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. 1:16-cv-10317-TLL-PTM

Honorable Thomas L. Ludington

Magistrate Judge Patricia T. Morris

REPLY BRIEF IN FURTHER SUPPORT OF
BLUE CROSS BLUE SHIELD OF MICHIGAN'S
MOTION FOR SUMMARY JUDGMENT

A. Plaintiffs' Claims Fail Because The MLR Regulations Do Not Apply

Plaintiffs incorrectly argue that the MLR regulations allow *any* payer of health services to pay at MLR, so long as the services were first "authorized by" a CHS program. *See* ECF No. 175 at 20-24. If Plaintiffs were right, then *any* health plan that happens to cover a Native American tribal member—not just plans affiliated with a tribe—could pay at MLR so long as a CHS program first authorized the service. But Plaintiffs are wrong. That interpretation is untenable and disregards the scope and purpose of § 506 of the MMA, as well as the regulations implementing it. Read in their entirety, the regulations—consistent with § 506—plainly apply only to payments made by IHS-funded CHS programs.[1]

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[1] While ultimately irrelevant, Plaintiffs devote much of their response to a false narrative that BCBSM believed that the MLR regulations applied to *all* payers. ECF No. 175 at 10-18, 20. Plaintiffs' "evidence," however, shows only that business people at BCBSM investigated whether it would be possible to create a *new product* that, perhaps somehow coordinating or working with a tribe's CHS program, would allow BCBSM to pay at MLR. *See, e.g.*, Burgess Dep., Ex. 1, 39:4-7 ("I was brought in to help potentially develop a program that could be an opportunity for us to enroll unenrolled business."); Root Dep., Ex. 2, 193:24-194:10. BCBSM's *legal* position, as expressed to the Grand Traverse Band of Ottawa Indians, was that "it does not appear that the new regulations apply to BCBSM or its ASC arrangement with the Tribe." Ex. 3.

Plaintiffs' characterization of BCBSA's understanding of MLR (and of BCBSM's business relationship with BCBSA for that matter), Resp. Br., ECF No. 175 at 7-10, 20, is also misleading, and, more to the point, entirely irrelevant—as Plaintiffs readily admit. *See id.* at 10 n. 6; *see also* ASC, ECF No. 79-3, Article V, PgID.3173. Similarly, Blue Cross Blue Shield of Minnesota, like BCBSM, understood that "MLR cannot be directly applied to a self-insured plan because 42

When construing regulations, "[p]urpose is paramount." *Xilinx, Inc. v. Comm'r*, 598 F.3d 1191, 1196 (9th Cir. 2010). The language "must be understood against the background of what . . . was [sought] to [be] accomplish[ed]." *Gustafson v. Alloyd Co.*, 513 U.S. 561, 575 (1995) (quotation omitted).

Here, the purpose of the MLR regulations is to conserve IHS resources (and, in turn, CHS program funds), not to conserve the resources of *any* payer who happens to be paying for the care of a Native American, whether it be a self-insured entity such as the Tribe or, in the case of a fully-insured plan where the employer pays a premium, the insurer itself. *See* Tribal Leader Letter, ECF No. 173-23, PgID.9239 ("The [MLR] regulations will reduce *contract health expenses* for hospital services. . . .") (emphasis added).

While Plaintiffs argue that "[t]he MLR regulations are clear and unambiguous," citing 42 C.F.R. § 136.30(b), the truth is that § 136.30(b) only defines the *type* of care or services to which MLR applies; it does not directly address *which payers* for the care may pay at MLR. In other words, Plaintiffs wrongly argue that *all payers* of the care may utilize MLR, but provisions of a statute or regulation "cannot be construed in a vacuum." *Davis v. Michigan Dept. of Treas.*, 489 U.S. 803, 809 (1989). "As part of the same regulatory framework, [the] sections . . . must be read together." *United States v. Moss*, 872 F.3d 304, 310

CFR 136 does not apply to self-insured plans; it applies to PRC [(*i.e.*, CHS)] tribal programs as outlined in 42 CFR 136." Ex. 4.

