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File Name: 14a0100p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

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.

Nos. 13-1773/1859

Appeal from the United States District Court
for the Eastern District of Michigan at Detroit
No. 2:11-cv-12557—Victoria A. Roberts, District Judge.

Argued: March 19, 2014

Decided and Filed: May 14, 2014

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

COUNSEL

ARGUED: Robin Springberg Parry, UNITED STATES DEPARTMENT OF LABOR, Washington, D.C., for Amicus Curiae. James J. Walsh, BODMAN PLC, Ann Arbor, Michigan, for Appellant/Cross-Appellee. Perrin Rynders, VARNUM, Grand Rapids, Michigan, for Appellees/Cross-Appellants. **ON BRIEF:** James J. Walsh, G. Christopher, Bernard, Rebecca D'Arcy O'Reilly, BODMAN PLC, Ann Arbor, Michigan, for Appellant/Cross-Appellee. Perrin Rynders, Aaron M. Phelps, Stephen F. MacGuidwin, VARNUM, Grand Rapids, Michigan, for Appellees/Cross-Appellants. Robin Springberg Parry, UNITED STATES DEPARTMENT OF LABOR, Washington, D.C., Ronald S. Lederman, Gerard J. Andree, SULLIVAN, WARD, ASHER & PATTON, P.C., Southfield, Michigan, for Amici Curiae.

OPINION

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 healthcare 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 (4) 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 F. App'x 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 employers 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 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'

[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).

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 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

[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."

[3]*See* 29 U.S.C. § 1024(b).

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

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 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 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.

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[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.

[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 (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.

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); s*ee also Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (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 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

[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.

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 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.

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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.

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 (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. Benefits 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 invested 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.

NAMD
National Association of Medicaid Directors

September 2, 2014

Cindy Mann, Director
Center for Medicaid and CHIP Services
Department of Health and
Human Services
200 Independence Avenue, SW
Washington, DC 20201

Shantanu Agrawal, Director
Center for Program Integrity
Department of Health and
Human Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Mann and Dr. Agrawal:

NAMD is pleased to submit a second set of recommendations which we believe can help to improve the effectiveness and efficiency of Medicaid managed care programs. The enclosed recommendations address critical issues impacting program integrity, ranging from the fundamental structure and contracts that underlie these programs to the prevention, identification and response to fraud, waste and abuse across multiple areas of the program.

Medicaid Directors view program integrity as a fundamental component of managed care programs, from the initial design of the program to execution and ongoing oversight of the contracts. States have developed a range of approaches for working with managed care entities to ensure they are delivering high-value and high-quality services while implementing measures to prevent, identify, audit and investigate providers who are committing fraud, waste or abuse in the Medicaid program. Many of these approaches reflect the respective capacities of the state and managed care entity as well as the authority vested with the state agency.

As states work to enhance their policies and tools to safeguard the program, we believe CMS also must do more to keep pace with the evolving delivery model and new tools used in the managed care environment. Doing so requires ongoing partnership with states to ensure Medicaid agencies can design and administer a

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program that aligns with the state structures, capacity, resources and program integrity goals.

In particular, states identified four key areas where additional CMS guidance could advance our shared goals to ensure the delivery of high-quality, high-value and appropriate care to enrollees. These program areas include the following:

- Provider enrollment
- Encounter and claims data
- Compliance and staffing
- Coordination of benefits

In addition to the enclosed recommendations, Medicaid Directors strongly support continuing and enhancing the resources for the Medicaid Integrity Institute. The MII is an effective platform for peer-to-peer learning about practices in this area and has proven an invaluable resource for state agency staff.

As CMCS and CPI move forward with your respective managed care efforts, we request that you continue to work through our association to consult with Medicaid Directors about the concepts under consideration. We believe that this will ensure optimal support for the ongoing operations of state programs.

We appreciate your consideration of our requests and look forward to ongoing dialogue with you on these and other issues.

Sincerely,

Darin J. Gordon
TennCare Director
Department of Finance and Administration
State of Tennessee
President, NAMD

Thomas J. Betlach
Arizona Health Care Cost
Containment System Director
State of Arizona
Vice-President, NAMD

Enclosure: Medicaid Managed Care Modernization: Employing New Tools and Efficiencies to Strengthen Program Integrity

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National Association of Medicaid Directors

Medicaid Managed Care Modernization:

Employing New Tools and Efficiencies to Strengthen Program Integrity

September 2014

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National Association of Medicaid Directors

Executive Summary

States are increasingly designing and implementing risk-based delivery system models in their Medicaid programs. These risk-based programs provide states with new tools to increase access to providers, improve budget predictability, better coordinate care and more efficiently manage servics.

The primary responsibility of State Medicaid Directors is to ensure the delivery of high-quality, high-value and appropriate care to eligible individuals. Holding the program to the highest quality standards is the best way to fulfill this responsibilities to Medicaid enrollees, health care providers and taxpayers. When fraud, waste, or abuse exist in the Medicaid program, precious resources are diverted from enrollees that need it and healthcare suffers. This is true regardless of the state's delivery system model.

