UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

SAGINAW CHIPPEWA INDIAN TRIBE AND ITS EMPLOYEE WELFARE PLAN,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 16-cv-10317

Honorable Thomas L. Ludington

Mag. Judge Patricia T. Morris

BLUE CROSS BLUE SHIELD OF MICHIGAN'S MOTION FOR SUMMARY JUDGMENT

Defendant Blue Cross Blue Shield of Michigan ("BCBSM") moves for summary judgment on the three remaining Medicare-Like Rate ("MLR") claims asserted by Plaintiffs Saginaw Chippewa Indian Tribe of Michigan (the "Tribe") and its Welfare Benefit Plans, including the "Employee Plan" and the "Member Plan" (collectively, the Employee Plan and Member Plan are referred to as the "Plans"). As discussed in detail in the accompanying Brief in Support, summary judgment with respect to each such claim is appropriate.

In accordance with L.R. 7.1, the undersigned states that there was e-mail correspondence between the parties' counsel, in which counsel for BCBSM

explained the nature of the motion and its legal basis and requested but did not obtain concurrence in the relief sought.

WHEREFORE, BCBSM respectfully requests that the Court grant BCBSM's motion, dismiss with prejudice each of Plaintiffs' remaining claims, and award to BCBSM its attorney's fees and costs under 29 U.S.C. § 1132(g)(1).

Respectfully submitted,

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BRIEF IN SUPPORT OF
BLUE CROSS BLUE SHIELD OF MICHIGAN'S
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ISSUES PRESENTED

1. Should the Court dismiss Plaintiffs' remaining claims in their entirety where only the Tribe's CHS program was eligible for Medicare-like rates ("MLR"); and the Tribe's Employee Plan and Member Plan were not MLR eligible because they were separate and distinct from the Tribe's CHS program?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

2. Should the Court dismiss Plaintiffs' ERISA breach of fiduciary duty claim related to the Employee Plan because the Tribe had actual knowledge by 2007 or 2008 that BCBSM did not process claims at MLR, and therefore the statute of limitations bars the cause of action?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

3. Should the Court dismiss Plaintiffs' ERISA breach of fiduciary duty claim because: (i) the Tribe's design of its Employee Plan did not provide BCBSM any discretion to apply MLR; (ii) ERISA does not impose any fiduciary duties with regard to how BCBSM designs and maintains its provider networks and corresponding network rates; and (iii) BCBSM lacked necessary information regarding the Tribe's CHS program?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

4. Should the Court dismiss Plaintiffs' Health Care False Claim Act ("HCFCA") claim because: (i) the healthcare claims of the Member Plan were never "false"; and (ii) BCBSM never "presented or caused to be presented" to Plaintiffs a single claim, both of which are required elements under the HCFCA?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

5. Should the Court dismiss Plaintiffs' common-law breach of fiduciary duty claim where the ASC establishing the Member Plan expressly permitted BCBSM to do precisely that which BCBSM did, and so under Michigan law no common-law fiduciary duty claim can exist?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

CONTROLLING OR MOST APPROPRIATE AUTHORITY

Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

42 C.F.R. § 489.29

42 C.F.R. § 136.30

29 U.S.C. § 1113

Larson v. United Healthcare Ins. Co., 723 F.3d 905 (7th Cir. 2013)

Calhoun Cnty v. BCBSM, 297 Mich. App. 1; 824 N.W.2d 202 (2012)

Mich. Comp. Laws § 752.1002

Mich. Comp. Laws § 752.1009

I. INTRODUCTION

Despite Plaintiffs' allegations to the contrary, BCBSM did not administer the Saginaw Chippewa Indian Tribe of Michigan's (the "Tribe") Contract Health Services ("CHS") program. This fact dooms Plaintiffs' Medicare-like rates ("MLR") claims, because only the CHS program is entitled to MLR.

The Tribe contracted with BCBSM *not* to administer a CHS program, but to simply process and pay medical claims of the Tribe's two welfare benefit plans—the "Member Plan" and the "Employee Plan" (collectively, the "Plans")—at BCBSM's discounted network rates. By the Tribe's own design, and as the Tribe knowingly intended, the Plans were completely separate from its CHS program. The Tribe consciously chose to treat the Plans as "alternate resources" that must first be exhausted before the CHS program paid for anything. Simply stated, because the Plans were never entitled to MLR, each of Plaintiffs' claims fail.

Plaintiffs' MLR claims also fail for many other reasons. Plaintiffs' ERISA claim is time-barred by ERISA's three-year "actual knowledge" statute of limitations. The Tribe learned of the MLR regulations no later than 2008, and the Tribe always had actual knowledge of BCBSM's conduct (*i.e.*, not paying claims at MLR), making Plaintiffs' January 2016 lawsuit untimely. The HCFCA claim fails because BCBSM never "presented or caused to be presented" to Plaintiffs a single claim, failing to satisfy a required element of that cause of action. Moreover, any

claims purportedly presented by BCBSM were never "false." Last, Plaintiffs' Common-Law Breach of Fiduciary Duty claim fails because the contracts between Plaintiffs and BCBSM expressly permitted BCBSM to do what BCBSM did, and so no common-law fiduciary duty claim can exist.

The undisputed facts, evidence, and law demonstrate that Plaintiffs' lawsuit is baseless and the Court should grant to BCBSM summary judgment.

II. FACTUAL BACKGROUND

A. The Tribe Contracted With BCBSM For Access To BCBSM's Network And Its Corresponding Network Rates

During the relevant timeframe,[1] the self-funded Plans were governed by two separate but nearly-identical Administrative Services Contracts ("ASCs"). Each provides: "BCBSM shall administer [the Tribe's] health care Coverage(s) in accordance with BCBSM's standard operating procedures.…" ASCs, ECF Nos. 79-3 and 79-4, Article II.A, PgID.3163 and 3181. BCBSM's "standard operating procedures" include the processing and payment of claims at discounted "network rates" negotiated by BCBSM with its network of healthcare providers (*e.g.*, hospitals). Harvey Dec., Ex. 1, ¶ 6. BCBSM negotiates "network rates" for its *entire business*, without regard to any particular customer or plan. *Id.* at ¶ 5. *Accord*

[1] Background regarding the parties' relationship and the Tribe's Plans is set forth in this Court's April 26, 2019 Opinion. ECF No. 146, Sec. II(A), PgID.7786-90. Some additional facts are here appropriate.

DeLuca v. BCBSM, 628 F.3d 743, 747 (6th Cir. 2010) (BCBSM does not maintain its network "on a plan-by-plan basis," but rather for its entire business).

Plaintiffs always knew that BCBSM applied its network rates for all claims paid by BCBSM. *See, e.g.*, Sprague Dep., Ex. 2, 8:12-10:20 (admitting to an understanding of BCBSM's network and corresponding discounted rate); 15:2-12 ("Q. … You understand that the discounted rate that [BCBSM] … provid[ed] to the Tribe is whatever rate [BCBSM] has negotiated with the provider in question, yes? … A. Yes. ….") (objections omitted); 18:25-19:5 ("Q. And so, at all times while the Tribe was obtaining coverage through [BCBSM], you knew that [BCBSM] was able to provide to the Tribe discounts because of the network that [BCBSM] had developed through its providers, yes? A. Yes."). Network rates aside, access to BCBSM's vast provider network was itself an important reason the Tribe chose BCBSM. *Id*. at 20:11-21:7 ("[T]here's a process at looking at carriers and it involves more than looking at rates[.] It's based on services available … across the U.S.…"). With this knowledge and for these reasons, the Tribe renewed the ASCs each year from 2004 through 2016. *Id.* at 63:12-24; Schedule "A"s and Sample Renewals, ECF Nos. 79-6, 79-7, 79-8, 79-9.

