No. 17-1932

United States Court of Appeals for the Sixth Circuit

SAGINAW CHIPPEWA INDIAN TRIBE OF MICHIGAN AND ITS WELFARE BENEFIT PLAN,

Plaintiffs-Appellants,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Defendant-Appellee.

On Appeal from the United States District Court for the Eastern District of Michigan in Case No. 16-cv-10317

BRIEF OF APPELLANTS SAGINAW CHIPPEWA INDIAN TRIBE OF MICHIGAN AND ITS WELFARE BENEFIT PLAN

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UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit
Case Number: 17-1932 Case Name: Saginaw Chippewa, et al v BCBSM

Name of counsel: Bryan R. Walters

Pursuant to 6th Cir. R. 26.1, Saginaw Chippewa Indian Tribe of Michigan
Name of Party

makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

No

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

No

CERTIFICATE OF SERVICE

I certify that on August 28, 2017 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

s/ Bryan R. Walters

This statement is filed twice: when the appeal is initially opened and later, in the principal briefs, immediately preceding the table of contents. See 6th Cir. R. 26.1 on page 2 of this form.

UNITED STATES COURT OF APPEALS
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Sixth Circuit
Case Number: 17-1932 Case Name: Saginaw Chippewa, et al v BCBSM

Name of counsel: Bryan R. Walters

Pursuant to 6th Cir. R. 26.1, Saginaw Chippewa Indian Tribe of Michigan Welfare Benefit Plan
Name of Party
makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

No

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Appellants request oral argument because the context in which the issues raised on appeal are presented is unusual, such that the issues on appeal have not been addressed previously by this Court in this context. Additionally, the total amount in controversy on the claims at issue on appeal exceeds $10,000,000. Moreover, the proper resolution of this appeal is of significant interest not just to Plaintiffs, but also to thousands of members of the Saginaw Chippewa Indian Tribe and thousands of employees of the Tribe. Finally, the Court's decision is likely to have a precedential effect on several similar cases currently pending in the Eastern District of Michigan. All of these considerations weigh in favor of granting oral argument.

STATEMENT OF JURISDICTION

The District Court exercised jurisdiction under 28 U.S.C. §§ 1331 and 1362.

This Court's jurisdiction is based on 28 U.S.C. § 1291. The District Court entered final judgment on July 14, 2017. Appellants timely filed their Notice of Appeal on August 11, 2017.

STATEMENT OF ISSUES

1. Did the District Court err by holding that the Tribe created two separate health and welfare benefit plans for participants, rather than a single plan?

Plaintiffs' answer: Yes.

Defendant will answer: No.

The District Court answered: No.

2. Assuming *arguendo* that there were two separate benefit plans, did the District Court err in concluding that plan participants designated by BCBSM as "Group 61672" were not covered by ERISA?

Plaintiffs' answer: Yes.

Defendant will answer: No.

The District Court answered: No.

3. Did the District Court err by holding that BCBSM's squandering of Plan assets by systematically paying health care claims in excess of Medicare-Like Rates (MLR) was not a breach of fiduciary duty under ERISA?

Plaintiffs' answer: Yes.

Defendant will answer: No.

The District Court answered: No.

4. Did the District Court err by holding that there was no genuine issue of material fact as to whether Plaintiffs paid additional amounts to BCBSM for BCBSM's Physicians Group Incentive Program (PGIP)?

Plaintiffs' answer: Yes.

Defendant will answer: No.

The District Court answered: No.

5. Did the District Court err by failing to award prejudgment interest as a component of Plaintiffs' damages on the $8.4 million judgment in Plaintiffs' favor for hidden fees charged by BCBSM?

Plaintiffs' answer: Yes.

Defendant will answer: No.

The District Court answered: No.

STATEMENT OF THE CASE

I. FACTUAL BACKGROUND

On January 29, 2016, the Saginaw Chippewa Indian Tribe of Michigan ("SCIT" or "the Tribe") and its Welfare Benefit Plan ("Plan") (collectively "Plaintiffs") sued Blue Cross Blue Shield of Michigan ("BCBSM") based on BCBSM's mismanagement of the Tribe's self-insured employee benefit Plan.

The Tribe's suit is part of a series of actions against BCBSM alleging that BCBSM breached its fiduciary duties by charging its customers a hidden administrative fee buried in marked-up hospital claims. Am. Compl., RE 7, PgID# 64-65. These charges were invisible to customers and were never disclosed.

BCBSM's liability for wrongfully charging hidden fees to its self-insured customers was established in *Hi-Lex Controls Inc. et. al v. BCBSM*, 2013 WL 2285453, No. 11–12557 (E.D. Mich. May 23, 2013). On appeal, this Court affirmed the district court's decision. *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751 F.3d 740 (6th Cir. 2014).

A. THE TRIBE'S ERISA WELFARE BENEFIT PLAN

SCIT is a federally recognized Indian Tribe that owns and operates a casino, hotel and waterpark, marina, retail store, pharmacy, and gas station. Pls.' Mot. Summ. J., RE 81-7, PgID# 4082 (Sprague Dep. 144:5-14); Pls.' Mot. Summ. J., RE 81-8, Page ID# 4019. The Tribe is a major employer in mid-Michigan, with more

than 3,400 employees, including more than 2,500 full-time employees. Pls.' Mot. Summ. J., RE 81-9, PgID# 4097 (Vogel Dep. Ex. 8). The Tribe employs both non-tribal and tribal members. Pls.' Mot. Summ. J., RE 81-10, PgID# 4104 (Vogel Dep. 25:3-24).

The Tribe's Health and Welfare Benefit Plan ("Plan") was created back in the 1980s when the Tribe began offering fully-insured medical benefit coverage to its employees. Pls.' Mot. Summ. J., RE 81-13, PgID# 4157 (Sprague Decl. ¶ 3); Pls.' Mot. Summ. J., RE 81-7, PgID# 4078 (Sprague Dep. 36:12-37:7). No formal plan documents were executed to memorialize the establishment of the Plan.

The Tribe first purchased medical insurance from BCBSM in the 1990s. Pls.' Mot. Summ. J., RE 81-13, PgID# 4158 (Sprague Decl. ¶ 5). BCBSM designated the Plan participants covered by this medical insurance policy as "Group 52885." *Id.*

Over time, the Tribe expanded its benefits offerings well beyond medical insurance, offering life insurance, Medigap insurance, dental benefits, vision benefits, and long term disability benefits. *See* Pls.' Mot. Summ. J., RE 81-7, PgID# 4076, 4085-4087 (Sprague Dep. 9:15-21, 164:16-167:3, 172:18-173:1); Pls.' Mot. Summ. J., RE 81-8, PgID# 4091 (Harvey Dep. 71:22-72:5).

In 2002, the Tribe entered into an Administrative Services Contract ("ASC") with BCBSM, formalizing a self-funded insurance structure for its tribal members

to accompany its existing fully-insured medical benefit policy for employees. *See* Pls.' Mot. Summ. J., RE 81-11, PgID# 4106-4124 (2002 ASC). BCBSM designated the Plan participants covered by this ASC as "Group 61672." Pls.' Mot. Summ. J., RE 81-17, PgID# 4210 (2002 Schedule A).

In 2004, the Tribe transitioned the medical benefits coverage for Plan participants designated by BCBSM as Group 52885 from a fully-insured to a self-funded arrangement. Pls.' Mot. Summ. J., RE 81-13, PgID# 4159 (Sprague Decl. at ¶ 10); Pls.' Mot. Summ. J., RE 81-14, PgID# 4165 (Cronkright Dep. 26:15-18). To do so, BCBSM required Plaintiffs to sign a second ASC, rather than simply adding these individuals to the ASC for Group 61672. *Id.* at PgID# 4167. BCBSM continued to refer to the Plan participants covered by the second ASC as "Group 52885." *See* Pls.' Mot. Summ. J., RE 81-18, PgID# 4212-4218 (2004 Annual Settlement).

Consequently, after 2004, the Tribe's Plan offered self-funded health insurance coverage to Plan participants through two ASCs with BCBSM; one designated as Group 52885 and one designated as Group 61672. Pls.' Mot. Summ. J., RE 81-14, PgID# 4165-4166 (Cronkright Dep. 26:23-27:11, 30:9-20).

Group 52885 included Plan participants who were non-tribal members who were employees of the Tribe, as well as tribal members who were employees of the Tribe. Group 61672 included Plan participants who were tribal members but not

employees of the Tribe, as well as tribal members who were employees of the Tribe. Pls.' Mot. Summ. J., RE 81-13, PgID# 4159 (Sprague Decl. ¶ 12); *see also* Pls.' Mot. Summ. J., RE 81-7, PgID# 4077-4079, 4086 (Sprague Dep. 12:8-13:2; 45:17-19; 167:13-17). In short, both groups included Plan participants who were employees of the Tribe and were provided healthcare benefits by the Tribe. *Id.*[1]

The Tribe's compensation and benefits manager handled the administration of insurance claims for both groups, as well as the Tribe's other benefits programs. *Id.* at PgID# 4076-4083 (Sprague Dep. 8:2-3, 9:5-24, 151:11-21). When purchasing medical insurance, the Tribe always sought bids from potential claims administrators pertaining to both groups simultaneously. *Id.* (Sprague Dep. 42:22-43:11). Meetings regarding medical insurance for both groups always occurred at the same time. Pls.' Mot. Summ. J., RE 81-14, PgID# 4165-4170 (Cronkright Dep. 26:23-27:5, 57:19-58:2); Pls.' Mot. Summ. J., RE 81-16, PgID# 4207 (Luke Dep. 43:22-44:19). BCBSM's account representatives and managers delivered reports and executed documents for both groups at the same time. *See* Pls.' Mot. Summ. J., RE 81-8, PgID# 4092 (Harvey Dep. 94:3-10); Pls.' Mot. Summ. J., RE 81-16, PgID# 4207 (Luke Dep. 43:22-44:19); Pls.' Mot. Summ. J., RE 81-14, PgID# 4170

[1] Labeling Group 52885 and Group 61672 the "Employee Group" and "Member Group," respectively, is misleading. Both groups included many employees of the Tribe. Both groups also included numerous Tribal Members. To avoid any confusion, Plaintiffs refer to the groups by their group numbers.

