into contracts with a third-party administrator which required the administrator to establish accounts for each plaintiff into which it would deposit funds received from each plaintiff for the purpose of paying medical claims. *Id*.

at *1. The third-party administrator was authorized to pay medical claims by writing checks from this account. *Id*. The Sixth Circuit held that "when [the third-party administrator] received Plan funds from Plaintiffs and deposited them into an account of its choice, [it] exercised control over those funds, as demonstrated by [its] use of Plan funds for its own purposes . . . ." *Id*. It then added that "[the third-party administrator] was a fiduciary under ERISA because it exercised authority or control over Plan assets." *Id*. at *3. Among the evidence of the third-party administrator's control or authority were its ability to write checks on the Plan account, and its ability to determine where Plan funds were deposited, and how and when they were disbursed. *Id*.

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

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

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

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

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

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

Blue Cross primarily relies on two cases for its argument that it is not a fiduciary. In *Seaway*, the Sixth Circuit held that a third-party administrator of an employee health benefit plan was not an ERISA fiduciary where the contracts between the parties allowed the administrator to "retain any funds

resulting from the provider discounts for its sole benefit." 347 F.3d at 618. The Court held:

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

Id. at 619.

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

Seaway does not control for one simple reason: Seaway holds that adherence to a contractual term does not give rise to fiduciary status "*unless the term*

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

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

> Here, the Trustee alleges only that "[the bank] regularly withdrew its fees and analysis charges from the trust funds it held. Nothing suggests that [the bank] did anything other than collect

> contractually owed fees. Unlike the *Briscoe* plaintiff, the Trustee does not allege that [the bank] unilaterally exercised any power to pay itself fees . . . [The bank] collected only routine fees authorized by its depository agreement . . .

Id. at 424.

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

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

Id.

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

2. The Disputed Fees Were Paid from Plan Assets

Defendant next argues that Plaintiffs cannot establish a loss to the ERISA plans because the plans had no assets. A loss is required for an action to be brought under ERISA § 409. Defendant says, "It follows that Plaintiffs must establish that Access Fees were paid

from 'plan assets' in order to demonstrate a remediable loss under § 409." According to Defendant, the weekly wire funds from Plaintiffs were not plan assets because the contracts explicitly disclaim that label. Defendant points out that the Burroughs Plan explicitly states that the plan has no assets, and the Hi-Lex Plan states that benefits are "paid directly out of the assets of the Company" and that "there is no special fund or trust from which self-insured benefits are paid."

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

The funds Plaintiffs deposited with Blue Cross are plan assets. In *Pipefitters*, the plaintiff entered into a nearly identical funding arrangement with Blue Cross, which Judge Tarnow described as follows: "[T]he [plaintiff] had to advance funds to [BCBSM], which then paid the claims on the [plaintiff's] behalf to the providers. Sometimes . . . [BCBSM] had to pay

more than was advanced, but the [plaintiff] was responsible for making up the difference, which is an inherent nature of a self-insuring arrangement." 654 F.3d at 626. Judge Tarnow then held that "[t]his shows that [BCBSM] exercised control over Plan assets, and there's really no factual dispute over this." This ruling was not disturbed on appeal, and there is no factual distinction between *Pipefitters* and the case before this Court.

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

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

982 F.2d at 1032.

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

Even if separate segregated accounts did not exist for plan assets from Hi-Lex and Burroughs, Blue Cross

could "earmark the funds" that Hi-Lex and Burroughs allocated to the plans. Under *Libbey–Owens–Ford*, Blue Cross controlled "plan assets."

3. Relief is Available to Plaintiffs under ERISA

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

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

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

Id.

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

C. Plaintiffs' State Law Claims are Preempted by ERISA

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

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

Plaintiffs' state law claims arise out of the same operative facts as the ERISA claims. Plaintiffs seek relief for the same conduct through "alternative enforcement mechanisms." *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp*., 399 F.3d 692, 698

(6th Cir.2005). As such, Briscoe requires that these claims be dismissed with prejudice. 444 F.3d at 501.

D. Liability

1. Count II–ERISA Prohibited Transaction

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

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

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

> § 1106(b)(1) . . . Thus, the undisputed facts establish, as a matter of law, that [the third-party administrator] breached his fiduciary duties by engaging in prohibited self-dealing.

Id.

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

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

unilaterally with respect to the Disputed Fees. This sort of self-dealing is a *per se* breach of Section 1106(b)(1).

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

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

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

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

- Whether the Value of Blue Reports accurately disclosed the Disputed Fees.

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

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

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

- Whether, and at what date, Plaintiffs gained actual knowledge of the facts constituting Blue Cross's alleged ERISA violations.

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

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

V. CONCLUSION

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

IT IS ORDERED.

APPENDIX F

FEDERAL STATUTES

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan. A distribution from a plan, fund, or program shall not be treated as made in a form other than retirement income or as a distribution prior to termination of covered employment solely because such distribution is made to an employee who has attained age 62 and who is not separated from employment at the time of such distribution.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this chapter providing one or more exempt categories under which—

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement,

shall, for purposes of this subchapter, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this chapter applicable to pension plans, such arrangement or payment shall be treated as a pension plan. An applicable voluntary early retirement incentive plan (as defined in section 457(e)(11)(D)(ii) of Title 26) making payments or supplements described in section 457(e)(11)(D)(i) of Title 26, and an applicable employment retention plan (as defined in section 457(f)(4)(C) of Title 26) making payments of benefits described in section 457(f)(4)(A) of Title 26, shall, for purposes of this subchapter, be treated as a welfare plan (and not

a pension plan) with respect to such payments and supplements.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit

plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. 1331-1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the meaning of the Labor Management Relations Act, 1947 [29 U.S.C. § 141 et seq.], or the Railway Labor Act [45 U.S.C. § 151 et seq.]

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.[1]

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise,

which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate,

is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

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[1] So in original. The period probably should be a comma.

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe a percentage lower than 50 percent for subparagraph (E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of Title 26 is permitted to make payments under section 1403 of this title shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor

cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

(17) The term "separate account" means an account established or maintained by an insurance company under which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company.

(18) The term "adequate consideration" when used in part 4 of subtitle B of this subchapter means (A) in the case of a security for which there is a generally recognized market, either (i) the price of the security prevailing on a national securities exchange which is registered under section 78f of Title 15, or (ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and (B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the

terms of the plan and in accordance with regulations promulgated by the Secretary.