BCBSM processed the medical claims of the Plans. But BCBSM never presented to Plaintiffs any medical claim for payment. Healthcare providers presented to BCBSM the claims, BCBSM processed and paid those claims on a

claim-by-claim basis, and the Tribe subsequently reimbursed BCBSM (and did so in the aggregate, rather than on a claim-by-claim basis). Reger Dep., Ex. 3, 40:14-41:5; Sprague Dep., Ex. 2, 32:24-34:17; 34:19-25 ("[Y]ou would agree that [BCBSM] never presented to the Tribe individual medical claims, correct? … Correct.") (objections omitted); *see also* Sample Quarterly Settlements, ECF Nos. 79-18 and 79-19; ASCs, ECF Nos. 79-3 and 79-4 ("The responsibilities of BCBSM pursuant to this Contract are limited to providing administrative services for the processing *and payment of claims*.") (emphasis added); *Calhoun Cnty v. BCBSM*, 297 Mich. App. 1, 5; 824 N.W.2d 202 (2012) (pursuant to the ASC "plaintiff reimburses [BCBSM] on a weekly basis for the medical claims submitted by its employees").

The Employee Plan was at all times funded by the Tribe's Fringe Internal Service Fund ("ISF"), "a fund … created and established for the sole purpose of taking care of employee benefits throughout the organization." Reger Dep., Ex. 3, 10:11-23; *see also* Order Granting In Part MSJ, ECF No. 112, PgID.6203-04. Funding for the Tribe's Fringe ISF included employee contributions. Reger 2017 Dep., Ex. 4, 21:19-25 and 25:2-6. The Member Plan was at all relevant times funded by the Gaming Trust. *Id.* at 11:8-20; Reger Dep., Ex. 3, 8:17-10:10. The Gaming Trust consists of gaming revenue generated by the Tribe's resort (but *not* Indian

Health Service ("IHS") monies). Reger 2017 Dep., Ex. 4, 15:12-16:17; Reger Aff., ECF No. 97-7, ¶ 7.

B. The MLR Regulations -- Enacted In 2007 -- Apply Only To Services Paid For By CHS Programs With CHS Funds

The history and background surrounding the MLR implementing statute and accompanying regulations are set forth in the Court's April 26, 2019 Opinion, and will not be repeated here. ECF No. 146, Section II.B, PgID.7790-95. In short, however, Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") (PL 108-173 (HR 1)) requires that Medicare-participating hospitals accept the payment methodology and payment rates set forth in the later-enacted 2007 MLR regulations (*e.g.,* MLR). However, per those regulations, hospitals are only required to accept MLR for medical care authorized and purchased by a CHS program. *Id.*; *see also* 42 C.F.R. § 489.29; 42 C.F.R. § 136.30 (b); July 30, 2013 IHS Corr., Ex. 5.

C. The Tribe Administered A CHS Program Completely Separate And Distinct From The Plans

IHS is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indians.[2] IHS provides direct, on-site health services when possible—through IHS and tribally-

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[2] *See* IHS Agency Overview, Ex. 6, *available at* https://www.ihs.gov/aboutihs/overview/ (last accessed on February 27, 2020).

operated hospitals, clinics, and health stations.[3] When needed services are not available on-site (directly), patients are referred to off-site providers. This is known as Contract Health Services ("CHS"), *i.e.*, "health services provided at the expense of [IHS] from public or private medical or hospital facilities. . . ." 42 C.F.R. § 136.21 (e).[4]

The Indian Self-Determination and Education Assistance Act ("ISDEAA") created a framework for tribes to enter into contracts and compacts with the United States to take on responsibility for their own CHS programs. *See Rancheria v. Hargan*, 296 F.Supp.3d 256, 260 (D.D.C. 2017) ("Under a self-determination contract, the federal government supplies funding to a tribal organization, allowing [the Tribe] to plan, conduct and administer a program or service that the federal government otherwise would have provided directly.") (quotation and citation

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[3] For example, the Tribe has on-site its Nimkee Medical Clinic (the "Clinic"), which provides direct health care to members of the Tribe, Direct Descendants of the Tribe and members of other U.S. Federally Recognized Tribes living in the Tribe's five-county service area (Isabella, Clare, Midland, Missaukee, and Arenac Counties). Fox Dep., Ex. 7, 30-31; *see also* Nimkee Medical Clinic Mission Statement, Ex. 8, *available at* http://www.sagchip.org/nimkee/medicalClinic/mission.aspx#.XkIY2GeWwdU (last accessed on February 27, 2020).

[4] In January 2014, the Consolidated Appropriation Act of 2014 (Pub. L. 113-76, 128 Stat. 5) renamed CHS to Purchased/Referred Care ("PRC"). However, all policies and practices remain the same. For consistency in this brief, "CHS" is used where "PRC" would also be appropriate.

omitted, alteration in original).[5] Pursuant to the ISDEAA, the Tribe executed a self-determination contract for the Tribe to plan, conduct, and administer its own CHS program, and IHS provides federal funding to the Tribe for use in the same. Am. Compl., ECF No. 7, ¶¶ 4-5; *see also* Sept. 27, 2019 Walters Corr., ECF No. 154-5, PgID.7917 (acknowledging that the Tribe, and not BCBSM, carries out a CHS program per the ISDEAA).

In addition to dollars received from IHS, the Tribe designates its own (limited) "tribal supplement" dollars to fund its CHS program (collectively, IHS and tribal supplement funds are referred to in this brief as "CHS Funds"). Reger Dep., Ex. 3, 12:7-12, 32:9-25; Raphael Dep., Ex. 9, 18:11-12, 20; Elliott Dep., Ex. 10, 9:15-19; Fox Dep., Ex. 7, 105-107; Reihl Dep., Ex. 11, 45:2-12; *see also* 25 U.S.C. § 5386(e) (tribes may redirect funds for compacted programs).

To be eligible, a patient seeking off-site care through the Tribe's CHS program must: (1) be a member of the Tribe or a descendant of a Tribal member, or

[5] "Self-determination" means giving an "effective voice" to Indian tribes "in the planning and implementation of programs for the benefit of Indians which are responsive to the true needs of Indian communities." 25 U.S.C. § 5301(a)(1); *see also* 25 U.S.C. § 5302(b) (self-determination "permit[s] an orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services").

a member of another Tribe;[6] (2) reside within the Tribe's five-county service area; and (3) have some type of insurance or other health care coverage, *i.e.,* an "alternate resource," that must first be exhausted. Fox Dep., Ex. 7, 29-32; Elliott Dep., Ex. 10, 9; Raphael Dep., Ex. 9, 12. Assuming patient eligibility, the Tribe imposes the following procedure for obtaining CHS-funded care from an off-site provider: (1) the CHS-eligible patient must first obtain a "purchase order" or "referral"[7] from the Tribe's CHS program (Robinson Dep., Ex. 13, 11:3-12:15); (2) the patient must then provide the referral to the off-site provider at the time of service (*Id*. at 20:21-21:1; Fox Dep., Ex. 7, 34:24-35); (3) the provider must then present its bill, or "claim," to any payer the Tribe designates as an "alternate resource" for payment *before* seeking payment from the Tribe's CHS program (*Id*. at 35-36);[8] and, finally (4) if the patient still owes a balance, including a co-pay, deductible, etc., the patient may present to

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[6] In three limited circumstances, non-Indians are also eligible for CHS. IHS CHS FAQs, Ex. 12, *available at* https://www.ihs.gov/prc/frequently-asked-questions-faq-s/#q15 (last accessed on February 27, 2020).

[7] The Tribe's CHS program refers to "purchase orders" under 42 C.F.R. § 136.24 (a) as "referrals." *See* ECF No. 154-10 (identifying documents within those Bates-labelled SCIT071208 - SCIT074607 as "purchase orders"); Elliott Dep., Ex. 10, 18-19 (identifying SCIT073053 as a "referral" from the Tribe's CHS program).