(Cronkright Dep. 55:20-56:8). The Tribe did not file a Form 5500 for either group. Pls.' Mot. Summ. J., RE 81-8, PgID# 4093 (Harvey Dep. 98:2-13).

Separate ASCs for Group 52885 and Group 61672 were prepared and signed at BCBSM's insistence and for BCBSM's own administrative ease; not by any desire of the Tribe. Pls.' Mot. Summ. J., RE 81-14, PgID# 4167 (Cronkright Dep. 31:15-33:7); Pls.' Mot. Summ. J., RE 82-5, PgID# 4466-4468 (Harvey 30(b)(6) Dep. 26:20-22, 33:8-36:1). Due to BCBSM's internal policies, when claims for Plan participants designated by BCBSM as Group 52885 transitioned from fully insured to self-insured, the Tribe was directed by BCBSM to sign a different ASC. Pls.' Mot. Summ. J., RE 81-14, PgID# 4166-4168 (Cronkright Dep. 26:11-27:11, 30:9-32:1, 34:14-35:6).

B. BCBSM'S PHYSICIAN GROUP INCENTIVE PROGRAM (PGIP)

1. BCBSM's Design of PGIP

BCBSM began charging the Tribe a hidden fee for BCBSM's Physicians Group Incentive Program ("PGIP") on January 1, 2005. Pls.' Mot. Summ. J., RE 87-1, PgID# 4687 (Simmer 30(b)(6) Dep. 10:11-13). PGIP was designed by BCBSM to reward physician organizations for meeting BCBSM objectives by paying cash bonuses (i.e., "incentives") to those physicians. *See id.* at PgID# 4687 (9:25-10-6). The bonuses are separate from what physicians are paid for their services. *Id.* at PgID# 4689 (32:14-20).

To fund the bonus payments, BCBSM increased the cost of physician charges to its self-funded customers, including the Tribe. *See* Pls.' Mot. Summ. J., RE 82-8, PgID# 4474-4477 (1/3/2005 Notice); Pls.' Mot. Summ. J., RE 82-9, PgID# 4478-4483 (BCBSM Publication, June 2004); Pls.' Mot. Summ. J., RE 87-1, PgID# 4690 (Simmer 30(b)(6) Dep. 37:24-38:24).

> PGIP is an amount for physician incentive *added into the amount due* on the claim and as such should be charged to the group. . . . Thus the PGIP amount on an individual claim would not be included in the amount paid to the provider (*just like ASC access fee* on the Local side is not part of the amount paid to the provider, but it is still the group's liability).

Pls.' Mot. Summ. J., RE 82-6, PgID# 4470-4472 (10/4/2007 Garofali E-mail (emphasis added)).

When PGIP started, BCBSM had not upgraded its claims processing system to automate the collection of PGIP fees. Pls.' Mot. Summ. J., RE 82-10, PgID# 4488 (Nieman 30(b)(6) Dep. 30:4-7). As a result, in 2005, BCBSM took the PGIP fees out of each self-funded customer's Savings Refund check, in which BCBSM refunds amounts owed to self-funded customers (like the Tribe) at the end of the year after year-end accounting is completed. *See* Pls.' Mot. Summ. J., RE 81-14, PgID# 4169 (Cronkright Dep. 48:11-24). BCBSM deducted the PGIP fee from the Tribe's 2005 Savings Refund check for the express purpose of funding "the physician incentive pricing component." *See* Pls.' Mot. Summ. J., RE 82-11, PgID# 4489-4493 (Michigan Savings Refund Settlement).

2. BCBSM Unilaterally Set the Amount of the PGIP Fees.

From 2005 until the present, BCBSM unilaterally set the "PGIP allocation" (the amount added to Plaintiffs' professional claims cost). Pls.' Mot. Summ. J., RE 87-1, PgID# 4691 (Simmer 30(b)(6) Dep. 65:17-20). The PGIP allocation started at 0.5% and rose steadily over the years to 5% of the cost of Plaintiffs' professional claims. *Id.* at PgID# 4688 (Simmer 30(b)(6) Dep. 15:22-16:2).

3. The Tribe Paid the PGIP Fees.

BCBSM confirmed that Plaintiffs paid for the PGIP program. The money used by BCBSM to pay the PGIP bonuses came directly from self-funded customers like Plaintiffs. *See* Pls.' Mot. Summ. J., RE 87-2, PgID# 4700-4702 (Julian Dep. 69:10-19; 71:25-72:21, 74:24-25, 75:1-6). Dr. Tom Simmer, the chief architect of PGIP for BCBSM, explained "that [PGIP] fee will be paid for by the– or the money will originate, so to speak, from whoever is covering that beneficiary financially. . . . In self-funded business it is the self-funded customer." Pls.' Mot. Summ. J., RE 87-1, PgID# 4690 (Simmer 30(b)(6) Dep. 37:24-38:24); *see also* Pls.' Mot. Summ. J., RE 82-14, PgID# 4496-4511 (Share 2/2012 Test 17) (BCBSM's Senior Vice President, testifying that "[t]he incentive pool is funded through a percentage of all professional payments.").

4. BCBSM's Periodic Reports to the Tribe Hid the PGIP Fees.

BCBSM kept track of the amount of PGIP fees each of its self-funded customers paid. *See, e.g.*, Pls.' Mot. Summ. J., RE 87-3, PgID# 4705 (Excerpt from Access_Fees_PGIP_6265). Pls.' Mot. Summ. J., RE 87-2, PgID# 4699 (Julian Dep. 50:18-51:22, 52:2-10). But instead of reporting to its self-funded customers the amount of PGIP fees paid, BCBSM buried the amount of the PGIP fees in its claims-processing system. Pls.' Mot. Summ. J., RE 87-2, PgID# 4696, 4699 (Julian Dep. 10:13-14, 53:2-22).

BCBSM designed its documents so that the customer would never know about the added PGIP cost. *See* Pls.' Mot. Summ. J., RE 82-8, PgID# 4474-4477 (1/3/2005 Notice) ("[a]pproved amount with the added incentive is $100.50," but "[m]ember copay and [Explanation of Benefits] will only show the $100"). Once BCBSM automated the charging of PGIP fees after 2005, BCBSM hid the PGIP fees in the claims cost for professional (i.e., physician) claims so the PGIP fees would be invisible to the self-funded customer. Pls.' Mot. Summ. J., RE 82-10, PgID# 4489 (Nieman 30(b)(6) Dep. 34:20-35:1).

BCBSM reported physician claims to the Tribe on a quarterly basis. *See, e.g.*, Pls.' Mot. Summ. J., RE 82-15, PgID# 4512-4518 (4/2011 – 6/2011 Quarterly Settlement). BCBSM also reported claims on an annual basis for a number of years

as well. *See, e.g.*, Pls.' Mot. Summ. J., RE 82-16, PgID# 4519-4526 (2006/07 Annual Settlement).

These reports falsely represented to the Tribe that all of the money collected for the payment of physician claims was actually used to pay claims for physicians providing medical services to the Tribe's enrollees. This is similar to the false reports related to BCBSM's hidden access fees scheme first litigated in *Hi-Lex*. *See, e.g.*, Pls.' Mot. Summ. J., RE 81-2, PgID# 3981, 3984, 3985 (Hi-Lex FFCL ¶¶ 38, 56, 61) (explaining that the standard reports BCBSM sent to ASC customers were false and misleading because they did not disclose that fees hidden within the plaintiffs' claims payments were actually used for something besides paying claims).

5. A "Reward Pool" of Money for the PGIP Bonuses Does Not Exist.

BCBSM defended PGIP by arguing that PGIP bonuses are paid from a "reward pool" funded by physicians, and Plaintiffs cannot complain about the separate compensation arrangements BCBSM has with physicians.

A "reward pool" for PGIP does not exist. BCBSM merely keeps track of the total amount of PGIP fees paid by its customers (like Plaintiffs) through a so-called "PGIP Liability Account." Exhibit formerly marked confidential to Mot. For Summ. J., RE 8702, PgID# 4703 (84:16-85:2). The PGIP Liability Account itself does not hold any cash. *Id.* at PgID# 4698 (22:25-23:2). In fact, the existence of a

segregated "reward pool" is impossible because the money that funds PGIP is comingled in BCBSM's general bank account. Pls.' Mot. Summ. J., RE 87-2, PgID# 4696, 4698, 4700 (Julian Dep. 10:19-11:12, 23:7-10, 67:19-22, 76:9-12); *see also* Pls.' Mot. Summ. J., RE 82-18, PgID# 4537-4544 (BCBSM's 4th Am. Answer to Dykema's 1st Set of Interrogs. No. 11); Pls.' Mot. Summ. J., RE 82-19, PgID# 4545-4551 (BCBSM's Resp. to Pls.' 1st Set of Interrog. No. 7).

C. MEDICARE-LIKE RATES (MLR)

"The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives." Pls.' Opp. Mot. Dismiss, RE 18-4, PgID# 269 (IHS Website – overview). "The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level." *Id.*

IHS operates a number of hospitals and clinics across the United States to provide health care services to American Indians and Alaska Natives. IHS services to Indians in Michigan are provided through IHS's Bemidji Area Office in Bemidji, Minnesota. Pls.' Opp. Mot. Dismiss, RE 18-5, PgID# 271-272 (IHS website – Bemidji). There are no IHS health care facilities in Michigan. *Id.*

In situations where an eligible Indian needs health care services but there is no IHS facility reasonably accessible to the Indian, IHS "contracts out" health care

services ("Contract Health Services") to private medical providers. *See, e.g.*, 42 C.F.R. § 136.23(a)(allowing Contract Health Services to be provided to an eligible Indian "when necessary services by an Indian Health Service facility are not reasonably accessible or available").

Certain federally recognized Indian tribes, including SCIT, are authorized under the Indian Self-Determination and Educational Assistance Act ("ISDEAA"), 25 U.S.C. § 450 *et seq.*, to carry out a Contract Health Services program on behalf of IHS. Am. Compl. ¶ 4, RE 7, PgID# 61-62. In essence, the Tribe stands in the shoes of IHS in administering Contract Health Services for Tribal members. When a Tribal member needs health care services beyond what is available at the Tribe's Wellness Clinic, the Tribe contracts out those services to private medical providers, since there are no IHS facilities in Michigan. Beginning in 2002, BCBSM was retained by the Tribe as the administrator of Contract Health Services paid for by SCIT for Tribal members. *Id.* ¶ 19, RE 7, PgID# 66.