Historically federal and state program integrity policies and tools were designed to focus on fee-for-service providers. With the trend to use risk-based programs the federal and state partners must work together to enhance and align their visions for program integrity in a managed care environment.

States need new tools, clear definitions and flexibility to adapt to rapid changes in health care delivery models, services, financing and technology. Policies and tools must be designed to look within and across managed care entities and health care programs.

As CMS reviews its regulations pertaining to program integrity, Medicaid Directors urge you to concentrate your work on four overarching areas.

Provider enrollment

To properly and effectively maintain Medicaid's integrity, states need to know who the providers are that deliver services to the Medicaid population, including providers in managed care networks. CMS could effectuate several technical modifications which would streamline and strengthen provider enrollment processes for the federal and state partners and providers.

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Data and Reporting

A fundamental principle of managed care is that states must know who is receiving payment for which services on behalf of a specific recipient. Reliable and accurate data are the most important aspect to ensuring program integrity in managed care systems. Therefore, states must require managed care entities to transfer reliable and accurate data in a timely fashion.

Several states have sophisticated encounter data collection and validation approaches that allow them to analyze information within and across plans in their state Medicaid program. CMS should align its guidance with these state models. In addition, CMS should focus more resources on knowledge-transfer activities to optimize these models in emerging state programs.

Compliance Staffing and Requirements

CMS should mandate that all Medicaid managed care entities submit an annual fraud, waste and abuse plan to the state. This policy should specify the baseline components of such a plan.

While minimum federal requirements in this area would be useful, the state and the managed care entity need flexibility in fighting fraud, waste and abuse. Priorities and schemes can often change quickly. Discretionary best practices would allow for meeting changes in the program.

CMS' approval and oversight of the state's risk-based programs should focus on whether or not the state addresses these core components, rather than the mechanics of how the state fulfills the federal requirements.

Coordination of Benefits

Federal law and regulations require states to assure that recipients use all other resources available to them to pay for all or part of their medical care needs before turning to Medicaid. A uniform minimum standard for coordination of benefits would assist states in ensuring that Medicaid remains the payer of last resort.

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Provider Enrollment

To properly and effectively maintain Medicaid's integrity, states need to know who the providers are that deliver services to the Medicaid population, including providers in managed care networks. CMS could effectuate several technical modifications which would streamline and strengthen provider enrollment processes for the federal and state partners and providers.

Listed below are some of the most impactful technical changes CMS could make.

1. Streamline the mechanisms and tools states may use to comply with federal provider screening and enrollment requirements. CMS' mandatory provider screening and enrollment requirements compel states to use disparate federal databases and processes, including the List of Excluded Individuals and Entities (LEIE), Provider Enrollment, Chain and Ownership System (PECOS), Excluded Parties List Search (EPLS), Termination Process, etc.). Multiple processes to check information adds to an already labor-intensive process.

   Rather than separate sets of closely related guidelines, CMS should create a single mechanism or template that incorporates all of these requirements for state registration. For example, using the disclosure requirements as the base document and adding in the other necessary relevant requirments would streamline the enrollment process and allow for some baseline standardization among states. CMS, with input from states, could establish the minimum required information while allowing states to insert additional, state-specific fields. This would allow CMS to conduct the necessary checks at the federal level before directing the provider to the state registration process.

   Alternatively, CMS should establish a single portal where states can access downloadable, real-time information contained in the aforementioned databases. States appreciate that CMS has been working to develop a portal (OnePI) to meet this obective and urge CMS to prioritize development of this centralized portal. CMS could also explore making existing data sources available to states to achieve the same goal. For example, the U.S. Treasury's "Do-Not-Pay" database aggregates all or most of the information that states

would need to comply with federal screening and enrollment requirements. We also encourage CMS to examine the feasbility of establishing a database that could provide information regarding previous civil or criminal action by other states or the federal government against managed care entities and/or the principals of those organizations.

Improvements to the provider enrollment process have become particularly important with the implementation of new federal requirements included in the Affordable Care Act. These new requirements are more extensive than the previous screening requirements, include enrollment of providers who were not previously required to enroll in Medicaid and require site visits for providers classified as high-risk. States are committed to complying with these rules, but request that CMS minimize the burden to states for doing so.

2. Clarify terminology and require states to share information about terminated Medicaid providers via a centralized system. CMS' terminated provider file is the most regular source of information about terminated providers across all state Medicaid programs. CMS can maximize the utility of this program integrity tool by requiring all states to participate in this collaborative information sharing system. Doing so will strengthen each state's work to protect the integrity of their Medicaid program and can similarly aid federal officials in doing so for the Medicare program.

   However, CMS must first clarify differences in terminology that currently result in confusion and misinterpretation of the states' data. At a minimum, CMS clarifications are needed for the following terms: for cause, not for cause, inactivate, reactivate, terminate, revoke, expire, enrollment, re-enrollment, re-validation and "for information only". As an example, there are several federal actions that impact Medicare participation and priviliges (e.g. revocation). Guidance on when the states must take action to disenroll or terminate the Medicaid provider based on the various federal actions is imperative to program integrity. Clear definitions and expectations from CMS will help to ensure consistent action across all states. In addition, consistent terminology would facilitate the reporting process as well as collaborations between the federal and state agencies.

