UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

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

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 16-cv-10317

Honorable Thomas L. Ludington

Magistrate Judge Patricia T. Morris

PLAINTIFFS' RESPONSE BRIEF IN OPPOSITION TO BCBSM'S MOTION FOR SUMMARY JUDGMENT (DKT. 173)

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ISSUES PRESENTED

1. Whether, under the Medicare-Like Rate ("MLR") regulations, MLR payment methodology applies to Plaintiffs' ERISA plans when the MLR regulations state that MLR payment methodology applies to all hospital services provided by a Medicare-participating hospital and authorized by a tribe carrying out a Contract Health Services ("CHS") program, and the Saginaw Chippewa Indian Tribe of Michigan's ("SCIT") CHS program authorized its tribal members to receive hospital services on thousands of occasions on which SCIT's self-insured plans paid for those services.

   Plaintiffs answer: Yes.

   BCBSM answers: No.

2. Whether, for purposes of Plaintiffs' ERISA and common law breach of fiduciary duty claims, Blue Cross Blue Shield of Michigan ("BCBSM") imprudently caused SCIT to overpay on claims that were eligible for a lower Medicare-Like Rate under the Medicare-Like Rate ("MLR") regulations when BCBSM (a) willfully delayed determining whether MLR pricing, which it knew would save one Michigan tribe money over BCBSM network rates, would also save SCIT money over BCBSM network rates; (b) led SCIT to believe that Blue Cross' network prices were comparable to MLR when MLR prices were *significantly lower* than BCBSM's network prices; and (c) failed to take prudent steps to develop the capacity to apply MLR pricing while leading the SCIT to believe that it was on the cusp of applying MLR pricing.

   Plaintiffs answer: Yes.

   BCBSM answers: No.

3. Whether Plaintiffs lacked the "actual knowledge" required to trigger ERISA's three-year statute of limitations where SCIT did not know that BCBSM had been squandering plan assets and causing Plaintiffs to overpay claims eligible for MLR at inflated rates until November 2014 or later.

   Plaintiffs answer: Yes.

   BCBSM answers: No.

4. Whether, under the Michigan Health Care False Claims Act, BCBSM "presented" claims to SCIT that were "false" when SCIT was entitled to pay hospitals lower MLR prices on eligible claims, but BCBSM requested reimbursement from SCIT and provided monthly claims listing reports to SCIT that listed only BCBSM's inflated network prices, misleading Plaintiffs into paying those higher prices.

   Plaintiffs answer: Yes.

   BCBSM answers: No.

5. Whether, under Michigan common law, BCBSM's Administrative Services Contracts with SCIT explicitly authorized it to deprive SCIT of MLR discounts SCIT was entitled to, when the ASCs nowhere mention MLR pricing.

   Plaintiffs answer: No.

   BCBSM answers: Yes.

CONTROLLING OR MOST APPROPRIATE AUTHORITY

Statutes and regulations

42 C.F.R. 136.30

42 C.F.R. 136.24

Mich. Comp. Laws 752.1002

Cases

Saginaw Chippewa Indian Tribe of Michigan v. Blue Cross Blue Shield of Michigan, 748 F. App'x 12 (6th Cir. 2018)

Little River Band of Ottawa Indians v. Blue Cross Blue Shield of Michigan, 183 F. Supp. 3d 185 (E.D. Mich. 2017)

Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross Blue Shield of Michigan, No. 14-CV-11349, 2017 WL 3116262, (E.D. Mich. July 21, 2017)

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Intel Corp. Inv. Policy Comm. v. Sulyma, No. 18-1116, __U.S.__, 2020 WL 908881 (Feb. 26, 2020)

Hi-Lex Controls, Inc. v. BCBSM, 751 F.3d 740 (6th Cir. 2014)

I. INTRODUCTION

The Sixth Circuit has already held that if the facts show that the hospital claims of the Saginaw Chippewa Indian Tribe of Michigan ("SCIT" or "the Tribe") and its self-insured plans were eligible for a lower Medicare-Like Rate ("MLR") and that Blue Cross Blue Shield of Michigan ("BCBSM"), due to its lack of prudence, consistently caused the Tribe to overpay on those claims, BCBSM breached its fiduciary duties to the Plaintiffs. In remanding the case, the Sixth Circuit effectively narrowed the remaining issues to whether "the Tribe can[] show, as a factual matter, that the regulations apply to its ERISA plan." *SCIT v. BCBSM*, 748 F. App'x. 12, 21 (6th Cir. 2018).

The MLR regulations are clear: MLR payment methodology applies to all hospital services provided by a Medicare-participating hospital and authorized by a Tribe carrying out a Contract Health Services ("CHS") program – period. The SCIT's CHS program authorized its tribal members to receive hospital services on thousands of occasions on which the Tribe's self-insured plans paid for those services. MLR payment methodology applied to those hospital claims.

BCBSM was fully aware of the MLR regulations and knew that they applied to SCIT's self-insured plans. BCBSM breached its "prudent person fiduciary obligation" to ensure that the assets of the Tribe's self-insured plans were not squandered. Instead, BCBSM (a) willfully delayed determining whether MLR

pricing, which it knew would save one Michigan tribe money over BCBSM network rates, would also save SCIT money over BCBSM network rates; (b) led SCIT to believe that Blue Cross' network prices were comparable to MLR when MLR prices were *significantly lower* than BCBSM's network prices; and (c) failed to take prudent steps to develop the capacity to apply MLR pricing while leading SCIT to believe that BCBSM was on the cusp of applying MLR pricing.

Perhaps it was self-interest by BCBSM, since implementing MLR pricing would require BCBSM's time and resources, and it was the Tribe's money – not BCBSM's money – that was being squandered. Perhaps it was BCBSM's reluctance to ruffle the feathers of its hospital partners who would be paid less under MLR pricing and who might demand price increases from BCBSM to offset the lost revenue from MLR pricing. Perhaps it was BCBSM's incompetence – its inability to accomplish what other Blue Cross member companies and insurance companies were able to do. But whatever the reason, BCBSM breached its fiduciary duties to the Plaintiffs. BCBSM's motion should be denied.

II. COUNTER-STATEMENT OF FACTS

A. MLR PRICING METHODOLOGY APPLIES TO ALL SERVICES FURNISHED BY A MEDICARE-PARTICIPATING HOSPITAL THAT ARE AUTHORIZED BY A TRIBE'S CHS PROGRAM.

For decades, the Indian Health Service of the United States Department of Health and Human Services ("IHS") has offered medical services to persons of

Indian descent at IHS facilities across the country – similar to how veterans can receive medical treatment at VA facilities. 42 C.F.R. 136.11-136.12. Most IHS facilities are in the Western United States, where the highest density of Native Americans reside. *See* https://www.ihs.gov/locations/ (visited 3/26/20). The closest IHS facility to Michigan is in Bemidji, Minnesota. *Id.*

To provide medical services to Native Americans who do not live near an IHS facility, Congress directed the IHS to offer Contract Health Services, through which a Native American can be authorized by IHS to go to a private hospital or doctor for treatment when an IHS facility is not reasonably available. 42 C.F.R. 136.23.[1] IHS pays for the cost of such services, but is the "payor of last resort" and only pays after "alternate resources" such as Medicare, Medicaid, state or local health care programs, or private insurance have been exhausted. 42 C.F.R. 136.61.

Under the Indian Self-Determination and Education Assistance Act of 1975 ("ISDEAA"), 25 U.S.C. 5301 *et seq.*, self-determined Indian tribes also can carry out a CHS program for eligible Native Americans living near the tribe's reservation. SCIT is a self-determined Indian tribe and has carried out a CHS program since 1997. SCIT Contract Health Service Eligibility Criteria, **Ex. A**.

[1] Contract Health Services was renamed "Purchase Referred Care" ("PRC") in 2014. The Indian Health regulations still use the term "Contract Health Services", such that this brief will use the term Contract Health Services or CHS.