On July 5, 2007, new federal regulations went into effect governing the amount that IHS (or a self-governing tribe standing in the shoes of IHS, such as SCIT) is required to pay for Contract Health Services. The regulations essentially provide that Medicare-participating hospitals must accept Medicare-equivalent

pricing ("Medicare-Like Rates" or "MLR") for Contract Health Services. *See, e.g.*, 42 C.F.R. § 136.30.[2]

BCBSM was well aware of the regulations allowing the Tribe to pay no more than Medicare-Like Rates for Contract Health Services for Tribal members. Am. Compl. ¶ 135, RE 7, PgID# 88. However, on thousands of claims it administered for Plaintiffs under the Plan, BCBSM failed to direct the Plan to pay Medicare-Like Rates for Contract Health Services from Medicare-participating hospitals. Instead, BCBSM systematically caused the Plan to pay BCBSM's standard contractual rates (which are typically higher than Medicare-Like Rates) for all Contract Health Services provided to Plan beneficiaries, squandering millions of dollars of the Plan's assets as a result. *Id.* at ¶ 136, PgID# 89.

II. PROCEDURAL HISTORY

A. MEDICARE-LIKE RATES

BCBSM filed a motion to dismiss the portion of the Amended Complaint relating to Medicare-Like Rates. In an Opinion and Order dated August 3, 2016, the district court granted BCBSM's motion. Op. and Order, RE 22.

The central premise of the district court's opinion was that "an ERISA fiduciary does not owe a duty to the plan to comply with obligations extrinsic to

[2] The regulations allow IHS (or self-governing tribes, such as SCIT) to pay the *lesser* of the Medicare-Like Rate or the Tribe's contractual rate with the hospital. 42 C.F.R. § 136.30(g)(4).

the text of ERISA and the plan." *Id.* at PgID# 460. Because "ERISA makes no reference to the MLR regulations [and] the MLR regulations make no reference to ERISA," BCBSM therefore had no "obligation to ensure the Plan paid Medicare-like Rates for healthcare claims." *Id.* at PgID# 462-464.

B. HIDDEN FEES

The parties proceeded with discovery on Plaintiffs' claims related to hidden fees and PGIP. After the completion of discovery, the parties filed cross-motions for partial summary judgment. The district court granted both parties' motions for partial summary judgment in part.

The district court held that the Tribe had two separate benefit plans. Op. and Order, RE 112, PgID# 6210. The district court ignored that the Plan had been originally established as an employee benefit plan and maintained for decades as an employee benefit plan. The district court also declined to apply this Court's "strong presumption" that "the employee health benefits offered by an employer constitute a single ERISA plan," *see Loren v. Blue Cross & Blue Shield of Michigan*, 505 F.3d 598, 605 (6th Cir. 2007), reasoning instead that the lack of formal ERISA plan documents somehow rendered that presumption inapplicable in this case. Op. and Order, RE 112, PgID# 6211.

Instead, the district court found that the Tribe had two plans–one created in its capacity as an employer, and the other in its capacity as a sovereign. The district

court based its holding on the "distinct eligibility standards" of each ASC. Although the district court acknowledged that a Tribe, acting in its capacity as a sovereign, certainly could create an ERISA plan with different eligibility standards, the district court reasoned this was not the case here because the Tribe did not intend to "provid[e] coverage to employees" when it entered into the second ASC with BCBSM. *Id.*, PgID# 6213.

The district court then analyzed "whether ERISA governs the plans." *Id.* at PgID# 6214. The district court quickly concluded that Group 52885 was governed by ERISA and entered summary judgment in Plaintiffs' favor in the amount of $8,426,278 on the hidden fees claim related to Plan participants designated as part of Group 52885.[3]

However, the district court held that ERISA did not apply to the benefits BCBSM administered for Plan participants designated as part of Group 61672, relying on out-of-circuit authority for the proposition that "membership in [an ERISA] plan" must be "based on the employment relationship," and again reasoning that this was a "separate plan . . . created to provide healthcare coverage to non-employee members." *Id.*, PgID# 6218, 6221-6222. The district court disregarded that many Plan participants designated by BCBSM as "Group 61672" were employees, reasoning that "[t]he Tribe set out to create a healthcare plan for

[3] BCBSM has not appealed this judgment.

the purpose of covering non-employees . . . and that "[a]ny inclusion of employees . . . was unrelated to their employment relationship with the Tribe." *Id.*, PgID# 6224. As a result, the district court granted partial summary judgment in favor of BCBSM.

C. PGIP

The district court also held that BCBSM's operation of PGIP did not violate its fiduciary duties to the Tribe. *Id.*, PgID# 6225. The district court described PGIP as customer service-driven program, and its customer-paid funding as simply an "internal reallocation of fees which would have been collected anyway" and "eventually paid to participants in the program." *Id.*, PgID# 6227.

Even though the Tribe provided extensive evidence that BCBSM charged a specific fee to fund PGIP, that self-funded customers paid these charges, and that BCBSM kept track of the amount of PGIP fees each of its self-funded customers paid, the district court concluded that "the Tribe [did] not establish that it was charged additional amounts *because of* PGIP." *Id.*, PgID# 6228. Instead, the district court held that the PGIP fees simply represented a "yearly fee increase." Under this interpretation, the district court concluded that BCBSM was not required to disclose the PGIP fee to its self-funded customers. *Id.* PgID# 6229.

Finally, despite the evidence that BCBSM used the PGIP fees to subsidize a program it created and maintained, the district court held that there was no self-

dealing because "BCBSM did not receive a financial benefit from PGIP." *Id.* PgID# 6231.

D. PREJUDGMENT INTEREST DAMAGES

Plaintiffs sought prejudgment interest as a component of its damages. *See, e.g.*, Pls.' Mot. Summ. J., RE 81, PgID# 3964. Although the district court granted the Tribe's motion for partial summary judgment as to hidden fees charged for members designated as Group 52885 and entered judgment against BCBSM in the amount of $8,426,278, the court did not award prejudgment interest as a component of Plaintiffs' damages (or even discuss prejudgment interest in its Opinion). Op. and Order, RE 112, PgID# 6232.

SUMMARY OF THE ARGUMENT

ERISA can be a complex area of law in which a district court's decisions are frequently reversed on appeal. Here, although the context in which Plaintiffs' ERISA claims arise is unusual, the district court made several fundamental errors that are inconsistent with established Supreme Court and Sixth Circuit precedent. The district court exhibited a high degree of hostility towards Plaintiffs' ERISA claims, issuing two opinions that were contrary to established precedent supporting a broad application of ERISA's protections to employee welfare plans and their participants.

The district court made five distinct and significant errors below.

First, the district court erred by holding that the Tribe created two separate plans for participants, rather than a single plan. The district court failed to properly consider numerous facts in the record supporting the conclusion that the Tribe established and maintained one plan for all of the various benefits it offered; ignored the strong presumption in favor of a finding that a single benefit plan exists; and brushed aside administrative guidance that also strongly supports the conclusion that a single plan governs all of the Tribe's health and welfare benefit offerings.

Second, assuming *arguendo* that there were two separate plans, the district court erred in concluding that Plan participants designated by BCBSM as "Group

61672" were not covered by ERISA. Even when considered in isolation, many of the Plan participants designated by BCBSM as Group 61672 were employees of the Tribe, such that Plan participants designated by BCBSM as Group 61672 are entitled to ERISA's protections against BCBSM's self-dealing and other breaches of fiduciary duty.

Third, the district court erred by holding that BCBSM's systematic squandering of Plan assets by paying for amounts in excess of Medicare-Like Rates (MLR) was not a breach of fiduciary duty under ERISA. Plaintiffs' claim related to MLR is based on the well-established obligations of ERISA fiduciaries to exercise due care to preserve plan assets. Two other Eastern District of Michigan judges rejected the district court's analysis on this issue. This Court should as well.

Fourth, the district court erred by holding that there was no genuine issue of material fact as to whether Plaintiffs paid additional amounts to BCBSM for PGIP. There is substantial evidence that Plaintiffs paid additional amounts to BCBSM for PGIP and that those payments for PGIP were hidden from Plaintiffs. Indeed, summary judgment should have been granted in favor of Plaintiffs for at least the PGIP fees charged in the first year of the program.

Finally, the district court abused its discretion by failing to award prejudgment interest as a component of Plaintiffs' damages on the $8.4 million

judgment in Plaintiffs' favor. The district court gave no explanation as to why BCBSM should not be required to disgorge the profits it unjustly received on the hidden fees BCBSM unlawfully collected from Plaintiffs dating back to 2002.

ARGUMENT

I. THE TRIBE ESTABLISHED A SINGLE ERISA PLAN.

This Court "review[s] the district court's grant of summary judgment in an action involving an ERISA claim *de novo*." *Williams v Int'l Paper Co.*, 227 F.3d 706, 710 (6th Cir. 2000).

Both established precedent and the factual record demonstrate that the Tribe established and maintained a single ERISA plan, of which Group 52885 and Group 61672 (and the Tribe's other benefit offerings) were component parts.

The district court's holding included the following errors: (1) ignoring that the Plan was established decades earlier for the purpose of providing employee health and welfare benefits; (2) failing to consider that the Tribe maintained all of its various benefit offerings under the umbrella of a single Plan; (3) misapplying *Loren*'s "default rule" regarding the number of welfare benefit plans and misconstruing the parties' Administrative Services Contracts; (4) failing to give proper weight to administrative guidance from the Department of Treasury, Department of Labor, and Department of Health and Human Services (5) improperly unbundling aspects of the Tribe's Plan to determine whether each component benefit offered under the Plan independently comes within ERISA; and (6) basing its opinion on its conclusory determination that Group 61672 was

created by the Tribe in its sovereign capacity without properly analyzing the commercial activities undertaken by Tribal employees in that group.

A. THE TRIBE'S BENEFIT PLAN WAS ESTABLISHED IN THE 1980'S AS AN EMPLOYEE BENEFIT PLAN.

Courts generally consider an employer's benefit program "as a whole" to determine whether ERISA covers a particular benefit structure. *Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404, 407 (9th Cir. 1995) (holding that the features of one component of the plan were "not determinative," because "the . . . policy was just one component of [the employer's] employee benefit program and . . . the program, taken as a whole, constitutes an ERISA plan.").