(5th Cir. 2017). Plaintiffs' interpretation founders because it ignores the entire statutory and regulatory framework surrounding § 136.30(b).

Starting with the plain text of 42 U.S.C. § 1395cc(a)(1)(U) (which MMA § 506(a) inserted to incorporate MLR), the statute specifically contemplates payment by a CHS program and nobody else, requiring a hospital to submit an agreement to the Secretary of the HHS "to be a participating provider of medical care . . . (i) under the [CHS] program funded by the [IHS] and operated by the . . . tribe." This is also how the Department of Health and Human Services saw it. *See* Final Rule, 72 FR 30706-01 ("Section 506 of the MMA . . . requires [Medicare-participating] hospitals . . . to participate in the [CHS] program . . . for any medical care *purchased by those programs* . . . in accordance with the . . . payment methodology, and payment rates set forth in the [MLR] regulations.") (emphasis added). One of the co-sponsors of § 506(a) similarly explained it as "*apply[ing] to [CHS] programs*." Opinion, ECF No. 146 at PgID.7790 (emphasis added).

This understanding permeates throughout the regulatory scheme. To begin, the title of § 136.30 itself states that it governs "[p]ayment to Medicare-participating hospitals for authorized *Contract Health Services*[,]" which the regulations define as "health services *provided at the expense of the [IHS]* from . . . hospital facilities[.]" 42 C.F.R. § 136.21(e) (emphasis added). A "title or heading is a permissible indicator of the meaning of [the] text." *United States v. Heon Seok*

Lee, 937 F.3d 797, 812 (7th Cir. 2019) (citing *Yates v. United States*, 574 U.S. 528, 539-40 (2015)). From there, numerous regulations contained in 42 C.F.R. part 136 reference *IHS-funded* sources/payers (often referred to in the regulations as "I/T/Us"), including CHS programs such as the one the Tribe administers.

For example, § 136.24(a) provides that "[n]o payment will be made for medical care and services" unless certain requirements are met, including issuance of an appropriate purchase order. 42 C.F.R. § 136.24(a). Section 136.30(i) similarly provides that "[p]ayment shall be made only for those items and services authorized by an I/T/U." 42 C.F.R. § 136.30(i). Within this regulatory framework, these provisions plainly contemplate "payment" by the I/T/U, and do not in any way regulate when a "payment" by a non-CHS payer like BCBSM can "be made."

The same goes for the provisions addressing MLR. Section 136.30(e) specifically references use of MLR for the "[t]he calculation of *the payment by I/T/Us*." 42 C.F.R. § 136.30(e) (emphasis added). Section 136.30(g)(4) in turn prohibits "[t]he I/T/U payment" from exceeding MLR. 42 C.F.R. § 136.30(g)(4). None of these provisions make any reference to payments *other* than from an IHS-funded source.

Moreover, the regulations provide for "coordination of benefits" with a third-party payer (like BCBSM), in which case a CHS program's payment "will not exceed" MLR. 42 C.F.R. § 136.30(g). If MLR applies to *all* payers, then these

provisions are impermissibly superfluous. That is, if a third-party payer must pay first, and no more than MLR, then the CHS program (the payer of last resort) will not pay more than MLR *with or without* coordination provisions. Such an interpretation should be rejected. *See Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 668-69 (2007) (cautioning against "reading a text in a way that makes part of it redundant").

Plaintiffs also ignore 42 C.F.R. § 489.29, under which hospitals are only required to "accept [MLR] . . . as payment in full *for . . . [a] CHS program*." (Emphasis added). Section 489.29 does not require hospitals to accept MLR from non-CHS payers like BCBSM—yet another indication that the regulations do not contemplate a wholesale application of MLR regardless of payment source.

In arguing otherwise, Plaintiffs cite *Little River Band of Ottawa Indians v. Blue Cross Blue Shield of Michigan*, 183 F. Supp. 3d 835 (E.D. Mich. 2017) ("*LRB*"), in which the court stated that "the governing regulations plainly require that payments be capped at [MLR] for *all* qualifying services, regardless of the source of funds[.]" *Id*. at 843. The court, however, did not cite a single statute or regulation. *Id*. at 843-44. Instead, the court apparently misread the IHS's 2008 "Medicare-Like Rates for CHS Services FAQ." *Id*.; *see also* ECF No. 173-27.