3. Align Medicare and Medicaid provider enrollment policies, where practical and possible. In several instances there are discrepancies or gaps in CMS policies that impact the integrity of Medicaid provider enrollment processes and create confusion as it relates to providers who care for dually eligible individuals. In others, enhancing information sharing across programs would streamline enrollment processes.

   For example, CMS is not currently requiring that the ordering, prescribing, and referring prescriber be enrolled in Medicare in order for the prescription to be allowable for Medicare payment. However, many states are currently implementing the requirement that the prescriber must be enrolled in the state's Medicaid program in order for the prescription to be eligible for Medicaid payment. CMS should ensure that both Medicare and Medicaid have similar application of the regulations so discrepancies between the programs do not exist. Required participation by referring, rendering and prescribing providers would enhance the integrity of both programs.

   Regarding high-risk providers, it is the general understanding that while CMS allows states to waive the site visits and fees upon Medicare enrollment during the last 12 months, CMS has not extended this option to background check results and required disclosures. The states are required to conduct background checks – and soon fingerprint-based background checks – in addition to the site visits. CMS should assess alternative methods to allow the states to rely on the background check outcomes – and fingerprints in the future – as well as the disclosure documentation, when providers are located in a state other than the one where the provider is seeking to enroll.

4. Assist states in developing streamlined enrollment processes for highly specialized providers. While rare, there are instances where the complex health care needs of Medicaid enrollees require the expertise of unique providers. In many instances, these specialized providers reside and have completed the screening, background check and disclosure requirements in their home state's Medicaid program or the Medicare program. States and their Medicaid beneficiaries would benefit from CMS guidelines related to expedited enrollment of highly specialized providers; the process would not apply to regular provider enrollment and credentialing processes.

Specifically, CMS should clarify that states may rely in part or entirely on the provider's home state Medicaid background check results and disclosures or those for Medicare, including for fingerprint-based background checks that will be required in the future. This would be limited to certain providers that are identified by the non-home state. A regional or centralized, standard process for specialized providers already screened by and enrolled in a state Medicaid program or Medicare would significantly minimize the burden on providers. In turn, this would help to facilitate access to critical services in a timely fashion for enrollees.

5. Develop technical resource tools for states pertaining to provider enrollment. In particular, states would benefit from tools which highlight model state practices for centralized or integrated provider enrollment systems. Many states have determined that such systems streamline the process for providers who otherwise must complete enrollment documents for multiple managed care entities. Technical assistance materials should address how states have maintained the flexibility for providers to enroll in the managed care program, the fee-for-service program, or both.

   In addition, technical assistance tools should highlight ways that states have leveraged a centralized or integrated system to strengthen their program integrity initiatives. Specifically, an integrated process can assist states with compliance-related assessments of providers' practices across health plan networks. A centralized approach would also allow states to examine and coordinate provider actions across networks instead of relying on managed care entities to coordinate those results, including linking individual providers to encounter data.

   A centralized resource tool should consist of all core provider credentialing information required across the board by states and managed care entities while allowing for certain additional information to be captured, at the states' or entities' discretion, based on an assessment of the provider type risk level, historical experience and other similar criteria. The additional information can be utilized to evaluate prospective providers according to certain identified

risks, which may vary over time – thus the need for flexibility in the additional information requested.

A centralized resource tool should not prevent the states from being more stringent with provider enrollment requirements, and the database should allow states access to all supportive documentation associated with provider enrollment and credentialing.

Data and Reporting

A fundamental principle of managed care is that states must know who is receiving payment for which services on behalf of a specific recipient. Reliable and accurate data are the most important aspect to ensuring program integrity in managed care systems. Therefore, states must require managed care entities to transfer reliable and accurate data in a timely fashion.

Several states have sophisticated encounter data collection and validation approaches that allow them to analyze information within and across plans in their state Medicaid program. CMS should align its guidance with these state models. In addition, CMS should focus more resources on knowledge-transfer activities to optimize these models in emerging state programs.

Specific steps CMS should take include the following:

1. Promote coherence across requirements for the collection, validation and use of encounter and claims data. States are leveraging and building on existing national standards for encounter and claims data to the greatest extent possible. At the same time, CMS is continuing to enhance its own reporting requirements and expectations of states.

   However, states are finding that CMS' standards and expectations are not sufficiently aligned across the various Medicaid transactions that occur. Specifically, transformed MSIS (TMSIS) submissions are inconsistent with the type of data that CMS is seeking through standard encounters and claims reporting structures and other transactions that impact program integrity

initiatives. This makes it difficult for states to align their own reporting requirements for risk-bearing entities and subsequently to provide CMS with the information it seeks. The basic information a state needs to collect identifies who is paid for a specific service, how much, for which enrollee and when.