(19) The term "nonforfeitable" when used with respect to a pension benefit or right means a claim obtained by a participant or his beneficiary to that part of an immediate or deferred benefit under a pension plan which arises from the participant's service, which is unconditional, and which is legally enforceable against the plan. For purposes of this paragraph, a right to an accrued benefit derived from employer contributions shall not be treated as forfeitable merely because the plan contains a provision described in section 1053(a)(3) of this title.

(20) The term "security" has the same meaning as such term has under section 77b(1) of Title 15.

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940 [15 U.S.C. § 80a-1 et seq.], such investment shall not by itself cause such investment company or such investment company's investment

adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this subchapter, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

(22) The term "normal retirement benefit" means the greater of the early retirement benefit under the plan, or the benefit under the plan commencing at normal retirement age. The normal retirement benefit shall be determined without regard to—

(A) medical benefits, and

(B) disability benefits not in excess of the qualified disability benefit.

For purposes of this paragraph, a qualified disability benefit is a disability benefit provided by a plan which does not exceed the benefit which would be provided for the participant if he separated from the service at normal retirement age. For purposes of this paragraph, the early retirement benefit under a plan shall be determined without regard to any benefit under the plan which the Secretary of the Treasury finds to be a benefit described in section 1054(b)(1)(G) of this title.

(23) The term "accrued benefit" means—

(A) in the case of a defined benefit plan, the individual's accrued benefit determined under the plan and, except as provided in section 1054(c)(3) of

this title, expressed in the form of an annual benefit commencing at normal retirement age, or

(B) in the case of a plan which is an individual account plan, the balance of the individual's account.

The accrued benefit of an employee shall not be less than the amount determined under section 1054(c)(2)(B) of this title with respect to the employee's accumulated contribution.

(24) The term "normal retirement age" means the earlier of—

(A) the time a plan participant attains normal retirement age under the plan, or

(B) the later of—

(i) the time a plan participant attains age 65, or

(ii) the 5th anniversary of the time a plan participant commenced participation in the plan.

(25) The term "vested liabilities" means the present value of the immediate or deferred benefits available at normal retirement age for participants and their beneficiaries which are nonforfeitable.

(26) The term "current value" means fair market value where available and otherwise the fair value as determined in good faith by a trustee or a named fiduciary (as defined in section 1102(a)(2) of this title) pursuant to the terms of the plan and in accordance with regulations of the Secretary, assuming an orderly liquidation at the time of such determination.

(27) The term "present value", with respect to a liability, means the value adjusted to reflect anticipated events. Such adjustments shall conform to such regulations as the Secretary of the Treasury may prescribe.

(28) The term "normal service cost" or "normal cost" means the annual cost of future pension benefits and administrative expenses assigned, under an actuarial cost method, to years subsequent to a particular valuation date of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(29) The term "accrued liability" means the excess of the present value, as of a particular valuation date of a pension plan, of the projected future benefit costs and administrative expenses for all plan participants and beneficiaries over the present value of future contributions for the normal cost of all applicable plan participants and beneficiaries. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(30) The term "unfunded accrued liability" means the excess of the accrued liability, under an actuarial cost method which so provides, over the present value of the assets of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(31) The term "advance funding actuarial cost method" or "actuarial cost method" means a recognized actuarial technique utilized for establishing the amount and incidence of the annual actuarial cost of pension plan benefits and expenses. Acceptable actuarial cost methods shall include the accrued benefit cost method (unit credit method), the entry age normal cost method, the individual level premium cost method, the aggregate cost method, the attained age normal cost method, and the frozen initial liability cost method. The terminal funding cost method and the current funding (pay-as-you-go) cost method are not acceptable actuarial cost methods. The Secretary of

the Treasury shall issue regulations to further define acceptable actuarial cost methods.

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935, or 1937 [45 U.S.C. § 231 et seq.] applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act [22 U.S.C. § 288 et seq.]. The term "governmental plan" includes a plan which is established and maintained by an Indian tribal government (as defined in section 7701(a)(40) of Title 26), a subdivision of an Indian tribal government (determined in accordance with section 7871(d) of Title 26), or an agency or instrumentality of either, and all of the participants of which are employees of such entity substantially all of whose services as such an employee are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential government function)[2]

(33)(A) The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of Title 26.

(B) The term "church plan" does not include a plan—

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[2] So in original. Probably should end with a period.

(i) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513 of Title 26), or

(ii) if less than substantially all of the individuals included in the plan are individuals described in subparagraph (A) or in clause (ii) of subparagraph (C) (or their beneficiaries).

(C) For purposes of this paragraph—

(i) A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(ii) The term employee of a church or a convention or association of churches includes—

(I) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(II) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of Title 26 and which is controlled by or associated with

a church or a convention or association of churches; and

(III) an individual described in clause (v).

(iii) A church or a convention or association of churches which is exempt from tax under section 501 of Title 26 shall be deemed the employer of any individual included as an employee under clause (ii).

(iv) An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(v) If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of Title 26 and which is controlled by or associated with a church or a convention or association of churches, the church plan shall not fail to meet the requirements of this paragraph merely because the plan—

(I) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(II) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within

the meaning of section 72(m)(7) of Title 26) at the time of such separation from service.

(D)(i) If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of Title 26 fails to meet one or more of the requirements of this paragraph and corrects its failure to meet such requirements within the correction period, the plan shall be deemed to meet the requirements of this paragraph for the year in which the correction was made and for all prior years.

(ii) If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this paragraph beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(iii) For purposes of this subparagraph, the term "correction period" means—

(I) the period ending 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to the plan's failure to meet one or more of the requirements of this paragraph; or

(II) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements, or, if the court does not specify such period, any reasonable period determined by the Secretary of the Treasury on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(III) any additional period which the Secretary of the Treasury determines is reasonable or necessary for the correction of the default,

whichever has the latest ending date.

(34) The term "individual account plan" or "defined contribution plan" means a pension plan which provides for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.

(35) The term "defined benefit plan" means a pension plan other than an individual account plan; except that a pension plan which is not an individual account plan and which provides a benefit derived from employer contributions which is based partly on the balance of the separate account of a participant—

(A) for the purposes of section 1052 of this title, shall be treated as an individual account plan, and

(B) for the purposes of paragraph (23) of this section and section 1054 of this title, shall be treated as an individual account plan to the extent benefits are based upon the separate account of a participant and as a defined benefit plan with respect to the remaining portion of benefits under the plan.