The *LRB* court first cited FAQ No. 17, which states that if a "Tribe pays for patients out side [sic] of its CHSDA [contract health service delivery area] with

Tribal Funds" it can still "pay using Medicare-like Rates" so long as the patients "meet CHS eligibility requirements within the regulations and services are authorized by the CHS program." Despite the *LRB* court's suggestion, the FAQ is not referring to application of MLR to *non-CHS program payments*.

The *LRB* court also relied on FAQ No. 28, which confirms that a hospital must accept MLR "if the local hospital is a Medicare participating hospital, and if [the] CHS program has authorized payment for the services." This of course contemplates *payment by the CHS program* and is thus similarly inapplicable.

Meanwhile, the *LRB* court did not cite the four FAQs explicitly stating that "*Medicare-like rates only apply for services payable through the CHS program*[.]" *Id*. at No. 10 (emphasis added); *see also id*. at 13 ("MLR applies as long as the eligible . . . member has his care paid for by a CHS program."), No. 29, and No. 42. Thus, *LRB* provides no support for Plaintiffs' novel interpretation of the MLR regulations. Indeed, Plaintiffs' position is so devoid of merit that the court in *Redding Rancheria v. Hargan*, 296 F. Supp. 3d 256 (2017), never gave it a thought when explaining how Redding Rancheria's self-insurance program "provides access to care at discounted rates through an arrangement with Anthem Blue Cross[,]" whereas "CHS reimburses health care providers at Medicare-like rates." *Id*. at 261. In short, there simply is no support for the idea that MLR pricing applies to payments made by non-CHS program payers like BCBSM.

B. Plaintiffs' ERISA Claim Is Barred By The Statute Of Limitations

Plaintiffs argue that their ERISA claim is not time-barred under the three-year "actual knowledge" statute of limitations because they were unaware "that BCBSM had been squandering plan assets and causing Plaintiffs to overpay claims eligible for MLR at inflated rates until November 2014 or later." ECF No. 175 at 30. Plaintiffs are mistaken, however, because awareness of the extent to which MLR pricing could differ from BCBSM's network rates is not the relevant "knowledge" for purposes of determining when the limitations period began to run.

As the Sixth Circuit explained in *Wright v. Heyne*, 349 F.3d 321 (6th Cir. 2003), the proper focus is on the defendant's "underlying conduct" and not "knowledge that the underlying conduct violates ERISA." *Id.* at 331. Here, BCBSM's "conduct" was its failure to obtain MLR pricing.[2] Whether that conduct resulted in the "squandering" of plan assets, *i.e.*, whether it violated ERISA, relates to the alleged *consequences* of BCBSM's conduct. A plaintiff, however, "need only have knowledge of *the act* and cannot wait until the consequences of the act become painful." *Id.* at 330 (quotation omitted) (emphasis added).

Judge Levy recognized this difference in *GTB v. BCBSM,* No. 14-CV-11349, 2017 WL 6594220 (E.D. Mich. Dec. 26, 2017), when she rejected the exact

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[2] With respect to BCBSM's *conduct*, Plaintiffs allege only that "BCBSM failed to ensure that Plaintiffs paid no more than MLR," ECF No. 7 at ¶ 136, a fact Plaintiffs concede knowing by 2008. ECF No. 175 at 18.

same argument that Plaintiffs are making here. In *GTB*, Judge Levy agreed with BCBSM that the plaintiffs' "ERISA fiduciary duty claim was time-barred because the basis of the fiduciary duty asserted was actually to achieve MLR, and plaintiffs were aware that BCBSM was not obtaining MLR. . . ." *Id*. at *2.

