No. 21-1226

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

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

Plaintiffs-Appellants,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant-Appellee.

On Appeal from the United States District Court for the
Eastern District of Michigan, the Honorable Thomas L. Ludington, Presiding
Case No. 1:16-CV-10317

BRIEF OF APPELLEE BLUE CROSS BLUE SHIELD OF MICHIGAN

Tacy F. Flint
Abigail B. Molitor
Rebecca B. Shafer
SIDLEY AUSTIN LLP
One South Dearborn Street
Chicago, Illinois 60603
(312) 853-7000
Counsel for Defendant-Appellee
Blue Cross Blue Shield of Michigan

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit
Case Number: 21-1226 Case Name: Saginaw Chippewa v. BCBSM

Name of counsel: Tacy F. Flint

Pursuant to 6th Cir. R. 26.1, Blue Cross Blue Shield of Michigan
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makes the following disclosure:

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

No

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

No

CERTIFICATE OF SERVICE

I certify that on March 17, 2021 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

s/Tacy F. Flint
Sidley Austin LLP
1 S. Dearborn St., Chicago, IL 60603

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

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INTRODUCTION

Years ago, the Saginaw Chippewa Indian Tribe of Michigan (the "Tribe") contracted with Blue Cross Blue Shield of Michigan ("BCBSM") to process claims for the Tribe's two self-funded healthcare plans—one for employees of the Tribe (the "Employee Plan"), and one for Tribal members (the "Member Plan"). BCBSM and the Tribe entered into standard Administrative Services Contracts ("ASCs") for the two Plans, under which BCBSM agreed to process healthcare claims according to its "standard operating procedures," by applying the discounted rates that BCBSM negotiates across its entire provider network. Neither the Employee Plan nor the Member Plan had any connection to the Tribe's Contract Health Services ("CHS") program—a program funded in part by the federal Indian Health Service, through which statutorily eligible Tribal members may obtain needed healthcare at no cost to themselves. The Tribe intentionally created, operated, and budgeted its CHS program entirely separate from its two self-funded healthcare Plans, and BCBSM played no role in administering, paying, or processing claims for the CHS program.

These simple, undisputed facts are dispositive of every claim in this appeal. The Tribe contends that BCBSM violated ERISA and various state laws by processing the Employee and Member Plans' claims in the manner set out in the parties' ASCs. The Tribe says BCBSM was instead required to pay no more than

"Medicare-Like Rates" ("MLR") for these healthcare claims. But the federal regulation governing MLR does not authorize healthcare plans—even tribal self-insured healthcare plans—to cap payments to hospitals at MLR. Instead, the regulation says unambiguously that only *payments by tribal CHS programs*—and *not* payments from other healthcare plans—are capped at MLR. Neither the Employee Plan nor the Member Plan is a tribal CHS program. BCBSM, therefore, had no authority to cap Employee or Member Plan payments at MLR.

What is more, the plain terms of the ASCs, which made clear that BCBSM would process claims according to its standard operating procedures, independently defeat liability. Neither ERISA nor the Tribe's state law authorities support liability where the defendant adhered to governing contract terms in processing claims. The Tribe may wish, in hindsight, that it had made different arrangements, but that cannot support liability against BCBSM. And in any event, because the Tribe has known all along that BCBSM was processing the Plans' claims according to its standard operating procedures and not at MLR, yet waited some eight years to file suit, its claims are untimely. For any or all of these reasons, the judgment should be affirmed.

STATEMENT OF THE ISSUES

1. Whether the district court correctly granted summary judgment on the Tribe's claim that ERISA required BCBSM to pay claims at MLR where the

payments BCBSM made under the Tribe's Employee Plan were not subject to any cap under the MLR regulation, BCBSM processed claims in accordance with the plain terms of the parties' contract, and the Tribe had actual knowledge by 2008 that BCBSM did not process Employee Plan claims at MLR.

2. Whether the district court correctly granted summary judgment on the Tribe's claim under the Michigan Health Care False Claim Act because BCBSM's payment of Member Plan claims according to the terms of the parties' contract was not "false," and did not satisfy the statute's "presentment" requirement.

3. Whether the district court correctly granted summary judgment on the Tribe's breach of common law fiduciary duty claim where BCBSM's payment of claims under the Member Plan was not capped at MLR, BCBSM adhered to the terms of the parties' contract, and the Tribe had actual knowledge by 2008 that BCBSM did not process Member Plan claims at MLR.

STATEMENT OF THE CASE

I. Background

A. The Tribe's BCBSM Plans.

BCBSM has provided healthcare coverage in various forms for the Tribe since the 1990s. Order Denying Motion to Dismiss, RE146, PageID#7786. Relevant to this appeal, the Tribe established two self-funded healthcare plans through BCBSM in the early 2000s—one in 2002 to provide coverage for Tribal members (the Member Plan) and another in 2004 to provide coverage for Tribe

employees (the Employee Plan). BCBSM Motion for Summary Judgment, RE79-3, PageID#3162-78; RE79-4, PageID#3180-3210. For each Plan, the Tribe paid BCBSM a fee to process and pay healthcare claims for the Plan's participants.

The parties executed nearly identical ASCs in connection with each Plan. *Id*. The ASCs stated that "[t]he responsibilities of BCBSM pursuant to this Contract are limited to providing administrative services for the processing and payment of claims." RE79-3, PageID#3163; RE79-4, PageID#3181. The ASCs further provided that "BCBSM shall administer [the Tribe's] healthcare Coverage(s) in accordance with BCBSM's standard operating procedures . . . ." *Id.* 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. BCBSM Motion for Summary Judgment, RE173-2, PageID#8936. BCBSM negotiates its network rates for its entire business, without regard to any particular customer or plan. *Id.*, PageID#8935-36.

Pursuant to the ASCs, BCBSM processed medical claims covered by the Plans. Healthcare providers presented claims to BCBSM for services rendered, BCBSM processed and paid those claims, and the Tribe later reimbursed BCBSM on an aggregate basis for the cost of claims. RE173-3, PageID#8961-63; RE173-4, PageID#8991-92; *see also* RE79-18, PageID#3431-37; RE79-19, PageID#3439-45; RE79-4, PageID#3182. The Tribe thus retained ultimate responsibility for the

payment of all claims under the Plans, and BCBSM received compensation only for its role in processing the claims.

The Tribe reimbursed BCBSM for claims paid under the Employee Plan with money from its Fringe Internal Service Fund ("ISF"), which was a fund "created and established for the sole purpose of taking care of employee benefits throughout the organization." RE173-4, PageID#8984; Order, RE112, PageID#6203-04. The Fringe ISF included not only the Tribe's money, but also premiums paid by employees covered by the Employee Plan. RE173-5, PageID#9009-10. Separately, the Tribe reimbursed BCBSM for claims paid under the Member Plan with funds from the Tribe's Gaming Trust, which held gaming revenue generated by the Tribe's resort. *Id.*; RE173-4, PageID#8983-84. Neither the Employee Plan nor the Member Plan was funded with any federal money from the Indian Health Service. RE173-4, PageID#8985, 8989-90; RE173-5, PageID#9006-07; RE97-7, PageID#5830.

B. The Tribe's CHS Program.

Entirely separate from the Tribe's BCBSM healthcare plans, the Tribe also operated a CHS[1] program to provide certain federal health services to Tribal

[1] "Contract Health Services" has been renamed "Purchased/Referred Care," though no substantive change accompanied that name change. *See* Indian Health Service, *Purchased/Referred Care (PRC) History*, available at https://www.ihs.gov/prc/history/. For consistency, this brief replaces "PRC" with "CHS."

members. A CHS program offers "health services provided at the expense of the [IHS] from public or private medical or hospital facilities other than those of the [IHS]." 42 C.F.R. § 136.21(e). The Tribe funded its CHS program with federal money received from IHS, in addition to a limited amount of "tribal supplement" funds. RE173-4, PageID#8986-88; RE173-8, PageID#9050-52; RE173-10, PageID#9065-66; RE173-11, PageID#9089; RE173-12, PageID#9129.

IHS is "the principal federal health care provider and health advocate for Indian people." RE173-7, PageID#9018. IHS seeks to provide "a comprehensive health service delivery system for American Indians and Alaska Natives," *id.*, and the Tribe itself provides direct IHS services through its Nimkee Medical Clinic. RE173-8, PageID#9028-30; RE173-9, PageID#9054-55. Sometimes, however, needed services are not available at an IHS facility and patients are referred to off-site providers to receive care through a CHS program. As discussed in greater detail below, when care is authorized and purchased by a CHS program at a Medicare-participating hospital, federal regulations require the hospital to accept "Medicare-Like Rates" (MLR) as full payment for the care provided. *See* 42 C.F.R. § 489.29; 42 C.F.R. § 136.30(b).