In addition, CMS, in partnership with other Health and Human Service agencies, should undertake an enterprise-wide audit which examines how its data collection efforts and requirements align with the federal agency's research and policy objectives. The federal strategic research objectives should align with any standards that are promulgated pertaining to the quality of the data that is submitted. The absence of this type of strategic alignment results in operational inefficiencies, may lead to confusion among entities that report and interpret the data, and can hinder states' ability to promote value in Medicaid.

2. Develop a process whereby CMS officials engage states to interpret and analyze a state's data submission. CMS is in the midst of implementing TMSIS and other initiatives that will expand its capacity to analyze and report more detailed information about the Medicaid program generally and an individual state's program. States welcome the opportunity to learn more about the value of the programs they develop and administer and how they are progressing over time.

However, as part of its ongoing data analysis efforts, states request that CMS standardize a process whereby federal officials engage states to interpret and analyze the data. Medicaid encounters, claims and other transaction data can be affected by a variety of extraneous variables, which are often difficult for federal officials to readily discern. In addition to data, states use policies, benefit limits or other state specific directives to permit small differences in what or how risk-bearing entities pay providers. These are critical pieces to correctly understanding state data.

State experts are best positioned to identify these issues for our federal partners so that they may conduct accurate analyses of an individual state's data and the Medicaid program generally. An improved communication

process between CMS officials and state data experts would positively impact that state's data interpretation and analysis.

3. Develop the next wave of resources for states on the collection, validation and use of encounters and claims data, while still ensuring these resources are aligned with CMS' strategy for this data. As part of ongoing initiatives to launch and enhance Medicaid managed care programs, states are utilizing the valuable technical assistance resources CMS has made available pertaining to data reporting and quality standards. States also appreciate that CMS is in the process of establishing some uniformity in the data through the X12/NCPDP transaction sets and the CORE Operating Rules. In addition, states welcome the opportunity to work with CMS to identify and employ the most effective tools for predictive modeling and expanded analytics.

   CMS should continue to promote its existing technical assistance resources which have already proven beneficial to many states. In doing so, CMS should clarify the scope and topical areas of these resources so that states may set clear expectations and identify other sources for any gaps that may exist.

   In addition, CMS should provide additional resources and technical assistance to states on the use of encounters and claims data in program integrity, in a manner consistent with the coherent CMS strategy for this data (see recommendation 1 above). States would benefit from additional toolkits and model practice guides pertaining to data uniformity, evolving trend analysis, and early identification of suspected activity. Other beneficial resources for states include model audit guides, information on best practices for promoting alignment between encounters and claims data and identification of inconsistencies between encounter data and paid claims data.

4. Develop resources for states pertaining to the risk-bearing entity and provider contractual obligations to meet the quality standards for and reporting of encounter and claims data. States would benefit from effective practices and policy guides as it relates to state and provider obligations. Unfortunately, the X12/NCPDP transaction sets and CORE Operating Rules do not apply to transactions exchanged between health plans unless required in the risk-

bearing entity contract. We encourage CMS to work with states to develop guidance in this area.

Compliance Staffing and Requirements

CMS should mandate that all Medicaid managed care entities submit an annual fraud, waste and abuse plan to the state. This policy should specify the baseline components of such a plan.

While minimum federal requirements in this area would be useful, the state and the managed care entity need flexibility in fighting fraud, waste and abuse. Priorities and schemes can often change quickly. Discretionary best practices would allow for meeting changes in the program.

CMS' approval and oversight of the state's risk-based programs should focus on whether or not the state addresses these core components, rather than the mechanics of how the state fulfills the federal requirements.

1. State policies or contracts should require the risk-bearing entity to annually develop, submit and adhere to a fraud, waste and abuse plan. Consistent with federal mandates, the appropriate state agency (e.g. the single state Medicaid agency, the Medicaid Inspector General's Office, or a similar office consistent with the state organizational structure) will establish the specific fraud, waste and abuse requirements or standards for the fraud, waste and abuse plan. The appropriate state agency will also approve and/or oversee the entity's adherence to the plan.

   At a minimum, the entity's plan *must* include a description of the entity's procedures for detecting and investigating possible acts of fraud or abuse, as well as the name, address, telephone number, and email address of the individual(s) responsible for carrying out the plan.

   Examples of what the state *may* wish to require in the entity's approved plan include, but are not limited to, the following:

- A plan that contains milestones, activities, goals, objectives, and any initiative that the MCO considers a best practice;
- A description of the entity's procedures for educating and training personnel to prevent fraud, waste and abuse;
- A description or chart outlining the organizational arrangement of the entity's personnel responsible for detecting, investigating and reporting possible acts of fraud, waste or abuse, along with a detailed chart of roles and responsibilities;
- A description of the entity's procedures for the mandatory reporting of possible acts of fraud or abuse to OIG;
- A detailed description of the results of investigations of fraud, waste and abuse conducted by the entity's state investigative unit;
- Provisions for maintaining the confidentiality of any patient information relevant to an investigation of fraud, waste or abuse;
- A methodology for PI audits exclusively, that would be approved by the state;
- A list of the audits, reviews, or data validations, conducted for purposes of fraud, waste and abuse only and a quarterly report outlining the results of such reviews, audits or data validations; and
- A methodology for internal audits that reflects the organization commitment to have safeguards in place to detect fraud, waste and abuse, and correct inconsistencies in the encounter system upon discovery.