(36) The term "excess benefit plan" means a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of Title 26 on plans to which that section applies without regard to whether the plan is funded. To the extent that a separable part of a plan (as

determined by the Secretary of Labor) maintained by an employer is maintained for such purpose, that part shall be treated as a separate plan which is an excess benefit plan.

(37)(A) The term "multiemployer plan" means a plan—

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 1301(b)(1) of this title are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this subchapter, notwithstanding the preceding provisions of this paragraph, for any plan year which began before September 26, 1980, the term "multiemployer plan" means a plan described in this paragraph (37) as in effect immediately before such date.

(E) Within one year after September 26, 1980, a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 1453(b) and (c) of this title,

that the plan shall not be treated as a multiemployer plan for all purposes under this chapter or the Internal Revenue Code of 1954 if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980—

(i) the plan was not a multiemployer plan because the plan was not a plan described in subparagraph (A)(iii) of this paragraph and section 414(f)(1)(C) of Title 26 (as such provisions were in effect on the day before September 26, 1980); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

(F)(i) For purposes of this subchapter a qualified football coaches plan—

(I) shall be treated as a multiemployer plan to the extent not inconsistent with the purposes of this subparagraph; and

(II) notwithstanding section 401(k)(4)(B) of Title 26, may include a qualified cash and deferred arrangement.

(ii) For purposes of this subparagraph, the term "qualified football coaches plan" means any defined contribution plan which is established and maintained by an organization—

(I) which is described in section 501(c) of Title 26;

(II) the membership of which consists entirely of individuals who primarily coach football as full-time employees of 4-year

colleges or universities described in section 170(b)(1)(A)(ii) of Title 26; and

(III) which was in existence on September 18, 1986.

(G)(i) Within 1 year after August 17, 2006—

(I) an election under subparagraph (E) may be revoked, pursuant to procedures prescribed by the Pension Benefit Guaranty Corporation, if, for each of the 3 plan years prior to August 17, 2006, the plan would have been a multiemployer plan but for the election under subparagraph (E), and

(II) a plan that meets the criteria in clauses (i) and (ii) of subparagraph (A) of this paragraph or that is described in clause (vi) may, pursuant to procedures prescribed by the Pension Benefit Guaranty Corporation, elect to be a multiemployer plan, if—

(aa) for each of the 3 plan years immediately preceding the first plan year for which the election under this paragraph is effective with respect to the plan, the plan has met those criteria or is so described,

(bb) substantially all of the plan's employer contributions for each of those plan years were made or required to be made by organizations that were exempt from tax under section 501 of Title 26, and

(cc) the plan was established prior to September 2, 1974.

(ii) An election under this subparagraph shall be effective for all purposes under this chapter and under the Internal Revenue Code of 1986, starting with any plan year beginning on or after January 1, 1999, and ending before January 1, 2008, as designated by the plan in the election made under clause (i)(II).

(iii) Once made, an election under this subparagraph shall be irrevocable, except that a plan described in clause (i)(II) shall cease to be a multiemployer plan as of the plan year beginning immediately after the first plan year for which the majority of its employer contributions were made or required to be made by organizations that were not exempt from tax under section 501 of Title 26.

(iv) The fact that a plan makes an election under clause (i)(II) does not imply that the plan was not a multiemployer plan prior to the date of the election or would not be a multiemployer plan without regard to the election.

(v)(I) No later than 30 days before an election is made under this subparagraph, the plan administrator shall provide notice of the pending election to each plan participant and beneficiary, each labor organization representing such participants or beneficiaries, and each employer that has an obligation to contribute to the plan, describing the principal differences between the guarantee programs under subchapter III of this chapter and the benefit restrictions under this subchapter for single employer and multi-employer plans, along with such other information as the plan administrator chooses to include.

(II) Within 180 days after August 17, 2006, the Secretary shall prescribe a model notice under this clause.

(III) A plan administrator's failure to provide the notice required under this subparagraph shall be treated for purposes of section 1132(c)(2) of this title as a failure or refusal by the plan administrator to file the annual report required to be filed with the Secretary under section 1021(b)(1) of this title.

(vi) A plan is described in this clause if it is a plan sponsored by an organization which is described in section 501(c)(5) of Title 26 and exempt from tax under section 501(a) of such Code and which was established in Chicago, Illinois, on August 12, 1881.

(vii) For purposes of this chapter and the Internal Revenue Code of 1986, a plan making an election under this subparagraph shall be treated as maintained pursuant to a collective bargaining agreement if a collective bargaining agreement, expressly or otherwise, provides for or permits employer contributions to the plan by one or more employers that are signatory to such agreement, or participation in the plan by one or more employees of an employer that is signatory to such agreement, regardless of whether the plan was created, established, or maintained for such employees by virtue of another document that is not a collective bargaining agreement.

(38) The term "investment manager" means any fiduciary (other than a trustee or named fiduciary, as defined in section 1102(a)(2) of this title)—

(A) who has the power to manage, acquire, or dispose of any asset of a plan;

(B) who (i) is registered as an investment adviser under the Investment Advisers Act of 1940 [15 U.S.C. § 80b-1 et seq.]; (ii) is not registered as an investment adviser under such Act by reason of paragraph (1) of section 203A(a) of such Act [15 U.S.C. § 80b-3a(a)], is registered as an investment adviser under the laws of the State (referred to in such paragraph (1)) in which it maintains its principal office and place of business, and, at the time the fiduciary last filed the registration form most recently filed by the fiduciary with such State in order to maintain the fiduciary's registration under the laws of such State, also filed a copy of such form with the Secretary; (iii) is a bank, as defined in that Act; or (iv) is an insurance company qualified to perform services described in subparagraph (A) under the laws of more than one State; and

(C) has acknowledged in writing that he is a fiduciary with respect to the plan.

(39) The terms "plan year" and "fiscal year of the plan" mean, with respect to a plan, the calendar, policy, or fiscal year on which the records of the plan are kept.

(40)(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

(ii) by a rural electric cooperative, or

(iii) by a rural telephone cooperative association.