[8] The Tribe's CHS program is the "payor of last resort" and therefore all alternative (re)sources of payment for which an Indian is eligible must be exhausted before CHS. 42 C.F.R. § 136.61; *see also* Fox. Dep., Ex. 7, 32:6-15, 33:9-13; Raphael Dep., Ex. 9, 44:3-21; Elliott Dep., Ex. 10, 33:3-19; Robinson Dep., Ex. 13, 55:25-56:18.

the CHS program his or her bill for payment of that balance. *Id*. at 36:23-37:5; Elliott Dep., Ex. 10, 40:15-41; Raphael Dep., Ex. 9, 30:8-14; Robinson Dep., Ex. 13, 22:18-23:14; *see also* August 23, 2012 E-mail Chain, Ex. 14 (if patient is "referred out for services [through CHS] then [the Tribe's CHS program] will … cover the co-pays and deductibles").

As an undisputed factual matter, the Tribe designed its CHS program to always treat each Plan as an "alternate resource."[9] *See, e.g.*, Fox Dep., Ex. 7, 37:6-38:15, 42:19-25, 66:20-25; Raphael Dep., Ex. 9, 43-45, 51:9-15; Reihl Dep., Ex. 11, 26:6-28:8, 32:11-33:15, 36:1-20, 41:19-42:1, 44:10-18. Thus, per the Tribe's own, very-deliberate design, the Tribe ensured that the Plans would always pay first, before the Tribe expended any CHS Funds through its CHS program, thereby stretching its CHS Funds as far as possible. *See* Elliott Dep., Ex. 10, 33:3-19. In fact, if a CHS-eligible patient obtained a referral but then failed to present his or her BCBSM insurance card to the provider, the Tribe would take the corresponding medical bill and "send that to [BCBSM] to ensure that [BCBSM] paid first." Ayling Dep., Ex. 15, 47:24-48 ("Q. So you would present the bill to [BCBSM] and ask that [BCBSM] pay on the bill first, correct? A. Yes.").

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[9] "Alternate resources means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to … Medicare, Medicaid[], State or local health care programs, and private insurance." 42 C.F.R. § 136.61(c).

Critically, then, the Tribe always maintained its CHS program completely separate, distinct, and independent from the Plans. *See, e.g.*, Elliott Dep., Ex. 10, 49-52 (testifying that she never discussed CHS eligibility with the Tribe's benefits department, which managed the Plans, and that the CHS program and the benefits department were entirely separate); Kamai Dep., Ex. 16, 105:23-106:22 and 108:3-23 (Gallagher Benefits Services ("Gallagher"), the Tribe's agent for the Plans, was *not* the Tribe's agent with respect to the Tribe's CHS program, which was entirely "separate," and the Plans were in place to "provide benefits above and beyond what CHS offered"); Sprague Dep., Ex. 2, 53:2-54:4, 67-69; Reger Dep., Ex. 3, 60-62; Quigno-Grundahl Dep., Ex. 17, 35:8-36:21; Raphael Dep., Ex. 9, 38:4-12; Ayling Dep., Ex. 15, 29:7-9; Robinson Dep., Ex. 13, 38-40; Fox Dep., Ex. 7, 59:12-60:5. Indeed, "[t]he [P]lans were never based on any coordination with any program," including the CHS program. Sprague Dep., Ex. 2, 69:8-20. Notwithstanding this lawsuit and the Tribe's switch in 2017 from BCBSM to Cofinity, the Plans' separateness from the CHS program remains unchanged today. *See*, *e.g.*, *id*. at 53:2-54:4; Reger Dep., Ex. 3, 10:24-11:8; *see also* Fox Dep., Ex. 7, 54:12-55:9 (the Tribe's CHS program continues to treat the Plans as alternate resources to the Tribe's CHS program, such that, by design, the Plans pay *first*).

In light of the Plans' separateness from the Tribe's CHS Program, BCBSM never had access to any information regarding the Tribe's CHS program. For

example, the Tribe never provided to BCBSM any "referral" documents, or identified for BCBSM those individuals enrolled in the Tribe's CHS program. *See, e.g.,* Fox (Executive Health Director) Dep., Ex. 7, 70:1-10, 73:11-74:3; Reger (Controller) Dep., Ex. 3, 42:25-44:9; Pelcher (Benefits Specialist) Dep., Ex. 18, 17-19; Reihl (former CHS Clerk) Dep., Ex. 11, 67:23-68:12; Elliott (CHS Clerk) Dep., Ex. 10, 49-50; Davis (Tribal Administrator) Dep., Ex. 19, 32-33; Mosqueda (Assistant Tribal Administrator) Dep., Ex. 20, 42:22-43:9; Quigno-Grundahl (former Tribal Council Member and former Assistant Health Administrator) Dep., Ex. 17, 32-34; Sprague (Benefits Manager) Dep., Ex. 2, 67-68; Raphael (Interim Assistant Health Administrator) Dep., Ex. 9, 71-73; Ayling (Elders Advocate) Dep., Ex. 15, 28-29; *see also* Plfs' Resp. to RFA Nos. 88-93, ECF No. 154-7. Accordingly, BCBSM never even knew which healthcare claims, if any, originated from the Tribe's CHS program.

Moreover, the Member Plan, Employee Plan, and CHS program were each funded by entirely separate sources. Reger Dep., Ex. 3, 11:2-6 ("[T]he IHS funds are kept completely separate from anything used to fund the [Plans], correct? A. Correct."), 33:17-24; Order Granting In Part MSJ, ECF No. 112, PgID.6203; Plfs' Resp. to RFA No. 2, ECF No. 163-3, PgID.8576. Each had its own independent and separate budget. Reger Dep., Ex. 3, 35:18-36:8. And the Tribe never used CHS Funds to reimburse BCBSM for any healthcare claims paid by BCBSM. Reger 2017

Dep., Ex. 4, 15:7-12, 19:13-22; *see also* April 15, 2010 E-mail Chain, Ex. 21 (confirming that the Tribe does not use CHS Funds to reimburse BCBSM). Indeed, the Tribe's Controller, Jacqueline Reger, confirmed that the Plans had absolutely no fiscal intersection with the Tribe's CHS program:

> Q. …[T]o your knowledge, as [] Tribal controller, was there … any intersection in terms of the budgeting, the funding, or any other financial aspect, between [the Employee Plan or Member Plan] and the Tribe's [CHS] program?
>
> A. No.

Reger Dep., Ex. 3, 60:20-61:22. *BCBSM thus never had access to the CHS Funds used to fund the CHS program*. *Id*. at 61:25-62:2. Only the Tribe's CHS program used CHS Funds to pay providers. And then only for the balance owed after the Plans and/or any other "alternate resources" were exhausted.

D. The Tribe Always Knew That BCBSM Did Not Process Claims At MLR

1. The Tribe knew about the MLR regulations in 2007/2008

The Tribe knew of the MLR regulations at the time they became effective in 2007, or "some time soon thereafter." Elliott Dep., Ex. 10, 52-53; *see also* Raphael Dep., Ex. 9, 63-64 ("Q. So immediately when [the MLR regulation] was enacted it would have gone to the [Tribe's] health administrator, is your understanding? … A. Correct. Q. And then it would have made its way to you, would you say, within a year of when it was enacted? … A. Yes.") (objections omitted). Indeed, by 2008 the

Tribe had received from IHS a "Dear Tribal Leader Letter," outlining the provisions of the MLR regulations. Ex. 22; *see also* Plfs' Resp. to BCBSM's RFA No. 64, ECF No. 154-3, PgID.7894 ("Plaintiffs admit that by January 1, 2008, they received certain communications sent by [IHS] to all tribes concerning the adoption of the MLR regulations."). The Tribe's CHS program even sought from providers, and actually obtained MLR for certain healthcare claims over the years, but only did so in circumstances the Tribe deemed appropriate. Elliott Dep., Ex. 10, 34-37, 54:15-56:12; Robinson Dep., Ex. 13, 33-36; Reihl Dep., Ex. 11, 47:20-48:5. Those circumstances did not involve BCBSM.