As discussed above, the Tribe began offering medical benefits to employees in the 1980s. No formal ERISA Plan documents were created by the Tribe.

Although the Tribe never prepared formal ERISA plan documents, an ERISA "employee welfare benefit plan" may be "***established or maintained*** . . . through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1) (emphasis added). Employers can establish an ERISA plan "rather easily," regardless of whether the plan sponsor complies with ERISA's formal requirements, such as having plan documents. *Int'l Res., Inc. v. N.Y. Life Ins. Co.*, 950 F.2d 294, 297 (6th Cir. 1991) (citation omitted); *Bolssen v. Unum Life Ins. Co. of Am.*, 629 F. Supp. 2d 878, 881–83 (E.D. Wis. 2009) ("courts have consistently rejected the argument

that the failure to comply with formal requirements can prevent the establishment of an ERISA plan").

There is no question that the Tribe established an ERISA plan when it began offering health insurance benefits to employees in the 1980s. The Tribe's failure to execute formal plan documents did not prevent the establishment of an ERISA plan by operation of the law.

Once an ERISA plan has been established, this Court has held that a second, separate plan is only created where "it is clear from the instruments governing the arrangements to provide medical care benefits that the benefits are being provided under separate plans and if the arrangements are operated pursuant to the instruments as separate plans." *Loren*, 505 F.3d at 605 (quoting Notice Of Proposed Rulemaking for Health Coverage Portability, 69 Fed. Reg. 78800-01 (proposed Dec. 30, 2004)(emphasis added)).

As discussed further below, there is *no* evidence – much less *clear* evidence – that the instruments governing medical insurance to Plan participants designated by BCBSM as "Group 52885" and "Group 61672" are being provided under separate plans. There is also no evidence – much less clear evidence – that the arrangements for medical insurance for Plan participants designated by BCBSM as Group 61672 were operated as a separate plan from the Plan established 20 years earlier for participants designated by BCBSM as Group 52885.

B. THE TRIBE MAINTAINED ALL OF ITS BENEFIT OFFERINGS UNDER THE UMBRELLA OF A SINGLE PLAN

A plan may also come within ERISA, regardless of how it is "established," if it is "maintained . . . through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1); *See also Anderson v. UNUM Provident Corp.*, 369 F.3d 1257, 1265 (11th Cir. 2004) (holding that "even if [an employer] did not originally establish the plan, ERISA would still apply if [the employer] subsequently maintained the UNUM Plan"); *Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652, 1661, 198 L. Ed. 2d 96 (2017) (recognizing that, "for various purposes, ERISA treats the terms 'establish' and 'maintain' interchangeably.").

"To 'maintain' a plan, in the ordinary meaning of the word, simply means to 'continue' a plan." *Anderson*, 369 F.3d at 1265. Thus:

> for example, if [a plan sponsor] began to involve itself more in the payment of benefits, changed the critical terms of the policy, or performed all the administrative functions associated with the maintenance of the plan, those would be actions on the part of the employer which could 'maintain,' rather than establish the plan as an employee welfare benefits plan.

Id.

Over time, the Tribe expanded its benefit offerings. In addition to medical insurance, the Tribe also offers life insurance, Medigap insurance, dental benefits, vision benefits, and long term disability benefits.

The Tribe always managed its portfolio of various benefits, including medical benefits for participants designated by BCBSM as Group 52885 and Group 61672, jointly. Connie Sprague, the Tribe's compensation and benefits manager, primarily handled the administration of both groups, as well as the Tribe's other benefits programs under the Plan. The Tribe always sought bids from different entities pertaining to both groups when purchasing insurance. Meetings regarding both groups always occurred at the same time. BCBSM's account representatives and managers delivered and executed documents regarding the policies, such as annual settlements, quarterly settlements, and renewals, for both groups at the same time. The Tribe did not file a Form 5500 for either group. The evidence is overwhelming that all benefits offered by the Tribe are maintained as part of a single Plan.

C. THE DISTRICT COURT FAILED TO APPLY *LOREN*, CONTRAVENING BINDING SIXTH CIRCUIT PRECEDENT.

This Court has held that "the default rule . . . [is that] all health benefits provided by an employer are considered a single group health plan." *Loren*, 505 F.3d at 605 (citation omitted).[4] "[T]he burden is on Defendant to defeat this

[4] It is axiomatic that an employee benefit plan may consist of "a group policy or multiple policies." *Donovan v. Dillingham*, 688 F. 2d 1367, 1373 (11th Cir. 1982); *see also* IRS Instructions to Form 5500, at 17 ("The fact that you have separate insurance policies for each different welfare benefit does not necessarily mean that you have separate plans").

presumption by establishing through sufficient evidence that these plans were intended to operate as separate plans, or operated as such in practice." *Id*

Among the factors a court should consider in deciding whether a defendant has overcome the presumption that a single plan was created are: "(1) [w]hether each plan had a different ERISA identification number; (2) whether the language of the plan documents indicated that the employer intended to establish multiple plans; and (3) whether the plans shared the same administrator or trust." *Id.* (citing *Chiles v. Ceridian Corp.*, 95 F.3d 1505, 1511 (10th Cir. 1996)).

1. ***Loren* requires a presumption that all benefits offered by an employer constitute one plan.**

The district court failed to give due consideration to the presumption that all the benefits offered by the Tribe constitute one plan. Op. and Order, RE 112, PgID# 6210-6211. The district court's failure to apply ERISA's default rule to this case runs contrary to binding Sixth Circuit precedent. *See Loren*, 505 F.3d at 604-05.

In *Loren*, the plaintiffs alleged that BCBSM violated ERISA by negotiating more favorable rates for a subsidiary of BCBSM than for certain self-insured plans that BCBSM administered. *Id.* at 602. One of the issues on appeal was whether the various individual medical insurance coverage options offered by the employer constituted one ERISA plan rather than multiple plans. *Id.* at 601, 604.

This Court held the various coverage options offered to employees constituted a single ERISA benefits plan *despite* the fact that the employer's "plan options ha[d] *distinct* claims processing administrators, [and] *different* levels of benefits and *different* funding regimes." *Id.* at 605-06 (emphasis added). Despite these differences in operation, BCBSM failed to "establish[] through sufficient evidence that these plans were intended to operate as separate plans, or operated as such in practice." *Id.* at 605. This Court grounded its holding in the "default rule that all medical benefits offered by an employer are generally considered to be part of one ERISA health plan." *Id.*

Not only did the district court below fail to apply the "default rule" from *Loren,* but the district court turned this presumption on its head by applying "a presumption of multiple plans" and placing the burden of proof *on the Tribe* to show that it had one plan and not two. Op. and Order, RE 112, PgID# 6210-6212. Notably, the district court based its new rule almost exclusively on the fact that "the Tribe signed two Administrative Service Contracts with BCBSM." *Id.*

Such an interpretation of ERISA's provisions runs directly contrary to *Loren* and other cases holding that the parties' Administrative Service Contracts have no bearing on a party's intent to "maintain or establish" more than one ERISA plan because Administrative Service Contracts are not "plan documents." *See Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 817 (7th Cir. 2002) ("The . . . problem

with HCSC's use of the ASA [Administrative Services Agreement] is that it is not a "plan document"); *L & W Assocs. Welfare Ben. Plan v. Estate of Wines ex rel. Wines*, No. 12-cv-13524, 2014 WL 117349, at *8 (E.D. Mich. Jan. 13, 2014) ("The Court rejects the [defendant's] suggestion that the ASC is the underlying ERISA plan document . . . . It contains no benefit-defining language, does nothing to apprise plan participants of their benefits or rights under the Plan and is not a Plan document."); *accord Moeckel v. Caremark, Inc.*, 622 F. Supp. 2d 663, 681-82 (M.D. Tenn. 2007) (finding that service contract between employer/plan sponsor and administrator is not a plan document and not part of an ERISA plan); *Local 56, United Food and Commercial Workers Union v. Campbell Soup Co.*, 898 F. Supp. 1118, 1136 (D.N.J. 1995) (finding that Administrative Services Agreement was not a plan document because the ASA merely memorialized the obligations of the employer and the insurer/administrator of the plan to one another).

The district court made an unfounded leap of logic in construing the ASCs relating to Group 52885 and Group 61672 as "plan documents" suggesting an intent by Plaintiffs "to establish multiple plans."[5] By failing to apply the default

[5] The District Court repeatedly referred to the ASCs as "plan documents" and gave great weight to the existence of these contracts in misapplying *Loren*. *See* Op. and Order, RE 112, PgID# 6211 ("Given the separate plan documents, there is no reason to presume that the Tribe intended to create a single plan"). However, other parts of the District Court's Opinion were internally inconsistent and properly noted that "the Tribe never executed ERISA plan documents." *Id.* at PgID# 6210-11.

rule that this Court established in *Loren* and by turning *Loren*'s default rule on its head, the district court committed reversible error.

2. The record supports the Tribe's position that it intended the groups to be part of one Plan and administered them as such.

In this case, the *Loren* factors support the conclusion that a single Plan exists.

First, the Tribe's plan was not established or "operated pursuant to the plan documents as separate plans." 505 F.3d at 606. There were not "different ERISA identification number(s)" or "language [in] plan documents indicat[ing] that the employer intended to establish multiple plans," because there were no plan documents at all. *Id.,* Pls.' Mot. Summ. J., RE 82-3, PgID# 4457 (Kamai Dep. 124:4-10).

Notably, Group 52885 and Group 61672 were *more* unified than the groups *Loren* held constituted a single ERISA plan. First, unlike the groups at issue in *Loren*, Group 52885 and Group 61672 "shared the same [third party] administrator" (BCBSM), and the same Human Resources personnel managed both groups for the Tribe. *See* Pls.' Mot. Summ. J., RE 81-7, PgID# 4083 (Sprague Dep. 151:11-21).

Second, the coverage options in *Loren* had different claims administrators and different "funding regimes"—one option was a fully insured option and the

other was a self-funded option, which were administered/insured by different entities. *Loren*, 505 F.3d at 606. Here, by contrast, Plaintiffs had a self-funded arrangement for both groups, which was administered by the same entity (BCBSM), and paid for by the same entity (the Tribe). *See* Pls.' Mot. Summ. J., RE 82-4, PgID# 4462 (Reger Dep. 10:16-13:5) (explaining sources of Tribal money outflows relating to the two ASCs, concluding that "in the end, it's all under one big umbrella called the "Tribal government"); Pls.' Mot. Summ. J., RE 81-7, PgID# 4082 (Sprague Dep. 142:20-143:3); *cf. Loren*, 505 F.3d at 606 (finding "a single ERISA group health plan with multiple benefit options" despite the fact that for the HMO option the insurer "bears the risk to pay the cost of health expenses whereas" for the self-insured option the plan sponsor "bears the risk to pay the cost of health expenses").