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term "control group" means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 1301(b) of this title, except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

(iv) the term "rural electric cooperative" means—

(I) any organization which is exempt from tax under section 501(a) of Title 26 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of Title 26 which is exempt from tax under section 501(a) of Title 26 and at least 80 percent of the members of

which are organizations described in subclause (I), and

(v) the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of Title 26 which is exempt from tax under section 501(a) of Title 26 and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

(41)[3] Single-employer plan

The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

(41)[3] The term "single employer plan" means a plan which is not a multiemployer plan.

(42) the term "plan assets" means plan assets as defined by such regulations as the Secretary may prescribe, except that under such regulations the assets of any entity shall not be treated as plan assets if, immediately after the most recent acquisition of any equity interest in the entity, less than 25 percent of the total value of each class of equity interest in the entity is held by benefit plan investors. For purposes of determinations pursuant to this paragraph, the value of any equity interest held by a person (other than such a benefit plan investor) who has discretionary authority or control with respect to the assets of the entity or any person who provides investment advice for a fee (direct or indirect) with respect to such assets, or any affiliate of such a person, shall be disregarded for purposes of calculating the 25 percent threshold.

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[3] So in original. Two pars. (41) have been enacted.

An entity shall be considered to hold plan assets only to the extent of the percentage of the equity interest held by benefit plan investors. For purposes of this paragraph, the term "benefit plan investor" means an employee benefit plan subject to part 4, any plan to which section 4975 of Title 26 applies, and any entity whose underlying assets include plan assets by reason of a plan's investment in such entity.

29 U.S.C. § 1106. Prohibited transactions

(a) Transactions between plan and party in interest

Except as provided in section 1108 of this title:

(1) A fiduciary with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect—

(A) sale or exchange, or leasing, of any property between the plan and a party in interest;

(B) lending of money or other extension of credit between the plan and a party in interest;

(C) furnishing of goods, services, or facilities between the plan and a party in interest;

(D) transfer to, or use by or for the benefit of a party in interest, of any assets of the plan; or

(E) acquisition, on behalf of the plan, of any employer security or employer real property in violation of section 1107(a) of this title.

(2) No fiduciary who has authority or discretion to control or manage the assets of a plan shall permit the plan to hold any employer security or employer real property if he knows or should know that holding such security or real property violates section 1107(a) of this title.

(b) Transactions between plan and fiduciary

A fiduciary with respect to a plan shall not—

(1) deal with the assets of the plan in his own interest or for his own account,

(2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or

(3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

(c) Transfer of real or personal property to plan by party in interest

A transfer of real or personal property by a party in interest to a plan shall be treated as a sale or exchange if the property is subject to a mortgage or similar lien which the plan assumes or if it is subject to a mortgage or similar lien which a party-in-interest placed on the property within the 10-year period ending on the date of the transfer.

29 U.S.C. § 1108. Exemptions from prohibited transactions

(a) Grant of exemptions

The Secretary shall establish an exemption procedure for purposes of this subsection. Pursuant to such procedure, he may grant a conditional or unconditional exemption of any fiduciary or transaction, or class of fiduciaries or transactions, from all or part of the restrictions imposed by sections 1106 and 1107(a) of this title. Action under this subsection may be taken only after consultation and coordination with the

Secretary of the Treasury. An exemption granted under this section shall not relieve a fiduciary from any other applicable provision of this chapter. The Secretary may not grant an exemption under this subsection unless he finds that such exemption is—

(1) administratively feasible,

(2) in the interests of the plan and of its participants and beneficiaries, and

(3) protective of the rights of participants and beneficiaries of such plan.

Before granting an exemption under this subsection from section 1106(a) or 1107(a) of this title, the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, and shall afford interested persons opportunity to present views. The Secretary may not grant an exemption under this subsection from section 1106(b) of this title unless he affords an opportunity for a hearing and makes a determination on the record with respect to the findings required by paragraphs (1), (2), and (3) of this subsection.

(b) Enumeration of transactions exempted from section 1106 prohibitions

The prohibitions provided in section 1106 of this title shall not apply to any of the following transactions:

(1) Any loans made by the plan to parties in interest who are participants or beneficiaries of the plan if such loans (A) are available to all such participants and beneficiaries on a reasonably equivalent basis, (B) are not made available to highly compensated employees (within the meaning of section 414(q) of Title 26) in an amount greater than the amount made available to other employees, (C) are made in accordance with

specific provisions regarding such loans set forth in the plan, (D) bear a reasonable rate of interest, and (E) are adequately secured. A loan made by a plan shall not fail to meet the requirements of the preceding sentence by reason of a loan repayment suspension described under section 414(u)(4) of Title 26.

(2) Contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.

(3) A loan to an employee stock ownership plan (as defined in section 1107(d)(6) of this title), if—

(A) such loan is primarily for the benefit of participants and beneficiaries of the plan, and

(B) such loan is at an interest rate which is not in excess of a reasonable rate.

If the plan gives collateral to a party in interest for such loan, such collateral may consist only of qualifying employer securities (as defined in section 1107(d)(5) of this title).

(4) The investment of all or part of a plan's assets in deposits which bear a reasonable interest rate in a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan and if—

(A) the plan covers only employees of such bank or other institution and employees of affiliates of such bank or other institution, or

(B) such investment is expressly authorized by a provision of the plan or by a fiduciary (other than such bank or institution or affiliate thereof) who

is expressly empowered by the plan to so instruct the trustee with respect to such investment.

(5) Any contract for life insurance, health insurance, or annuities with one or more insurers which are qualified to do business in a State, if the plan pays no more than adequate consideration, and if each such insurer or insurers is—

(A) the employer maintaining the plan, or

(B) a party in interest which is wholly owned (directly or indirectly) by the employer maintaining the plan, or by any person which is a party in interest with respect to the plan, but only if the total premiums and annuity considerations written by such insurers for life insurance, health insurance, or annuities for all plans (and their employers) with respect to which such insurers are parties in interest (not including premiums or annuity considerations written by the employer maintaining the plan) do not exceed 5 percent of the total premiums and annuity considerations written for all lines of insurance in that year by such insurers (not including premiums or annuity considerations written by the employer maintaining the plan).

(6) The providing of any ancillary service by a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan, and if—

(A) such bank or similar financial institution has adopted adequate internal safeguards which assure that the providing of such ancillary service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority, and

(B) the extent to which such ancillary service is provided is subject to specific guidelines issued by such bank or similar financial institution (as determined by the Secretary after consultation with Federal and State supervisory authority), and adherence to such guidelines would reasonably preclude such bank or similar financial institution from providing such ancillary service (i) in an excessive or unreasonable manner, and (ii) in a manner that would be inconsistent with the best interests of participants and beneficiaries of employee benefit plans.