To be eligible for off-site medical care through the Tribe's CHS program, a patient must (1) be a member of the Tribe, a descendant of a Tribal member, or a member of another Tribe; (2) reside within the Tribe's five-county service area;

and (3) have some type of insurance or other healthcare coverage (called an "alternate resource" within the CHS framework) that would be tapped first to pay for claims, before the CHS program would pay. RE173-8, PageID#9027-29; RE173-10, PageID#9064; RE173-11, PageID#9089. If a patient satisfies these eligibility requirements, the Tribe then requires the patient to obtain a "purchase order" or "referral" from the Tribe's CHS program for the medical care sought. RE173-14, PageID#9155-56. The patient must then give that referral to the off-site healthcare provider at the time of the medical service. RE173-14, PageID#9157-58; RE173-8, PageID#9032-34.

To obtain payment, the off-site healthcare provider would first submit a claim for payment from the patient's "alternate resource" provider before seeking any payment from the Tribe's CHS program. RE173-8, PageID#9031-35. As Tribe witnesses testified, the BCBSM Employee Plan and Member Plan constituted such "alternate resources"—separate from the CHS program—"that needed to be exhausted" before the CHS program would pay. RE173-8, PageID#9035-36; RE173-11, PageID#9092. Finally, only if the patient still owed a balance on the claim after the alternate healthcare coverage provider had paid, the patient could then take their bill to the Tribe's CHS office for payment. RE173-8, PageID#9034-35; RE173-10, PageID#9067; RE173-11, PageID#9097; RE173-14, PageID#9159-60. The Tribe's CHS program was designed in this way to stretch CHS funds as far

as possible by first relying on an alternate source of payment (like healthcare coverage, such as the BCBSM Plans) wherever it could. RE173-11, PageID#9092; RE173-16, PageID#9181-82.

C. The Tribe's BCBSM Plans and the Tribe's CHS Program Operated Independently and Were Funded By Different Sources.

It is undisputed that the CHS program operated independently from the Tribe's BCBSM Plans. The Tribe's CHS clerk testified that the CHS department existed separately from the Tribe's benefits department (which managed the BCBSM Plans) and that she never discussed CHS eligibility with either the Tribe's benefits department or BCBSM. RE173-11, PageID#9102-04. The Tribe's benefits manager similarly testified that the CHS program and the BCBSM Plans operated separately and that she did not coordinate in any way with the CHS program. RE173-3, PageID#8966. The fact that the BCBSM Plans operated separately from the Tribe's CHS program was further confirmed by several other Tribe employees, including the Tribe's controller; its Assistant Health Administrator, who was a former member of the Tribal Council; and the director of the Tribe's Nimkee Medical Clinic. RE173-4, PageID#8996-98; RE173-18, PageID#9205-06; RE173-8, PageID#9042-43; *see also* RE173-10, PageID#9069; RE173-14, PageID#9166-67; RE173-16, PageID#9180; s*ee also* RE173-17, PageID#9192 (Tribe's insurance agent confirmed the BCBSM Plans and the CHS program operated separately).

Given that the Tribe's own benefits program operated separately from the Tribe's CHS program, benefits personnel had little insight into the eligibility requirements of the CHS program or which individuals had CHS-authorized claims. RE173-3, PageID#8972-73; RE173-11, PageID#9102. And, another step removed, the Tribe never provided BCBSM any referral documents identifying CHS-authorized claims or any information about which individuals were enrolled in the CHS program, as confirmed by several Tribe employees.[2] RE173-3, PageID#8973 (Benefits Manager); RE173-4, PageID#8993-95 (Tribe Controller); RE173-8, PageID#9045-47 (Executive Health Director for Nimkee Clinic); RE173-10, PageID#9079-80 (Interim Assistant Health Administrator); RE173-11, PageID#9102-03 (CHS Clerk); RE173-12, PageID#9135-36 (former CHS Clerk); RE173-14, PageID#9166-67 (former CHS Clerk); RE173-16, PageID#9179-80 (Elders Advocate); RE173-18, PageID#9202-04 (former Tribal Council Member and Assistant Health Administrator); RE173-19, PageID#9213-15 (Benefits Specialist); RE173-20, PageID#9224-25 (Tribal Administrator); RE173-21, PageID#9234-35 (Assistant Tribal Administrator); *see also* BCBSM Motion to Deem Certain Matters Admitted, RE154-7, PageID#7933-41. BCBSM had no way

[2] The Tribe has conceded that "the Tribe, *not BCBSM*, (1) was responsible for determining whether a particular participant was eligible for CHS and (2) was responsible for determining whether the services requested would be either authorized or rejected by the Tribe's CHS program." RE154-5, PageID#7917 (emphasis added).

of knowing which healthcare claims, if any, had been authorized by the Tribe's CHS program.

Indeed, relative to the Employee Plan (which provided coverage to Tribe employees without reference to Tribal membership status), BCBSM did not even know which participants were Tribal members. *See* Tribe Response to BCBSM Motion to Compel, RE48, PageID#1564-65 (the Tribe did not maintain "records showing who is *both* a member of the Tribe and an employed participant of the Tribe's Plan"). Only a small percentage of Tribe employees were also Tribal members, Amended Complaint, RE7, PageID#64, and the majority of Tribal members chose to obtain coverage under the Member Plan because it (unlike the Employee Plan) did not require participants to pay any premiums. RE79-5, PageID#3216-17; *see also* RE 79-23, PageID#3635. So, in addition to having no information about which claims, in fact, originated from the Tribe's CHS program, BCBSM also had no way of even guessing which small percentage of Employee Plan participants *might* have CHS-eligible claims because it did not know which participants were Tribal members.

The BCBSM Plans and the CHS program were also funded by entirely separate sources. As discussed, *supra* pp. 5-6, the BCBSM Plans were funded by the Tribe's gaming trust (for the Member Plan) and the Tribe's Fringe ISF (for the Employee Plan). The Tribe's CHS program, on the other hand, was paid for with

IHS funds plus supplemental tribal money (collectively the "CHS funds"). RE173-10, PageID#9065-66. As the Tribe's Controller testified and as the Tribe has conceded in this litigation, no IHS money was used to fund the BCBSM Plans or reimburse BCBSM for any healthcare claims it paid.[3] RE173-4, PageID#8985, 8989-90; RE173-5, PageID#9006, 9008; RE173-22, PageID#9237; BCBSM Request to Admit No. 2, RE163-3, PageID#8576. Moreover, BCBSM *had no access at all* to the Tribe's CHS funds. RE173-4, PageID#8997-98. Only the CHS program used CHS funds to pay healthcare providers, and it did so only for

[3] The Tribe argued for the first time in its motion to alter or amend the summary judgment order that "*CHS funds* and Tribal Member Plan funds were held in the same trust and same bank account." Tribe Motion to Alter or Amend, RE199, PageID#12673 (emphasis added). The Tribe takes yet another position on appeal, stating that "*IHS funds* used to pay healthcare claims for the Member Plan were held in the same trust and same bank account as [Tribal] funds used for that purpose." Tribe Br. 7 (emphasis added). Both statements are inconsistent with concessions the Tribe made in this case. The Tribe conceded that "the funds provided by IHS for the funding of [the CHS program] *are held in an account separate from the account used to fund the Plans*." RE163-3, PageID#8576 (emphasis added). In addition, the Tribe argued at summary judgment that "BCBSM was *not* a fiduciary over the Tribe's CHS funds." Tribe Summary Judgment Opposition Brief, RE177, PageID#10851 (emphasis added). Further, the Tribe's Controller's deposition transcript, which the Tribe cites in support of its position on appeal, Tribe Br. 7, does not say that IHS funds were used to pay Member Plan claims, or that IHS funds and Member Plan funds were kept in the same bank account, as the Tribe now argues. RE199-2, PageID#12695-96. It does not even mention the Member Plan. The Controller instead testified that there was no "intersection in terms of budgeting, funding or other financial aspects" between the CHS Program and either BCBSM Plan. RE173-4, PageID#8987-90, 8996-98; *see also id.*, PageID#8985; RE173-5, PageID#9008.

balances owed after other third-party payors, like BCBSM, had already paid on a claim.

The separate organization and funding of the BCBSM Plans and the CHS program were a direct result of the fact that the Tribe intended for the two programs to serve different purposes. The Tribe's CHS program fits within the federal IHS framework to provide medical care to members of Indian tribes "when necessary health services by an [IHS] facility are not reasonably accessible or available." 42 C.F.R. § 136.23(a). The Tribe established the BCBSM Plans, on the other hand, to provide healthcare coverage for its employees and Tribal members by gaining access to BCBSM's discounted network rates, available services, and provider network (which spanned a broader geographic area than the CHS program). RE173-3, PageID#8953, 8969-70. As the Tribe's insurance broker confirmed, the Tribe established the BCBSM plans because it "wanted to provide benefits above and beyond what CHS offered." RE173-17, PageID#9193.

D. The Tribe Knew that BCBSM Processed Claims According to the Terms of the Parties' Contract and Not at Medicare-Like Rates.