In July 2007, "Subpart D" of the IHS regulations governing Indian Health went into effect. These new regulations are entitled "Limitation on Charges for Services Furnished by Medicare-Participating Hospitals to Indians" and are codified at 42 C.F.R. 136.30-136.32 (the "MLR regulations").[2]

The MLR regulations are clear and unambiguous. All levels of care furnished by a Medicare-participating hospital that are authorized by a Tribe carrying out a CHS program under the ISDEAA are eligible for MLR pricing:

> **§136.30 Payment to Medicare-participating hospitals for authorized Contract Health Services.**
>
> (b) *Applicability.* **The payment methodology under this section applies to all levels of care furnished by a Medicare-participating hospital**, whether provided as inpatient, outpatient, skilled nursing facility care, as other services, of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) that is authorized under part 136, subpart C by a contract health service (CHS) program of the Indian Health Service (IHS); **or authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act**, as amended, Pub. L. 93-638, 25 U.S.C. § 450 *et seq.;* or authorized for purchase under § 136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h))(hereafter "I/T/U"). 42 C.F.R. 136.30(b)(emphasis added).

Notably, neither the enabling statute nor the regulations state that the hospital services authorized by the Tribe's CHS program must be paid for with

[2] The MLR regulations are a subset of the regulations on Indian Health relevant to this dispute, which are attached for the Court's convenience as **Ex. B**. Most of the regulations governing CHS programs date back to 1999. *Id.* p. 730.

CHS funds for the MLR payment methodology to apply. Authorization of the hospital services by the Tribe's CHS program – not payment from CHS funds – is the regulatory predicate for services provided by a Medicare-participating hospital to be eligible for MLR pricing under the plain language of 42 C.F.R. 136.30(b).

1. The MLR Regulations Entitle The Tribe To Pay The Lesser Of The Medicare-Like Rate Or The Amount Negotiated With The Hospital By The Tribe.

The "payment methodology under this section" for hospital claims authorized by a CHS program is based on what "the Medicare program would pay under a prospective payment system" with some minor additional charges – thus the phrase "Medicare-Like Rates." 42 C.F.R. 136.30(c)-(e). Notably, the MLR regulations provide that Tribe "will pay the *lesser* of the payment amount determined under [the MLR regulations] or the amount negotiated with the hospital or its agent." 42 C.F.R. 136.30(f). A Tribe's CHS program is the "payor of last resort" and must coordinate benefits with any third-party payers, with the CHS program paying for services only after other "alternate resources" have been considered and paid. 42 C.F.R. § 136.31(g)(2).

2. A Tribal CHS Program Authorizes Health Care Services By Issuing A Purchase Order Or Referral.

The two requirements for authorization of a Native American's medical care by a CHS program date back to 1999 – well before the MLR regulations:

- Before receiving treatment, the patient must "supply information that the ordering official [the Tribe's CHS program] deems necessary to determine the relative medical need for services and the individual's eligibility."[3] 42 C.F.R. 136.24(b); and

- After reviewing that information, a "purchase order" must be issued by the Tribe's CHS program evidencing that the Tribe's CHS program has determined that (a) the patient is eligible for contract health services; and (b) the patient is authorized to receive the specific services described in the purchase order. 42 C.F.R. 136.24(a).

3. Native Americans Who Reside In The Contract Health Services Delivery Area Are Generally Eligible For CHS.

Contract Health Services are generally available "to persons of Indian descent belonging to the Indian community served by the local facilities and program." 42 C.F.R. 136.12(a). Contract health services will be provided to Native Americans "when necessary health services by an Indian Health Service facility are not reasonably accessible or available" and when the patient resides within the contract health services delivery area. 42 C.F.R. 136.23(a).[4]

B. SCIT'S CHS PROGRAM AUTHORIZED ELIGIBLE NATIVE AMERICANS TO RECEIVE CONTRACT HEALTH SERVICES.

Pursuant to 42 C.F.R. 136.23(a) and 24(b), SCIT's CHS program required a patient seeking off-site care to confirm eligibility by providing proof that he or she:

[3] In cases of emergency or when there is otherwise good cause for the failure to provide the Tribe's CHS department prior notice, this information can be provided within 72 hours after the start of treatment. 42 C.F.R. 136.24(b)-(c).

[4] The *contract health services delivery area* includes "a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation." 42 C.F.R. 136.22(a)(6).

(1) is a member of the Tribe or a descendant of a Tribal member, or a member of another Tribe; and (2) resides within the Tribe's five-county contract health service delivery area. SCIT Contract Health Service Eligibility Criteria, **Ex. A**.

If the patient met the above criteria and the CHS program determined that the medical services being sought were deemed necessary[5], the Tribe's CHS program (as the "ordering official") issued a "purchase order" or "referral," authorizing the service in accordance with 42 C.F.R. 136.24(a). *See, e.g.*, 6/12/15 Referral, **Ex. C**; Raphael Dep., **Ex. D**, at 11:19-24; Robinson Dep., **Ex. E**, 11:3-12:15. The patient was then required to present the purchase order/referral from the CHS program to the provider at the time of service. *See* Robinson Dep., **Ex. E**, at 20:21-21:1; Fox Dep., **Ex. F**, 34:24-35. SCIT's CHS program issued a purchase order/referral authorizing all of the claims at issue in this lawsuit.

C. THE BLUE CROSS BLUE SHIELD ASSOCIATION REQUIRES BLUE CROSS MEMBER COMPANIES TO APPLY MLR PRICING WHEN THE NATIVE AMERICAN AUTHORIZED TO RECEIVE SERVICES IS INSURED BY ANOTHER BLUE CROSS MEMBER COMPANY.

The Blue Cross Blue Shield Association ("BCBSA") is the national association that regulates the BCBS brand and licenses to Blue Cross companies covering all 50 states. *See* https://www.bcbs.com/learn/frequently-asked-questions

[5] Not all medical services were deemed necessary. In accordance with 42 C.F.R. 136.23(e), the Tribe prioritized care based on relative medical need to cover all authorized services. *See* Raphael Dep., **Ex. D**, at 23:3-5 *see also* Nimkee Clinic PowerPoint, **Ex. G**, at SCIT041713-17.

(visited 3/26/20). The BCBSA establishes rules for processing claims between its member companies (*i.e.*, claims when a person insured by a BCBS company receives medical services outside of their BCBS territory), but does not regulate how a BCBS member company processes claims within its own territory.

In communications to its member companies across the country (including BCBSM), the BCBSA consistently and repeatedly used the straightforward reading of the plain language of the MLR regulations summarized above.

Indeed, the BCBSA issued "National Programs Business Applications Business Requirements Indian Health Services – Medicare Like Rates" ("National Business Requirements – MLR") in 2013 which explicitly required its member companies across the country (including BCBSM) to apply MLR pricing methodology when processing hospital claims for a Native American insured by another BCBS member company, so long as four basic requirements were met:

1. The member is Native American, and
2. The services were rendered at a non-IHS institutional facility, and
3. The member received an approved Purchase Order, and
4. The facility accepts Medicare Assignment.

National Business Requirements – MLR, § 6.4, **Ex. H**; 8/20/13 BCBSA National Programs 2014 Scope Overview, **Ex. I**, at 101 and 111.

But BCBSA went much further in its MLR Business Requirements for Blue Cross member companies. As part of its National Business Requirements for

Medicare-Like Rates, BCBSA eliminated any excuses by a BCBS member company not to price eligible claims using MLR pricing methodology.

For example, the MLR Business Requirements state that "Home Plans will have access to the Medicare-like Rates or they will have to get it." BCBSA National Business Requirements - MLR § 5.2, **Ex. H** (emphasis added). This eliminated the excuse offered by some BCBS member companies (such as BCBSM in this lawsuit) that they could not price claims at MLR because they did not have the technical capability to perform MLR pricing.

BCBSA also eliminated the excuse of a BCBS member company not pricing claims at MLR because the BCBS member company did not know whether a purchase order had been issued by the Tribe's CHS program authorizing the services at issue. The National Business Requirements state that "it is Home Plan's responsibility to determine if a Purchase Order is needed for a claim. Home Plan may obtain a Purchase Order by: [] contact[ing] the member for a copy of the Purchase Order; [or] ask[ing] the Host Plan to contact the provider." *Id.* § 6.8.