Such ancillary services shall not be provided at more than reasonable compensation.

(7) The exercise of a privilege to convert securities, to the extent provided in regulations of the Secretary, but only if the plan receives no less than adequate consideration pursuant to such conversion.

(8) Any transaction between a plan and (i) a common or collective trust fund or pooled investment fund maintained by a party in interest which is a bank or trust company supervised by a State or Federal agency or (ii) a pooled investment fund of an insurance company qualified to do business in a State, if—

(A) the transaction is a sale or purchase of an interest in the fund,

(B) the bank, trust company, or insurance company receives not more than reasonable compensation, and

(C) such transaction is expressly permitted by the instrument under which the plan is maintained, or by a fiduciary (other than the bank, trust company, or insurance company or an affiliate

thereof) who has authority to manage and control the assets of the plan.

(9) The making by a fiduciary of a distribution of the assets of the plan in accordance with the terms of the plan if such assets are distributed in the same manner as provided under section 1344 of this title (relating to allocation of assets).

(10) Any transaction required or permitted under part 1 of subtitle E of subchapter III of this chapter.

(11) A merger of multiemployer plans, or the transfer of assets or liabilities between multiemployer plans, determined by the Pension Benefit Guaranty Corporation to meet the requirements of section 1411 of this title.

(12) The sale by a plan to a party in interest on or after December 18, 1987, of any stock, if—

(A) the requirements of paragraphs (1) and (2) of subsection (e) of this section are met with respect to such stock,

(B) on the later of the date on which the stock was acquired by the plan, or January 1, 1975, such stock constituted a qualifying employer security (as defined in section 1107(d)(5) of this title as then in effect), and

(C) such stock does not constitute a qualifying employer security (as defined in section 1107(d)(5) of this title as in effect at the time of the sale).

(13) Any transfer made before January 1, 2022, of excess pension assets from a defined benefit plan to a retiree health account in a qualified transfer permitted under section 420 of Title 26 (as in effect on July 6, 2012).

(14) Any transaction in connection with the provision of investment advice described in section 1002(21)(A)(ii) of this title to a participant or beneficiary of an individual account plan that permits such participant or beneficiary to direct the investment of assets in their individual account, if—

(A) the transaction is—

(i) the provision of the investment advice to the participant or beneficiary of the plan with respect to a security or other property available as an investment under the plan,

(ii) the acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice, or

(iii) the direct or indirect receipt of fees or other compensation by the fiduciary adviser or an affiliate thereof (or any employee, agent, or registered representative of the fiduciary adviser or affiliate) in connection with the provision of the advice or in connection with an acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice; and

(B) the requirements of subsection (g) of this section are met.

(15)(A) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest (other than a fiduciary described in section 1002(21)(A) of this title) with respect to a plan if—

(i) the transaction involves a block trade,

(ii) at the time of the transaction, the interest of the plan (together with the interests of any other plans maintained by the same plan sponsor), does not exceed 10 percent of the aggregate size of the block trade,

(iii) the terms of the transaction, including the price, are at least as favorable to the plan as an arm's length transaction, and

(iv) the compensation associated with the purchase and sale is not greater than the compensation associated with an arm's length transaction with an unrelated party.

(B) For purposes of this paragraph, the term "block trade" means any trade of at least 10,000 shares or with a market value of at least $200,000 which will be allocated across two or more unrelated client accounts of a fiduciary.

(16) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest if—

(A) the transaction is executed through an electronic communication network, alternative trading system, or similar execution system or trading venue subject to regulation and oversight by—

(i) the applicable Federal regulating entity, or

(ii) such foreign regulatory entity as the Secretary may determine by regulation,

(B) either—

(i) the transaction is effected pursuant to rules designed to match purchases and sales at the best price available through the

execution system in accordance with applicable rules of the Securities and Exchange Commission or other relevant governmental authority, or

(ii) neither the execution system nor the parties to the transaction take into account the identity of the parties in the execution of trades,

(C) the price and compensation associated with the purchase and sale are not greater than the price and compensation associated with an arm's length transaction with an unrelated party,

(D) if the party in interest has an ownership interest in the system or venue described in subparagraph (A), the system or venue has been authorized by the plan sponsor or other independent fiduciary for transactions described in this paragraph, and

(E) not less than 30 days prior to the initial transaction described in this paragraph executed through any system or venue described in subparagraph (A), a plan fiduciary is provided written or electronic notice of the execution of such transaction through such system or venue.

(17)(A) Transactions described in subparagraphs (A), (B), and (D) of section 1106(a)(1) of this title between a plan and a person that is a party in interest other than a fiduciary (or an affiliate) who has or exercises any discretionary authority or control with respect to the investment of the plan assets involved in the transaction or renders investment advice (within the meaning of section 1002(21)(A)(ii) of this title) with respect to those assets, solely by reason of providing services to the plan or solely by reason of a relationship to such a service provider described in subparagraph

(F), (G), (H), or (I) of section 1002(14) of this title, or both, but only if in connection with such transaction the plan receives no less, nor pays no more, than adequate consideration.

(B) For purposes of this paragraph, the term "adequate consideration" means—

(i) in the case of a security for which there is a generally recognized market—

(I) the price of the security prevailing on a national securities exchange which is registered under section 78f of Title 15, taking into account factors such as the size of the transaction and marketability of the security, or

(II) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of the party in interest, taking into account factors such as the size of the transaction and marketability of the security, and

(ii) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by a fiduciary or fiduciaries in accordance with regulations prescribed by the Secretary.

(18) Foreign exchange transactions

Any foreign exchange transactions, between a bank or broker-dealer (or any affiliate of either), and a plan (as defined in section 1002(3) of this title) with respect to

which such bank or broker-dealer (or affiliate) is a trustee, custodian, fiduciary, or other party in interest, if—

(A) the transaction is in connection with the purchase, holding, or sale of securities or other investment assets (other than a foreign exchange transaction unrelated to any other investment in securities or other investment assets),

(B) at the time the foreign exchange transaction is entered into, the terms of the transaction are not less favorable to the plan than the terms generally available in comparable arm's length foreign exchange transactions between unrelated parties, or the terms afforded by the bank or broker-dealer (or any affiliate of either) in comparable arm's-length foreign exchange transactions involving unrelated parties,

(C) the exchange rate used by such bank or broker-dealer (or affiliate) for a particular foreign exchange transaction does not deviate by more than 3 percent from the interbank bid and asked rates for transactions of comparable size and maturity at the time of the transaction as displayed on an independent service that reports rates of exchange in the foreign currency market for such currency, and

(D) the bank or broker-dealer (or any affiliate of either) does not have investment discretion, or provide investment advice, with respect to the transaction.