The Tribe became aware of the regulations requiring Medicare-participating hospitals to charge no more than "Medicare-Like Rates" for care authorized and purchased by a CHS program no later than 2008. RE173-10, PageID#9076-77; RE173-11, PageID#9105-06; RE173-23, PageID#9239; *see also* RE154-3, PageID#7894. Indeed, the Tribe sought and obtained MLR for healthcare claims

through its CHS program in instances that did not involve BCBSM. RE173-11, PageID#9093-96; 9107-09; RE173-12, PageID#9131-32; RE173-14, PageID#9161-64.

The Tribe also knew that claims processed by BCBSM did not receive MLR, as testified by several Tribe employees. RE173-11, PageID#9110-12 (CHS Clerk); RE173-8, PageID#9037-39 (Executive Health Director for Nimkee Clinic); RE173-10, PageID#9068, 9070 (Interim Assistant Health Administrator); RE173-12, PageID#9134 (former CHS Clerk); RE173-14, PageID#9165 (former CHS Clerk). Dating back to at least 2009, the Tribe repeatedly discussed with both its insurance agent and BCBSM the fact that claims processed under the BCBSM Plans were not paid at MLR. RE173-24, PageID#9242; RE173-25, PageID#9250-52, 9258-60; RE173-26, PageID#9268-71; RE173-17, PageID#9191. What is more, the Tribe knew that BCBSM was paying rates different from MLR and knowingly assumed the risk that the rates BCBSM was paying were higher than MLR. RE173-3, PageID#8969. Throughout this time period, notwithstanding this knowledge, the Tribe continued to renew its contracts with BCBSM each year. *See, e.g.,* RE79-8, PageID#3275-86; RE79-9, PageID#3288-3309.

The Tribe renewed those contracts in significant part *because* it knew that BCBSM applied its network rates to the claims it processed on the Tribe's behalf, per the terms of the parties' agreement. RE173-3, PageID#8943-45, 8948, 8951-

52. Access to BCBSM's network rates and provider network was a key reason the Tribe chose to have BCBSM service its Employee Plan in the first place. *Id.*, PageID#8951-54. As the Tribe's benefits manager explained, the Tribe's decision to renew its contract with BCBSM each year from 2004 through 2016 was influenced by a number of factors beyond BCBSM's network rates, including the available services, locations, administrative rates, and stop-loss rates. *Id.*, PageID#8953, 8969-70. Even after this litigation had commenced, the Tribe still did not pursue MLR on claims processed by the Tribe's new healthcare claims processor. RE173-11, PageID#9099-9100, 9103; RE173-3, PageID#8948.

II. Procedural History

The Tribe filed this action in January 2016, alleging ERISA violations and accompanying state law claims. The Tribe's complaint pointed to a regulation, 42 C.F.R. § 136.30, that requires Medicare-participating hospitals to accept "Medicare-Like Rates" as payment in full for contract health services paid for by a tribe's CHS program. RE7, PageID#88. According to the Tribe, BCBSM was required by ERISA and state law to pay no more than MLR when it paid claims under the Employee and Member Plans.

The district court dismissed the claim on the pleadings, holding that BCBSM did not owe the Tribe such a fiduciary duty under ERISA. Op. Granting Motion to Dismiss, RE22, PageID#463-64. The Tribe appealed the district court's MLR

decision (among other rulings). This Court held that the Tribe had—on the pleadings—adequately alleged that a duty arose under ERISA to take advantage of MLR with respect to the Tribe's Employee Plan. Specifically, this Court determined that the Tribe had sufficiently *alleged* "that all . . . conditions precedent to the MLR claim were met." *Saginaw Chippewa Indian Tribe of Mich. v. Blue Cross Blue Shield of Mich.*, 748 F. App'x 12, 21-22 (6th Cir. 2018). On the strength of those *allegations*, this Court held, the Tribe's MLR claim should not have been dismissed under Rule 12. But the panel "emphasize[d] that we express no opinion on the ultimate merits of the Tribe's MLR claim, and we hold only that it would be premature to dismiss the Tribe's claim at this stage of the proceedings." *Id.* at 22.

On remand, the district court reinstated the Tribe's MLR-based ERISA claim as to the Employee Plan. Only that Plan was subject to ERISA because, as this Court separately held, participation in the BCBSM Member Plan "was unrelated to . . . employment status with the Tribe," and the Member Plan is therefore not an ERISA plan. *Saginaw Chippewa*, 748 F. App'x at 19, 20 n.4. The district court reinstated the Tribe's MLR-related claims under state law as to the Member Plan—including the Michigan Health Care False Claim Act ("HCFCA") and a common law breach of fiduciary duty theory. RE141, PageID#7659. No state

law claims are advanced with respect to the Employee Plan, because ERISA preempts state law claims as to that Plan. RE22, PageID#463.

The parties commenced discovery on the nature and operation of the Tribe's CHS program, as well as the sources of funding for both the CHS program and the BCBSM Plans. While the Tribe argued before the Sixth Circuit in the prior appeal that "BCBSM was retained by the Tribe as the administrator of Contract Health Services paid for by [the Tribe] for Tribal members," RE173-28, PageID#9313, evidence in the record has since proven that assertion false. As discussed, BCBSM played no role in administering the CHS program, the CHS program operated entirely separate from the BCBSM Plans, and no CHS money was ever used to pay for the BCBSM Plans.

BCBSM moved for summary judgment on the MLR claims. The district court granted BCBSM's motion, holding that "MLR is only applicable for those services funded by CHS." Opinion, RE197, PageID#12655. Because "BCBSM was not authorized nor did it pay for services using funds from CHS," the MLR regulation did not apply to BCBSM's payments to providers. *Id.* The district court therefore determined that BCBSM did not have a fiduciary duty under ERISA to seek MLR on behalf of the Tribe and further held that the Tribe's HCFCA claim and common law fiduciary duty claim failed for the same reason. *Id.*

The Tribe subsequently moved to alter or amend the district court's summary judgment order and raised a variety of arguments, all of which were rejected. The district court held that any funding differences between the two Plans were irrelevant because neither Plan made payments using CHS Funds, a requirement for the application of MLR. Order, RE202, PageID#12786. The district court also rejected each of the Tribe's arguments relating to interpretation of the MLR regulations and the Tribe's self-determined status. *Id*., PageID#12786-94. The Tribe then filed this appeal.

SUMMARY OF ARGUMENT

The Tribe purchased one contractually defined service (BCBSM's standard processing of medical claims at BCBSM network rates for the Tribe's Employee and Member Plans), but now seeks to hold BCBSM liable for not providing a different service (a custom-made plan including analysis and identification of the Tribe's CHS-eligible claims, determination of whether MLR applied, and the processing of individual MLR-eligible claims). But that is not what ERISA requires. The Tribe did not hire BCBSM to run its CHS Program, and it cannot after the fact hold BCBSM liable for failing to do so.

Rather, as the record shows, the Tribe's ERISA claim fails for several reasons. First, none of the claims paid by BCBSM were capped at MLR under the plain terms of the MLR regulation, 42 C.F.R. § 136.30. On its face, that regulation

caps the payments that Medicare-participating hospitals must accept from "I/T/Us," which—as relevant to this case—means tribal CHS programs. The regulation distinguishes between "I/T/U payments" and payments by "third party payors" such as healthcare plans—and it provides only that the former are capped at MLR. 42 C.F.R. § 136.30(g)(4) ("*The I/T/U payment* will not exceed the rate calculated" under the regulation.) (emphasis added). The regulation thus did not operate to limit the payments BCBSM made under the Employee Plan, which were not payments by the Tribe's CHS program.

On its face, the regulation does not require Medicare-participating hospitals to accept payments at MLR from a healthcare plan that is not a tribal CHS program, and the Court need look no further to affirm the judgment below. Notably, BCBSM's reading of the regulatory text is supported by the Tribe's *amici*, who acknowledge that "a health insurance plan (or other third-party payor)" may pay "amounts equal to or more than the MLR" when paying for authorized contract health services. *Amici* Br. 8-9. It is also supported by IHS guidance, which provides that "[s]ince Tribal self-insurance plans are not CHS programs, the CHS rates rule does not address the amount these plans will pay for services." *See infra*, p. 27. Likewise, the broader regulatory landscape and authorizing statute confirm that the regulation is targeted at capping *CHS program payments* (which are funded in part with federal IHS funds)—not a tribe's overall healthcare

expenditures. Thus, the necessary premise of the Tribe's ERISA claim—that BCBSM had authority under the regulation to limit payments under the Employee Plan to MLR—is wrong.

The Tribe's ERISA claim equally fails because the parties' ASC expressly provided that BCBSM would process Employee Plan claims according to its "standard operating procedures"—*i.e.*, using BCBSM network discounts. As a matter of law, BCBSM did not act as a fiduciary, nor breach any fiduciary duty, when it adhered to governing contract terms. In addition, because BCBSM played no role in connection with the Tribe's CHS program, it lacked knowledge about which Employee Plan claims (if any) were authorized by the CHS program. For this reason as well, BCBSM had no fiduciary duty to pay any (unidentified) MLR-eligible claims in a manner different from what the ASC required. Finally, because the Tribe was aware from at least 2008 that BCBSM was paying standard rates—not MLR—for claims under the Employee Plan, its 2016 lawsuit came far too late under ERISA's three-year statute of limitations.