In seeking reconsideration, the *GTB* plaintiffs argued, as the Tribe does here, that they didn't know BCBSM's network rates were sometimes higher than MLR, and that "the earliest time they had knowledge that BCBSM was squandering plan assets was …. when a third-party administrator … determined that plaintiffs were overpaying for their claims under the plan." *Id.* *3. Judge Levy rejected that argument, explaining that this went to whether the plaintiffs "knew they had a claim for breach of fiduciary duty," and that the relevant issue for purposes of determining their "actual knowledge" was whether they knew BCBSM was not providing MLR—"which they admittedly [did]." *Id.*

Like the *GTB* plaintiffs, the Plaintiffs here were well aware in 2008 of BCBSM's alleged breach of fiduciary duty, *i.e*., its failure to provide MLR pricing, and did not file suit until more than three years later. Plaintiffs' claim is therefore time-barred under § 1113(2), just as the *GTB* plaintiffs' claims were.[3]

[3] Although Plaintiffs' awareness of the potential cost difference between MLR and BCBSM's discounted rates is irrelevant to the "actual knowledge" determination, newly produced evidence (*see* ECF No. 172) shows that the Tribe had this knowledge, as well, at least by September 1, 2010 when a competitor of its agent Gallagher sent a letter to the Tribe touting its "proprietary [MLR] process," how it

Plaintiffs' ERISA claim is also barred by § 1113's six-year statute of repose, which provides that regardless of when a plaintiff acquired "actual knowledge" of a breach of fiduciary duty, a claim must still "be brought within six years after the breach." *McGuire v. Metro. Life Ins. Co.*, 899 F. Supp. 2d 645, 662 (E.D. Mich. 2012). Although at the motion to dismiss stage the Court found the accrual date for Plaintiffs' MLR claim to be unclear, Plaintiffs' own evidence now shows that BCBSM explored obtaining MLR pricing beginning in October 2007, but never did. ECF No. 175 at 10-12. According to Plaintiffs, BCBSM then "shelved any further actions to implement MLR pricing." *Id*. at 12. In the meantime, BCBSM had been processing claims at network rates, and not MLR. Thus, there is no reasonable dispute that all events giving rise to BCBSM's alleged "fail[ure] to ensure that Plaintiffs paid no more than MLR for MLR-eligible services"—which again is the "conduct" constituting BCBSM's alleged breach of its fiduciary duty—occurred no later than 2007 or 2008. As a result, the six-year statute of repose expired long before Plaintiffs filed suit in January 2016.[4]

"would produce significant cost savings" for the Tribe, and how it had already "produced millions of dollars in savings for [other tribes]." Ex. 5.

[4] Plaintiffs' effort to rely on § 1113's "fraud or concealment" exception fails. ECF No. 175 at 33 n. 12. Plaintiffs' awareness that BCBSM was not processing claims at MLR necessarily defeats any reliance on this exception. *See Brown v. Owens Corning Inv. Review Comm.*, 622 F.3d 564, 574 (6th Cir. 2010), abrogated on other grounds by *Intel Corp. Invest. Policy Comm. v. Sulyma*, ___ U.S. ___, 140 S.Ct. 768 (2020) ("Defendants could not have engaged in fraud to conceal from the

C. Plaintiffs' HCFCA Claim Fails

Aside from the fact that Plaintiffs were never entitled to MLR, Plaintiffs' HCFCA claim also fails because it is based on an alleged "lack of prudence in pricing claims" that, even if proven, does not violate the HCFCA. ECF No. 175 at 34. The HCFCA is not ERISA; it does not speak in terms of what is or is not "prudent." *Cf.* 29 U.S.C. § 1104(a) (defining ERISA's "[p]rudent man standard of care"). Thus, alleged *im*prudence—rooted in fiduciary principles—does not rise to the level of a presenting a "false" claim under Mich. Comp. Laws § 752.1002(c).