2. The Tribe always knew that BCBSM did not apply MLR

The Tribe knew *at all times* that BCBSM did not process the Plans' claims at MLR. Margaretta Elliott, a 19-year clerk in the Tribe's CHS program office who saw as many as millions of health care claims flow through the Tribe's CHS program, knew that BCBSM *never* processed the Plans' claims at MLR:

> Q…. You always understood that insurance companies [including BCBSM] did not obtain MLR, correct? …
>
> A. Yes, to my knowledge they did not seek it.

Ex. 10, 65:4-9 (objection omitted); *see also id.* at 63-64. Ms. Elliot's testimony is not an outlier. It is clear that several Tribal employees knew that claims paid by insurance -- *i.e.*, alternate resources (including the Plans) -- did not obtain MLR. Raphael Dep., Ex. 9, 37:5-9 ("Q. And you always understood that if a claim went

through insurance it was not receiving [MLR]? … A. Correct.") (objection omitted), 40:15-41:18; Reihl Dep., Ex. 11, 50:4-9; Fox Dep., Ex. 7, 41:17-43:8.[10]

Ultimately, *none* of the Tribe's witnesses ever believed that BCBSM applied MLR. But multiple Tribal witnesses testified that they knew about BCBSM's network rates. The foregoing thus establishes that each year when the Tribe renewed the ASCs (ECF Nos. 79-8, 79-9), it did so with the knowledge that BCBSM processed claims using network rates—and *not* MLR.

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[10] Though perhaps overkill, it must be noted that numerous times over the years, beginning no later than 2009, the Tribe discussed with both its insurance agent Gallagher and BCBSM the fact that the Plans were not receiving MLR. *See, e.g.*, February 27, 2009 E-mail and attached February 26, 2009 Meeting Notes, Ex. 23 ("Minutes from yesterday's meeting" sent by Dan Brooks of Gallagher to the Tribe's Benefits Manager, noting that "audit of BCBS Claims through IHS Medicare-Like Rates may not yield significant savings but will be verified in conversations with BCBS"); Brooks Dep., Ex. 24, 23-25 and 38:21-39:7, 48:1-21 (Brooks always knew that BCBSM did not provide MLR and that BCBSM's rates differed from MLR; and he explained as much to the Tribe, or let BCBSM do so); 31:23-33:18, 35:18-36:16, and 62:22-63:1 (February 26, 2009 meeting notes, Ex. 23, are consistent with Brooks's recollection of meeting with the Tribe and Gallagher's engagement with the Tribe); Kamai Dep., Ex. 16, 23:1-13 ("[W]ere there conversations between Gallagher, the Tribe and a person from [BCBSM] as relates to annual renewal of the lines of coverage with [BCBSM]? … [Yes] at various points [MLR] came up as [a] point of discussion."); Harvey Dep., Ex. 25, 33:10-36:19 (Harvey, BCBSM Account Manager for the Tribe, discussed with the Tribe during 2012, the first year she was assigned to the account, BCBSM's <u>in</u>ability to obtain MLR on behalf of the Tribe).

3. The Tribe consciously accepted the risk that BCBSM's network rate was higher than MLR

The Tribe did not necessarily know the MLR dollar amount for any particular claim, and thus never compared the same with BCBSM's network rate.[11] Sprague Dep., Ex. 2, 13:13-17. The Tribe did understand, however, that BCBSM's network rate *may well* have varied from MLR. *Id.* at 14:16-15:12, 17-19. Armed with this knowledge, the Tribe consciously "accept[ed] … the risk" that BCBSM's network rate was at times higher than MLR. *Id.* at 46:18-47:25, 63-64.

The Tribe did so because myriad other considerations impacted the Tribe's decision to choose BCBSM, including access to the vast network itself (beyond the CHS program's five-county service area), the location of individuals requiring healthcare services (country-wide), and the amount of administrative fees. *Id.* at 59:8-16 ("Q. Why is it, relative to [BCBSM] that you were willing to accept the risk that what [BCBSM] was providing by way of the [BCBSM] rate, [was] possibly … different than [MLR]? … A. As I stated earlier, rates is only one part of what I look at….") (objection omitted).

In fact, through its current claims processor, Cofinity, the Tribe *still* does not obtain MLR for the Plans' claims. And again—that is by the Tribe's own choosing

[11] IHS did, however, provide to the Tribe resources to compute MLR, had the Tribe so desired. *See* MLR for CHS Services FAQ (attachment to September 29, 2011 IHS E-mail to Raphael), Ex. 26, No. 45, p. 8.

and design. Elliott Dep., Ex. 10, 43:2-43:7 ("Q. … Currently today in the case of a [CHS] eligible individual with insurance through the Tribe through [Cofinity], it is not the policy of the Tribe's [CHS] program to obtain MLR for those claims, correct? A. Yes."), 50; Sprague Dep., Ex. 2, 15:2-15:7.

E. Plaintiffs Sued BCBSM For Adhering To The Plans' Design

Plaintiffs first asserted a claim against BCBSM related to MLR in their initial complaint, filed on January 29, 2016 (ECF No. 1). *See also* Am. Compl., ECF No. 7. Despite BCBSM providing to Plaintiffs exactly what they bargained for, expected, and understood they were receiving, Plaintiffs nonetheless assert that "BCBSM failed to ensure that Plaintiffs paid no more than MLR for MLR-eligible services, instead using Plan assets to pay standard contractual [network] rates on services that were eligible for lower MLR payment rates." Am. Compl., ¶ 136. Alternatively, Plaintiffs also allege that "it was BCBSM's fiduciary obligation to ensure that all conditions precedent to Plaintiffs' claims being eligible for lower MLR payment rates were met, and/or to inform Plaintiffs of any conditions precedent to Plaintiffs' claims being MLR-eligible that were not being met." *Id.* ¶ 138.

The remaining procedural backdrop for this dispute is set forth in the Sixth Circuit's August 30, 2018 Opinion (ECF No. 135, PgID.7631) and this Court's April 26, 2019 Opinion (ECF No. 146, PgID.7782-84). The Sixth Circuit remanded

Plaintiffs' MLR-based ERISA claim for further proceedings, without deciding BCBSM's argument "that its administration of the Tribe's [Plans] simply [are] not subject to the MLR regulations." ECF No. 135, PgID.7640. The Sixth Circuit deemed that issue "a factual matter," and "emphasiz[ed] that [it] express[ed] no opinion on the ultimate merits of the Tribe's MLR claim, and [held] only that it would be premature to dismiss the Tribe's claim at [that] stage in the proceedings." *Id*. at PgID.7641.[12]

III. ARGUMENT

A. Legal Standard

A party is entitled to summary judgment "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Alexander v. CareSource*, 576 F.3d 551, 557-58 (6th Cir. 2009) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986)). "The mere existence of a scintilla of evidence in support of the [non-moving party's] position will be insufficient; there must be evidence on which the [fact-finder] could reasonably find for [that party]." *Anderson*, 477 U.S. at 252.

[12] Notably, in their Sixth Circuit Brief on Appeal, Plaintiffs represented: "Beginning in 2002, BCBSM was retained by the Tribe as the administrator of [CHS] paid for by [the Tribe] for Tribal members." Ex. 27, Case No. 17-1932, Doc. No. 17, 10/10/2017, p. 26. With discovery closed, it is now clear that is untrue. The Tribe's CHS program was (and today remains) entirely separate and distinct from the Plans, and intentionally so.

B. Each Remaining MLR Cause Of Action Fails Because MLR Did Not Apply To BCBSM Payments For The Plans' Healthcare Claims

The MLR regulations "only apply for services payable through the CHS program, for individuals who are eligible for CHS coverage…." MLR for CHS Services FAQs, Ex. 26, No. 10, p. 2; *see also id.* at No. 29, p. 4 ("[T]he service … must be provided to a CHS eligible individual and paid by a … tribal CHS program"); 42 C.F.R. § 489.29 (hospitals "must accept" MLR "as payment in full for … [a] CHS program …, carried out by an Indian Tribe … pursuant to the [ISDEAA]"); 42 C.F.R. § 136.30 (b) (the MLR payment methodology applies to care "authorized by a Tribe … carrying out a CHS program of the IHS under the [ISDEAA]"); April 26, 2019 Opinion, ECF No. 146, PgID.7790-93 (citing Conference Report explaining that MLR "would apply to [CHS] programs operated by … an Indian tribe" and citing summary of final rule as requiring hospitals to accept MLR for "any medical care purchased by [CHS]").