Finally, BCBSA eliminated the excuse that a BCBS member company would not price a claim using MLR pricing methodology because the BCBS member company did not know whether the hospital that provided services participated in Medicare. The National Business Requirements state that "when Home Plans are determining whether or not to apply the Medicare-like Rate to a

Native American they should assume the provider accepts Medicare Assignment," as almost all hospitals accept Medicare. *Id.* § 6.18.[6]

D. BCBSM KNEW THAT MLR PRICING APPLIED TO HOSPITAL SERVICES AUTHORIZED BY SCIT'S CHS PROGRAM, BUT FAILED TO APPLY MLR PRICING TO THOSE CLAIMS.

BCBSM's own internal documents – from before this lawsuit was filed – also adopt this interpretation of the MLR regulations. BCBSM consistently and repeatedly acknowledged that MLR pricing methodology applied to SCIT's claims at issue in this lawsuit – yet BCBSM failed to act prudently to develop the capacity to price those claims using MLR pricing methodology.

BCBSM knew of the MLR regulations within a month of when they went into effect. Tellingly, BCBSM described the MLR regulations as follows:

> **Do you have any tribal Contract Health groups? The IHS has ruled that they pay Medicare or lower at the hospital.** 8/22/07 email, **Ex. J** (emphasis added).

By October 2007, BCBSM began internal discussions on how to implement MLR pricing for its Tribal clients operating CHS programs, focusing initially on the Grand Traverse Band of Ottawa and Chippewa Indians ("GTB"), as GTB first

[6] Because the BCBSA does not regulate a BCBS member company within its own territory, BCBSA stopped short of requiring BCBS member companies to apply MLR pricing to its own claims. *See* 12/20/13 email, **Ex. K** ("The Association is not requiring a Blue Plan acting as a TPA for a self-funded tribe to pay no more than the Medicare-Like Rates. We are leaving that up to each Plan to determine the appropriate payment for services.")(emphasis added).

brought the MLR regulations to BCBSM's attention. 10/25/07 email, **Ex. L**. BCBSM discussed using its Blue Care Network (BCN) system to calculate MLR pricing and identifying this as "corporate project." *Id.*, 10/25/07 email ("BCN can process claims like Medicare").[7]

By January of 2008, BCBSM also was discussing MLR with Blue Cross Blue Shield of Minnesota, who had already developed MLR pricing capability for hospital services approved by a tribe's CHS program:

> Our affiliate, CCStpa, is offering to reprice claims as a service to Indian Tribes. **Most of the tribes have little or no chance of figuring out what a Medicare-like rate might be**, so CCStpa is offering to perform that service on a service bureau basis.
>
> Our materials are very explicit in the disclaimers that this is not a health plan and **the repricing only applies to persons who are approved for medical services through the tribe's IHS/CHS program**. 1/21/08 email, **Ex. M** (emphasis added).

In early 2009, BCBSM agreed to provide GTB with an additional 8% discount on claims at Munson hospital approved by GTB's CHS program, to make

[7] Notably, BCBSM's early internal discussions also reference the potential impact of MLR pricing on BCBSM's Provider Health Agreements (PHA) with hospitals. Because Medicare-participating hospitals are legally required to accept MLR pricing as "payment in full" for services authorized by a tribal CHS program under 42 C.F.R. § 136.31(j), in circumstances where the MLR price was lower than BCBSM's network price negotiated with the hospital, the hospital would be paid less than for the same services than other BCBSM insureds. Concern about the impact of MLR pricing on its provider hospitals – and whether hospitals would in turn seek a network price increase from BCBSM to offset the lost revenue to the hospital from MLR pricing – is one reason BCBSM was so reluctant to implement MLR pricing for its tribal clients. Root Dep. **Ex. N**, 85:9-87:7, 89:24-91:3.

the net amount paid by GTB's self-insured member plan for those claims "close to" MLR pricing. Deiss Dep. **Ex. O**, at 32:19-33:12, 34:9-13, 35:25-36:12.

With GTB placated (at least for the time being), BCBSM shelved any further actions to implement MLR pricing. The issue of MLR pricing did not come up again until 2011, when Gallagher Benefits Services ("Gallagher") – the insurance broker for SCIT and several other Michigan tribes – raised the MLR issue:

> Per our conversation yesterday, please find a presentation about the Native American BCBS/Tribal Care plan being launched in AZ. Besides, AZ, there are a few states in the Pacific Northwest where BCBS and other carriers are on the cutting edge of Medicare-Like Repricing (MLR), a unique function of claims offered to Native Americans. . . .
>
> Unfortunately, BCBS MI doesn't coordinate any of these discounted rates so the Tribes are losing money. Since we at GBS are the agents for the majority of the MI Tribes, **we need to make sure that the carriers are capturing every discount available to the NA [Native American] community.** 1/7/11 email, **Ex. P** (emphasis added).

Gallagher introduced BCBSM executives to HealthSmart, the company who developed the TribalCare program that BCBS of Arizona was using for MLR pricing. 8/12/11 email, **Ex. Q**. Gallagher urged BCBSM to partner with HealthSmart to provide MLR pricing to tribal clients, even if only on a short-term basis while BCBSM developed its own internal capabilities to conduct MLR pricing. *Id.*; 7/6/11 email, **Ex. R** ("we presented an option to BCBS that would be the easiest course to incorporate MLR pricing. I don't know where that stands at BCBS but now would be a good time to put it on the fast track").

By late 2011, BCBSM again confirmed that its tribal clients were entitled to MLR and that BCBSM's failure to provide MLR was a risk to its tribal business:

> **Medicare Like Rates (MLR) – All tribal groups are eligible to receive MLR when paying for services at our hospitals. To date, we have been unable to configure our system to gain this discount for our BCBSM tribal groups** and are only able to give estimates based on Medicare volumes. Tribal Care is a TPA selling this service to our tribal customers. 12/13/11 email, **Ex. S** (emphasis added).

Yet BCBSM put off developing MLR pricing capabilities again, determining that it did not have the IT resources available to develop MLR pricing capability. 10/19/11 email, **Ex. T** (also noting that lack of MLR pricing had not hindered BCBSM's sales efforts for new casino business from tribal customers).

Gallagher raised the MLR issue again with BCBSM in September 2012 in a pointed (and prescient) email:

> Over the past few years, we've tried to find a way for BCBS to identify and incorporate Medicare-Like Repricing (MLR) into their system **to assure MI Tribal Nations that they are getting the best financial outcomes** for their citizens . . . . I'd like to put this issue back on the table.
>
> * * *
>
> **If it turns out BCBS discounts are better [than MLR pricing], that's great. However, we need to have data in order to educate the clients and counter the competition.**
>
> **If it turns out that we can reduce the spend (and exposure to Stop Loss), we should waste no more time getting this process incorporated. It wouldn't look good if BCBS was aware of the MLR savings and chose not to identify and incorporate them.** 9/4/12 email, **Ex. U** (emphasis added).

Gallagher continued to ask BCBSM whether BCBSM's lack of MLR pricing capability was causing self-insured tribal plans (such as SCIT) to pay more than they should be for hospital claims:

> [B]elieve me, **I'm not looking past the discounts that BCBSM has here in Michigan and I'm not entirely sure that Medicare-like rates will be much different than those discounts. But, I'm sure you can understand that we can't just make that assertion and hope for the best.** Our mutual clients are going to want proof and at the very least, know that BCBSM is investigating who they can accommodate processing claims at Medicare-Like Rates. 10/5/12 email, **Ex. V** (emphasis added); *see also* 10/9/12 email, **Ex. W** (complaining that BCBSM's MLR effort "is going nowhere fast").

By late 2012, BCBSM once again put off developing MLR pricing capability, again blaming IT constraints for the delay. 11/11/12 email, **Ex. X**. Upon learning that BCBSM was once again delaying implementation of MLR pricing for tribal clients, Gallagher (again) warned BCBSM that if "**the Tribes could have been saving millions [with MLR pricing], it will look bad for BCBS**." 1/9/13 email, **Ex. Y** (emphasis added).