Third, the enrollees in both groups received the same health care benefits. Pls.' Mot. Summ. J., RE 81-7, PgID# 4087 (Sprague Dep. 170:1-11). This is significant evidence that Plaintiffs did not intend Plan participants designated by BCBSM as Group 61672 to be part of a separate plan from participants designated as Group 52885.

Although the Tribe did sign two ASCs with BCBSM, this structure was developed at BCBSM's insistence and for BCBSM's own administrative ease, not

by any desire of the Tribe. There is no evidence the Tribe signed a second ASC for the purpose of creating a second plan.

Applying the *Loren* presumption in this case is all the more appropriate because there can be no dispute that the Tribe did, in fact, have an ERISA Plan for decades. The Tribe first started providing benefits to employees in the 1980s. By 2002, the Tribe had operated the Plan through its human resources department for thousands of employees for nearly 20 years.

In 2002, the Tribe decided to extend its medical insurance offerings to non-employee Tribal members. The Tribe did so through the same operational platform that had been in place for decades. Thus, the issue for this case is not whether the Tribe created two plans in 2002 and 2004 respectively (the dates the ASCs were signed). Rather, the issue is whether the Tribe created a new, second plan when the Tribe decided in 2002 to extend benefits to also to cover non-employee tribal members. Applying the *Loren* factors confirms that the Tribe continued to have only one Plan.

At bottom, the Tribe never created plan documents for multiple benefit plans or exhibited any intention to maintain multiple benefit plans, *both* of which are necessary to create more than one welfare benefit plan. *See Loren* at 605 ("the employer or employee organization can establish more than one group health plan if it is clear from the instruments governing the arrangements to provide medical

care benefits that the benefits are being provided under separate plans *and* if the arrangements are operated pursuant to the instruments as separate plans")(quotation omitted).

3. The district court erroneously relied on inapplicable out-of-circuit authority for its holding.

Beyond ignoring *Loren*, The district court relied on several readily distinguishable out-of-circuit authorities to support its holding. Op. and Order, RE 112, PgID# 6213 (citing *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102, 1105 (11th Cir. 1999); *Kemp v. IBM Corp.*, 109 F.3d 708 (11th Cir. 1997); *Zeiger v. Zeiger*, 131 F.3d 150 (9th Cir. 1997) (unpublished table decision); *Robertson v. Grant & Co.*, 798 F.2d 868, 871 (5th Cir. 1986)). None of those decisions are relevant here because, in contrast to the coverage options at issue in *this* case, the plans in those cases all either: (1) covered *only non-employees*; or (2) provided benefits completely unrelated to ERISA.[6] *See Slamen*, 166 F.3d at 1105 (disability insurance covering only sole proprietor of dental practice); *Kemp*, 109 F.3d at 710 (reimbursement for educational expenses that the parties agreed fell outside of ERISA); *Zeiger*, 131 F.3d 150 (plan covering only husband and wife); *Robertson*, 798 F.2d at 871 (retirement plan benefitting only partners).

[6] The Supreme Court has explicitly held that ERISA "does not apply to plans established and maintained exclusively for substantial owners." *Yates v Herndon*, 541 U.S. 1, 15 (2004)(quotation omitted).

Here, there is clear evidence that the Tribe's Plan always had at least one employee—including an employee designated by BCBSM as part of Group 61672—participating in the Plan at all times. Accordingly, those cases do not support the district court's holding or otherwise diminish the district court's error in of ignoring *Loren*.

D. THE DISTRICT COURT FAILED TO GIVE PROPER WEIGHT TO ADMINISTRATIVE GUIDANCE.

The district court's opinion also failed to give proper weight to the position of the administrative agencies that have enforcement responsibility for ERISA. The Department of Treasury, Department of Labor, and Department of Health and Human Services have all spoken on the issue before the Court. The position of these agencies—which have enforcement responsibility for ERISA under 29 U.S.C. § 1204—should be given significant weight. *See Kasten v. Saint-Gobain Performance Plastics Corp.*, 563 U.S. 1, 14-15 (2011) ("[G]iven Congress' delegation of enforcement powers to federal administrative agencies, we also give a degree of weight to their views about the meaning of this enforcement language."); *Henry T. Patterson Trust by Reeves Bank & Trust Co. v. United States*, 729 F.2d 1089, 1095 (6th Cir. 1984) ("[T]he construction offered by the agency charged with the enforcement of the statute will often be accorded dispositive weight.").

The Department of Treasury has taken the position that all health benefits provided by a plan sponsor are part of one plan, unless it is *clear* that the benefit packages are separate plans. *See* 26 C.F.R. § 54.4980B-2.A-6 ("all health care benefits . . . provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan, unless (1) it is ***clear from the instruments*** governing an arrangement or arrangements to provide health care benefits that the benefits are being provided under separate plans; ***and*** (2) the arrangement or arrangements are ***operated pursuant to such instruments as separate plans.***")(emphasis added).

The Department of Labor and the Department of Health and Human Services have also taken the identical position. *See* Notice of Proposed Rulemaking for Health Coverage Portability, 69 Fed. Reg. 78800–01 (proposing the same default rule as 26 C.F.R. § 54.4980B-2.A-6) (proposed Dec. 30, 2004).

As this Court has recognized, this proposed rule acknowledges that that the applicable regulations "provide plan sponsors great flexibility *while minimizing the burden of making decisions about how many plans to maintain." Loren*, 505 F.3d at 605 (quotation omitted). This flexibility manifests as a result of "the default rule . . . [that] all health benefits provided by an employer are considered a single group health plan" such that, for example, a plan sponsor has "no need to furnish a certificate of creditable coverage when an employee merely switches coverage

among the options made available by the employer"; such requirements "would arise only if the employer designated separate benefit packages as separate plans in the plan documents ***and only if the benefit packages were also operated pursuant to the plan documents as separate plans."*** *Id.* (emphasis added).

This Court has also recognized that "[b]ecause of the paucity of case law on the issue" of whether multiple ERISA plans exist, the Court would "look to administrative interpretation" such as the foregoing to inform its decision. *Id.* at 604. The district court, however, took an entirely different approach: it *avoided* the import of this critical administrative guidance by first lumping it in with *Loren* ("[t]he analytical framework provided in the regulations is . . . substantially similar to the analysis in *Loren*") and then disregarding it entirely. Op. and Order, RE 112, PgID# 6211-12.

E. THE DISTRICT COURT IMPROPERLY UNBUNDLED THE COMPONENTS OF THE TRIBE'S PLAN IN ANALYZING WHETHER IT FELL UNDER ERISA.

The district court also incorrectly examined the Tribe's benefit programs separately rather than analyzing the Tribe's benefits program as a whole. *Id.*, PgID# 6210-6218. This Court has repeatedly refused to "divorce," "unbundle," or otherwise separate the different aspects of an employer's benefits plan in analyzing whether a plan—or one of the component benefits offered under the plan—falls under ERISA. *See Gross v. Sun Life Assur. Co. f Canada*, 734 F.3d 1, 8 (1st Cir.

2013)(declining to "divorce" the particular class of benefits at issue from the employer's "benefit program and . . . separately evaluate whether ERISA applies to it."); *Postma v. Paul Revere Life Ins. Co.*, 223 F.3d 553, 538 (7th Cir. 2000) (holding that "[f]or purposes of determining whether a benefit plan is subject to ERISA, its various aspects ought not to be unbundled.") (citations omitted).

The importance of the restriction against "unbundling" is apparent in view of the principle that even if a component insurance policy *itself* fails to comply with ERISA, it will nevertheless be subject to ERISA's requirements if the employer's broader benefit program, taken as a whole, falls under ERISA. For example, in *Peterson v. American Life & Health Insurance Company*, the court concluded that an employer's insurance policy which, on its own, did not comply with ERISA requirements nonetheless fell under the statute because it "was just one component of [the] employee benefit program and . . . the program, taken as a whole, constitutes an ERISA plan." 48 F.3d at 407. Analyzing the employer's benefits program "as a whole," the court noted that throughout the relevant time period the employer "continued to provide insurance to at least one . . . employee," paid the premiums for all the policies, and "played an active role in the administration of the coverage . . . ." *Id.* at 407-08. The court further reasoned that since the employer's "policies [were] derived from ERISA plans, they continue[d] to be governed by ERISA even after conversion." *Id.* at 408.

Notably, the fact that an employer's benefit programs may contain different benefit structures or eligibility requirements does not prevent the program from falling under ERISA under this "bundling" principle. *See, e.g.*, *Boos v AT&T*, 643 F.3d 127, 131-33 (5th Cir. 2011)(holding that a telecommunication provider's plan, which offered different benefits to different classes of retirees, was a single ERISA plan rather than two plans); *Steiner v. Fortis Benefits Ins. Co.*, No. CIV A 97-0265, 2000 WL 877013, at *1–2 (E.D. La. June 29, 2000) ("Under the Policy, there are two eligible classes of persons who may be covered."); *Fisher v. Prudential Ins. Co. of Am.*, 842 F. Supp. 397, 401 (N.D. Cal. 1993) (finding "benefit plan, which consists of *three insurance plan components*," to be single plan for ERISA purposes where it was "backed by one single trust, has a single Trustee and a single insurer for its three life and disability programs . . . is underwritten entirely by Prudential and is administered by the Trust's designated Plan agent . . . .solicitation for all three plans and the determination of eligibility are overseen by [the same agent]," and "[t]he same administrative and clerical staff oversees all three plans.")(emphasis added).

As discussed above, the Tribe offers a host of various health and welfare benefits, including medical insurance, life insurance, Medigap insurance, dental benefits, vision benefits and long-term disability benefits. Taken to its logical

conclusion, the district court's Opinion would treat each of these benefit offerings as a separate plan. This Court has clearly rejected such an analysis.

F. THE DISTRICT COURT'S DECISION WRONGLY HINGED ON ITS CONCLUSION THAT GROUP 61672 WAS CREATED BY THE TRIBE IN ITS CAPACITY AS SOVEREIGN.