2. States should articulate expectations for the entity's procedures for the detection and investigation of possible fraud, waste and abuse. For example, states may wish to define the scope of the entity's data mining activities within its Medicaid line of business and how such activities are integrated with other functions within the plan, such as medical management, provider services and claims pre-payment reviews and adjudication.

3. States should establish minimum standards for compliance staffing for the risk-bearing entity. While CMS would require states to address this, each state would develop the standards or ratios applicable to its program(s). For example, states may wish to require that compliance officers who manage the managed care entity's PI unit or the Corporate Compliance program have

certain certifications or professional criteria. This will help ensure that these units are appropriately staffed to ensure compliance with policy and contracts and to interpret regulations and statutory provisions that are a critical component of PI activities. In addition, states *may* wish to require that plans have a Special Investigations staff which focuses on or is specifically dedicated to the entity's Medicaid line of business.

4. States should articulate specific programmatic requirements and components. The states' managed care contract is a key driver in ensuring program integrity. As state managed care programs mature, Medicaid agencies are using these contracts to hold the risk-bearing entities to the highest quality standards.

Coordination of Benefits

1. Establish uniform minimum standard for coordination of benefits (COB). To ensure that Medicaid remains the payer of last resort, CMS should require states to maintain centralized lists of Medicaid clients where the state or its designee has confirmed commercial insurance coverage and provide these lists to risk-bearing entities. Further, CMS should validate an approach whereby the state requires that the risk-bearing entity document all COB activities conducted and that other insurers were billed prior to submission of any Medicaid encounters to the state.

rates, and the pattern of differences found for persons aged 65 and above. Of particular concern for the aged is the observed pattern in the health plans of comparatively higher inpatient, and especially medical, admissions coupled with lower rates of use of outpatient office visits. Since the aged are an especially vulnerable population, it is important to establish that these differences do not imply inadequate access to services or inappropriate utilization in either payment setting, or deleterious disruptions in established doctor-patient relationships as persons are enrolled in health plans.

- In the youngest and middle age groups, the results suggest an overall impression of increased utilization of both inpatient medical services and outpatient office visits by health plan eligibles, accompanied by generally lower rates of use by users of the emergency department. This overall pattern is generally consistent with an interpretation of comparatively similar or improved access to services for health plan eligibles, although it may also mean higher rates of inappropriate use of these services.
- The health plans had more pregnant women enrollees in this time period, but use of hospital services by pregnant women and their babies in both payment settings was virtually identical. Also identical was the low rate in both groups of deliveries by Cesarean section, which was approximately half of the state wide rate. This low rate in both settings raises questions about the influence of social class on medical decisions in this area, but this report offers no evidence that there were any adverse consequences to either mothers or babies.
- The observed rates of use of Pap smears and mammograms indicate the need to increase their use in the Medicaid population, particularly among those enrolled in the health plans.
- DHS should obtain access to health plan claims data to facilitate further investigation of utilization rates and costs. The use of summary data on the

experience of Medicaid eligibles in the health plans, while useful, as this report demonstrates, limits investigation of important measures of utilization and cost. Not only are important service areas such as mental health, chemical dependency, and dental care not examined in this report due to the lack of useful data from the health plans, possible differences in case mix could not be investigated due to the lack of person level data from the health plans.

- The limitations and difficulties encountered in this study point to the importance of efforts, such as those of the Minnesota Utilization Data Definitions Committee, to establish common definitions of service areas which facilitate appropriate comparison of utilization data across different data systems. Additional effort is needed to extend the work of this group to define many more outpatient services and add greater detail to all service areas.
- The existence of substantial differences in utilization rates in these two settings raises questions about what DHS is buying in terms of services from both the health plans and fee-for-service providers, and the value of these services. One implication of these differences bears on rate setting in the prepaid program. Health plan payment rates are based on utilization in the fee-for-service setting but, as this study indicates, patterns of care appear quite different in the two settings. This indicates the need to further examine rate setting strategies to assure appropriate reimbursement for services from the health plans.

… Enhanced auditing techniques, including data mining, have been deployed by the government to rout fraud perpetrators and indifferent providers from overbilling for services and abusing the healthcare system. These efforts have yielded $4.1 billion in recoveries this past year alone. **The government's return on investment runs from 6 to 1 for fraud activities and 14 to 1 yield for prepayment and claims audits.**

While $4.1 billion dollars recovered is nothing to sneeze at **it is important to note that in an article in the *National Review Online* the Cato Institute's Michael F. Cannon pointed out that fraud against Medicare and Medicaid alone costs about $87 billion a year….**

The question remains, why do private employers not seem as interested as our government in compliance auditing to uncover excessive or inappropriate claims payments? Employers have a fiduciary duty to their owners, shareholders and employees to pay only for appropriate and necessary services

….Typically these audits uncover savings related to lost Rx rebates, benefit coverage errors or improper payments/discounts made by the third party administrator and uncovering eligibility errors. Some audit initiatives can uncover up to *10 percent or higher* returns for the employer. Also, remember that there are new SPD rules in place that require modifications to lifetime and annual benefit limits, claims review timeliness, appeals language changes and general information reformatting and design changes to comply with the PPACA between now and 2014; not complying with these changes can subject you to fines and penalties.