(19) Cross trading

Any transaction described in sections 1106(a)(1)(A) and 1106(b)(2) of this title involving the purchase and

sale of a security between a plan and any other account managed by the same investment manager, if—

(A) the transaction is a purchase or sale, for no consideration other than cash payment against prompt delivery of a security for which market quotations are readily available,

(B) the transaction is effected at the independent current market price of the security (within the meaning of section 270.17a-7(b) of title 17, Code of Federal Regulations),

(C) no brokerage commission, fee (except for customary transfer fees, the fact of which is disclosed pursuant to subparagraph (D)), or other remuneration is paid in connection with the transaction,

(D) a fiduciary (other than the investment manager engaging in the cross-trades or any affiliate) for each plan participating in the transaction authorizes in advance of any cross-trades (in a document that is separate from any other written agreement of the parties) the investment manager to engage in cross trades at the investment manager's discretion, after such fiduciary has received disclosure regarding the conditions under which cross trades may take place (but only if such disclosure is separate from any other agreement or disclosure involving the asset management relationship), including the written policies and procedures of the investment manager described in subparagraph (H),

(E) each plan participating in the transaction has assets of at least $100,000,000, except that if the assets of a plan are invested in a master trust containing the assets of plans maintained by employers in the same controlled group (as

defined in section 1107(d)(7) of this title), the master trust has assets of at least $100,000,000,

(F) the investment manager provides to the plan fiduciary who authorized cross trading under subparagraph (D) a quarterly report detailing all cross trades executed by the investment manager in which the plan participated during such quarter, including the following information, as applicable: (i) the identity of each security bought or sold; (ii) the number of shares or units traded; (iii) the parties involved in the cross-trade; and (iv) trade price and the method used to establish the trade price,

(G) the investment manager does not base its fee schedule on the plan's consent to cross trading, and no other service (other than the investment opportunities and cost savings available through a cross trade) is conditioned on the plan's consent to cross trading,

(H) the investment manager has adopted, and cross-trades are effected in accordance with, written cross-trading policies and procedures that are fair and equitable to all accounts participating in the cross-trading program, and that include a description of the manager's pricing policies and procedures, and the manager's policies and procedures for allocating cross trades in an objective manner among accounts participating in the cross-trading program, and

(I) the investment manager has designated an individual responsible for periodically reviewing such purchases and sales to ensure compliance with the written policies and procedures described in subparagraph (H), and following such review, the individual shall issue an annual

written report no later than 90 days following the period to which it relates signed under penalty of perjury to the plan fiduciary who authorized cross trading under subparagraph (D) describing the steps performed during the course of the review, the level of compliance, and any specific instances of non-compliance.

The written report under subparagraph (I) shall also notify the plan fiduciary of the plan's right to terminate participation in the investment manager's cross-trading program at any time.

(20)(A) Except as provided in subparagraphs (B) and (C), a transaction described in section 1106(a) of this title in connection with the acquisition, holding, or disposition of any security or commodity, if the transaction is corrected before the end of the correction period.

(B) Subparagraph (A) does not apply to any transaction between a plan and a plan sponsor or its affiliates that involves the acquisition or sale of an employer security (as defined in section 1107(d)(1) of this title) or the acquisition, sale, or lease of employer real property (as defined in section 1107(d)(2) of this title).

(C) In the case of any fiduciary or other party in interest (or any other person knowingly participating in such transaction), subparagraph (A) does not apply to any transaction if, at the time the transaction occurs, such fiduciary or party in interest (or other person) knew (or reasonably should have known) that the transaction would (without regard to this paragraph) constitute a violation of section 1106(a) of this title.

(D) For purposes of this paragraph, the term "correction period" means, in connection with a

fiduciary or party in interest (or other person knowingly participating in the transaction), the 14-day period beginning on the date on which such fiduciary or party in interest (or other person) discovers, or reasonably should have discovered, that the transaction would (without regard to this paragraph) constitute a violation of section 1106(a) of this title.

(E) For purposes of this paragraph—

(i) The term "security" has the meaning given such term by section 475(c)(2) of Title 26 (without regard to subparagraph (F)(iii) and the last sentence thereof).

(ii) The term "commodity" has the meaning given such term by section 475(e)(2) of Title 26 (without regard to subparagraph (D)(iii) thereof).

(iii) The term "correct" means, with respect to a transaction—

(I) to undo the transaction to the extent possible and in any case to make good to the plan or affected account any losses resulting from the transaction, and

(II) to restore to the plan or affected account any profits made through the use of assets of the plan.

(c) Fiduciary benefits and compensation not prohibited by section 1106

Nothing in section 1106 of this title shall be construed to prohibit any fiduciary from—

(1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is computed and paid on a basis which is

consistent with the terms of the plan as applied to all other participants and beneficiaries;

(2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full time pay from an employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or

(3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

(d) Owner-employees; family members; shareholder employees

(1) Section 1107(b) of this title and subsections (b), (c), and (e) of this section shall not apply to a transaction in which a plan directly or indirectly—

(A) lends any part of the corpus or income of the plan to,

(B) pays any compensation for personal services rendered to the plan to, or

(C) acquires for the plan any property from, or sells any property to,

any person who is with respect to the plan an owner-employee (as defined in section 401(c)(3) of Title 26), a member of the family (as defined in section 267(c)(4) of such title) of any such owner-employee, or any corporation in which any such owner-employee owns, directly or indirectly, 50 percent or more of the total

combined voting power of all classes of stock entitled to vote or 50 percent or more of the total value of shares of all classes of stock of the corporation.

(2)(A) For purposes of paragraph (1), the following shall be treated as owner-employees:

(i) A shareholder-employee.

(ii) A participant or beneficiary of an individual retirement plan (as defined in section 7701(a)(37) of Title 26).

(iii) An employer or association of employees which establishes such an individual retirement plan under section 408(c) of such title.