The Tribe's state law claims as to the Member Plan fail for similar reasons. The Tribe cannot prevail on its claim under the Michigan Health Care False Claim Act because BCBSM's payment of claims according to the plain terms of the ASC was not "false," nor did BCBSM "present" the claims to the Tribe within the meaning of the statute. And just as the Tribe cannot establish breach of any

fiduciary duty under ERISA, nor can it do so under state law. Judgment should be affirmed.

STANDARD OF REVIEW

This Court reviews the grant of summary judgment *de novo*. *Minadeo v. ICI Paints*, 398 F.3d 751, 756 (6th Cir. 2005). "[T]his [C]ourt can affirm a decision of the district court on any grounds supported by the record, even if different from those relied on by the district court." *Wallace v. Oakwood Healthcare, Inc.*, 954 F.3d 879, 886 (6th Cir. 2020) (citation and internal quotation marks omitted).

ARGUMENT

I. The Tribe's ERISA Claim Fails.

A. The Tribe's ERISA Claim Fails on the Merits.

1. Under the MLR Regulation, BCBSM Could Not Have Capped Its Employee Plan Payments at MLR.

The Tribe's case hinges on its argument that BCBSM should have paid only MLR for certain unidentified Employee Plan claims. That premise is inconsistent with the regulatory text, and the Tribe's ERISA claim therefore fails.

a. The MLR regulation caps only payments by tribal CHS programs.

(i) *The MLR regulation was developed to address the problem of insufficient funding for CHS programs.*

The MLR regulation supports the "Indian healthcare system[, which] is comprised of the IHS and health programs operated by Indian Tribes" or other tribal organizations. *Limitation on Charges for Services Furnished by Medicare*

Participating Inpatient Hospitals to Indians, 71 Fed. Reg. 25124-02, 25125 (Apr. 28, 2006). The tribes "provide, to the extent possible, primary, preventive, and chronic healthcare services to eligible IHS beneficiaries" in facilities they operate themselves. *Id.* But some eligible IHS beneficiaries need to seek care from other providers, so "the Indian Health Service and Tribes (I/Ts) are authorized to pay for medical care provided to IHS beneficiaries by non-I/T public or private providers as contract health services." *Id.*

To authorize such "contract health services," a tribe's CHS program issues "a purchase order" or referral "to the non I/T public or private providers." *Id.* The money that CHS programs use to pay for "contract health services" comes in part from IHS. *See* 42 C.F.R. § 136.21(e) (defining "contract health services" as "health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service"). A tribe can also supplement IHS funding for its CHS program with other federal funds or other tribal income. *See, e.g.*, 25 U.S.C. § 1641(d)(2)(A) (allowing use of payments under the Social Security Act); 25 U.S.C. § 5325(m) (allowing use of program income earned "in the course of carrying out a self-determination contract" to "further the general purposes of the contract"); *see generally Amici* Br. 7. In that situation, the tribal supplemental funds and the IHS funds together comprise the tribe's CHS funds.

Historically, "contract health services" had been provided at rates "that substantially exceeded the Medicare allowable rates." 71 Fed. Reg. at 25125. This proved costly to tribes' CHS programs, and "the need for contract health services in the population served by [CHS] programs routinely exceed[ed] funding available to these programs." *Id.* To address this situation, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"), P.L. 108-173, authorized the Secretary of the Interior to promulgate regulations requiring hospitals to accept "Medicare-Like Rates" or MLR for services provided to IHS beneficiaries through CHS programs.

The resulting regulation is 42 C.F.R. § 136.30, which is titled "Payment to Medicare-participating hospitals for authorized Contract Health Services." When Medicare-participating hospitals provide contract health services that are (as relevant here) "authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS," the regulation provides that the hospital must accept "as payment in full" the payments provided for in the body of the regulation. *Id.* § 136.30(a)-(b).

(ii) *The MLR regulation limits payments by CHS programs—not health benefit plans.*

The Tribe's primary argument is that the regulation's terms apply to all "contract health services" that are (1) provided by a Medicare-participating hospital, and (2) "authorized" by a tribal CHS program. *See* Tribe Br. 34-35 (citing

42 C.F.R. 136.30(b); *Little River Band v. Blue Cross Blue Shield of Mich.*, 183 F. Supp. 3d 835, 842-44 (E.D. Mich. 2016)). The Tribe says that for all such authorized "contract health services," "MLR discounts apply." *Id.* at 37. But the Tribe's reading ignores *how* the regulation applies to "contract health services" that have been authorized by a tribal CHS program. The MLR regulation does not establish general "MLR discounts" for services authorized by a tribal CHS program, without regard to who is paying. *See, e.g.*, Tribe Br. 37.

Instead, as detailed below, the regulation caps the amount Medicare-participating hospitals must accept *from specified payors*—namely "I/T/Us." "I/T/U" is defined in the regulation to mean (1) a CHS program of the IHS; (2) a tribe or tribal organization carrying out a CHS program; or (3) an urban Indian organization. 42 C.F.R. § 136.30(b). The parties agree that the relevant form of I/T/U at issue here is the second, specifically the Tribe's CHS program. *See* Tribe Br. 2. Under the regulation, therefore, Medicare-participating hospitals must accept MLR as payment from the Tribe's CHS program, but the regulation does not cap payments from other "third party payors," including healthcare plans like the Employee Plan.

First, in subsections (a) and (b), the regulation details which hospitals and the scope of care to which the MLR regulation is applicable. 42 C.F.R. § 136.30(a)-(b). Then, in subsections (c) and (d), the regulation sets forth how

MLR are to be calculated. *Id.* § 136.30(c)-(d). Next, in subsections (e), (f), and (g), the regulation specifies *which* payments are capped pursuant to the MLR calculations: "The calculation of the payment *by I/T/Us* will be based on determinations made under paragraphs (c) and (d) . . . ." *Id.* § 136.30(e) (emphasis added); *see also id.* (setting forth the rates that "*I/T/Us* shall pay") (emphasis added). The regulation further provides that if an I/T/U has negotiated a rate lower than MLR with a particular hospital, then "*the I/T/U* will pay the lesser of" MLR or the negotiated amount. *Id.* § 136.30(f) (emphasis added). In short, each provision in the regulation capping a payment for contract health services at MLR applies to payments *by I/T/Us*—here, payments by the Tribe's CHS program.

Elsewhere, the regulation distinguishes between payments by a "third party payor," like a healthcare plan, and payments by an I/T/U—with only the latter being capped at MLR. The regulation first states that "[t]he I/T/U shall be the payor of last resort under § 136.61." *Id.* § 136.30(g)(1). It explains that "[i]f there are any third party pay[o]rs," then the I/T/U pays only "the amount for which the patient is held responsible after . . . all other alternative resources have been considered and paid." *Id.* § 136.30(g)(2) (emphasis added). The cross-referenced section, § 136.61(c), explains that "alternate resources" include "health care programs for the payment of health services" that are not funded by IHS—

including federal, state, or local healthcare programs, as well as "private insurance."

The MLR regulation then states explicitly that "*[t]he I/T/U payment* will not exceed the rate calculated" according to the MLR regulation. *Id.* § 136.30(g)(4) (emphasis added). There is no similar limitation on the payments made by "third party payors." In other words, the regulation expressly separates (1) payments by an I/T/U (here, a tribal CHS program), and (2) payments by all other payors. And the regulation limits only the amount paid by the tribal CHS program—"the I/T/U payment." Thus, with respect to a tribal healthcare plan that is *not* a tribal CHS program (as the Employee Plan is not), the MLR regulation does not compel Medicare-participating hospitals to accept payments from the plan at MLR.