With healthcare now comprising a major portion of a company's budget, CEOs and CFOs cannot afford to overlook the potential impact on their financial statements. The issues we discussed highlight the importance of monitoring compliance and performance of ERISA based benefits. While ERISA plans offer employers many levels of savings and freedom from multiple jurisdictional regulations, it does not relieve them of the responsibility to exercise fiduciary duties. If you have not audited your plan within the last two years, you need to do it as soon as possible. If you have audited your plan recently, did the report evaluate the impact of phantom discounts or R&C? Has it evaluated the fairness of benefit decisions and the veracity of clinical information supporting the underlying decisions to pay or deny a claim? Is there consistency in your benefit decisions across the board (i.e.: highly compensated vs. non-highly compensated employees)?

…the consequences of not auditing your benefit plan can be more expensive than you expected, you just will not know it! Ask yourself, "Why am I not auditing my own benefit plan when the government has increased its audits ten-fold …" ####

Why It Is Necessary to Watch Over Your Service Providers

By Mark E. Furlane **Joseph C. Faucher**

Sometimes the real lesson to be learned from a litigation case has little to do with the court's holding. Take for example a recent decision by the U.S. Court of Appeals for the Sixth Circuit—*Guyan International, Inc. v. Professional Benefits Administrators, Inc.*

The holding of the case itself is fairly obvious—a third party administrator breached its fiduciary duty by engaging in what the court described as a "classic case of self-dealing" and had to reimburse the plans for its breach. The lesson for plan fiduciaries, however, doesn't appear in the holding. It's that the plan fiduciaries could have paid the price if they had not monitored the TPA's conduct, learned of the self-dealing, and taken action.

In *Guyan*, the defendant was a third party administrator, Professional Benefits Administrators (PBA), that was hired to administer and pay benefits for health plans sponsored by the plaintiffs. Like many such contracts, the contract between PBA and the plan sponsors required PBA to establish separate accounts for each plan sponsor, notify the plan sponsors of the amounts needed to pay claims, and pay health care providers out of the account attributable to each plan sponsor. PBA, however, commingled monies that were contributed by several sponsors (and therefore earmarked for their own plans), and used those monies for its own purposes. As the court stated, "when PBA received too many complaints from medical providers or Plan participants, PBA would withdraw funds from its main, commingled account and put that money into the respective Plaintiff's separate account to pay the claim(s) in question." Predictably, PBA fell short in paying the claims, and several employers sued PBA claiming that it breached its fiduciary duty under ERISA. The court agreed.

Once it reached the fairly obvious conclusion that PBA was a fiduciary because it exercised authority over plan assets, it was a short leap to the conclusion that it breached its fiduciary duties.

What is not so obvious is that before filing this lawsuit, the plan sponsor plaintiffs (in the role of plan fiduciaries) needed to recognize that something was amiss—and then do something about it. Plan fiduciaries are obligated to monitor the conduct of their service providers, including other fiduciaries. Failing to take the proper steps to monitor those other fiduciaries and service providers is in itself a breach of fiduciary duty.

The obligation of the fiduciaries was to have proper procedures in place to reasonably monitor PBA, to document their monitoring activities, and—if they discovered that something wasn't right—to take appropriate action. Apparently, in *Guyan*, the plan sponsors, wearing their fiduciary hats, took seriously this duty to monitor. If they hadn't, however, they could just as easily been "on the other side of the 'v'" in the caption title of the case—as defendants in a lawsuit by plan participants.

Undisclosed Fees in the Health Plan Setting, and the Potential Danger to Health Plan Sponsors

By Joseph C. Faucher **Michael A. Vanic**

In recent years, the Department of Labor has put an increased focus on compensation paid to retirement plan service providers, which has culminated in an additional regulation under ERISA §408(b)(2). That regulation, which took effect July 1, 2012, requires fiduciaries and covered service providers to "covered plans"—meaning most retirement plans—to provide written disclosures of all of the direct and indirect compensation they receive in connection with their work for those plans.

The DOL reserved part of the regulation--29 C.F.R.§ 2550.408b-2(c)(2)--for future guidance on disclosure requirements for welfare plans. As one recent court decision shows, however, a lack of transparency regarding service provider fees is already an issue for welfare plans as well as retirement plans..

The issue came to a head in two recent decisions—*Burroughs Corporation, et al. v. Blue Cross Blue Shield of Michigan* and *Hi-Lex Controls Inc., et al. v. Blue Cross Blue Shield of Michigan*. In those cases, a U.S. District Court in Michigan found that Blue Cross Blue Shield of Michigan (BCBSM) engaged in breaches of fiduciary duty and prohibited transactions in connection with the compensation that it received from the Burroughs and Hi-Lex health plans. Burroughs and Hi-Lex had identical administrative services contracts with BCBSM, which provided claims administration services for both employers' self-funded health plans.