(B) Paragraph (1)(C) shall not apply to a transaction which consists of a sale of employer securities to an employee stock ownership plan (as defined in section 1107(d)(6) of this title) by a shareholder-employee, a member of the family (as defined in section 267(c)(4) of such title) of any such owner-employee, or a corporation in which such a shareholder-employee owns stock representing a 50 percent or greater interest described in paragraph (1).

(C) For purposes of paragraph (1)(A), the term "owner-employee" shall only include a person described in clause (ii) or (iii) of subparagraph (A).

(3) For purposes of paragraph (2), the term "shareholder-employee" means an employee or officer of an S corporation (as defined in section 1361(a)(1) of Title 26) who owns (or is considered as owning within the meaning of section 318(a)(1) of Title 26) more than 5 percent of the outstanding stock of the corporation on any day during the taxable year of such corporation.

(e) Acquisition or sale by plan of qualifying employer securities; acquisition, sale, or lease by plan of qualifying employer real property

Sections 1106 and 1107 of this title shall not apply to the acquisition or sale by a plan of qualifying employer securities (as defined in section 1107(d)(5) of this title) or acquisition, sale or lease by a plan of qualifying employer real property (as defined in section 1107(d)(4) of this title)—

(1) if such acquisition, sale, or lease is for adequate consideration (or in the case of a marketable obligation, at a price not less favorable to the plan than the price determined under section 1107(e)(1) of this title),

(2) if no commission is charged with respect thereto, and

(3) if—

(A) the plan is an eligible individual account plan (as defined in section 1107(d)(3) of this title), or

(B) in the case of an acquisition or lease of qualifying employer real property by a plan which is not an eligible individual account plan, or of an acquisition of qualifying employer securities by such a plan, the lease or acquisition is not prohibited by section 1107(a) of this title.

(f) Applicability of statutory prohibitions to mergers or transfers

Section 1106(b)(2) of this title shall not apply to any merger or transfer described in subsection (b)(11) of this section.

(g) Provision of investment advice to participant and beneficiaries

(1) In general

The prohibitions provided in section 1106 of this title shall not apply to transactions described in subsection (b)(14) if the investment advice provided by a fiduciary adviser is provided under an eligible investment advice arrangement.

(2) Eligible investment advice arrangement

For purposes of this subsection, the term "eligible investment advice arrangement" means an arrangement—

(A) which either—

(i) provides that any fees (including any commission or other compensation) received by the fiduciary adviser for investment advice or with respect to the sale, holding, or acquisition of any security or other property for purposes of investment of plan assets do not vary depending on the basis of any investment option selected, or

(ii) uses a computer model under an investment advice program meeting the requirements of paragraph (3) in connection with the provision of investment advice by a fiduciary adviser to a participant or beneficiary, and

(B) with respect to which the requirements of paragraph (4), (5), (6), (7), (8), and (9) are met.

(3) Investment advice program using computer model

(A) In general

An investment advice program meets the requirements of this paragraph if the requirements of subparagraphs (B), (C), and (D) are met.

(B) Computer model

The requirements of this subparagraph are met if the investment advice provided under the investment advice program is provided pursuant to a computer model that—

(i) applies generally accepted investment theories that take into account the historic returns of different asset classes over defined periods of time,

(ii) utilizes relevant information about the participant, which may include age, life expectancy, retirement age, risk tolerance, other assets or sources of income, and preferences as to certain types of investments,

(iii) utilizes prescribed objective criteria to provide asset allocation portfolios comprised of investment options available under the plan,

(iv) operates in a manner that is not biased in favor of investments offered by the fiduciary adviser or a person with a material affiliation or contractual relationship with the fiduciary adviser, and

(v) takes into account all investment options under the plan in specifying how a participant's account balance should be invested and is not inappropriately weighted with respect to any investment option.

(C) Certification

(i) In general

The requirements of this subparagraph are met with respect to any investment advice program if an eligible investment expert

certifies, prior to the utilization of the computer model and in accordance with rules prescribed by the Secretary, that the computer model meets the requirements of subparagraph (B).

(ii) Renewal of certifications

If, as determined under regulations prescribed by the Secretary, there are material modifications to a computer model, the requirements of this subparagraph are met only if a certification described in clause (i) is obtained with respect to the computer model as so modified.

(iii) Eligible investment expert

The term "eligible investment expert" means any person—

(I) which meets such requirements as the Secretary may provide, and

(II) does not bear any material affiliation or contractual relationship with any investment adviser or a related person thereof (or any employee, agent, or registered representative of the investment adviser or related person).

(D) Exclusivity of recommendation

The requirements of this subparagraph are met with respect to any investment advice program if—

(i) the only investment advice provided under the program is the advice generated by the computer model described in sub-paragraph (B), and

(ii) any transaction described in subsection (b)(14)(A)(ii) of this section occurs solely at the direction of the participant or beneficiary.

Nothing in the preceding sentence shall preclude the participant or beneficiary from requesting investment advice other than that described in subparagraph (A), but only if such request has not been solicited by any person connected with carrying out the arrangement.

(4) Express authorization by separate fiduciary

The requirements of this paragraph are met with respect to an arrangement if the arrangement is expressly authorized by a plan fiduciary other than the person offering the investment advice program, any person providing investment options under the plan, or any affiliate of either.

(5) Annual audit

The requirements of this paragraph are met if an independent auditor, who has appropriate technical training or experience and proficiency and so represents in writing—

(A) conducts an annual audit of the arrangement for compliance with the requirements of this subsection, and

(B) following completion of the annual audit, issues a written report to the fiduciary who authorized use of the arrangement which presents its specific findings regarding compliance of the arrangement with the requirements of this subsection.

For purposes of this paragraph, an auditor is considered independent if it is not related to the person offering the arrangement to the plan and is not related

to any person providing investment options under the plan.