The Tribe asserts that subsection 136.30(g) is "entirely irrelevant," because it "simply speak[s] to the order of payment for healthcare claims, not whether MLR discounts apply to the claims." Tribe Br. 37. Again, the Tribe ignores that the regulation does not create general "MLR discounts," but caps specified *payments*—"I/T/U payments"—for authorized contract health services. Notably, the Tribe's *amici* agree with BCBSM's reading of subsection 136.30(g). The *amici* accurately explain that under § 136.30(g), "a health insurance plan (or other third party payor)" may pay "amounts equal to *or more than the MLR*" where a tribal CHS program has authorized the care. *Amici* Br. 8-9 (emphasis added). In that

circumstance, where a third-party payor's payment for authorized contract health services is equal to or greater than MLR, then the tribal CHS program would have no obligation to pay the hospital anything further, because *its* payment obligation is capped at MLR. *Id.* at 9; 42 C.F.R. § 136.30(g)(3).[4]

Because the regulatory text is unambiguous, the Court need not consider agency guidance. However, to the extent any ambiguity remains, IHS guidance definitively rejects the Tribe's position that the regulation caps at MLR anything other than a payment from a tribal CHS program. *See, e.g.*, *Kisor v. Wilkie*, 139 S. Ct. 2400, 2415-16 (2019); *Garcia-DeLeon v. Garland*, --- F.3d ---, No. 20-3957, 2021 WL 2310055, at *4 (6th Cir. June 4, 2021) ("If [a] regulation is genuinely ambiguous, we defer to the agency's reasonable interpretation of its own regulations."). As the district court recited, IHS's responses to frequently asked questions consistently and repeatedly explain that the MLR regulation caps only payments made "'*through the CHS program*.'" RE197, PageID#12651 (quoting RE173-27, PageID#9276) (emphasis in original); *see also id.* (MLR regulation payment cap applies "'so long as the *CHS pays for the services*'"; services are

[4] *Amici* also correctly explain that where the I/T/U has authorized care under the MLR regulation, the provider is barred "from attempting additional collections from the tribal member who received the service." *Amici* Br. 8-9 & n.4 (citing 42 C.F.R. § 136.30(g)(2); 25 U.S.C. § 1621u).

payable at MLR if "'*paid by an IHS or tribal CHS program*'") (quoting RE173-27, PageID#9276, 9278) (emphases in original).[5]

IHS guidance likewise addresses the specific question of payments by tribal healthcare coverage plans. In a memorandum produced in response to a subpoena in this litigation, IHS explained that "the MLR only applies to CHS programs," and "the MLR would not apply to 'health benefits coverage' purchased by a Tribe . . . or to other types of health benefits coverage offered by a Tribe that does not adhere to all current CHS rules." RE173-6, PageID#9016. And in another guidance document, interpreting materially identical regulatory text (42 C.F.R. § 136.203), IHS explained: "Since Tribal self-insurance plans are not CHS programs, *the CHS rates rule does not address the amount these plans will pay for services*." IHS,

[5] The Tribe argues that this IHS guidance should not be considered because "no evidence suggests the FAQs at issue are IHS's words, much less its formal position." Tribe Br. 44. This is false: The FAQs' cover page makes clear that that IHS created the document, and the accompanying email reflects that IHS distributed the FAQs to CHS programs across three states. RE173-27, PageID#9273-74. Moreover, IHS has been consistent in interpreting identical regulatory text over several years, confirming that this is the agency's considered judgment. *See Kisor*, 139 S. Ct. at 2415-16. The Tribe further argues that the guidance should not be considered because the Tribe is not bound by agency guidance to which it has not agreed. Tribe Br. 44 (citing 25 U.S.C. § 5329(c)). But the MLR regulation does not bind Tribes, it binds Medicare-participating hospitals. *See* 42 C.F.R. § 136.30(a). And the FAQs interpreting the regulation do not change its meaning or effect—they merely restate the regulatory requirement that hospitals must accept I/T/U payments capped at MLR. Thus whether or not the Tribe consented to the FAQs is irrelevant.

Purchased/Referred Care Rates FAQs No. 2 (emphasis added), available at https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/prcri/Purchased_Referred_Care_Rates_FAQ.pdf.

Numerous other provisions in the regulatory framework confirm that the only payments capped under the regulation are payments by a CHS program using CHS funds. For example, the regulation defines "Contract Health Services," payment for which is covered under the regulation, as "health services provided *at the expense of the Indian Health Service*." 42 C.F.R. § 136.21(e) (emphasis added). Because tribal CHS programs are funded in part by IHS, care that they issue payments for is care "provided at the expense of the Indian Health Service"—while care paid for by the Tribe's Employee Plan is not. Another provision provides that IHS "*will not be responsible for or authorize payment for* contract health services to the extent" that the care could instead be paid for using "alternate resources," including "private insurance." 42 C.F.R. § 136.61 (emphasis added). Another requires Medicare-participating hospitals to accept MLR "as payment in full for … [a] *CHS program* . . . carried out by an Indian Tribe or Tribal organization." 42 C.F.R. § 489.29(a)(2) (emphasis added). The text of these regulations underscores that they are concerned with payments made by CHS programs, which include in part IHS funds—and not payments by third-party payors like private insurance plans.

These implementing regulations are consistent with the statutory text, which requires hospitals that agree to provide medical care "*under the contract health services program funded by the Indian Health Service*" to accept MLR as payment from the I/T/U. 42 U.S.C. § 1395cc(a)(1)(U)(i) (emphasis added). Moreover, a report furnished by a co-sponsor of the legislation stated that the statute "would prohibit hospitals . . . that provide . . . services *under the contract health services program funded by the Indian Health Services* from charging more than the Medicare established rates for these services." H.R. REP. NO. 108–391, at 656 (2003) (Conf. Rep.) (emphasis added). It is plain that Congress was concerned with regulating payments by CHS programs funded in part by IHS, not payments by third-party payors with no access to CHS funds, and the regulation follows this congressional imperative. The district court correctly determined that "MLR is only applicable for [ ] services funded by CHS" programs. RE197, PageID#12655; RE202, PageID#12778-79, 12782.

b. Because the BCBSM Employee Plan is not a tribal CHS program, the MLR regulation did not cap BCBSM's payment of claims for the Employee Plan.

By its terms, the MLR regulation's cap on "payment by I/T/Us" did not apply to BCBSM's payment of claims under the BCBSM Employee Plan, because neither BCBSM nor the Employee Plan is a tribal CHS program or I/T/U. The Tribe contends that BCBSM's payments of claims under the Employee Plan

nonetheless qualify as I/T/U payments that are capped under the regulation "because all services were paid with IHS funds or Tribal funds." Tribe Br. 36-37 (citing RE97-7, PageID#5829-30). But this misreads the regulation and misstates the facts.

First, it is undisputed that BCBSM paid claims on behalf of the Employee Plan—not the tribal CHS program. *Supra*, pp. 4-5, 9-10. And as described above, the identity of the payor controls under the regulatory text, which distinguishes between (1) payments by an I/T/U and (2) payments by third-party payors such as health benefit plans, which constitute "alternate resources." *See* 42 C.F.R. § 136.30(g); *see also Amici* Br. 8 (characterizing a healthcare coverage plan as a third-party payor under the regulation). Indeed, the regulation and accompanying IHS guidance are clear that because tribal self-insurance plans like the Employee Plan are not CHS programs, the MLR regulation "does not address" what such plans must pay for services. *Supra*, pp. 24-28. That is likely why the clerk of the Tribe's CHS program testified that the Tribe consistently distinguished between payments by "the Blue Cross member and employee plans," which "were considered alternate resources," and payments by the CHS program. RE173-11, PageID#9092; *accord* RE173-8, PageID#9035-36.[6]

[6] The Tribe cites *Redding Rancheria v. Hargan*, 296 F. Supp. 3d 256 (D.D.C. 2017), for the proposition that its tribal self-insurance plans are not "alternate resources." Tribe Br. 37-38. The court in *Redding Rancheria* interpreted a different

Second, when the Tribe reimbursed BCBSM for claims paid under the Employee Plan, the Tribe did not draw the funds from its CHS program, and neither IHS funds nor any other CHS funds were used to fund the Employee Plan or reimburse BCBSM for any claims under that Plan. RE173-4, PageID#8985, 8989-90; RE173-5, PageID#9006, 9008; RE173-22, PageID#9237; RE163-3, PageID#8576. The district court was therefore correct to conclude that "BCBSM was not authorized nor did it pay for services using funds from CHS." RE197, PageID#12655.

Instead, the Employee Plan was funded through the Tribe's Fringe ISF—"a fund . . . created and established for the sole purpose of taking care of employee benefits." RE173-4, PageID#8984. The Fringe ISF included contributions both from the Tribe and from employee participants, who paid premiums for their coverage.[7] RE173-4, PageID#8984; RE112, PageID#6203-04; RE173-5,

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statute, 25 U.S.C. § 1623(b), and did not evaluate whether tribal self-insurance plans are included among the payors that may pay claims at MLR under § 136.30. *See* 296 F. Supp. 3d at 267-74. Contrary to the Tribe, IHS has advised that (with an inapplicable exception) "Tribal self insurance can be billed as an [alternate resource]." RE173-13, PageID#9143. Moreover, contrary to its current litigating position, the Tribe designed its CHS program so that its Employee and Member Plans were designated "alternate resources" required to be exhausted before its CHS program paid any claim. *See* RE173-8, PageID#9035-36 ("[T]he Tribe treated both of those Blue Cross plans as alternate resources.").

[7] If the Tribe means to argue that the Fringe ISF included only "Tribal funds," Tribe Br. 37, that too is incorrect. As the Tribe's controller testified, the Fringe ISF also included employee premiums. RE173-5, PageID#9009-10; RE79-22,

PageID#9009-10. Because it contained the employees' own payments, the Tribe would not have been permitted to use the Fringe ISF to pay for contract health services even for eligible employees: by statute, patients receiving contract health services "shall not be liable for the payment of any charges or costs associated with the provision of such services." 25 U.S.C. § 1621u(a); *see also Amici* Br. 9 ("CHS authorization protects patient from liability to provider"). Thus, employee premiums—which the Tribe *did* use to reimburse BCBSM for Employee Plan claims via the Fringe ISF—could not be used to pay for contract health services authorized by the Tribe's CHS program.