The dispute involved certain BCBSM fees that Burroughs and Hi-Lex claimed were effectively concealed from them. The fees (described as the Provider Network Fee, contingency and any other cost transfer surcharges) were mentioned in the administrative services contract, which provided that those fees would be "contained in the Amounts Billed."

According to the decision, however, the bills generated by BCBSM "… were not itemized to indicate how much money was owed for the hospital claim, versus how much was owed for the other fees." In fact, based on an internal BCBSM document, the court concluded that the whole purpose of BCBSM's billing practice was to create a circumstance in which periodic changes to the fees would be "… no longer visible to the customer."

The court held that BCBSM exercised discretion over the plans' assets, because the administrative service contract did not disclose the amount of the fees or how they were calculated. On that basis, it concluded that BCBSM was a fiduciary, because "[i]f 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."

Having concluded that BCBSM was a fiduciary relative to the plan, the court went on to analyze whether it had breached its fiduciary duty and engaged in a prohibited transaction in connection with its billing practices. It made short work of the prohibited transaction claim:

"[ERISA § 406 (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 [406](b)(1) sets forth 'an absolute bar against self dealing' by a fiduciary, Blue Cross is liable."

The *Burroughs* and *Hi-Lex* decisions are significant in their own right, because they resulted in a finding of a prohibited transaction against a major insurance company acting as claims administrator. Assuming that

other administrative service contracts issued by Blue Cross entities contain similar provisions, the potential for more cases like *Burroughs* and *Hi-Lex* looms large.

What may not be so immediately obvious, however, is the lesson that sponsors of self-funded health plans should take from the decision in these cases.

Specifically, if it was a prohibited transaction for BCBSM to receive the purportedly "hidden fees" from these plans, one might argue that, if the plan fiduciaries had not taken action to address the prohibited transaction, it would have been a breach of their own fiduciary duties. This is because fiduciaries are obligated to understand the fees that are being charged to their plans and to determine that they are reasonable.

With more and more awareness that service providers may have hidden fees, it may not be enough for fiduciaries to argue that they were unaware of the fees charged because they were not clearly explained by the service provider. Plan fiduciaries may want to provide questionnaires to their service providers inquiring about all the fees—direct and indirect—that are being charged to the plan and/or its participants.

Don't overlook the value of claims auditing

By Brian Anderson and David Cusick

June 4, 2014

PARTNER INSIGHTS

When seeking ways to keep expenses under control, health care plan sponsors may overlook the value of claims auditing. Auditing fees may not be inconsequential, but the fact is that an accurate audit including both pharmacy and medical claims has the potential to pay back the investment many times over.

The more members a plan has enrolled and the more complex the plan's benefit setup, the more likely a plan is to have a greater amount of claims payment errors. Every plan will have claims paid in error. It is often tempting simply to assume claims have been paid with a certain degree of accuracy, and then move on without verifying whether the assumption is correct. Nevertheless, there will always be instances of duplicate billing, wrong or missing discounts and rebates, mistakes in member eligibility, incorrect plan setup, or other problems.

Regular audits of medical and pharmacy claims can find these discrepancies, leading to the recovery of overpayments. Even more importantly, audits can identify problems in the way a plan is set up and point the way to eradicating inaccuracies, reducing cost, and preventing waste in the future. Auditing can give plan sponsors vital information for revising and improving contracts with third-party administrators and pharmacy benefit managers, which can lead to significant reductions in costs.

Many engagements begin with auditing one plan year, and then extend to multiple plan years based on the results of the first audit. Some plans have implemented processes that include monthly oversight reporting, which provides ongoing auditing and trend metrics. The monthly reporting is set up as an online service so that the reports can be automatically emailed to the health plans and accessed via an encrypted web portal.

Auditing is applicable to all types of health care plans, including self-insured plans, Medicaid, Medicare, Taft-Hartley funds, and commercial plans. In our opinion, any organization that is at risk for paying medical or pharmacy claims must consider the value of claims auditing.

What happens during an audit?

Once all the initial preparation has been completed, the process of a good, cost-effective audit usually involves two steps. The first assesses all available claims and eligibility data, including claims adjustments and reversals, using sophisticated electronic testing techniques. Compared to audits done in previous years, it is now possible to examine the entirety of a plan's data rather than only a sample.

The second involves a more hands-on stage with a close examination of the patterns of claims issues identified by the electronic audit. Individual claims are pinpointed for further investigation according to these patterns.

A comprehensive claims audit tests at least the following areas:

- Eligibility: Is the member eligible for the claim at the time of service?
- Financial:
    - Were the contracted pricing arrangements (or usual and customary limits) applied properly?
    - Were there any duplicate charges for a procedure or drug?
    - Have the administrative fee invoices been reconciled?
    - Have the claims invoices been reconciled?
- Plan design:
    - Is the member cost sharing accurate?
    - Do the payments exceed plan limits and maximums?
    - Have other features of the plan design been properly applied?
    - Are there opportunities for coordination of benefits?
- Performance guarantee review: Are the claims processing and other customer services compliant with established performance guarantees as defined in the contractual agreements with the TPA or PBM?