In other words, MLR applies only to care funded by a CHS program.[13] In response to a subpoena served by BCBSM, IHS produced a publication confirming

[13] The MLR regulation cites 25 U.S.C. § 13, which provides that IHS "shall direct, supervise, and expend such moneys as Congress may … appropriate, for the benefit, care, and assistance of the Indians throughout the United States[,]" and 42 U.S.C. § 2001, which provides that in carrying out its duties, the federal government may "contract with … organizations for the provision of health services to such people." *See* April 26, 2019 Opinion, ECF No. 146, PgID.7793, n. 3. The structure and purpose of these underlying statutes relate to expending IHS funds and contracting

that MLR applies only to CHS programs and their corresponding funds, and *not* to other Tribal health benefits programs:

> [T]he MLR only applies to CHS programs operated by … Tribes … pursuant to CHS rules…. By regulation, [the MLR] *does not apply to any other Tribal health program (as defined by the [Indian Health Care Improvement Act (IHCIA)]), or to any other program or plan operated by a Tribe outside of an [ISDEAA] contract or compact*. In addition, … the MLR would not apply to "*health benefits coverage*" purchased by a Tribe … under section 402 of the reauthorized IHCIA or to other types of *health benefits coverage* offered by a Tribe that does not adhere to all current CHS rules even though, such coverage may appear similar in form and function to CHS.

See IHS E-mail responding to Subpoena, and attached 7/30/2013 IHS Corr., Ex. 5.

In no way do the MLR regulations limit the payment that hospitals are required to accept from a non-CHS payor like BCBSM, which was *not*: (a) administering the Tribe's CHS program; (b) adhering to CHS rules; or (c) expending IHS/CHS Funds. Instead, "[i]f there are any third party payers, [a CHS program] will [only] pay the amount for which the patient is being held responsible *after the provider of services [i.e., hospital] has coordinated benefits and all other alternative resources have been considered and paid*." 42 C.F.R. § 136.30 (g)(2)

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for the provision of health services to American Indians (*e.g.*, CHS). Any interpretation of the MLR regulation in tension with that structure and purpose must be rejected. *Federal Exp. Corp v. Holowecki*, 552 U.S. 389, 401-402 (2008). Or, put differently, in light of the underlying statutory provisions, because the Plans *were not* the Tribe's CHS program and *never* expended CHS Funds, the Plans could not be (and were not) governed by the MLR regulations.

(emphasis added). Only that remaining amount paid by a CHS program is entitled to the benefit of MLR.

Because here the Tribe consciously required the separate and distinct BCBSM Plans to pay *first*, the Tribe's CHS program (with its corresponding MLR payment methodology) could only authorize, or pay for, any remaining amount.[14] The testimony of Ms. Karmen Fox – the Tribe's Executive Health Director and the highest-ranking employee overseeing the Tribe's CHS program – could not have made this point any clearer:

> Q. … [T]he CHS program of the Tribe was designed in such a way that [BCBSM] would first pay once the provider presented the claim to [BCBSM], correct?
>
> A. Correct. Any insurance would first pay and then – yes and then [CHS would] pay the difference.

Fox Dep., Ex. 7, 38:10-15.

Sure, the Tribe *could have* coordinated its CHS program and the Plans in order to ensure that claims possibly eligible for MLR were only paid (and paid first) by the Tribe's CHS program with CHS Funds, thereby achieving MLR for those claims. The Redding Rancheria ("RR") Tribe of California did just that:

[14] "This methodology [under 42 C.F.R. § 136.30 (g)] aggregates payments from all payers so that the total payment [by CHS] for a service would not exceed the rate established by the MLR rule. For example, if a payer primary to a CHS program, such as a third party insurer, pays the provider more than the MLR; no further payment would be authorized by the CHS program." July 30, 2013 IHS Corr, Ex. 5.

> In addition to its CHS program … the [RR] Tribe established its own Tribal Self–Insurance Program … [("TSIP")] to increase the availability of monies for health care for Tribal members. The [TSIP] provides access to care at discounted rates through an arrangement with Anthem Blue Cross. *In comparison,* CHS reimburses health care providers at Medicare-like rates. For certain care needs, the [TSIP] can purchase coverage at lower rates while for other needs, CHS is able to obtain a lower [MLR] rate. To conserve resources so the Tribe pays the lowest possible rate, *the [TSIP] … excludes from coverage those services that are eligible for Medicare-like rates* …. The TSIP Coordination Policy further provides that the [TSIP] "will not be treated as an alternate resource" ….

Rancheria v. Hargan, 296 F.Supp.3d 256, 261–62 (D.D.C. 2017) (emphasis added).

To accomplish its coordination, the RR Tribe entered into a Master Plan Document and Summary Plan Description that set forth its coordination policy, containing a provision providing that the TSIP "shall not cover or pay any benefits for Eligible Care that has been paid for by the CHS Program and for which the provider is required to accept [MLR] …." Excerpts of 124-Page Combined Master Plan Document and Plan Description of the RR Health Plan, Ex. 28, p. 65. The RR Tribe also hired and directly contracted with a separate Claims Administrator for the Tribe's CHS program, and to coordinate benefits with the TSIP. *See* Excerpts from Administrative Services Agreement between Health Smart Benefit Solutions, Inc. and RR, Ex. 29. In so doing, the TSIP paid (and received discounted rates through Anthem Blue Cross's provider network) for all care *not* entitled to MLR. On the other hand, RR's *CHS program* paid MLR for care otherwise entitled to MLR

(again, a coordination requirement so that RR could take advantage of MLR in the first place).

Critically, however, the Tribe *in this case* never coordinated in such a manner, deciding instead to treat the Plans as alternate resources that must always pay first (at network rates).[15]

In sum, the Plans' claims were paid neither by the Tribe's CHS program, nor with CHS Funds. In fact, the Tribe, by its own admission, always intended for the Plans to pay first, at BCBSM's network rates, before any resort to the Tribe's CHS program. BCBSM thus did not have the legal right, let alone a duty, to obtain MLR. Any effort to do so would have been contrary to the MLR regulations and the Tribe's conscious design of its CHS program. For this reason -- and this reason alone -- all

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[15] There are services offered by, for instance, Forest County Potawatomi Insurance Department ("FCPID") (Plaintiffs' expert Natalyn Gardner is employed by FCPID) to "recover hospital overpayments incurred since July 5th, 2007 in accordance with [the MMA] Section 506." *See* Section 506 Recovery, Ex. 30, *available at* https://insurance.fcpotawatomi.com/section-506-recovery/ (last accessed on March 2, 2020); *see also* April 26, 2019 Opinion, ECF No. 146, PgID.7793-94 ("The regulation also provided a mechanism for Indian organizations to recover from hospitals that did not apply the required MLR rates.") (citing 42 C.F.R. § 136.32). The Tribe has not sought out these services. *See, e.g.*, Raphael Dep., Ex. _, 64:6-17; Plfs' Resp. to RFA No. 23 and Rog No. 19, ECF No. 163-3, PgID.8588, 8609. And there is a reason for that: the Tribe is not entitled to "recover" any amounts paid by BCBSM because the Plans were *not entitled to MLR*. Ex. 30 ("FCPID has the resources to recover overpayments that were originally paid *with [CHS] program dollars*…."); *see also* Excerpts of Dep. Tr. of Plfs' expert Natalyn Gardner (testifying in *Little River Band of Ottawa Indians v. BCBSM*, Case No. 15-cv-13708 (E.D. Mich.), that the amount FCPID seeks back from a provider is only the amount paid by the Tribe's CHS program and not any amount paid by BCBSM), Ex. 31.

of Plaintiffs' remaining MLR claims fail, and BCBSM is entitled to summary judgment as to each.