It makes sense that the Tribe funded the Employee Plan this way because the Employee Plan was, by the Tribe's own design, entirely separate from the Tribe's CHS Program. The Tribe established the Employee Plan to provide healthcare coverage for its employees. RE79-5, PageID#3215, 3221, 3227, 3229; RE79-22, PageID#3631. Tribal membership was not required for participation in the Employee Plan, and the overwhelming majority of Employee Plan participants were not Tribal members. RE7, PageID#64; RE79-5, PageID#3215, 3222; *see also*

PageID#3631. To the extent the declaration the Tribe cites (RE97-7, PageID#5829-30) contradicts the controller's prior testimony, the Court should disregard it. *See, e.g.*, *Reich v. City of Elizabethtown*, 945 F.3d 968, 976 (6th Cir. 2019) (party may not create a dispute of fact by submitting a declaration that contradicts the declarant's prior testimony).

RE79-23, PageID#3635. Indeed, individuals who were both employees of the Tribe and Tribal members frequently chose *not* to participate in the Tribe's Employee Plan, because they preferred to participate in the Tribe's Member Plan, which did not require them to pay premiums. RE79-5, PageID#3216-17; *see also* RE79-23, PageID#3635. Thus, only a small percentage of Employee Plan participants were even eligible for care through the Tribe's CHS program. And BCBSM had no way of knowing which Employee Plan participants were among that small percentage. *See* RE48, PageID#1564-65.

Because the Employee Plan was set up to be entirely separate from the Tribe's CHS Program, the Tribe also never informed BCBSM if any of the claims submitted by providers to the Employee Plan were claims that the Tribe's CHS program had previously authorized. *See* RE173-3, PageID#8973; RE173-4, PageID#8993-95; RE173-8, PageID#9045-47; RE173-10, PageID#9079-80; RE173-11, PageID#9102-03; RE173-12, PageID#9135-36; RE173-14, PageID#9166-67; RE173-16, PageID#9179-80; RE173-18, PageID#9202-04; RE173-19, PageID#9213-15; RE173-20, PageID#9224-25; RE173-21, PageID#9234-35; *see also* RE154-7, PageID#7933-41. In its brief on appeal, the Tribe broadly asserts that its "CHS program authorized all healthcare claims at issue in this lawsuit," Tribe Br. 11, but it has conceded that it did not inform

BCBSM of any alleged CHS program authorizations at the time, when it mattered. RE177, PageID#10853-54.[8]

In sum, BCBSM did not administer or make payments on behalf of the CHS program, but instead processed claims for the separately administered and separately funded Employee Plan. Because BCBSM's payments of claims under the Employee Plan were not "payments by an I/T/U" within the meaning of 42 C.F.R. § 136.30, the MLR regulation does not cap those payments at MLR.

c. Nothing in the Tribe's Brief or the Brief of Amici Curiae supports a different reading of the MLR regulation.

The Tribe and its *amici* raise various other arguments, but none can overcome the plain text of the MLR regulation.

(i) *The district court did not impose any "tracing" or "source of funds" requirement.*

The Tribe and *amici* argue that the district court supposedly misread the MLR regulation by "requir[ing the Tribe] to prove that each healthcare claim was

[8] Even in this litigation, the Tribe has not identified evidence of any Employee Plan claims paid by BCBSM for which the CHS program had issued a purchase order. The string cite in footnote 4 on page 11 of the Tribe's Brief in this Court includes general testimony about how the Tribe's CHS program operated (RE177-5, PageID#10895; RE177-6, PageID#10971-72), and one purchase order provided to an unnamed patient who obtained health coverage from a different health benefit plan, not a BCBSM plan (RE177-4, PageID#10883). In the district court, the Tribe asserted that its "CHS program issued a purchase order/referral authorizing all of the claims at issue in this lawsuit" without citing any record evidence at all. RE177, PageID#10832.

paid for entirely with IHS funds," and to "trace each IHS dollar it spends to each healthcare service received for an MLR discount to apply." Tribe Br. 34-36; *see also Amici* Br. 4. This is incorrect. The district court accurately read the MLR regulation to provide that "CHS payment is necessary for the application of MLR," RE197, PageID#12652, because the regulation on its face caps only "I/T/U payment[s]" at MLR, 42 C.F.R. § 136.30(e)-(g). The court did not require that any payment must be traced to an IHS appropriation before the MLR regulation would apply. Moreover, the district court explicitly acknowledged that the Tribe "funds its CHS program with money from the IHS *and money from the Tribe*," RE197, PageID#12648 (emphasis added); *accord* RE202, PageID#12781, meaning that a "CHS payment" in the Tribe's case includes a mix of IHS and Tribal funds.

Nor did the district court impose the "source of funds" requirement that *amici* theorize. According to *amici*, "[t]he district court would have patients and providers confirm the bank account that issued payment, and the source of funds in the account, in order to determine whether the obligation on the provider to accept MLR as payment in full, and protection for the patient against balance billing, apply." *Amici* Br. 12. None of this appears in the district court's opinions. To the contrary, the district court correctly read the MLR regulation to cap only "CHS payment[s]," RE197, PageID#12652, but imposed no administrative requirements on how the Tribe makes such payments or what account it uses. The district court

did not need to address such details on this record, which makes clear that BCBSM was not administering the Tribe's CHS program or acting as an I/T/U, but instead was paying claims under an employee healthcare benefit plan entirely separate from the CHS program. *See* RE197, PageID#12655.[9]

To the extent this Court finds, as *amici* do (*Amici* Br. 10-11), any ambiguity in the district court's rulings, it should nonetheless affirm the judgment by applying the regulation's plain text. The regulation caps only "I/T/U payments" at MLR. 42 C.F.R. § 136.30(e)-(g). Interpreting the statute as the Tribe does—to provide for "MLR discounts" no matter which entity is paying for the care, *see* Tribe Br. 37—conflicts not only with this regulatory text, but also with the statute it implements. The MMA calls for the promulgation of regulations narrowly directed to the provision of medical care "*under the contract health services program funded by the Indian Health Service*," 42 U.S.C. § 1395cc(a)(1)(U)(i) (emphasis added); *supra*, p. 29, making clear Congress intended MLR to cap payments by CHS programs in particular—not any form of health program that

[9] Despite arguing that BCBSM should not rely on IHS guidance, the Tribe and its *amici* argue that several IHS FAQs contradict the district court's non-existent tracing requirement. *See* Tribe Br. 45 (citing RE173-27, PageID#9276-78, 9281); *Amici* Br. 16-19 (citing RE173-27, PageID#9276-81). Because the district court did not hold, and BCBSM does not argue, that the MLR regulation imposes any tracing requirement, these citations are irrelevant. None contradicts the plain text of the regulation, which provides that only payments by the Tribe's CHS program are capped.

simply bears a connection to a tribe. The Tribe's reading of the regulation is flatly inconsistent with the statute and must be rejected. *See Tenn. Hosp. Ass'n v. Azar*, 908 F.3d 1029, 1037 (6th Cir. 2018) (rejecting proposed interpretation of regulation that would make the rule "contrary to" the statute authorizing the rule).

(ii) *Neither the Indian canon of construction, nor any self-governance principles, nor the ISDEAA supports the Tribe's reading of the regulation.*

The Tribe and its *amici* also argue that the Indian canon of construction supports their reading of the regulation. That canon instructs that statutory or regulatory ambiguities are to be resolved in favor of Indian tribes. *See, e.g.*, *South Carolina v. Catawba Indian Tribe, Inc.*, 476 U.S. 498, 506 (1986). The MLR regulation is not ambiguous, so the Indian canon has no application. *See id.* Moreover, even if the regulation were ambiguous, the Indian canon does not "permit disregard of the clearly expressed intent of Congress." *Id.* The Tribe's interpretation cannot prevail because it is contrary to the clearly expressed intent of Congress to cap only payments made *by a Tribe's CHS program*. *See supra*, pp. 20-22, 29.

The Tribe's arguments based on self-governance and self-determination principles are similarly misplaced. Under the principle of self-governance, "[a] clear statement is required for a statute to undermine central aspects of tribal self-government—that is, a tribe's ability to govern its own members," such as by

"determin[ing] tribal membership, regulat[ing] domestic relations among members, prescrib[ing] rules of inheritance among members, and punish[ing] tribal offenders." *N.L.R.B. v. Little River Band of Ottawa Indians Tribal Gov't*, 788 F.3d 537, 544, 550 (6th Cir. 2015). The ISDEAA promotes tribal autonomy in running federally administered programs. *Solomon v. Interior Reg'l Hous. Auth.*, 313 F.3d 1194, 1199 (9th Cir. 2002). The MLR regulation does not implicate either doctrine because it does not undermine tribal self-governance or self-determination. Instead, it imposes restrictions *on hospitals*, dictating what payment they must accept from tribal CHS programs in exchange for providing contract health services. As the district court recognized, "[t]he Tribe is given the authority to create and manage the [CHS] program in a way it sees fit." RE202, PageID#12794.