In the spring of 2013, GTB dropped BCBSM and switched to another carrier to administer claims for GTB's tribal members. This "shot across the bow" acted as a (temporary) wake-up call to BCBSM, leading BCBSM to do the following:

- Reach out to BCBS member companies with larger Native American populations to discuss how they handle MLR pricing. 3/11/13 email, **Ex. Z**;
- Reconnect with BCBS of Minnesota to discuss whether BCBS of Minnesota could perform MLR pricing for BCBSM. 3/25/13 email, **Ex. AA**;

- Obtain BCBS of Minnesota's interpretation of the MLR regulations. 4/10/13 email, **Ex. BB** ("**MINN. Blues also say that if a tribe is 'self-determined' (manage their own CHS program), ALL members are entitled to MLR whether they have other coverage or not**")(emphasis added); *see also* 7/29/13 email, **Ex. CC** (BCBS Minnesota "opinion [is] that all tribal members regardless of their employment status are eligible for Medicare like rates").

- Confirm its own internal understanding that "**the non-employed tribal groups (CHS – Contract Health Services) are unquestionably entitled to Medicare-like rates and act as the tribes insurer of last resort**…." 7/17/13 email, **Ex. DD** (emphasis added).

- Once again question how much tribal groups might save with MLR pricing. 4/12/13 email, **Ex. EE** ("trying to estimate the impact Medicare Like Rates will have on our tribal groups").

- Discuss with other BCBS member companies the logistics of how to confirm that the services had been authorized by the tribe's CHS program. 4/12/13 BCBSM internal email, **Ex. FF** ("would the Indian Health Services/Tribal Clinic enter an authorization for its specific services, or is the activation of medical eligibility [] the only authorization of services required?"); 7/16/13 email, **Ex. GG** (discussing with BCBS of New Mexico options for how to set up a claims system to account for the purchase order from the tribe's CHS department to validate CHS authorization).

- Put a "project team in place working to find a solution to Tribal MLR processing for all tribes across the state." 8/23/13 email, **Ex. HH**; 9/13/13 email, **Ex. II** ("**as you may be aware, tribal members are entitled to Medicare-like rates at a hospital. In order to accommodate this requirement, a work group has been formed … to deliver a solution for our tribes**")(emphasis added).

However, despite this short flurry of activity, BCBSM's overall effort to comply with MLR pricing methodology for its self-insured tribal clients continued "to go nowhere fast." BCBSM still failed to make a data-based determination of

how MLR prices actually compared to BCBSM network prices. *See* 7/3/13 email, **Ex. JJ** ("If we could determine the PHA/MLR discount difference with some confidence – and it was on the narrower end of the scale it might take some of the steam out of the MLR situation …. If the spread turns out to be wide we'll at least know that we need to move to a solution for the tribes pretty quickly"); 7/22/13 email, **Ex. KK** ("MLR advantage over BCBSM in MI unknown"); 3/21/14 email, **Ex. LL** ("hoping the re-pricing results come in this afternoon!").[8]

In February 2014, BCBSM pulled the plug on using BCBS of Minnesota to provide MLR pricing upon determining that using BCBS Minnesota would require BCBSM to follow the BCBSA National Requirements for MLR (since BCBSM would be using another BCBS member company to price claims):

> I have left a few voicemails but wanted to send a follow up email in regards to the fact that **due to requirements of BCBSA mandate around processing MLR claims BCBSMI is pursuing an internal solution at this time.** 2/7/14 email, **Ex. MM**.

BCBSM then shifted back <u>yet again</u> to the possibility of using its Blue Care Network system to price claims at MLR, but were told by the BCN group that "we are a bit bound up for 1/1/15 but I could get something going for later timelines."

[8] BCBSM remained willfully ignorant about whether its self-insured tribal clients would save money with MLR pricing compared to BCBSM network pricing. Although BCBSM knew by 2009 that MLR pricing was approximately 8 percent lower than BCBSM network pricing at Munson Hospital in Traverse City, BCBSM did not make any effort to determine if MLR pricing would save money for its other self-insured tribal clients, such as SCIT.

6/23/14 email, **Ex. NN**. BCBSM then considered implementing a manual MLR repricing process, but stopped in Fall of 2014 once it determined that MLR only applied to self-insured plans. This meant that MLR would only apply to a small number of tribal clients, because most of BCBSM's tribal clients switched to traditional fully insured programs after adoption of the Affordable Care Act. 9/26/14 email, **Ex. OO** (applying MLR pricing only to self-insured tribal groups "would narrow this down … to the Sag Chips").

By the end of 2014, BCBSM had only two self-insured tribal clients, one of which was SCIT. 2/12/15 email, **Ex. PP**. BCBSM's efforts to implement MLR pricing crawled to a stop once BCBSM realized that only two of its clients would benefit from MLR pricing. 1/16/15 BCBSM email, **Ex. QQ** (MLR only applied to "Odawa and Sag Chips" and asking for further direction "given that only self-funded tribes are in scope"); 3/6/15 email, **Ex. RR** ("the cost benefit analysis on this [developing MLR pricing capability] may be a tough one").

When Gallagher asked BCBSM in June 2015 (again) to "tell me where things stand with BCBS implementing MLR for tribal claims?", the immediate internal response of BCBSM was "Oh boy … see below." 6/25/15 email, **Ex. SS**.

In response to renewed pressure from Gallagher on MLR pricing, BCBSM finally estimated the difference between MLR pricing and BCBSM network pricing – and determined that the difference was <u>massive</u>:

> **Basically in 2007 (it could be even earlier) the government passed regulations that allow for tribal members to receive Medicare Like Rates for services provide[d] at hospitals that participate with Medicare.** We have many competitors that are able to apply these rates which can bring the claims payment down anywhere from **10 to 18% under our negotiated rates** depending on region etc. 8/7/15 BCBSM email, **Ex. TT** (emphasis added).[9]

In Fall 2015, BCBSM re-entered discussions with both HealthSmart and BCBS of Minnesota to partner on MLR pricing, including discussing:

- The possibility that the Tribe might need to "amend its tribal employee self-insured program to coordinate the PRC program with the self-insured program" once MLR pricing capability was put in place; and

- How to "coordinate the authorization of tribal members for PRC eligibility and to coordinate the purchase order process." 9/9/15 email, **Ex. UU**.

In January 2016 – after years of getting the runaround by BCBSM on MLR pricing – SCIT filed this lawsuit. 1/29/16 Compl., ECF No. 1. Less than a month after being sued, BCBSM put MLR pricing on hold. 2/26/16 email, **Ex. VV**.

E. SCIT DID NOT KNOW THAT BCBSM WAS SQUANDERING PLAN ASSETS.

There is no question that SCIT understood within the first year after the MLR regulations went into effect that BCBSM did not have a system in place to determine the MLR price for a hospital claim. What SCIT did not know is that BCBSM's failure act prudently to develop a means to price the Tribe's hospital

[9] For context, SCIT's self-insured plan for tribal members spent upwards of $10 million per year on hospital claims. A savings of 10 to 18 percent over BCBSM network prices would have saved the Tribe millions of dollars annually.

claims at MLR was causing the Tribe to pay millions of dollars more from plan assets than it should have been. Sprague Dec., **Ex. WW**, at ¶¶ 8-9.

As discussed above, Gallagher (SCIT's insurance broker) did not know whether MLR pricing was lower than BCBSM network pricing, despite repeatedly asking BCBSM for such information. Kamai Dep., **Ex. XX**, at 57:3-22, 59:9-60:10, 62:8-63:5, 79:14-21, 80:6-16 (discussions with SCIT about any difference between MLR and BCBSM pricing were "really speculative conversation" because BCBSM failed to provide any information comparing MLR with BCBSM pricing); Brooks Dep., **Ex. YY**, at 58:16-61:20 (noting that BCBSM consistently downplayed the possibility of MLR savings by describing any difference between MLR pricing and BCBSM network pricing as "not significant" and refusing to provide data on any difference between MLR and BCBSM network pricing).[10]

III. LAW AND ARGUMENT

A. BCBSM BREACHED ITS FIDUCIARY DUTIES TO THE TRIBE AND ITS SELF-INSURED PLANS.

It is law of the case that BCBSM was a fiduciary to SCIT and its self-insured plans. *SCIT v. BCBSM*, 748 Fed. App'x at 20-21. As the Sixth Circuit noted, this means that BCBSM owed the following fiduciary duties to Plaintiffs:

[10] SCIT's Executive Director for its health care clinic also testified that she did not know that MLR pricing was lower than BCBSM network pricing. *See* Fox Dep. 144:3-145:5, **Ex. F**.