C. BCBSM Is Entitled To Summary Judgment On The ERISA Claim

1. The ERISA claim is time-barred

ERISA specifies a three-year limitations period for breach of fiduciary duty claims, which is triggered on the "earliest date on which the plaintiff had actual knowledge of the breach or violation." 29 U.S.C. § 1113(2). "'Actual knowledge' means 'knowledge of the *underlying conduct* giving rise to the alleged violation,' rather than 'knowledge that the underlying conduct violates ERISA,'" *Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 548 (6th Cir. 2012) (emphasis added) (quoting *Wright v. Heyne*, 349 F.3d 321, 331 (6th Cir. 2003)), and that the plaintiff was "in fact . . . aware of that information," *Intel Corp. Inv. Policy Comm. v. Sulyma*, No. 18-1116 __ U.S. __, 2020 WL 908881 *5 (Feb. 26, 2020). *Accord Ternes v. Tern–Fam, Inc.*, 904 F.2d 708, 1990 WL 80915 at *4 (6th Cir.1990) ("[T]o trigger the ERISA statute of limitations, the plaintiff need only have knowledge of the act and cannot wait until the consequences of the act become painful.").[16]

The "underlying conduct" or "act" here, as stated on remand by the Sixth Circuit, is that "BCBSM was aware of the [MLR] regulations, [but] always [paid] standard contract rates for health services [of the Plans], even when these services

[16] All unpublished cases cited herein are attached, with index, as Ex. 32.

were [allegedly] eligible for a Medicare-like rate." ECF No. 135, PgID.7639; *see also* ECF No. 7 Am. Compl., ¶ 146.[17] That is, BCBSM applied its network rates in processing and paying the Employee Plan's claims, without ever applying MLR—facts that Plaintiffs *always* knew. *See*, *e.g.*, Elliott Dep., Ex. 10, 63-65; Fox Dep., Ex. 7, 43, 77-78; Raphael Dep., Ex. 9, 37, 40-41; Reihl Dep., Ex. 11, 46-50, 73-74; Sprague Dep., 8-10, 15, 25-30; *see also, supra*, Section II.D.2 and 3, p. 13-16; Section II.A, p. 3. Plaintiffs were thus aware of the "underlying conduct" giving rise to their ERISA claim *at least* by 2008, and in any event well before January 29, 2013, making their January 29, 2016 claim untimely.

Moreover, while Plaintiffs may not have known the dollar value of MLR as to any particular claim, they always knew that the MLR regulations existed for the purpose of "reduc[ing] contract health expenses for hospital services and enabl[ing] Indian health programs to use the resulting savings to increase services to their beneficiaries." Dear Tribal Leader Letter, Ex. 22. And while the Tribe may not have known whether MLR yielded "significant savings" (Ex. 23) *vis a vis* BCBSM's network rate, the Tribe also never believed that BCBSM's network rate was *always* lower than MLR. Sprague Dep., Ex. 2, 14:16-23 ("Could be more, could be less.

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[17] Plaintiffs may attempt to recast the underlying conduct as "squandering plan assets," but that is a legal concept, not conduct. *Wright*, 349 F.3d at 331 ("If the statute were tolled until an attorney informs the plaintiff that he or she has an ERISA claim, a plaintiff could delay accrual of a claim simply by waiting before consulting an attorney. … Congress surely did not intend [this] result….").

That's all … based on the carrier and what they have negotiated with [the providers].”). Indeed, Connie Sprague admitted that she knowingly accepted the risk that BCBSM's network rates were sometimes higher. *Id*. at 47, 58:22-59:19, 64:15-20.

Still, Plaintiffs assert that “the Tribe learned in November 2014 that [another tribe] had been overpaying on hospital claims for tribal members administered by BCBSM *and had secured substantial savings* by switching to a different third-party administrator who priced claims using MLR methodology.” Plfs' Supp. Resp. to Rog No. 20, Ex. 33 (emphasis added). But the Tribe's supposed unknown fact prior to November 2014—the actual monetary difference between MLR and BCBSM's network rates—is an issue of damages, not breach (and certainly not an issue concerning BCBSM's *conduct*, which remained wholly unchanged from 2007 to 2016). *See Wallace v. Kato*, 549 U.S. 384, 391 (2007) (“The cause of action accrues even though the full extent of the injury is not then known or predictable.”) (citation omitted).

Put differently, whether the Tribe investigated the difference between BCBSM's network rates and MLR—a question of *the Tribe's* “conduct”—is wholly irrelevant. Besides, any “willful blindness” on the part of the Tribe (*e.g.,* acceptance of the risk) does not excuse a failure to bring suit until almost a decade later. *See, e.g., Edes v. Verizon Commc'ns, Inc.*, 417 F.3d 133, 142 (1st Cir. 2005) (“[W]e do

not think Congress intended the actual knowledge requirement [of Section 1113] to excuse willful blindness by a plaintiff")); *Wright*, 349 F.3d at 330 ("Among the basic policies served by statutes of limitations is preventing plaintiffs from sleeping on their rights …."); *Intel Corp. Inv. Policy Comm.*, 2020 WL 908881 at *7 (under ERISA, "willful blindness" can "support[ ] a finding of 'actual knowledge.'").

In the end, Plaintiffs actually knew the necessary information and facts regarding BCBSM's underlying conduct sufficient to allege an ERISA claim back in 2008. Plaintiffs always knew exactly what BCBSM provided with respect to the Employee Plan—network rates. And the Tribe was similarly aware, no later than 2008, of the existence of the MLR regulations. There is thus no issue of material fact with respect to Plaintiffs' ERISA claim being time-barred. 29 U.S.C. § 1113(2).[18] BCBSM is therefore entitled to summary judgment.

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[18] Plaintiffs' ERISA claim also fails under ERISA's six-year statute of repose (29 U.S.C. § 1113(1)) for the reasons previously explained by BCBSM in its Motion to Dismiss and Reply Brief in Support thereof, which argument is reincorporated herein. ECF No. 142, PgID.7672-75; ECF No. 145, PgID.7774-76. At the Rule 12(b)(6) stage, the Court previously noted: "Plaintiffs emphasize that their Complaint does not allege that BCBSM even knew about the MLR regulations on July 5, 2007, thus suggesting that the 'original wrongful act' must have occurred at some later but unidentified period of time." April 26, 2019 Opinion, ECF No. 146, PgID.7797 (quotations and citation omitted). It is now an undisputed fact that BCBSM knew of the MLR regulations in 2007. Deiss Dep., Ex. 34, 13-14. And under this Court's decision in *McGuire v. Metro. Life Ins. Co.*, 899 F.Supp.2d 645, 662 (E.D. Mich. 2012) (Ludington, J.), "[t]he fact that [BCBSM] calculated [medical claims] each later year uniformly applying the [rate negotiated with the hospitals] does not constitute a new violation." Thus, Plaintiffs had until July 2013 to file their lawsuit, *i.e.,* six years after: (a) MLR became available; and (b) BCBSM

2. Plaintiffs' ERISA claim fails on the merits

(a) Summary of applicable law

Even if Plaintiffs' ERISA claim is not time-barred, it fails for myriad other reasons.

Under ERISA, a person is a plan fiduciary to the extent he or she exercises any discretionary authority or control respecting the management or disposition of the *plan's assets* or has any authority or discretionary responsibility in the administration of such plan. 29 U.S.C. § 1002(21)(A); *Seaway Food Town, Inc. v. Medical Mut. of Ohio*, 347 F.3d 610, 616 (6th Cir. 2003). "The Supreme Court has recognized that ERISA defines 'fiduciary' not in terms of formal trusteeship, but in functional terms of control and authority over the plan.…" *Id.* (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993)).