Finally, nothing in *Redding Rancheria v. Hargan*, 296 F. Supp. 3d 256 (D.D.C. 2017), supports the Tribe's position either. *See* Tribe Br. 51-53; *Amici* Br. 22. *Amici* suggest that the district court violated self-determination principles by holding that "tribes must . . . 'create a system similar to Redding Rancheria'" if they are to have payments for contract health services capped at MLR. *Id.* The district court did not mandate any system for the Tribe's CHS program, and said only that "[t]he Tribe *could* create a system similar to Redding Rancheria" if it sought to maximize the share of payments capped at MLR. RE202, PageID#12791 (emphasis added). Indeed, the district court was correct that *Redding Rancheria* is

instructive. The Redding Rancheria tribe devised a system to ensure that, whenever MLR was lower than the rates offered by its self-funded healthcare coverage plan, the tribe's CHS program would pay for contract health services (instead of the self-funded plan) so as to lock in MLR. 296 F. Supp. 3d at 261-62. That tribe's system—and the *Redding Rancheria* court's decision upholding it—are in full accord with the ruling here that only CHS payments may be capped under the MLR regulation.

2. BCBSM Did Not Breach Any Fiduciary Duty in Adhering to the Terms of the Parties' Agreement.

a. BCBSM's adherence to the terms of the parties' contract was not a fiduciary act.

Even if any of BCBSM's payments to healthcare providers under the Employee Plan could have been capped at MLR, BCBSM did not breach any fiduciary duty under ERISA by paying claims according to its standard operating procedures, because that is exactly what the parties' contract dictated. It is axiomatic that under ERISA, an ERISA plan service provider does not engage in a fiduciary act or breach any fiduciary duty when it adheres to explicit contract terms.

As the Supreme Court has explained, ERISA administrators "may wear different hats," and an administrator wears a "fiduciary hat" only "'to the extent' that he acts in such a capacity in relation to a plan." *Pegram v. Herdrich*, 530 U.S.

211, 225-26 (2000) (quoting 29 U.S.C. § 1002(21)(A)). Applying contractual terms is not a fiduciary act. "'[I]f a specific [contract] term (not a grant of power to change terms) is bargained for at arm's length, adherence to that term is not a breach of fiduciary duty. No discretion is exercised when an insurer merely adheres to a specific contract term.'" *Seaway Food Town, Inc. v. Med. Mut. of Ohio*, 347 F.3d 610, 618 (6th Cir. 2003) (quoting *Ed Miniat, Inc. v. Globe Life Ins. Grp., Inc.*, 805 F.2d 732, 737 (7th Cir. 1986)); *see also Harris Tr. & Sav. Bank v. John Hancock Mut. Life Ins. Co.*, 302 F.3d 18, 27-28 (2d Cir. 2002) (rejecting argument that an ERISA plan administrator "would be in breach of his duties whenever he rejects a request by a plan trustee that is contrary to the parties' agreed-upon terms for operation of the plan"; "[w]e cannot countenance such a broad reading of the scope of ERISA's fiduciary duties").

Here, the ASC did not authorize BCBSM to choose in its discretion whether to pay MLR on claims under the Employee Plan. To the contrary, the ASC provided that "BCBSM shall administer [the Tribe's] healthcare Coverage(s) in accordance with BCBSM's *standard operating procedures*." RE79-4, PageID#3181 (emphasis added). These "standard operating procedures" included the payment of claims at discounted "network rates" that applied across-the-board

for all BCBSM customers. RE173-2, PageID#8936.[10] Moreover, the Tribe was aware that BCBSM's standard operating procedures did not encompass paying claims at MLR, and yet renewed the ASC each year with this explicit contract language in place. *See, e.g.,* RE79-9, PageID#3288-3309. By paying claims at network rates, pursuant to its standard operating procedures, BCBSM adhered to the bargained-for terms of the ASCs.

BCBSM's decision not to depart from the contract terms in order to pay claims at MLR was not a fiduciary act or breach of any fiduciary duty. Indeed, courts routinely so hold. For example, in *Seaway*, this Court held that the administrator of a self-funded health benefit plan did not act as an ERISA fiduciary, and thus did not breach any fiduciary duty, when it retained healthcare provider discounts that the contract "specifically authoriz[ed]" the administrator to retain. 347 F.3d at 619. Similarly, in *Harris Trust & Savings Bank*, the Second Circuit rejected a claim that a retirement plan administrator breached its fiduciary duty by declining to engage in a rollover of plan funds that was outside the terms of the parties' agreement: "[N]either the language nor the policy of ERISA support the imposition of a duty that would require Hancock to agree to Sperry's request

[10] BCBSM's negotiation of its network rates also did not constitute a fiduciary act. *See DeLuca v. Blue Cross Blue Shield of Mich.*, 628 F.3d 743, 746-47 (6th Cir. 2010).

for an extra-contractual rollover. . . . [The statutory text] and case law interpreting ERISA fiduciary standards generally lead to the conclusion that Hancock was not acting in a fiduciary capacity when it refused Sperry's request." 302 F.3d at 27.

In *Larson v. United Healthcare Ins. Co.*, 723 F.3d 905 (7th Cir. 2013), the Seventh Circuit rejected a claim that an insurer breached its fiduciary duty by imposing allegedly unlawful copayment requirements for chiropractic services pursuant to express policy terms. As the court explained, the plaintiffs' claim was "a challenge to the *content* of the insurance policies; 'decisions about the content of a plan are not themselves fiduciary acts.'" *Id.* at 917 (quoting *Pegram*, 530 U.S. at 226). So too here: the Tribe's claim is a challenge to the content of the ASC, specifically its provision that BCBSM would process claims according to standard operating procedures rather than paying eligible claims at MLR. But decisions about the content of the ASC are not fiduciary acts, and the Tribe's breach of fiduciary claim therefore fails.

The Tribe's arguments on the point lack merit. Contrary to the Tribe's argument, it is not "law of the case that BCBSM was a fiduciary to [the Tribe] and its self-insured plans" for purposes of its MLR claim. Tribe Br. 32. In the Tribe's prior appeal, this Court held only that the Tribe "sufficiently *pleaded*" a breach of fiduciary claim, and "emphasize[d] that [it] express[ed] no opinion on the ultimate merits" of that claim. 748 F. App'x at 22 (emphasis added). In light of the

procedural posture, the Court did not consider either the terms of the parties' ASC or whether BCBSM engaged in a fiduciary act when it adhered to those terms. *See id.* Nor is the Tribe helped by *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751 F.3d 740 (6th Cir. 2014). *See* Tribe Br. 6-7. In *Hi-Lex*, the Court held that BCBSM engaged in a fiduciary act when it retained access fees because those fees were not prescribed by contract, but instead "discretionarily imposed" and "sometimes waived entirely." 751 F.3d at 744-45. Here, the contract is unambiguous, and BCBSM undisputedly *never* paid any claim at MLR. *See* RE177, PageID#10843.

b. BCBSM had no knowledge of which Employee Plan claims were supposedly eligible for MLR.

BCBSM also did not breach any fiduciary duty because it lacked the necessary information to pursue MLR for any Employee Plan claims. It is undisputed that the Tribe (1) never informed BCBSM that any claims submitted to the Employee Plan for payment were for contract health services authorized by the Tribe's CHS program, (2) never provided BCBSM a list of which participants in the Employee Plan were eligible for contract health services, and (3) did not even inform BCBSM which Employee Plan participants were Tribal members. *Supra* pp. 8-10. With no knowledge of which claims were even potentially eligible for MLR, BCBSM did not breach any fiduciary duty in paying claims according to its standard operating procedures, as prescribed in the ASC.

The Fourth Circuit rejected a breach of fiduciary duty claim on similar grounds in *Gordon v. CIGNA Corp.*, 890 F.3d 463 (4th Cir. 2018). The court held that an insurer had no fiduciary duty to notify a policy member that his coverage had not been approved because the insurer did not receive "individual information about specific employees" from the employer. *Id.* at 476. "Given this arrangement, it is unclear how the [insurer] could have even known that a particular employee was paying for coverage that had not been approved," because the employer "simply did not submit that level of detail to [the insurer], nor was it required by the Plan." *Id.* And in an even more analogous case, the Northern District of Alabama rejected a claim that Blue Cross Blue Shield of Alabama ("BCBSAL") squandered plan assets by "improperly paying claims" that should have been billed to Medicare, because BCBSAL lacked information regarding which plan participants were eligible for Medicare. *See Birmingham Plumbers and Steamfitters Local Union No. 91 Health and Welfare Tr. Fund v. Blue Cross Blue Shield of Ala.*, No. 2:17-cv-00443, 2018 WL 1210930, at *3 (N.D. Ala. Mar. 8, 2018). Where the plaintiff never "provided [Medicare eligibility] information regarding the participant at issue . . ., there can be no claim . . . that [BCBSAL] breached its fiduciary duty." *Id.* at *5.