Plaintiffs' HCFCA claim also fails for another reason: Plaintiffs cite no authority imposing liability against a claims administrator like BCBSM merely for

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Plaintiffs what the Plaintiffs already knew."). The bottom line is that Plaintiffs admit knowing no later than 2008 that they were *not receiving MLR*. Nor is there any merit to Plaintiffs' reliance on the "continuing violations doctrine." The case cited by Plaintiffs, *Novella v. Westchester County*, 661 F.3d 128 (2d Cir. 2011), did not actually apply the doctrine, and observed that it is not a good "fit" in cases where "the plaintiff['s] claims are based on a single decision that results in lasting negative effects." *Id.* at 146 (quotation omitted). That is precisely the case here. Plaintiffs allege that beginning on July 5, 2007, BCBSM failed to apply MLR rates to the Tribe's medical claims, causing Plaintiffs to consistently "overpa[y] for services eligible for lower MLR payment rates." Am. Compl., ECF No. 7 at ¶ 139. Those alleged overpayments were not "discrete wrongs," but rather "perpetuated the harm from the original [alleged] wrong." *Med. Mut. of Ohio v. k. Amalia Enterprises Inc.*, 548 F.3d 383, 394 (6th Cir. 2008); *see also McGuire*, 899 F. Supp. 2d at 662 (holding that each yearly calculation of dividends based on a change in the defendant's methodology did not "constitute a new violation" for purposes of ERISA's six-year statute of repose).

obtaining reimbursement of the amounts *it* paid[5] in processing health care claims. BCBSM did not "present" any "claims" to Plaintiffs for "the payment of a health care benefit." Mich. Comp. Laws §§ 752.1002(a), 1003(1). The claims were presented *to BCBSM* by the medical providers, and *BCBSM* paid them. That is why Plaintiffs' focus on the "monthly claims listing" is wrong—it is simply a report of the claims that were processed and paid *by BCBSM*.

D. Plaintiffs' Common-Law Fiduciary Duty Claim Fails

Despite Plaintiffs' strained effort to avoid it, *Calhoun County* is dispositive of their common-law breach of fiduciary duty claim because the alleged breach "resulted from" BCBSM applying that which it was "contractually entitled" to apply—its standard network rates. *Calhoun County v. BCBSM*, 297 Mich. App. 1, 21; 824 N.W.2d 202 (2012). *See* ASC, ECF No. 79-3, Article II.A (providing that "BCBSM *shall* administer . . . Coverage(s) in accordance with BCBSM's *standard operating procedures*," which indisputably include application of network rates).

Plaintiffs' criticism that the "ASC's 'standard operating procedures' language . . . says nothing about MLR pricing," ECF No. 175 at 40, is meritless because BCBSM's procedures do not need to be "in a compilation or manual." *BCBSM v. Genesee Cty Rd Comm'n*, No. 305512, 2013 WL 2662806, *3 (Mich.

[5] Because BCBSM did not keep the difference between network rates and MLR, it is disingenuous for Plaintiffs to state that BCBSM "cheat[ed]," "bilk[ed]," "swindle[d]," and "systematically fleeced" them. ECF No. 175 at 34, 38-40.

App. June 13, 2013) (Ex. 6). All that is required is that BCBSM has a "regular method" for processing claims at its network rates, *id.*, which it indisputably does.

Nor is there any merit to Plaintiffs' assertion that the court in *ADAC Plastics, Inc. v. BCBSM*, No. 12-CV-15615-DT, 2013 WL 5313455 (E.D. Mich. Sept. 20, 2013) (Ex. 7) already found *Calhoun County* to be "inapplicable . . . in an analogous context." ECF No. 175 at 39. In *ADAC*, the parties disputed the extent to which the parties' agreement addressed certain "fees." Here, there is no such dispute because the Member Plan ASC *expressly authorized* BCBSM to process claims using its network rates, not MLR.[6] Thus, *Calhoun County* is controlling.

Respectfully submitted,

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[6] Plaintiffs also posit that "BCBSM cannot contract away its legal obligations," citing *Citizens Ins. Co. of America v. Federated Mut. Ins. Co.*, 199 Mich. App. 345, 347; 500 N.W.2d 773 (1993). *Citizens* recognized that insurers cannot include provisions in their policies that contravene specific statutory requirements. Plaintiffs do not, and cannot, identify any such specific statutory requirement that BCBSM supposedly "contracted away."

CERTIFICATE OF SERVICE

I hereby certify that on April 13, 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: */s/ Brandon C. Hubbard*