The Supreme Court has stated plainly that ERISA's definition of a plan "is ultimately circular," so one "is thus left to the common understanding of the word 'plan' as referring to *a scheme decided upon in advance*." *Pegram v. Herdrich*, 530 U.S. 211, 222 (2000) (emphasis added). Specifically, then, an ERISA plan is "a set

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nevertheless continued to process claims at something other than MLR. Because Plaintiffs did not file until January 2016, Plaintiffs' claim is time-barred. BCBSM preserves but will not fully rehash this argument in this brief, because there is an earlier date by which the statute of limitations ran—three years after Plaintiffs obtained *actual knowledge* of the conduct constituting the alleged breach, as set forth above.

of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Id.*

Since this "set of rules" is "decided upon in advance" (*id.*), ERISA's statutory scheme "is built around reliance on the face of the written plan documents." *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100-101 (2013) (internal citations omitted). Thus, where a "plan is established, the administrator's statutory duty is to see that the plan is maintained pursuant to that written instrument." *Heimeshoff v. Hartford Life & Acc. Ins. Co*, 571 U.S. 99, 108 (2013) (quoting 29 U.S.C. § 1102(a)(1)). This principal "is the crux of a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Black v. Lincoln Nat. Life Ins.*, 262 F.Supp.3d 568, 572 (N.D. Ill. 2017) (citing *Heimeshoff*, 571 U.S. at 108).

Here, it is undisputed that the Tribe had no "plan documents," but entered into the ASCs with BCBSM to establish the Plans. *See, e.g., supra*, Section II.A; July 14, 2017 Order on Partial Motions for Summary Judgment, ECF No. 112, PgID.6210-11; Sixth Circuit's August 30, 2018 Opinion, ECF No. 135, PgID.7634.

(b) BCBSM is not an ERISA fiduciary with respect to any claims eligible for MLR because the assets required to pay those claims are CHS Funds, not ERISA Plan assets

BCBSM is an ERISA fiduciary only to the extent it has discretionary authority or control over ERISA plan assets. *Seaway*, 347 F.3d at 616. Claims are only eligible for MLR if paid for by CHS Funds. *See, e.g.*, 42 C.F.R. § 489.29; MLR for CHS Services FAQs, Ex. 26, Nos. 10 and 29, pp. 2, 4. The Tribe intentionally separated the Employee Plan's assets from its CHS assets (*i.e.*, the CHS Funds). *See, supra*, Section II.A, pp. 4-5; Section II.C, pp. 11-12. The Tribe never appointed BCBSM with any control over its CHS Funds and, regardless, the Tribe's CHS program (and, thus, its CHS Funds) are not governed by ERISA. Any alleged cause of action for failure to pay healthcare claims at MLR requires discretion and control over CHS Funds, not Plan funds. Neither the Tribe's Plan nor its separate CHS program gave BCBSM this authority.[19] Put simply, obtaining MLR cannot be an ERISA fiduciary duty under the facts of this case because the assets required to pay healthcare claims at MLR were not Plan assets under BCBSM's control.

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[19] Since BCBSM did not have *discretion*, or control, over the Tribe's CHS Funds or CHS program, and since claims of the Employee Plan were not eligible for MLR, BCBSM did not have *discretion* to pay at MLR at all. This fact distinguishes Judge Levy's analysis in *Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross Blue Shield of Michigan*, No. 14-CV-11349, 2017 WL 3116262, at *6 (E.D. Mich. July 21, 2017), where, at the *pleadings stage*, Judge Levy noted that plaintiffs had at least *alleged* that defendant "had discretion to pay the lower rate rather than the contractual rate."

(c) BCBSM did not breach any fiduciary duty when it followed the specific design of the Employee Plan

Plaintiffs allege that BCBSM "squandered plan assets" by not *defying* the Employee Plan in an effort to obtain MLR for Tribal healthcare claims. Despite Plaintiffs' artful pleading, this claim must fail. Again, the Employee Plan was never eligible for MLR. Furthermore, the Tribe itself established the Employee Plan, and separately designed its own CHS program. The Tribe's own policy required its CHS Clerks to bill the Employee Plan as an alternate resource *before* billing any claims to the CHS program. *See, supra*, Section II.C, pp. 8-9. Any claims processed through the Employee Plan could not achieve MLR due to the Tribe's design and structuring of its health programs as a whole, something falling completely outside of BCBSM's administration of the Employee Plan (including BCBSM's discretion). ERISA claims for breach of fiduciary duty arising out of the *Tribe's design* of its self-funded Plans are not actionable. *Moeckel v. Caremark, Inc.*, 622 F.Supp.2d 663, 684 (M.D. Tenn. 2007) ("[Pharmacy benefit manager's] execution of the plan design adopted by [an employer plan sponsor] is immune from fiduciary liability.").

The case *Larson v. United Healthcare Ins. Co.*, 723 F.3d 905 (7th Cir. 2013), is instructive. The plaintiff in *Larson* claimed that the defendant insurance company breached its ERISA fiduciary duty in failing to exercise its "authority, control, or responsibility" over the plan by issuing "policies requiring illegal copayments for chiropractic services" and for failure "to eliminate these illegal copayments," despite

the fact that the defendant "knew, or should have known" that this would result in an improper expense to the plan. *Id.* at 917 (emphasis omitted). The *Larson* court properly held that even if the policy documents contained a provision that was "illegal" under state law, the plaintiff could not maintain a cause of action for breach of fiduciary duty because the provisions themselves were not the result of a fiduciary act but rather the result of plan design. *Id*.

The Tribe designed its Employee Plan and its CHS program to be separate, and did not give BCBSM authority or control over CHS Funds. The Tribe did not design the Employee Plan to coordinate with its CHS program, and in fact required the Employee Plan to pay first at BCBSM rates. BCBSM properly exercised its ERISA fiduciary duties when it paid claims at BCBSM rates as the Tribe intended. The facts here do not provide the foundation for a breach of fiduciary duty claim. *Larson*, 723 F.3d at 917.

(d) BCBSM's negotiation of its network rates and the Tribe's selection of that network are not fiduciary decisions

Plaintiffs similarly fault BCBSM for not abandoning the network rate in favor of MLR. Setting aside the fact that the Plans were not (and could never be) entitled to MLR, courts addressing similar claims routinely find that the negotiation of a "network rate" involves a business decision, not a discretionary act giving rise to a breach of fiduciary duty. *DeLuca*, 628 F.3d at 747; *Moeckel*, 622 F.Supp.2d at 677-

678 (rejecting breach of fiduciary duty claim arising out of defendant's failure to achieve more favorable network prescription prices on behalf of ERISA plan).

Negotiation of a network rate is not a unilateral act of discretion on behalf of a single plan; rather, any such negotiation depends on the actions of a third-party (*i.e.,* the healthcare providers with which negotiations took place). *Id.* at 677. BCBSM's negotiations are entirely "separate and distinct from [BCBSM's] contractual relationship with [the Tribe] or any of its other customers." *Id.* Negotiation of a network and corresponding rates thus relates to BCBSM's administration of its *own* business, not administration of the Tribe's Employee Plan. *Id.* at 677-78 (citing *Pipefitters Local v. Blue Cross & Blue Shield of Mich.*, 213 Fed.Appx. 473, 479 (6th Cir. 2007)).

Again, the Tribe chose to offer its employees (including Tribal members and *non*-Tribal members alike) BCBSM's network, based upon several considerations. *See, supra*, Section II.A, p. 3; Section II.D.3, p. 15. This constitutes the Tribe's own business decision, not an act of BCBSM's discretion. And BCBSM played no role in the Tribe's administration of its completely separate CHS program. *See, supra*, Section II.C, pp. 10-13. The CHS program is not an ERISA program, and the Tribe specifically designed the ERISA-governed Employee Plan to be separate. There is no ERISA duty related to the CHS program that BCBSM could have possibly breached.

(e) BCBSM lacked necessary information regarding the Tribe's CHS program

Even if one accepts that Plaintiffs' ERISA claim does not relate to the Tribe's plan design or various business decisions, and that the Plans were entitled to MLR (they were not), BCBSM still lacked the necessary information to seek MLR. Given that fact, there can be no act of discretion or breach of fiduciary duty. The case of *Birmingham Plumbers and Steamfitters Local Union No. 91 Health and Welfare Trust Fund v. Blue Cross Blue Shield of Alabama (BCBSAL)*, No. 2:17-cv-00443, issued March 8, 2018; 2018 WL 1210930 (N.D. Al. 2018), is informative.