> (1) the duty of loyalty, which requires "all decision regarding an ERISA plan … be made with an eye single to the interests of the participants and beneficiaries"; (2) the "prudent person fiduciary obligation," which requires a plan fiduciary to act with the "care, skill, prudence, and diligence of a prudent person acting under similar circumstances," and (3) the exclusive benefit rule, which requires a fiduciary to "act for the exclusive purpose of providing benefits to plan participants." *Id.* at 20.

More specifically, it is also law of the case that, if the claims at issue were eligible for a lower, Medicare-like rate and BCBSM, as a result of its lack of prudence, consistently caused the Tribe to overpay on those claims, that constitutes a breach of fiduciary duty by BCBSM. *Id.* at 20-21. In remanding the case, the Sixth Circuit narrowed the remaining issues to whether "the Tribe can[] show, as a factual matter, that the regulations apply to its ERISA plan." *Id.* at 21.

1. MLR Pricing Methodology Applies To All Hospital Services Authorized By SCIT's CHS Program.

a. *Hospital claims do not have to be paid for by CHS program funds to be eligible for MLR pricing.*

The MLR regulations are clear and unambiguous. All levels of care furnished by a Medicare-participating hospital that are authorized by a Tribe's CHS program are eligible for MLR pricing. 42 C.F.R. 136.30(b). This is what the BCBSA concluded upon reviewing the regulations (and required of BCBS member companies when pricing claims for other BCBS member companies); this is what BCBS of Minnesota concluded upon reviewing the regulations; and this is what BCBSM itself admitted – over and over again – prior to this litigation.

This was also the conclusion of Judge Lawson in *Little River Band of Ottawa Indians v. Blue Cross Blue Shield of Michigan*, 183 F. Supp. 3d 185 (E.D. Mich. 2017), where the court rejected BCBSM's identical argument:

> **[T]he governing regulations plainly require that payments be capped at "Medicare-Like Rates" for *all* qualifying services, regardless of the source of funds, as long as the services were authorized** by the rules of the federally-funded Indian Health Services "Direct Care" or "Contract Health Services" programs. *Little River Band*, 183 F. Supp. 3d at 843 (emphasis added)(italics in original).

None of BCBSM's cited sources state that MLR pricing only applies to the extent CHS funds are used to pay for the claim. BCBSM can only make its own conclusory assertion that "[i]n other words, MLR applies only to care funded by a CHS program." BCBSM Br. at 18.

BCBSM's cherry-picked quotes from a July 2013 IHS letter are particularly misleading. Besides being of marginal legal relevance, the IHS letter fully supports SCIT's position. The letter includes numerous statements that directly mirror SCIT's plain-language interpretation of the MLR regulations:

- "42 U.S.C. § 1395cc(a)(1)(U) **requires Medicare participating hospitals to accept no more than MLR for services authorized by Tribal contract health service (CHS) programs**";
- "Section 506 of the MMA authorized [IHS] to establish a payment methodology, payment rates, and admission practices **for non-IHS services referred through CHS programs**";

- "The Department promulgated regulations on June 4, 2007, **governing payment of non-IHS services approved by CHS programs, including CHS programs operated by Tribes**";

- "**The MLR rule expressly limits use of the MLR to non-IHS services authorized by CHS programs, including CHS programs operated by Tribes**";

- "The MLR would not apply to … other types of health benefits coverage offered by a Tribe **that does not adhere to all current CHS rules**;"

- "**In summary, the MLR is limited to CHS services authorized by IHS; or by a Tribe or Tribal organization carrying out an ISDEAA contract or compact**." BCBSM Br., Ex. 5, PgID 9015-9017 (emphasis added).

b. ***Whether SCIT's self-insured plans are primary or secondary payors to the Tribe's CHS program is irrelevant.***

BCBSM argues that the Tribe's CHS program is the "payor of last resort," such that "alternate resources" – including the Tribe's self-insured plans – must pay first before the Tribe's CHS funds are used. BCBSM also argues that the Tribe's self-insurance plans must pay before the Tribe's CHS program funds are used because the Tribe's self-insured plans do not have coordination of benefits provisions that make the self-insured plans secondary to the Tribe's CHS program.

Whether the Tribe's self-insured plans must pay first prior to the Tribe's CHS funds being used to pay for services is completely irrelevant. The question at issue here is whether the MLR payment methodology applies to the hospital services authorized by SCIT's CHS program that were paid for through the Tribe's self-funded insurance plans – not who pays first. As discussed above, MLR payment

methodology applies to all levels of care provided by a Medicare-participating hospital authorized by a Tribe carrying out a CHS program – without reference to what funding sources paid for the authorized care (or the order of payment).

The MLR regulations do not state that a tribal CHS program cannot authorize a referral to a hospital when an "alternate resource" is available to pay for some or all of the costs for the services being authorized. Rather, the MLR regulations state that CHS funds cannot be spent for those outside services until those "alternate resources" available to pay for the hospital services are exhausted.

But even when other insurance sources are available to the Native American, a referral to a hospital can still be authorized by the Tribe's CHS program. "Alternate resources" and coordination of benefits deal with whether the Tribe's CHS program pays first or second – not whether the referral for outside hospital services is authorized by the Tribe's CHS program.

SCIT's CHS program routinely authorized hospital services for which its CHS funds were secondary to another payment source–whether that was Medicare, Medicaid, one of the self-insurance plans sponsored by the Tribe, or other insurance available to the patient. As "payor of last resort", the Tribe's CHS program only paid any balance not paid by other insurers (such as deductibles, copays). Indeed, while some patients whose outside health care was authorized by the Tribe's CHS program had no other insurance, most of the patients whose

outside health care was authorized by SCIT's CHS program did have some other source of insurance coverage – whether under one of the Tribe's self-insured plans or otherwise. Raphael Dep., **Ex. D**, at 14:19-25; Fox Dep., **Ex. F**, at 13:1-14 (noting that one of the Tribe's criteria for assessing CHS eligibility was that an individual show proof of any insurance or health care coverage).

That is not to say that the scope of health care services that a tribal CHS program can authorize is unlimited. The Tribe's CHS program must pay for any health care service that it authorizes for referral to an outside provider once "alternate resources" are exhausted. As such, the CHS regulations require the tribe's CHS program to establish a priority schedule for the types of health care services the CHS program will authorize for outside referral. This ensures that Native Americans with the greatest relative medical need for outside medical services always can obtain authorization from the tribe's CHS program and have those medical services paid for by some source of coverage. 42 C.F.R. § 136.24(e).

SCIT followed the CHS regulations, adopting priority levels that limited the types of health care services that the Tribe's CHS program would authorize for outside referral. *See* SCIT CHS/PRC Policies, **Ex. ZZ (**defining the scope and limits of the types of services the Tribe's CHS program would authorize for various types of medical care); Raphael Dep., **Ex. D**, at 23:3-5; Nimkee Clinic PowerPoint, **Ex. G**, at SCIT041713-17. All of the hospital claims at issue in this lawsuit met

the priority levels established by SCIT's CHS program and that were authorized for referral to an outside hospital by the Tribe's CHS program.

c. *SCIT's self-insured plans are not "alternate resources."*

Even assuming *arguendo* that MLR payment methodology does not apply to "alternate resources", SCIT's self-insured plans are not "alternate" resources to the Tribe's CHS program because the Tribe's self-insured plans are funded by the Tribe. As explained in detail by the District Court in *Redding Rancheria*, "[c]onsistent with congressional intent not to burden Tribal resources, the Agency [IHS] has made a determination that **tribally-funded self-insured plans are not to be considered alternate resources** for purposes of the IHS' Payor of Last Resort Rule." *Rancheria v. Hargan*, 296 F. Supp. 3d 256, 271 (D.D.C. 2017)(emphasis added)(quoting IHS's pre-2010 interpretation of "alternate resources" the Indian Health Manual and rejecting IHS's justification for changing its interpretation after 2010 as an "erroneous" interpretation that would "directly contradict" congressional intent); *see also* 25 U.S.C. § 1621a(d)(5)(defining alternate resources under the CHEF program created under the Act as limited to "other Federal, State, local, or private source(s) of reimbursement" – not tribal resources).