The district court also committed reversible error in issuing summary judgment based on its conclusory and immaterial determination "that the plans were *apparently created by the Tribe acting in different capacities* . . . . The Employee Plan was created by the Tribe in its capacity as an employer, while the Member Plan *seems to have been created by the Tribe in its capacity as a sovereign.*" Op. and Order, RE 112, PgID# 6212-13 (emphasis added). Although the district court characterizes its conclusion as "important" and even "crucial to the determination that the Employer Plan and Member Plan are distinct," it cited to no legal precept to support its conclusion. *Id.*

The district court's focus on the Tribe's sovereignty is wholly unwarranted. Congress has established the relevant analytical framework for whether tribal insurance programs are governed by ERISA. In August 2006, Congress amended ERISA to confirm which tribal plans are subject to ERISA and which are exempt. *See Coppe v. Sac & Fox Healthcare Plan*, No. 2:14-cv-02598-GLR, 2015 WL 6806540, at *3 (D. Kan. Nov. 5, 2015) (ERISA applies to Indian tribes despite their sovereign status if the plan covers some employees engaged in commercial

activities). Under the 2006 amendment, any tribal benefit plan with *some* employees engaged in commercial activities is subject to ERISA. *Little River Band of Ottawa Indians v. BCBSM*, 183 F. Supp. 3d 835, 841 (E.D. Mich. 2016).[7]

Congress' amendment of ERISA is consistent with the Department of Labor's position that (a) an employee benefit plan only needs to have one employee participant to be covered by ERISA, and (b) the employer's subjective intention is irrelevant (*see* Section II(A), *infra*). The district court's reliance on the Tribe's sovereignty to support a crucial aspect of its holding without engaging in *any* analysis of either the law or the factual record concerning the commercial activities of Tribal employees designated by BCBSM as Group 61672 was reversible error.

G. THE DISTRICT COURT'S HOLDING ALSO UNDERMINES SIGNIFICANT POLICY GOALS UNDERGIRDING ERISA'S REQUIREMENTS.

It is perhaps unsurprising that, as the district court's opinion contradicts established precedent and administrative guidance, its holding also undermines ERISA's underlying policy concerns. Courts have consistently interpreted ERISA's

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[7] It is undisputed that many Plan participants designated by BCBSM as Group 61672 were employees engaged in commercial activities. In 2014, for example, some worked at the casino or hotel in such positions as "Bartender," "Bell Person," "Table Games Shift Manager," "Director of Hotel Operations," "Table Games Dealer," and "Bingo Floorworker." *See* Exs. 11-23 to Pls. Resp. to Def.'s Mot., RE 94-13, PgID# 5714-5718 (2014 List of Employees); *see also Stopp v. Mutual of Omaha Life Ins. Co.*, No. CIV-09-221-FHS, 2010 WL 1994899, at *1-*3 (E.D. Okla. May 18, 2010) (finding positions at a tribe's hotels, casinos, and restaurants to be commercial).

provisions to promote "ERISA's goal . . . of 'uniform national treatment of [ ] benefits'" and avoid "the anomaly that the same plan will be controlled by discrete regimes[.]" *Yates*, 541 U.S. at 17; *see also Helfman v. GE Group Life Assur. Co.*, 573 F.3d 383, 390 (6th Cir. 2009) (same). Indeed, as this Court has noted, "the ERISA policy of uniform regulation dictates a finding that a single plan may not be variously governed by both ERISA and state law depending on the particular employee in question." *Helfman*, 573 F.3d at 390. Accordingly, "if a benefits plan is an ERISA-qualified employee benefits plan in some circumstances, then it is an ERISA-qualified plan in *all* circumstances." *Arnold v. Lucks*, 392 F.3d 512, 519 (2d Cir. 2004)(emphasis in original).

If the district court's holding is not reversed, the Tribe's Plan and employees will be subject to unequal rights and remedies because one of its benefit structures will have to comply with ERISA and another with disparate state employee benefit law. This is precisely the outcome the Supreme Court and this Court have sought to avoid because it leads to "the anomaly that the same plan will be controlled by discrete regimes[.]" *Yates*, 541 U.S. at 17.

II. EVEN IF THE COURT CONCLUDES THERE WERE TWO DISTINCT PLANS, BCBSM WAS A FIDUCIARY UNDER ERISA FOR TRIBAL MEMBER CLAIMS.

The district court's determination on summary judgment that ERISA does not apply to Plan participants designated by BCBSM as Group 61672 is reviewed *de novo*. *Williams*, 227 F.3d at 710..

A. ERISA GOVERNS BECAUSE GROUP 61672 INCLUDES EMPLOYEES.

"In enacting ERISA, Congress designed a comprehensive system of regulating employee benefit plans in order to provide the maximum degree of protection to working men and women whose employers provide benefits." *Madonia v Blue Cross & Blue Shield of Va.,* 11 F.3d 444, 448 (4th Cir. 1993). (quotation omitted). To protect employees, ERISA governs any "employee benefit plan." 29 U.S.C. § 1003(a). An *employee benefit plan* includes an "employee welfare benefit plan." 29 U.S.C. § 1002(3).

Consistent with ERISA's goals, the Department of Labor has determined that an "employee welfare benefit plan" is governed by ERISA if *at least one employee* is a participant. 29 C.F.R. § 2520.3-3(b). The Department of Labor has noted that an employer's subjective intent has no bearing on whether an employee benefit plan is governed by ERISA:

> [T]he status of an arrangement as an employee benefit plan subject to title I coverage is not affected by the fact that the arrangement is limited to covering a single employee, is negotiated between the employer and employee, *or is not intended by the employer-plan sponsor to be an employee benefit plan for purposes of title I coverage.*

Pls.' Resp. to Def.'s Mot. Summ. J., RE 94-23, PgID# 5721 (U.S. Dep't of Labor, Letter to Joel P. Bennett, Oct. 22, 1985) (emphasis added). Courts have held that the Department of Labor's views on this issue carry "considerable weight." *See Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir. 1991) (citing the above opinion letter to conclude "a plan covering a single employee, where all other requirements are met, is covered by ERISA.").

ERISA applies to Plan participants designated as part of Group 61672 because the benefits provided to those participants were sponsored by an employer whose employees were Plan participants. BCBSM admits that between 100 and 218 employees of the Tribe were designated as part of Group 61672 over the relevant time period. *See* Def.'s Mot. Summ. J., RE 79, PgID# 3635.

Group 61672's non-employee participants fall squarely within the types of persons courts have found to be non-employee "participants" whose participation in the Plan does not take the Plan out of the protections of ERISA. *See, e.g.*, *Santino v Provident Life and Acs. Inc. Co.*, 276 F.3d 772, 775 (6th Cir. 2001); *Peterson*, 48 F.3d at 407. Congress intended "to provide the maximum degree of protection to working men and women' whose employers provide benefits."

Madonia, 11 F.3d at 448. The district court's reliance upon an intent-based test to determine whether Plan participants designated as Group 61672 received the benefit of ERISA's protections ignored administrative guidance that is due considerable weight, constituting reversible error.

B. BCBSM'S "SOVEREIGNTY" ARGUMENT HAS BEEN ADDRESSED BY CONGRESS AND HAS NO APPLICABILITY HERE.

For the same reasons that the district court's focus on the Tribe's sovereignty was immaterial with respect to whether the Tribe established one or two plans, tribal sovereignty is also not relevant as to whether, if there are two plans, participants designated as part of Group 61672 are protected by ERISA. *See* Section I(F), *supra.* The district court's summary elevation of the Tribe's sovereignty to a critical element of its holding was erroneous and constitutes reversible error.

C. THE TRIBE MAINTAINED BENEFITS FOR GROUP 61672 WITHIN THE SCOPE OF ERISA.

As discussed above, a plan may come within ERISA regardless of how it is "established" provided that it is "maintained . . . through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1).

The Tribe consistently maintained benefits for Plan participants designated by BCBSM as Group 61672 for the benefit of *all* participants designated as Group 61672, including over 100 tribal employees designated as part of this group. The

evidence in the record is clear that the Tribe "performed all the administrative functions associated with the maintenance" of the Plan related to Group 61672, including those administrative functions relating to over 100 employees of the Tribe designated as part of Group 61672. Regardless of the district court's determination of the purpose for which benefits for participants designated as Group 61672 was "established," the Tribe's ongoing maintenance of benefits for Plan participants designated by BCBSM Group 61672 renders Plan participants designated as part of Group 61672 subject to ERISA.

III. BCBSM BREACHED ITS FIDUCIARY DUTIES BY SYSTEMATICALLY SQUANDERING PLAN ASSETS BY PAYING CLAIMS IN EXCESS OF MEDICARE-LIKE RATES.

The district court's dismissal for failure to state a claim is reviewed *de novo*. *Williams*, 227 F.3d at 710.

A. AS AN ERISA PLAN FIDUCIARY, BCBSM OWES PLAINTIFFS THE STRICTEST AND HIGHEST FIDUCIARY DUTIES KNOWN TO LAW.

This Court has held that "the duties charged to an ERISA fiduciary are the highest known to the law." *Chaw v. Hall Holding Co.,* 25 F.3d 415, 426 (6th Cir. 2002). ERISA imposes "strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries." *Acres v. Palmer*, 71 F.3d 226, 229 (6th Cir. 1995). This "requires a plan fiduciary to act with the care, skill, prudence, and diligence of a prudent

person acting under similar circumstances" and to make "all decisions regarding an ERISA plan [] with an eye single to the interests of the participants and beneficiaries." *Pipefitters Local 636 Ins. Fund v. BCBSM*, 722 F.3d 861, 867 (6th Cir. 2013)(quotation omitted).

"ERISA adopted much of what the common law had, over time, come to require of fiduciaries. . . . [R]ather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility." *Clark v. Feder Semo and Bard, P.C.*, 739 F.3d 28, 31 (D.C. Cir. 2014)(quotation omitted); *see also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989)("ERISA abounds with the language and terminology of trust law. ERISA's legislative history confirms that the Act's fiduciary responsibility provisions codify and make applicable to ERISA fiduciaries certain principles developed in the evolution of the law of trusts")(quotations omitted).