In *Plumbers*, the plaintiff sued BCBSAL for "squandering plan assets" by "improperly [paying] claims" that should have been billed to Medicare. The court held that BCBSAL did not "breach[] its fiduciary duty to properly pay a claim (*i.e.*, to bill Medicare as the primary payer)," because BCBSAL lacked necessary information regarding Medicare eligibility. *Id.* at *3-4 (where plaintiff never "provided such information regarding the participant at issue…there can be no claim that [BCBSAL] failed to act in accordance with the Plan documents or that [BCBSAL] breached its fiduciary duty"). The same is true with respect to any eligibility for MLR in the current case.

Not all participants in the Employee Plan are even American Indian, let alone CHS, or MLR, eligible. *See, supra,* Section II.C, pp. 7-8; Nov. 6, 2019 Walters E-mail, Ex. 35. The Tribe never provided to BCBSM any CHS program information,

including referral documents showing that the Tribe's CHS program authorized medical services, nor any list of CHS-eligible individuals. *See, supra*, Section II.C, pp. 10-11. Indeed, the Sixth Circuit picked up on this important concern, and Plaintiffs' counsel assured the panel: "So, [Plaintiffs alleged in their] complaint that BCBSM *knew* that these Tribal members were eligible for [MLR]. That may or may not be true, but we haven't had a chance to do discovery on that." Court Audio, 3/14/18, Case No. 17-1932 *available at* https://www.ca6.uscourts.gov/audio-files-completed-arguments (emphasis added), approx. minute 12:00/33:35. Plaintiffs have now "had a chance" for discovery on this issue, and there is zero evidence that BCBSM knew which (if any) Employee Plan participants, or claims, were eligible for MLR. BCBSM lacked the necessary information to administer claims in the manner Plaintiffs suggest. Plaintiffs' ERISA claim thus fails for this additional, independent reason.

D. Plaintiffs' Health Care False Claim Act Claim Fails

1. The Member Plan claims were not false, as they were never eligible for MLR, and the Tribe knew BCBSM was not processing or paying claims at MLR

As with their other claims, Plaintiffs' HCFCA claim fails primarily because none of the claims of the Member Plan were entitled to MLR. *See, supra*, Section III.B. Because none of the claims BCBSM processed and paid were entitled to MLR, and because the Tribe knew that BCBSM applied its network rates instead of MLR,

the Member Plan claims were not "false" in any respect. The purpose of the HCFCA is to protect health care insurers such as BCBSM where providers present claims that are "wholly or partially untrue or deceptive" (Mich. Comp. Laws § 752.1002, 752.1009). It is not to create liability on the part of a claims processor (BCBSM) where the providers (hospitals) bill BCBSM according to Plaintiffs' own predetermined, mutually-known, and identified Plan. *See* BCBSM's Mtn. to Dismiss, ECF No. 142, PgID.7682-84.

2. BCBSM did not "present" or "cause to be presented" false claims

Plaintiffs' HCFCA claim also fails because Plaintiffs admit that BCBSM did not "present or cause to be presented a claim" as required before any liability can be triggered under the Act. *See* Mich. Comp. Laws § 752.1009 (requiring that a "person … knowingly present[] or cause[] to be presented a claim which contains a false statement.").

It is undisputed that the claims were "presented" *to* BCBSM by medical providers, and BCBSM thereafter paid them. *Id.* Under the parties' ASC, Plaintiffs were then obligated to *reimburse* BCBSM for the claims paid. *Id.* BCBSM previously briefed this argument in detail, and the facts obtained through discovery now confirm: BCBSM cannot be held liable in the manner Plaintiffs suggest where BCBSM *paid*, and never *presented*, the claims at issue. *See* BCBSM's Mtn. to Dismiss, ECF No. 142, PgID.7680-84; and BCBSM's Reply in Support of Mtn. to

Dismiss ECF No. 145, PgID.7778-79 Sprague Dep., Ex. 2, 33-34 ("[Y]ou would agree that the providers would present the claims [of the Plans] to [BCBSM] for payment, yes? A. Yes. …. Q. … So to be clear, you would agree that [BCBSM] never presented to the Tribe individual medical claims, correct? … A. Correct.") (objections omitted).

3. Plaintiffs never alleged/identified the particular claims at issue as required by the Michigan Supreme Court

Claims pursuant to the HCFCA must satisfy a heightened pleading standard, just as a claim for common law fraud. *State ex rel. Gurganus v. CVS Caremark Corp.*, 496 Mich. 45, 63; 852 N.W.2d 103 (2014) (citing MCR 2.112(B)(1)). This requires Plaintiffs to identify the specific fraudulent transactions at issue. *Id.* at 113.

Plaintiffs have not once identified a single "false" claim. *See generally* Am. Compl., ECF No. 7; *see also* Nov. 6, 2019 Walters E-mail, Ex. 35. Rather, they have rested on their initial allegation that BCBSM generally processed MLR-eligible claims at an inflated rate. Am. Compl., ECF No. 7 at ¶ 168-170. Plaintiffs' HCFCA claim fails because Plaintiffs have not identified the specific claims at issue, *e.g.,* those claims that Plaintiffs believe should have been processed by BCBSM at MLR because MLR was less than the BCBSM rate for those specific claims.

E. BCBSM Is Entitled To Summary Judgment On Plaintiffs' Common Law Breach Of Fiduciary Duty Claim

Plaintiffs' common law breach of fiduciary duty claim fails for all of the same reasons that their ERISA claim fails, including that none of the claims of the Plans were entitled to MLR. But there is another independent reason why Plaintiffs' state law claim fails. The Member Plan ASC authorized BCBSM to process claims at something *other than* MLR. Under Michigan law, if the parties' contract authorizes the conduct at issue, no breach of fiduciary duty can lie. *Calhoun Cnty*, 297 Mich. App. at 5, 21 ("The ASC is the central contract for the insurance arrangement, and it determines the rights and obligations of each party.…[A]s a result of our holding that [BCBSM] was authorized by the contract to charge the access fee, plaintiff cannot maintain its breach-of-fiduciary duty claim."); *Cf. Thompson v. Cmty. Ins. Co.*, 213 F.R.D. 284, 301 (S.D. Ohio 2002).

The ASC expressly required BCBSM to process the Tribe's claims pursuant to BCBSM's "standard operating procedures." ASCs, ECF Nos. 79-3 and 79-4, Article II.A, PgID.3163 and 3181. It is undisputed that BCBSM's "standard operating procedure" is to administer claims at rates negotiated by BCBSM with its network of providers, *i.e.,* something *different* than MLR. *See, supra*, Section II.A; Harvey Dec., Ex. 1, ¶¶ 5-6. BCBSM cannot be held liable for breaching any duty where, as here, it scrupulously followed the express provisions of the ASC, the only document governing BCBSM's obligations to the Member Plan. Any contrary result

is without merit, particularly in the context of a factual record showing that Plaintiffs obtained exactly that for which they bargained. *See also* BCBSM's Mtn. to Dismiss, ECF No. 142, PgID.7684-86 and BCBSM's Reply in Support of Mtn. to Dismiss ECF No. 145, PgID.7779-80, reincorporated herein.

IV. CONCLUSION

For the foregoing reasons, BCBSM respectfully requests that the Court grant BCBSM's motion, dismiss with prejudice each of Plaintiffs' remaining claims, and award to BCBSM its attorney's fees and costs under 29 U.S.C. § 1132(g)(1).

Respectfully submitted,

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Dated: March 6, 2020

CERTIFICATE OF SERVICE

I hereby certify that on March 6, 2020, I electronically filed the foregoing paper with the Clerk of the Court using the ECF system which will send notification of such filing to counsel of record.

By: *<u>/s/ Brandon C. Hubbard</u>*