2. That BCBSM Is Not A Fiduciary Over The Tribe's CHS Funds Is Irrelevant.

BCBSM's "fiduciary over CHS funds" argument is a red herring. The Tribe is not arguing that BCBSM squandered the assets of the Tribe's CHS funds. The Tribe agrees that BCBSM was not a fiduciary over the Tribe's CHS funds.

BCBSM conflates the Tribe's CHS program authorizing the referral for outside hospital services with who paid for the hospital services. The Tribe only seeks recovery for hospital services authorized by the Tribe's CHS program that were paid for by the Tribe's self-insurance plans, for which BCBSM is a fiduciary.

3. BCBSM'S Argument That It "Simply Followed The Specific Design Of The Employee Plan" Mischaracterizes The Tribe's Claims And Should Be Rejected.

BCBSM mischaracterizes the Tribe's position as alleging that BCBSM was required to defy the terms of the Tribe's plans to obtain MLR pricing for the Tribe. BCBSM Br. at 30, PageID.8922. This is blatantly incorrect and is (again) based on the legally incorrect premise that the MLR payment methodology only applies to claims paid for with CHS funds. MLR pricing applies to all hospital claims authorized by the Tribe's CHS program without reference to the source of payment.

It was entirely appropriate for the Tribe not to include language in its self-insured plans related to coordination of benefits with CHS funds and to require its self-insured plans to pay for hospital services prior to CHS funds being used. The

Tribe is not arguing that its self-insured plans should have been treated as secondary or should not have paid claims until CHS funds were exhausted.

4. The Tribe Is Not Arguing That BCBSM Breached Its Fiduciary Duties In Negotiating Its Network Rates With Healthcare Providers.

BCBSM attempts to re-litigate its "fiduciary" designation by the Sixth Circuit by characterizing its lack of prudence in applying MLR pricing as a mere "business decision" that somehow involves "negotiation" with various unrelated providers (ECF No. 173, PageID.8923). The Sixth Circuit previously rejected a similar tack by BCBSM in the context of BCBSM's access fee fraud. *See Hi-Lex Controls, Inc. v. BCBSM*, 751 F.3d 740, 746 (6th Cir. 2014) ("While BCBSM attempts to characterize its arrangement with Hi-Lex as a service agreement between two companies—with no thought toward ERISA and its protections—that argument is unavailing.").

BCBSM's focus on irrelevant network rate negotiations is a strawman. Plaintiffs are not arguing that BCBSM was a fiduciary when it negotiated network rates with providers. Plaintiffs' claims address BCBSM's failure "to preserve plan assets by continually and consistently overpaying claims that defendant found eligible for coverage," which is not analogous to negotiating rates. *Grand Traverse Band of Ottawa & Chippewa Indians v. BCBSM,* No. 14-CV-11349, 2017 WL 3116262, at *4–5 (E.D. Mich. July 21, 2017).

For the same reasons, BCBSM's reliance on *DeLuca* and *Moeckel* is misplaced. Unlike *DeLuca* and *Moeckel*, this case does not relate to the initial development of formularies marketed to customers or negotiation of prices paid to providers. In the Sixth Circuit's words, BCBSM knew providers were required to accept MLR by regulation in lieu of other contract rates and systematically failed to comply with the regulation, which would have preserved plan assets. *SCIT v. BCBSM*, 748 Fed. App'x at 20-21. Contrary to BCBSM's creative (mis)reading of Plaintiffs' claims, the *DeLuca* Court expressly indicated these claims do implicate fiduciary concerns. *See DeLuca v. BCBSM*, 628 F.3d 743, 747-48 (6th Cir. 2010) (squandering plan assets implicates fiduciary concerns); *see also Pegram v. Herdrich*, 530 U.S. 211, 231 (2000)(the "trustee's most defining concern historically" is "the payment of money in the interest of the beneficiary").

5. BCBSM'S Argument That Its Breaches of Fiduciary Duty Should Be Excused Because It Did Not Know Which Claims Had Been Authorized by the Tribe's CHS Program Should Be Rejected.

BCBSM's final "Hail Mary" argument is that its breaches of fiduciary duty should be excused because BCBSM did not know which particular hospital claims had been authorized by the Tribe's CHS program – and thus did not know exactly which claims were eligible for MLR pricing. BCBSM's position is meritless.

BCBSM's argument fundamentally mischaracterizes both the scope of BCBSM's fiduciary duties and the nature of the Tribe's allegations. BCBSM had a

"prudent person fiduciary obligation" related to the funds in the Tribe's self-funded insurance plans. Effectively, BCBSM had to make decisions about payment of claims from plan funds the same way it would if it was BCBSM's money.

BCBSM knew that SCIT operated a CHS program. It was imprudent – indeed reckless – for BCBSM to ignore MLR pricing discounts generally applicable to SCIT tribal members just because BCBSM buried its head in the sand concerning which claims had been authorized by the Tribe's CHS program.

The obvious and prudent thing for BCBSM to do would have been to ask SCIT for those purchase order authorizations – whether manually or by developing an automated system for obtain those authorizations from either the CHS program or from providers. Indeed, that is what the BCBSA required its Blue Cross member companies to do for MLR-eligible claims exchanged between Blue Cross member companies. *See* National Business Requirements – MLR, § 6.8, **Ex. H**.

BCBSM fully understood that, as part of implementing MLR pricing, it would have to develop a method to obtain purchase order authorizations from the CHS programs of its self-insured tribal customers. As discussed above, BCBSM repeatedly explored the logistics of obtaining purchase order authorizations from tribal CHS programs with HealthSmart and BCBS of Minnesota, among others.

It goes without saying that SCIT would have fully cooperated with providing purchase order referrals from its CHS program to BCBSM if the lack of proof of

authorization was what was preventing BCBSM from applying MLR pricing methodology. Of course, the reason SCIT did not provide purchase order referrals to BCBSM is because those documents were useless to BCBSM – because BCBSM never developed the capability to apply MLR pricing methodology.

B. THE TRIBE'S ERISA CLAIM IS NOT TIME BARRED.

The Tribe's ERISA claim is not time-barred because the Tribe did not know that BCBSM had been squandering plan assets and causing Plaintiffs to overpay claims eligible for MLR at inflated rates until November 2014 or later. *See* Sprague Dec., **Ex. WW**, at ¶¶ 8-9; *see also* Section II.E, *supra*.

BCBSM alleges Plaintiffs had "actual knowledge" of BCBSM's misconduct because the Tribe "always knew" that "BCBSM applied its network rates . . . without ever applying MLR." (ECF No. 173, PageID.8916). But the "actual knowledge" standard requires knowledge of all "material facts upon which [Plaintiffs'] claims for breach of ERISA fiduciary duties are based," not just those snippets of facts that BCBSM believes relate in some way to the breach. *Wright v. Heyne*, 349 F.3d 321, 331 (6th Cir. 2003).

The material facts underlying BCBSM's fiduciary breaches – which BCBSM conveniently ignores – are BCBSM's willful ignorance over whether it was squandering plan assets by failing to apply MLR pricing; BCBSM's lack of prudence by failing to develop a means of applying MLR pricing, whether

internally or by partnering with another vendor; and resulting repeated and systematic overpayments (using Plan assets) on claims eligible for lower MLR prices. As the Sixth Circuit characterized Plaintiffs' claim: "BCBSM failed to preserve plan assets by consistently causing the Tribe to overpay on claims that were eligible for a lower, Medicare-Like Rate." *SCIT v. BCBSM* , 748 Fed. App'x at 20-21 (emphasis added).