The audit should also test a number of factors that are specific to either medical or pharmacy claims.

For medical claims, they should include outlier physician charges (charges that are significantly higher than usual for a given procedure) and tests that are inconsistent with standards promulgated by the National Correct Coding Initiative of the Centers for Medicare and Medicaid Services, such as code pairs tests (procedures that, according to the NCCI, should not be reported together because one service inherently includes the other or because the two codes are mutually exclusive).

For pharmacy claims, an audit examines a number of elements, such as compliance with formulary and/or generic drug provisions, patterns of use including early refills and quantity limits, proper application of clinical edits (e.g., step therapy, prior authorization, drug utilization review, etc.), “reasonableness” of any rebates, and the value associated with the maximum allowable cost list.

Early detection

If feasible, it is a good idea to have claims audited every one or two years. At least as important, however, is the *implementation audit*. An implementation audit takes place shortly after a plan has been set up. A good time frame is 90 days after beginning work with a new vendor or any substantially new contract. Implementation audits are akin to taking off the training wheels. They help ensure that a plan has been set up correctly and that the plan sponsor is getting all of the benefits it contracted for during the implementation process. They happen after enough time has passed to gain a body of experience data but still soon enough to head off a major course change requiring extensive retroactive corrections.

Expect an audit to take three to six months. After that the recovery effort begins, in twofold fashion: recovering any money that the plan may have overpaid, and the equally important work of correcting errors in the system that were identified in the audit. Plan sponsors may engage an overpayment recovery vendor, or choose to handle it in-house.

The benefits of proactive auditing for the plan sponsor should be evident: to verify the integrity of vendor contracts and to meet fiduciary responsibilities. As with anything, there is no guarantee an audit will pay for itself every time. But it is not unusual for an audit to have findings about 3% to to 5% of paid claims costs, with recoveries of about 1% to 2%. Today, for many reasons, claims audits are more effective than ever. They can be relied on to uncover *something* in the working of a plan that can be improved, isolated issues as well as systemic and redundant errors, contractual compliance questions, or basic data entry problems.

Brian Anderson is a consultant and David Cusick is a health care technology consultant with Milliman, a consulting firm.

Highlights on Significant Developments

I. This is a new opportunity for Employer sponsored Health Plans to forensically examine past medical claims and recover "misspent dollars" by their TPA's and ASO's. For years, there was surety in that funds were being misappropriated, but "fuzzy" on legally nailing down how much and a definitive strategy to recover such funds. This has changed.

II. In early fall of 2012 some of our Indiana associates with extensive medical claims expertise came up with a breakthrough in a cogent, repeatable analysis of employer claims data that would verify "overcharges" coming out of plan assets. This is a legally verifiable approach that isn't accusing anyone of malfeasance, but basically could be compared to running a corporate checking account for errors. The first five companies to allow this process to take place, the analysis found 5-12% error rates. These studies ranged from 1 to 2 years on appropriate claims data. We have over 150 case studies of companies recovering funds in this category. To date, NO PLAN has been found not to have recoverable dollars. Needless to say, companies spending millions or hundreds of millions yearly on health care have a fiduciary responsibility to fix such leaks.

III. The bigger breakthrough came to our attention the end of November 2012. A large corporate law firm out of Michigan won a landmark ERISA case for two of its clients against BCBS-Michigan. The "undisclosed mark-ups" we were familiar with and had an administrative system to circumvent, were determined by the Sixth District Federal Court to be "prohibited transactions" and "self-dealing". Ron Dobervich, chief consultant with Sage Benefit Group, along with two other team associates have been appointed by the Court to work with this law firm in helping them to determine the losses to the qualified plans. The Court has subsequently issued twelve more summary judgments against BCBSM for the same offense. The case shows that BCBSM has been charging hidden access fees since 1993. This has raised the amount of potential recovery dollars four to seven fold. On May 22, 2013 the Court handed down the first penalty. An 800 person firm was awarded $5.1 million with interest (bringing the total to around $6.1 million dollars). Just scale this up for large companies and the numbers are staggering. A class action law suit by the American Chiropractic Association is accusing CIGNA of doing the same thing. In fact the expert witness for BCBS Michigan said this is "common industry practice".

IV. The DOL (Department of Labor) issued new regulations on January 1st 2013 on auditing employer health plans and what companies need to have on file when they come calling. Some of our associates have had input on these new regulation guidelines. Current health plan "auditing" practices are not sufficient to meet these new requirements. Current audits are nothing more than "bean counter" audits

that trace raw dollar amounts from one source to another. Ours is a “forensic” approach.

V. Our solution is along the lines of compliance and fiduciary obligation and responsibility. We want to talk with a company’s internal audit head, chief legal counsel and the named fiduciary of the plan. We are offering a compliance tool that will put them in good standing with the new DOL regs. The wording of the contract will contain language that “if abnormalities or inappropriate loss of plan assets are discovered” that they will be pursued to the full extent of the law.