(6) Disclosure

The requirements of this paragraph are met if—

(A) the fiduciary adviser provides to a participant or a beneficiary before the initial provision of the investment advice with regard to any security or other property offered as an investment option, a written notification (which may consist of notification by means of electronic communication)—

(i) of the role of any party that has a material affiliation or contractual relationship with the fiduciary adviser in the development of the investment advice program and in the selection of investment options available under the plan,

(ii) of the past performance and historical rates of return of the investment options available under the plan,

(iii) of all fees or other compensation relating to the advice that the fiduciary adviser or any affiliate thereof is to receive (including compensation provided by any third party) in connection with the provision of the advice or in connection with the sale, acquisition, or holding of the security or other property,

(iv) of any material affiliation or contractual relationship of the fiduciary adviser or affiliates thereof in the security or other property,

(v) the manner, and under what circumstances, any participant or beneficiary information provided under the arrangement will be used or disclosed,

(vi) of the types of services provided by the fiduciary adviser in connection with the provision of investment advice by the fiduciary adviser,

(vii) that the adviser is acting as a fiduciary of the plan in connection with the provision of the advice, and

(viii) that a recipient of the advice may separately arrange for the provision of advice by another adviser, that could have no material affiliation with and receive no fees or other compensation in connection with the security or other property, and

(B) at all times during the provision of advisory services to the participant or beneficiary, the fiduciary adviser—

(i) maintains the information described in subparagraph (A) in accurate form and in the manner described in paragraph (8),

(ii) provides, without charge, accurate information to the recipient of the advice no less frequently than annually,

(iii) provides, without charge, accurate information to the recipient of the advice upon request of the recipient, and

(iv) provides, without charge, accurate information to the recipient of the advice concerning any material change to the information required to be provided to the

recipient of the advice at a time reasonably contemporaneous to the change in information.

(7) Other conditions

The requirements of this paragraph are met if—

(A) the fiduciary adviser provides appropriate disclosure, in connection with the sale, acquisition, or holding of the security or other property, in accordance with all applicable securities laws,

(B) the sale, acquisition, or holding occurs solely at the direction of the recipient of the advice,

(C) the compensation received by the fiduciary adviser and affiliates thereof in connection with the sale, acquisition, or holding of the security or other property is reasonable, and

(D) the terms of the sale, acquisition, or holding of the security or other property are at least as favorable to the plan as an arm's length transaction would be.

(8) Standards for presentation of information

(A) In general

The requirements of this paragraph are met if the notification required to be provided to participants and beneficiaries under paragraph (6)(A) is written in a clear and conspicuous manner and in a manner calculated to be understood by the average plan participant and is sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of the information required to be provided in the notification.

(B) Model form for disclosure of fees and other compensation

The Secretary shall issue a model form for the disclosure of fees and other compensation required in paragraph (6)(A)(iii) which meets the requirements of subparagraph (A).

(9) Maintenance for 6 years of evidence of compliance

The requirements of this paragraph are met if a fiduciary adviser who has provided advice referred to in paragraph (1) maintains, for a period of not less than 6 years after the provision of the advice, any records necessary for determining whether the requirements of the preceding provisions of this subsection and of subsection (b)(14) of this section have been met. A transaction prohibited under section 1106 of this title shall not be considered to have occurred solely because the records are lost or destroyed prior to the end of the 6-year period due to circumstances beyond the control of the fiduciary adviser.

(10) Exemption for plan sponsor and certain other fiduciaries

(A) In general

Subject to subparagraph (B), a plan sponsor or other person who is a fiduciary (other than a fiduciary adviser) shall not be treated as failing to meet the requirements of this part solely by reason of the provision of investment advice referred to in section 1002(21)(A)(ii) of this title (or solely by reason of contracting for or otherwise arranging for the provision of the advice), if—

(i) the advice is provided by a fiduciary adviser pursuant to an eligible investment advice arrangement between the plan

sponsor or other fiduciary and the fiduciary adviser for the provision by the fiduciary adviser of investment advice referred to in such section,

(ii) the terms of the eligible investment advice arrangement require compliance by the fiduciary adviser with the requirements of this subsection, and

(iii) the terms of the eligible investment advice arrangement include a written acknowledgment by the fiduciary adviser that the fiduciary adviser is a fiduciary of the plan with respect to the provision of the advice.

(B) Continued duty of prudent selection of adviser and periodic review

Nothing in subparagraph (A) shall be construed to exempt a plan sponsor or other person who is a fiduciary from any requirement of this part for the prudent selection and periodic review of a fiduciary adviser with whom the plan sponsor or other person enters into an eligible investment advice arrangement for the provision of investment advice referred to in section 1002(21)(A)(ii) of this title. The plan sponsor or other person who is a fiduciary has no duty under this part to monitor the specific investment advice given by the fiduciary adviser to any particular recipient of the advice.

(C) Availability of plan assets for payment for advice

Nothing in this part shall be construed to preclude the use of plan assets to pay for reasonable

expenses in providing investment advice referred to in section 1002(21)(A)(ii) of this title.

(11) Definitions

For purposes of this subsection and subsection (b)(14) of this section—

(A) Fiduciary adviser

The term "fiduciary adviser" means, with respect to a plan, a person who is a fiduciary of the plan by reason of the provision of investment advice referred to in section 1002(21)(A)(ii) of this title by the person to a participant or beneficiary of the plan and who is—

(i) registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. 80b-1 et seq.) or under the laws of the State in which the fiduciary maintains its principal office and place of business,

(ii) a bank or similar financial institution referred to in subsection (b)(4) or a savings association (as defined in section 1813(b)(1) of Title 12), but only if the advice is provided through a trust department of the bank or similar financial institution or savings association which is subject to periodic examination and review by Federal or State banking authorities,

(iii) an insurance company qualified to do business under the laws of a State,

(iv) a person registered as a broker or dealer under the Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.),

(v) an affiliate of a person described in any of clauses (i) through (iv), or

(vi) an employee, agent, or registered representative of a person described in clauses (i) through (v) who satisfies the requirements of applicable insurance, banking, and securities laws relating to the provision of the advice.

For purposes of this part, a person who develops the computer model described in paragraph (3)(B) or markets the investment advice program or computer model shall be treated as a person who is a fiduciary of the plan by reason of the provision of investment advice referred to in section 1002(21)(A)(ii) of this title to a participant or beneficiary and shall be treated as a fiduciary adviser for purposes of this subsection and subsection (b)(14) of this section, except that the Secretary may prescribe rules under which only 1 fiduciary adviser may elect to be treated as a fiduciary with respect to the plan.

(B) Affiliate

The term "affiliate" of another entity means an affiliated person of the entity (as defined in section 80a-2(a)(3) of Title 15).

(C) Registered representative

The term "registered representative" of another entity means a person described in section 3(a)(18) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(18)) (substituting the entity for the broker or dealer referred to in such section) or a person described in section 202(a)(17) of the Investment Advisers Act of 1940 (15 U.S.C. 80b-2(a)(17)) (substituting the entity for the investment adviser referred to in such section).