Plaintiffs did not know BCBSM had been overpaying MLR-eligible claims at amounts in excess of MLR until the Tribe learned in November 2014 that GTB 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.[11] *See* Sprague Dec., **Ex. WW**, at ¶¶ 8-9; *see also* Section II.E, *supra*. BCBSM admits Plaintiffs' lack of actual knowledge in this regard (ECF No. 173, PageID.8907) ("The Tribe did not necessarily know the MLR dollar amount for any particular claim . . . compared . . . with BCBSM's network rate.").

[11] BCBSM's fabrication of its misconduct at issue (as a mere failure to apply MLR) unravels when considered as a practical matter. Imagine that BCBSM's network rate for a medical procedure is $50, but the MLR price is $100. In that scenario, BCBSM does not breach its fiduciary duty by paying its network rate and not applying MLR pricing methodology. But imagine that the reverse is true– BCBSM's network rate is $100, but the available MLR price is $50. In that case, BCBSM squanders plan assets and breaches its fiduciary duty by not using due care to take advantage of the lower MLR price.

BCBSM attempts to obfuscate the material facts underlying its fiduciary breaches by conflating its own misconduct with the Tribe's damages (ECF No. 173, PageID.8917). While the specific amounts of BCBSM's overpayments might be a damages issue, the fact that BCBSM's lack of prudence resulted in systematic overpayments of claims by the plans is BCBSM's fiduciary breach, which the Tribe was not aware of until November 2014. *See* Section II.E, *supra*.

BCBSM also asserts the Tribe should have known about BCBSM's fiduciary breaches because IHS sent the Tribe materials explaining the MLR regulations' purpose (ECF No. 173, PageID.8916). The Supreme Court recently rejected BCBSM's "receipt of materials" defense as improperly based on constructive, not actual knowledge. *Intel Corp. Inv. Policy Comm. v. Sulyma*, No. 18-1116, __U.S.__, 2020 WL 908881, at *5 (Feb. 26, 2020) ("As presently written, therefore, § 1113(2) requires more than evidence of disclosure alone.").

In any event, the IHS correspondence speaks to what BCBSM should have, but did not do (take advantage of MLR pricing when available), not what the Tribe actually knew about BCBSM's misconduct. *See id.* (Section 1113(2)'s limitations period "begins only when a plaintiff actually is aware of relevant facts, not when he should be.").

BCBSM also misconstrues the narrow "willfully blind" exception by asserting that the Tribe "accepted the risk" of being cheated out of MLR by

BCBSM. The Tribe never "accepted" any such risk, but "accepting the risk" does not establish willful blindness. *See Global-Tech Appliances, Inc. v. SEB S.A.*, 563 U.S. 754, 769-70 (2011) ("[A] willfully blind defendant is one who takes deliberate actions to avoid confirming a high probability of wrongdoing and who can almost be said to have actually known the critical facts."). Instead, the "willful blindness" standard requires conduct by the Tribe that surpasses even recklessness, which BCBSM does not even allege, much less establish. *See id.* at 769 ("[T]hese requirements give willful blindness an appropriately limited scope that surpasses recklessness and negligence."). In any event, "willful blindness" is ultimately an "inference the jury *may* make, not a rule of law that *must* be applied."[12] *See Fish v. GreatBanc Trust Co.*, 749 F.3d 671, 685 (7th Cir. 2014)(emphasis in original).

[12] In a footnote, BCBSM improperly attempts to resurrect its prior losing argument that ERISA's statute of repose precludes Plaintiffs' claims (ECF No. 173, PageID.8918). BCBSM's perfunctory argument is not properly before this Court. *See InterRoyal Corp. v. Sponseller*, 889 F.2d 108, 111 (6th Cir. 1989) (district court not required to speculate on which portion of the record the non-moving party relies, nor is court obligated to "wade through" the record for specific facts). In any event, this Court already acknowledged that BCSBM's mere knowledge of the MLR regulations in 2007 "does not prove that as of July 5, 2007, BCBM acted imprudently or failed to use due care on the Tribe's behalf." (ECF No. 146, PageID.7796). Moreover, BCBSM concealed its misconduct by leading the Tribe to believe it was developing MLR pricing processes, when, in fact, it was not. *See* Section II(D), *supra*. Even if BCBSM's footnote is somehow a valid argument, it only addresses overpaid claims prior to 2013, not the Tribe's other claims overpaid thereafter, for which the Tribe can recover under the continuing violations doctrine. *See Novella v. Westchester Cnty.*, 661 F.3d 128, 146 (2d Cir. 2011).

C. BCBSM IS LIABLE TO PLAINTIFFS UNDER THE HEALTH CARE FALSE CLAIMS ACT.

1. BCBSM's Claims Were False And Deceptive.

BCBSM is liable under the HFCA for cheating Plaintiffs out of MLR discounts. Contrary to BCBSM's distortion of the facts, the Tribe is a healthcare insurer protected by the HFCA against BCBSM's misconduct. *See Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross & Blue Shield of Michigan* 391 F. Supp. 3d 706, 713 (E.D. Mich. 2019) (Indian tribe that offered health care benefits to employees continuously was a "health care insurer" with statutory standing under HCFCA as to non-employee tribe members).

BCBSM asserts its claims were not "false," but its lack of prudence in pricing claims for payment by the Tribe's self-insured plans easily meet the HFCA's broad definitions of "false" and "deceptive." *See* MCL 752.1002(c) (defining "false" as "wholly or partially untrue or deceptive"); MCL 752.1002(b) (defining "deceptive" in part as the failure to reveal a material fact leading to the belief that the state of affairs is something other than it actually is).

Under the MLR regulations, the Tribe was entitled to pay hospitals lower MLR prices on eligible claims, but BCBSM presented the Tribe with claims only at its inflated network prices, misleading Plaintiffs into paying those higher prices. Sprague Dec., **Ex. WW**, at ¶¶ 6-8. That violates the HFCA. *See United States ex rel. Morsell v. Symantec Corp.*, 130 F. Supp. 3d 106, 120 (D.D.C. 2015) (plaintiff

stated presentment claim under analogous FCA provision where contractor implied it was offering government lowest price, but contractor failed to disclose more favorable pricing and adjust government's price accordingly).

BCBSM's higher network pricing presented to the Tribe for hospital claims was only a half-truth about the actual prices the Tribe was entitled to pay for those claims under the MLR regulations. BCBSM's failure to identify the MLR prices for those claims (and failure to price the claims in accordance with the MLR regulations) was a material omission to the Tribe. BCBSM is liable under the HFCA for presenting claims to the Tribe in this false and deceptive manner.[13] *State ex rel. Gurganus v. CVS Caremark Corp.*, No. 299997, 2013 WL 238552, at *8 (Jan. 22, 2013), judgment rev'd in part, vacated in part on other grounds, 496 Mich. 45, 852 N.W.2d 103 (2014) (presentation of claims for payment in a manner that violates regulations "entails omission of a material fact" and thereby meets HFCA's "deceptive" claim definition); *see also Universal Health Servs., Inc. v. United States*, __U.S.__, 136 S. Ct. 1989, 1999-2000 (2016) (claims that contain

[13] BCBSM's argument that it should be immune from liability under the HFCA because its false claims were submitted pursuant to the ASCs and "Plaintiffs' own predetermined, mutually-known, and identified Plan" (ECF No. 173, PageID.8972), is a red herring. In an analogous situation under the FCA, the Seventh Circuit held that claims presented pursuant to contractual performance "fit neatly into the FCA" because "[i]t is perfectly logical for a contracting party to knowingly submit a false invoice purportedly pursuant to a valid contract." *United States v. Pecore*, 664 F.3d 1125, 1133 (7th Cir. 2011). The same is true here.

"half-truths" or fail to disclose violations of statutory or regulatory violations are encompassed by the analogous "false claims" provision of the FCA).