ERISA not only generally adopts the law of trusts, it specifically identifies several duties that a fiduciary must meet. Among these fiduciary duties are:

1. BCBSM's fiduciary obligation to discharge its duties "solely in the interest of the participants and beneficiaries. . . ."; and

2. BCBSM's fiduciary obligation to discharge its duties "with the care, skill, prudence and diligence under the circumstances then prevailing that a

prudent man acting in a like capacity and familiar with such matters would use. . . ."

29 U.S.C. § 1104(1)(A)-(B).

B. PLAINTIFFS HAVE STATED A CLAIM THAT BCBSM BREACHED ITS FIDUCIARY DUTIES BY CAUSING PLAINTIFFS TO SYSTEMATICALLY OVERPAY HEALTH CARE CLAIMS ELIGIBLE FOR MEDICARE-LIKE RATES.

The district court held that although BCBSM was a fiduciary over the Plan, it had no duty to ensure that claims eligible for lower Medicare-Like Rates were paid for at the MLR rate. The district court reasoned that BCBSM had no such duty because ERISA does not explicitly incorporate the MLR regulations into the statutory text of ERISA, such that the district court held that BCBSM "does not owe a duty to the plan to comply with obligations extrinsic to the text of ERISA and the plan." Op. and Order, RE 22, PgID# 460.

On its face, this conclusion is nonsensical. The Tribe hired BCBSM to administer the its self-insured health care Plan. Plaintiffs relied on BCBSM (and paid BCBSM a *lot* of money) to process claims for medical services rendered to Plan participants. As the fiduciary administering the Tribe's self-insured Plan, it was BCBSM's job to determine, on behalf of the Tribe, whether or not a particular health care claim should be paid by Plaintiffs and, if so, how much the Plan should pay to the provider for the medical service rendered. It was BCBSM who directed

Plaintiffs to pay standard contract rates for medical claims that were eligible for lower Medicare-Like Rates. Am. Compl. ¶34, 136, RE 7, PgID# 68, 88.

BCBSM was required under the plain language of ERISA to make its decisions about whether to direct Plaintiffs to pay a health care claim, and how much to direct Plaintiffs to pay, with the best interests of the Plaintiffs in mind and in a manner that preserved Plan assets. BCBSM was also required under the plain language of ERISA to make its decisions about whether to direct Plaintiffs to pay a health care claim, and how much to direct Plaintiffs to pay, with the care, skill, prudence, and diligence of a prudent person.

A prudent person paying for the cost of a hospital visit would pay the lowest price possible to the hospital. If the hospital offered a discount to people who are indigent, elderly, or in this case American Indian, any prudent person would take advantage of that discount and pay the lowest possible rate for the medical services provided.

BCBSM did not do so. BCBSM was fully aware of the Medicare-Like Rate discounts available to Plaintiffs, yet routinely and systematically caused Plaintiffs to pay higher standard contractual rates for Contract Health Services that were eligible for a lower Medicare-Like Rate from the providing hospital. BCBSM squandered millions of dollars of Plan assets as a result. *Id.* ¶135, PgID#88. The

district court's conclusion that Plaintiffs' breach of fiduciary duty claims are somehow "extrinsic to the text of ERISA and the Plan" is simply incorrect.

C. THE DISTRICT COURT'S REASONING HAS BEEN REJECTED BY TWO OTHER EASTERN DISTRICT OF MICHIGAN JUDGES

In *Little River Band of Ottawa Indians v. BCBSM*, 183 F. Supp. 3d 835 (E.D. Mich. 2016), the Hon. David M. Lawson of the United States District Court for the Eastern District of Michigan specifically considered and rejected the argument that BCBSM had no fiduciary duty to ensure that the Plan paid lower Medicare-Like Rates on claims eligible for Medicare-Like Rates:

> Where the plaintiffs also allege that Blue Cross knew that the payments should have been capped [at Medicare-Like Rates], and that it nevertheless paid medical providers at rates higher than those allowed by law, that is a sufficiently plausible allegation that the defendant failed to perform its duties diligently to make all decisions regarding an ERISA plan with an eye single to the interests of the participants and beneficiaries and to act with the care, skill, prudence, and diligence of a prudent person acting under similar circumstances.
>
> ***
>
> The complaint sufficiently alleges an overpayment theory based on Blue Cross's obligation to avoid squandering Plan assets on the cost of services that should have been capped at Medicare-Like Rates.
>
> The plaintiffs have alleged sufficient facts to establish a right to relief on their ERISA claims.

Little River Band, 183 F. Supp. 3d 843-44 (quotations and citations omitted).

Similarly, in *Grand Traverse Band of Ottawa and Chippewa Indians v. BCBSM*, No. 14-cv-11349, 2017 WL 3116262 (E.D. Mich. Jul. 21, 2017), the Honorable Judith E. Levy also rejected the district court's analysis below:

> In this case, plaintiffs have made allegations similar to those considered by the *SCI Tribe* court. But construing the complaint in the light most favorable to plaintiffs, the allegations do not assert a fiduciary duty to obtain MLR, but instead a fiduciary duty to, among other things, preserve plan assets and make decisions with the care of a prudent person, which, as set forth above, are established fiduciary duties.
>
> ***
>
> The Court agrees with Judge Lawson's analysis [in *Little River Band*]. Plaintiffs in this case allege that defendant failed to act as a prudent person, to preserve plan assets, and act for the exclusive purpose of providing benefits to beneficiaries – in other words, breached a fiduciary duty – by failing to pursue an avenue to significantly reduce payments by the Plan (in this case "systematically fail[ing] to take advantage of MLR discounts available to Plaintiffs" despite knowing the regulations required providers to accept MLR as full payment even where the parties had negotiated service rates).
>
> ***
>
> [A]s the Supreme Court has recognized, "[t]here is more to plan (or trust) administration than simply complying with the specific duties imposed by the plan documents or statutory regime; it also includes the activities that are 'ordinary and natural means' of achieving the 'objective' of the plan." *Varity Corp. v. Howe*, 516 U.S. 489, 504 (1996). Here, although the plan does not expressly require pursuit of MLR, it is plausible that, in deciding whether to pay claims and whether the negotiated rate should apply, defendant should have requested the provider accept MLR as payment in full as an "ordinary and natural means" of preserving plan assets and providing benefits to plan beneficiaries. Accordingly, defendant's motion to dismiss on this ground is denied.

Grand Traverse Band, 2017 WL 3116262, at * 3-4.

This Court should adopt the well-reasoned analysis on this issue of Judges Lawson and Levy in their opinions in *Little River Band* and *Grand Traverse Band* and reverse the district court's ruling.

IV. THE DISTRICT COURT ERRED IN GRANTING SUMMARY JUDGMENT ON PLAINTIFFS' BREACH OF FIDUCIARY DUTY CLAIMS RELATED TO PGIP.

This Court "review[s] the district court's grant of summary judgment in an action involving an ERISA claim *de novo*." *Williams*, 227 F.3d at 710. On a review of a motion for summary judgment, the district court "may not make credibility determinations or weigh the evidence." *Adams v. Metiva*, 31 F.3d 375, 379 (6th Cir. 1994).

The lynchpin of the district court's analysis on PGIP was the district court's finding that Plaintiffs did not pay an *additional* amount *because of* PGIP. *See, e.g.,* Op. and Order, RE 112, PgID# 6288 ("Simply put, the Tribe has not established that it was charged additional amounts *because of* PGIP, as opposed to because of the yearly fee increase (which the Tribe does not challenge)"). However, there is *significant* evidence in the record hat the Tribe did pay additional amounts because of PGIP, such that summary judgment in favor of BCBSM was inappropriate.

A. 2005: PLAINTIFFS PAID AN EXTRA AMOUNT SOLELY ATTRIBUTABLE AND SOLELY BECAUSE OF PGIP.

For 2005, the district court's finding is directly contradicted by the record. PGIP was an *additional* cost paid by Plaintiffs that Plaintiffs would not have otherwise paid. BCBSM expressly admitted that PGIP was an additional fee.

> Beginning July 1, 2004, physicians will receive an average 2 percent increase in the BCBSM maximum payments for most procedures. **Also, an additional 0.5 percent increase in payments will be used to fund the Physician Group Incentive Payment Program** that will be effective Jan. 1, 2005.

Pls.' Mot. Summ. J., RE 82-9, PgID# 4479 (BCBSM Publication, June 2004) (emphasis added).

BCBSM's internal notice for the initial implementation of PGIP also made clear that the 0.5 percent increase for PGIP was an additional fee:

> Services rendered – Approved amount with fee update is $100[;] – ***Approved amount with the added incentive is $100.50***.

Pls.' Mot. Summ. J., RE 82-8, PgID# 4476 (Jan. 3, 2005, Letter). As BCBSM explained in an internal email:

> PGIP is an amount for physician incentive ***added into the amount due*** on the claim and as such should be charged to the group. . . . Thus the PGIP amount on an individual claim would not be included in the amount paid to the provider (***just like ASC access fee*** on the Local side is not part of the amount paid to the provider, but it is still the group's liability).

Pls.' Mot. Summ. J., RE 82-6, PgID# 4470-4472 (10/4/2007 Garofali E-mail (emphasis added)).

Moreover, at the end of 2005, BCBSM deducted $11,273 from Plaintiffs' Michigan Savings Refund for PGIP. *See* Michigan Savings Refund Settlement, Pls.' Mot. Summ. J., RE 82-11, PgID# 4493. This occurred *after* Plaintiffs paid for their professional claims throughout the year.

The district court acknowledged that "[t]he language of the January 3, 2005, letter does suggest that the PGIP payment was *added onto* the yearly fee update, as opposed to contained within it." Op. and Order, RE # 112, PgID# 6230. However, the district court dismissed that evidence based on the deposition testimony of a BCBSM witness and a self-serving declaration from the author of one of the BCBSM internal emails who tried to explain away how BCBSM operated PGIP. *See id.*, PgID# 6230-31.

Problematically for BCBSM, the deposition testimony showed that its witness did not know if her recollection of how PGIP operated was consistent with the January 3, 2005 letter.[1] Pls.' Mot. Summ. J., RE 82-10, PgID# 4489 (Nieman 30(b)(6) Dep. at 33-34). Furthermore, any testimony stating that PGIP did not additionally increase fees is clearly contradicted by BCBSM's own representations. *See* Pls.' Mot. Summ. J., RE 82-9, PgID# 4479 (BCBSM Publication, June 2004). At a minimum, there are genuine issues of material fact that render summary judgment in favor of BCBSM wholly inappropriate.

B. 2006 TO PRESENT: GENUINE ISSUES OF MATERIAL FACT EXIST.

As explained above, after 2005, BCBSM paid for the PGIP program by automatically including the PGIP amounts in Plaintiffs' professional claims cost. However, the district court found that the undisclosed, not-agreed-to, PGIP amounts were legal because the amount contributed to PGIP was built into the Fee Update, and the Fee Update was purportedly determined without regard to how much the PGIP allocation would be. *See* Op. and Order, RE 112, PgID# 6227.

Again, the district court ignored significant evidence in the record on the issue. BCBSM's corporate representative plainly stated that whenever the PGIP allocation was changed, BCBSM *did* discuss that in connection with the Fee Update:

> Q: Okay. Just to clarify that, when you were changing the PGIP allocation amount you were discussing that in connection with the fee schedule update?
> A: Right.

Pls.' Mot. Summ. J., RE 79-24, PgID# 3686 (Simmer Dep. 67:3-12).

The district court's conclusion that PGIP played no role in increasing Plaintiffs' professional claims cost simply ignores the testimony of BCBSM's own corporate representative which creates a genuine issue of material fact for trial.

C. PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT FOR PGIP SHOULD HAVE BEEN GRANTED FOR 2005.

1. BCBSM Was A Fiduciary When It Secretly Collected PGIP Fees.

Plaintiffs challenge to the PGIP fee is virtually identical to the Plaintiffs' challenge to the OTG fee charged by BCBSM in *Pipefitters*. There, BCBSM paid a "Medigap obligation" to the state of Michigan. *Pipefitters*, 722 F.3d at 866. "**[BCBSM] chose to collect the funds necessary to cover its Medigap obligation to the state by assessing the OTG fees to its customers.**" *Id.* (emphasis added) "[BCBSM] was an ERISA fiduciary with respect to Defendant's collection of the OTG fee from Plaintiff." *Id.*

Here the action subject to the complaint is BCBSM's scheme to mark up claims without permission and without reporting the mark-ups to Plaintiffs. Even if BCBSM was required to pay PGIP bonuses (as it was required to pay the OTG in *Pipefitters*), "[BCBSM] chose to collect the funds necessary to cover its [PGIP] obligation to [physicians] by assessing the [PGIP allocation] to its customers." *See Pipefitters*, 722 F.3d at 866. And it did so secretly.

"Under ERISA, an entity that exercises *any* authority or control over disposition of a plan's assets becomes a fiduciary." *Id.* at 865 (quotation omitted). "BCBSM was a fiduciary when it allocated the Disputed Fee from plan assets itself. By accepting deposits from Plaintiffs for the purpose of paying health

claims, Blue Cross exercised practical control over an ERISA plan's money." *Hi-Lex Controls Inc. v. BCBSM*, No. 11-12557, 2013 WL 22854553, at *20 (E.D. Mich. May 23, 2013) (quotation omitted). Here, BCBSM accepted Plaintiffs' deposits, and then had complete control and discretion over what would be contributed to PGIP. BCBSM was a fiduciary in collecting PGIP fees.

2. BCBSM Violated ERISA.

ERISA Section 1106(b)(1) sets forth "an absolute bar against self-dealing." *Brock v. Hendershott*, 840 F.2d 339, 341 (6th Cir. 1988). "A third-party administrator engages in self-dealing when it marks up insurance premiums when charging expenses to an ERISA plan." Pls.' Mot. Summ. J., RE 81-2, PgID# 4016 (*Hi-Lex*, FFCL ¶ 199) (citing *Patelco Credit Union v. Sahni*, 262 F.3d 897, 911 (9th Cir. 2001)). "A fiduciary also engages in self-dealing by 'determin[ing] his own administrative fees and collect[ing] them himself from the Plan's funds.'" *Id.* (*Hi-Lex* FFCL ¶ 200) (quoting *Patelco*).

Here, BCBSM unilaterally marked-up Plaintiffs' professional claims to cover the expenses for PGIP. BCBSM determined the amount that it needed for PGIP, collected that amount from Plaintiffs *in addition to* the amounts Plaintiffs already paid, and then used that amount to pay bonuses to physicians. Plaintiffs never agreed to pay for PGIP and were never told about PGIP. Instead of using the disclosed administrative fee that Plaintiffs already paid to subsidize PGIP, BCBSM

required Plaintiffs to pay additional plan-asset money to fund BCBSM's bonus program. *See Hi-Lex*, 2013 WL 2285453, at *22, ¶ 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).").

As was the case in *Hi-Lex*, Plaintiffs do not need to prove anything else to establish a violation of Section 1106(b)(1):

> 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). . . . 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; . . . . 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).

See Op. and Order, RE 112, PgID# 4758 (*Hi-Lex*, 9/7/2012 Order Granting Summ. J. In Part).

The fact that BCBSM did not *directly* retain the PGIP amounts collected from Plaintiffs does not negate their illegality. In *Pipefitters*, BCBSM used all of the OTG fee to pay for its Medigap obligation to the State of Michigan, but this Court still held that the OTG fee to violated ERISA. *See Pipefitters*, 722 F.3d at 868 ("By discretionarily setting the OTG fee and using those funds to fulfill its Medigap obligation to the State of Michigan, [BCBSM] ran afoul of both ERISA's fiduciary duties under § 1104(a) and its prohibition against self-dealing under §

1106(b)(1)."). Summary Judgment should have been entered in favor of Plaintiffs for PGIP fees for 2005.

V. THE DISTRICT COURT ERRED REGARDING THE PREJUDGMENT INTEREST COMPONENT OF PLAINTIFFS' DAMAGES.

The award of prejudgment interest as a component of Plaintiff's damages is reviewed for abuse of discretion. A district court "abuses its discretion if it denies a prevailing ERISA benefit claimant's request for prejudgment interest, absent exceptional or unusual circumstances." *Leonard v. Southwestern Bell Corp. Disability Income Plan*, 408 F.3d 528, 533 (8th Cir. 2005) (citing *Children's Broad. Corp. v. Walt Disney Co.*, 357 F.3d 1094, 1102-03 (6th Cir. 1993)).

Courts award prejudgment interest on wrongfully withheld money because "[a]ny additional time one gains, rightfully or wrongfully, in not having to submit payment of a sum of money owed another is without a doubt a benefit" and the harmed party "has been deprived of the benefit of those payments." *Tiemeyer v. Cmty. Mutual Ins. Co.*, 8 F.3d 1094, 1102 (6th Cir. 1993) (quotation omitted).

Allowing defendant "to retain the interest it earned on funds wrongfully withheld from a beneficiary would be to approve of an unjust enrichment." *Id.* This Court has warned that "[r]elieving defendants from the payment of prejudgment interest would create an incentive for insurers to delay payment and would

undercompensate victims by forcing them to absorb expenses incurred as a result of the delay." *Id.* at 1094 (citation omitted).

"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, 686 (6th Cir. 2013). Without an award of prejudgment interest "the relief granted would fall short of making the beneficiary whole because he has been denied the use of money which was his." *Id.* Otherwise, BCBSM will benefit from "what amounts to an interest free loan procured as a result of illegal activity." *SEC v. Moran*, 944 F. Supp. 286, 295 (S.D.N.Y. 1996).

Here, the district court abused its discretion by failing to award Plaintiffs prejudgment interest. BCBSM's liability for illegally charging hidden access fees to Plaintiffs has been determined by the district court and has not been appealed by BCBSM. Plaintiffs consistently pursued prejudgment interest in the district court. The district court did not identify any "exceptional or unusual circumstances" that would warrant the denial of Plaintiffs' claim for prejudgment interest damages.

CONCLUSION

The Appellants request that the Court reverse the District Court's dismissal of Plaintiffs' "MLR claim" (RE 22), reverse the District Court's entry of partial summary judgment in favor of BCBSM (RE 112), enter partial summary judgment

in favor of Plaintiffs on their PGIP claim for 2005, and remand the matter to the district court for further proceedings.

Respectfully submitted,

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Date: October 10, 2017

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CERTIFICATE OF COMPLAINCE

Pursuant to FRAP 32(a)(7)(C), I hereby certify that the foregoing Appeal Brief (exclusive of content excluded pursuant to FRAP 32(a)(7)(B)(iii) and 6th Cir. R. 32(b)) contains 12,812 words, per the word processing software used to prepare the brief.

Date: October 10, 2017

By: s/ Bryan R. Walters
Bryan R. Walters (MI Bar #P58050)

CERTIFICATE OF SERVICE

I, Bryan R. Walters, do hereby certify that on this 10th day of October, 2017, I electronically filed the foregoing document with the Clerk of the Court using the ECF system.

Date: October 10, 2017

By: s/ Bryan R. Walters
Bryan R. Walters (MI Bar #P58050)

DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

Appellants state that all relevant documents to this appeal are part of the electronic record in the Eastern District of Michigan, Southern Division. To facilitate the Court's reference to the electronic record, said documents, as referred to herein above, are as follows:

RECORD ENTRY #	DESCRIPTION OF DOCUMENT	PAGE ID#
1	Complaint	1-53
7	Amended Complaint	60-112
18	Plaintiffs' Response to Motion to Dismiss Plaintiff's First Amended Complaint Pursuant to FRCP 12(b)(6)	218-285
22	Opinion and Order Granting Motion to Dismiss, Dismissing Counts I & III-IX of Amended Complaint with Prejudice	455-464
79	Defendant's Motion for Partial Summary Judgment	3110-3923
81	Plaintiffs' Motion for Partial Summary Judgment	3932-4367
82	Exhibit to Record Entry 81 *(20- 46)* Plaintiffs' Motion for Partial Summary Judgment	4368-4637
87	Exhibit *Formerly Marked Confidential* re Plaintiffs' Motion for Partial Summary Judgment	4683-4740
94	Exhibit *11-23* re Plaintiffs' Response to Motion for Partial Summary Judgment	5616-5721
112	Opinion and Order Granting in Part Defendant's Motion for Partial Summary Judgment, Granting in Part Plaintiff's Motion for Partial Summary Judgment and Denying as Moot, Motion in Limine	6200-6232
113	Judgment	6233-6234

RECORD ENTRY #	DESCRIPTION OF DOCUMENT	PAGE ID#
114	Notice of Appeal	6235

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