2. BCBSM "Presented" And "Caused To Be Presented" False Claims To The Tribe.

BCBSM's allegation that it did not "present" any "claim" to the Tribe is self-contradictory and absurd. The HFCA broadly defines a "claim" as "any attempt to cause a health care corporation or health care insurer to make the payment of a health care benefit." MCL § 752.1002(a) (emphasis added). BCBSM itself admits that, after BCBSM paid providers, Plaintiffs were "then obligated to reimburse BCBSM for the claims paid." (ECF No. 173, PageID.8927) (emphasis in original).

Plaintiffs agree; one way BCBSM "presented" false claims to the Tribe was through reimbursement requests to the Tribe for amounts BCBSM paid to providers. Reger Dec., **Ex. AAA**, at ¶¶ 6-9. That process alone is sufficient to establish "presentment" of claims under the HFCA.[14] *Cf. United States v. Hawley*, 619 F.3d 886, 893 (8th Cir. 2010) ("presentment" of claims established under analogous FCA provision where "requests for payment" were "forwarded in some

[14] As a practical matter, this makes sense; adopting BCBSM's cramped interpretation of the HFCA's "presentment" provision would improperly immunize any false claim that occurs through a reimbursement process instead of a direct payment process. There is simply no basis under the HFCA for assigning liability to one form of transaction but not the other, when both result in payment of a false claim and accompanying damages to the ultimate payor.

form" to the government, including through electronic communications that triggered release of funds and through "reimbursement" requests).

Another way BCBSM "presented" false claims to the Tribe was through the "monthly claims listing" BCBSM was contractually required to provide the Tribe under the parties' contract. Sprague Dec., **Ex. WW**, at ¶¶ 6-8. This included a list of "Facility [*i.e.*, Hospital] claims listings showing charges by claim and in total." Administrative Services Contracts, **Ex. BBB** (quoting 2002 ASC, Art. IV (B)(4)(1)). The Tribe then had 60 days after receipt of the claims listing to review the claims listing and notify BCBSM in writing if the Tribe objected to or otherwise disputed BCBSM's payment of any of the claims on the claims listing. *Id.* at Art. II(D). This settlement and reconciliation process is also evidence of "presentment" of false claims to the Tribe under the HFCA. *Cf. Hawley*, 619 F.3d at 893-94 (annual settlement and reconciliation process where government determined whether any payments it made should be recouped from insurance company was "presentment" under analogous FCA provision).

BCBSM misleadingly quotes its attempt to elicit legal conclusions from the Tribe's lay witnesses about whether providers ever presented medical claims to BCBSM (ECF No. 173, PageID.8896, 8928). But those transactions are not the false claims at issue. After all, the MLR regulations do not regulate the amount providers can charge, but only what providers must accept as payment in full. 42

C.F.R. 136.30(a). BCBSM used those payment transactions (its directions to the Tribe on what to pay BCBSM) to bilk Plaintiffs out of MLR discounts.

3. Plaintiffs Have Sufficiently Identified BCBSM's False Claims.

BCBSM improperly seeks to dial back the clock to the pleadings stage by arguing that Plaintiffs' Complaint does not identify "false claims." (ECF No. 173, PageID.8928). The pleading stage is obviously already closed. BCBSM's status as a fiduciary has already been determined by the Sixth Circuit, as well as the basis for its liability for "causing the Tribe to overpay on claims that were eligible for a lower, Medicare-Like Rate." *SCIT v. BCBSM*, 748 Fed. App'x at 20-21.

Moreover, BCBSM is well aware of the specific category of false claims at issue, as described in its own Exhibit 35 (ECF No. 173-36, PageID.9445-9448).[15] In any event, Plaintiffs' preliminary expert report provides a detailed sampling of the "false claims" at issue; *i.e.*, claims BCBSM should have paid from the Tribe's assets at MLR pricing because MLR was less than BCBSM's network rate.

[15] BCBSM's argument is all the more disingenuous because it has exclusive possession of Plaintiffs' claims data, key components of which it has delayed in turning over for a variety of reasons. *See* 3/23/20 email, **Ex. DDD** (turning over claims data for expert review only a week ago); *see also State ex rel. Gurganus v. CVS Caremark Corp.*, 496 Mich. 45, 71, 852 N.W.2d 103, 116 (2014)(Cavanaugh, J. concurring) ("[T]he heightened pleading standard may be applied less stringently when the specific factual information is peculiarly within the defendant's knowledge or control.") (citation and quotation omitted).

3/30/20 Preliminary Expert Report of Natalyn Gardner, **Ex. CCC** (supporting spreadsheets not attached).

D. BCBSM Is Liable Under Michigan Common Law For Breach Of Fiduciary Duty.

For the same reasons BCBSM is liable under ERISA, it is liable under Michigan common law for its breaches of fiduciary duty. BCBSM mistakenly relies on *Calhoun Cnty. v. BCBSM*, 297 Mich. App. 1, 824 N.W.2d 202 (2012) for the proposition that the ASCs somehow authorized BCBSM to swindle the Tribe out of MLR discounts it was legally entitled to receive. *Calhoun County* is inapplicable here, as this Court recognized in an analogous context. *See ADAC Plastics, Inc. Employee Benefits Plan v. BCBSM*, No. 12-CV-15615-DT, 2013 WL 5313455, at *6 (E.D. Mich. Sept. 20, 2013), ("The *Calhoun* case referred to by Blue Cross is not relevant since that case specifically addressed 'Access Fees' which are disclosed in the ASC or Schedule A.").

Calhoun County involved a breach of fiduciary duty claim against BCBSM for its charging of an access fee to the county. *Calhoun Cnty.*, 297 Mich. App. at 4-8. The Michigan Court of Appeals held the access fee charges were not a fiduciary breach because "[t]he agreed-upon terms of the ASC allowed for the collection of the access fee." *Id.* at 16. In contrast, BCBSM cannot point to any provision in the ASCs (much less express language) that authorized BCBSM to deprive the Tribe of its legally-entitled MLR discounts. Unlike *Calhoun County*,

the Tribe did not "unequivocally agree" that BCBSM could disregard the MLR regulations by squandering the Tribe's funds through overpayments.

While it is now apparent that BCBSM systematically fleeced the Tribe out of MLR discounts, the ASCs never disclosed–much less authorized–that misconduct. The ASC's "standard operating procedures" language that BCBSM points to says nothing about MLR pricing, much less broadly immunizes BCBSM from its fiduciary breaches, as BCBSM theorizes. ASCs, ECF Nos. 79-3 and 79-4, Article II.A, PageID.3163 and 3181. Moreover, while the amount of the access fee was "reasonably ascertainable" in *Calhoun County*, here BCBSM never identified or incorporated the MLR rates into its procedures for the Tribe. *Cf.* 1/21/08 email, **Ex. M** ("most of the tribes have little or no chance of figuring out what a Medicare-like rate might be"). In any event, BCBSM cannot contract away its legal obligations. *See Citizens Ins. Co. of America v. Federated Mut. Ins. Co.*, 199 Mich. App. 345, 347, 500 N.W.2d 773 (1993)(holding insurance company was "not permitted to contract away its statutory obligation"). BCBSM's overwrought interpretation of *Calhoun County* should be rejected.

IV. CONCLUSION

For the foregoing reasons, BCBSM's motion should be denied.

VARNUM LLP
Counsel for Plaintiffs

Dated: March 30, 2020 By: */s/ Bryan R. Walters*

Perrin Rynders (P38221)
Bryan R. Walters (P58050)
Herman D. Hofman (P81297)
Business Address, Telephone, and E-Mail:
P.O. Box 352
Grand Rapids, MI 49501-0352
(616) 336-6000
prynders@varnumlaw.com
brwalters@varnumlaw.com
hdhofman@varnumlaw.com

CERTIFICATE OF SERVICE

I certify that on March 30, 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.

VARNUM LLP
Counsel for Plaintiffs

Dated: March 30, 2020 By: */s/ Bryan R. Walters*

Perrin Rynders (P38221)
Bryan R. Walters (P58050)
Herman D. Hofman (P81297)
Business Address, Telephone, and E-Mail:
P.O. Box 352
Grand Rapids, MI 49501-0352
(616) 336-6000
prynders@varnumlaw.com
brwalters@varnumlaw.com
hdhofman@varnumlaw.com

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