In the district court, the Tribe argued that even though BCBSM did not know which claims were eligible for MLR, ERISA required BCBSM "to develop a

method to obtain purchase order authorizations" from the Tribe. RE177, PageID#10854. But under the ASC, the Tribe was solely responsible for determining employees' eligibility for coverage under the Employee Plan, RE79-4, PageID#3182 (Art. II.B), and the Tribe has conceded that "the Tribe, not BCBSM, . . . was responsible for determining whether a particular participant was eligible for CHS." RE154-5, PageID#7917. BCBSM therefore had no fiduciary obligation to uncover the information necessary to identify any MLR-eligible claims. *See Fink v. Union Cent. Life Ins. Co.*, 94 F.3d 489, 492 (8th Cir. 1996) (no breach of fiduciary duty for accepting premium payments without verifying employee's eligibility for coverage because the employer, not the insurer, "was responsible for determining employee eligibility").

B. The Tribe's ERISA Claim is Time-Barred.

The Tribe's ERISA claim independently fails because it is untimely. ERISA requires the Tribe to have filed suit within three years of obtaining actual knowledge of the purported "breach or violation forming the basis for the claim." *Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 548 (6th Cir. 2012); 29 U.S.C. § 1113(2). It is undisputed that the Tribe had actual knowledge no later than 2008 that BCBSM was not processing or paying claims for the Employee Plan at MLR. *See, e.g.*, RE173-11, PageID#9110-12 (CHS clerk testified that the Tribe "always understood" that BCBSM did not obtain MLR, including in connection with the

Employee Plan); *see also supra* at pp. 12-13 (collecting citations). The Tribe was likewise aware that BCBSM's network rate would sometimes be higher than MLR, and it knowingly accepted the risk that it would pay more under BCBSM's network rates. RE173-3, PageID#8965, 8968-69, 8971. Indeed, starting in at least 2009, the Tribe repeatedly communicated with BCBSM and the Tribe's insurance agent about the fact that BCBSM was not processing or paying claims at MLR. *See* RE173-25, PageID#9250-52, 9258-60 (Tribe insurance agent testified that he "always knew" that BCBSM "never offered Medicare-like Rates" and explained that to the Tribe).

This evidence leaves no doubt that the Tribe had actual knowledge of the purported breach more than three years before it filed this lawsuit. As this Court has explained, "'[a]ctual knowledge means 'knowledge of the underlying conduct giving rise to the alleged violation,' rather than 'knowledge that the underlying conduct violates ERISA.'" *Cataldo*, 676 F.3d at 548 (quoting *Wright v. Heyne*, 349 F.3d 321, 331 (6th Cir. 2003)). Here, the Tribe contends that BCBSM breached its fiduciary duty when it engaged in the underlying conduct of processing healthcare claims at standard network rates instead of at MLR. *See* RE7, PageID#88, ¶ 136. The Tribe had actual knowledge of this underlying conduct no later than 2008—making its claim in this suit untimely. Indeed, the district court in an analogous case reached precisely that conclusion. *See Grand Traverse Band of Ottawa &*

Chippewa Indians v. Blue Cross & Blue Shield of Mich., No. 14-CV-11349, 2017 WL 6594220, *2-3 (E.D. Mich. Dec. 26, 2017) (Levy, J.) (where tribe alleged that BCBSM violated ERISA by not "obtaining MLR for MLR-eligible claims," plaintiffs had actual knowledge of the conduct underlying their ERISA claim as soon as they "knew they were not getting MLR").

The Tribe argued before the district court that its claim was not untimely, because it "*did not know BCBSM had been overpaying* MLR-eligible claims at amounts in excess of MLR until [it] learned in November 2014" that another tribe "had secured substantial savings by switching to a different third-party administrator who priced claims using MLR methodology." RE177, PageID#10855-56 (emphasis in original). But none of these allegedly later-discovered facts revealed "the underlying *conduct* giving rise to the alleged violation." *Cataldo*, 676 F.3d at 548 (emphasis added). The Tribe admittedly knew that BCBSM was paying claims at its standard network rates, which the Tribe also knew could be higher than MLR. Rather, the knowledge that paying MLR might have led to "substantial savings" at most revealed the *consequences* of the supposed breach, which does not support timeliness: A plaintiff "need only have knowledge of the act [underlying its ERISA claim] and cannot wait until the consequences of the act become painful" to file suit. *Wright*, 349 F.3d at 330 (citation and internal quotation marks omitted).

Tellingly, Judge Levy rejected this same argument when it was raised by Grand Traverse Band in support of its analogous MLR-focused ERISA claim. "The facts plaintiffs [claim they did not know] go entirely to whether they were aware that . . . they had a claim for breach of fiduciary duty, not whether they were aware . . . that BCBSM would not provide MLR (which they admittedly were)." *Grand Traverse Band*, 2017 WL 6594220, at *3. So too here.

In the district court, the Tribe also asserted in a footnote, without explanation or support, that "BCBSM concealed its misconduct by leading the Tribe to believe it was developing MLR pricing processes, when, in fact, it was not." RE177, PageID#10858 n.12. It is not clear whether this passing reference was meant to invoke the "fraud or concealment" exception to ERISA's statute of limitations. *See* 29 U.S.C. § 1113 ("in the case of fraud or concealment," a lawsuit may be brought up to "six years after the date of discovery of such breach or violation"). To the extent the Tribe argues "fraud or concealment" in this Court, the Tribe has waived that argument by failing to develop it below. *See, e.g.*, *Stone Surgical, LLC v. Stryker Corp.*, 858 F.3d 383, 392 (6th Cir. 2017) (argument raised to district court through "cursory references" without development "into a full-fledged argument" is waived on appeal). Regardless, the fraud-or-concealment exception does not apply here. As Judge Levy wrote in *Grand Traverse Band*, the Tribe's allegations of "promises that BCBSM would attempt to do better at some

point in the future" did not establish fraud or concealment, but instead "again put plaintiffs on notice that they were not receiving MLR." 2017 WL 6594220, at *5.

II. The Tribe's Michigan Health Care False Claim Act Claim Fails.

The Tribe's HCFCA claim as to the Member Plan fails for multiple, independent reasons. The HCFCA provides that a person who "knowingly presents or causes to be presented" to a "health care corporation or a health care insurer" any "claim which contains a false statement shall be liable to the health care corporation or health care insurer." Mich. Comp. Laws Ann. § 752.1009. The Tribe contends that it qualifies as a "healthcare insurer," and it claims that "BCBSM 'presented' false claims to [the Tribe] through reimbursement requests to the Tribe for amounts BCBSM paid to providers." Tribe Br. 54-55.

First, there was nothing "false" about BCBSM's requests for reimbursement of claims that it undisputedly paid for healthcare provided to Member Plan participants. *See* Mich. Comp. Laws Ann. § 752.1002(c) (defining "false" as "wholly or partially untrue or deceptive"). The Tribe argues that "BCBSM knowingly misled [the Tribe] about the nature of its rates, causing [the Tribe] to pay at materially higher rates than [it was] entitled to." Tribe Br. 55-56. But this is wrong. As detailed above, the Tribe was not "entitled to" MLR discounts on the claims that BCBSM paid. *Supra* at pp. 29-34. That conclusion compels affirmance of summary judgment on the Tribe's HCFCA claim.

Moreover, the record is clear that the Tribe knew that BCBSM was paying claims at its standard rates—not at MLR. The Member Plan ASC stated explicitly that BCBSM would apply "BCBSM's standard operating procedures," RE79-3, PageID#3163, and the Tribe understood that BCBSM was accordingly processing claims using its standard network discounts and *not* MLR. *Supra* at pp. 13-14. Indeed, that is why the Tribe continually raised the question of whether BCBSM would change its practices to start paying claims at MLR, RE173-24, PageID#9242; RE173-25, PageID#9250-52, 9256-59; RE173-26, PageID#9268-71; RE173-17, PageID#9191: *because the Tribe knew that BCBSM was not doing so*. Thus, even if the claims processed by BCBSM had been eligible for MLR (which they were not), there was nothing deceptive or misleading in BCBSM's payment of claims as the ASC prescribed.

The Tribe's authority confirms this conclusion. *See* Tribe Br. 56. The cases to which the Tribe points hold that a claim under the HCFCA or federal False Claims Act may be adequately pleaded if the defendant presented for payment a claim that violated a contractual or statutory pricing requirement. *See United States ex rel. Morsell v. Symantec Corp.*, 130 F. Supp. 3d 106 (D.D.C. 2015) (federal False Claims Act claim survived dismissal where defendant was alleged to have falsely certified its compliance with a contract pricing term); *State ex rel. Gurganus v. CVS Caremark Corp.*, No. 299997, 2013 WL 238552, at *13-14 (Jan.

22, 2013) (HCFCA claim survived dismissal where defendant pharmacies were alleged not to have priced generic drugs as required by statute), *judgment rev'd in part, vacated in part*, 852 N.W.2d 103 (2014). Here, BCBSM processed claims exactly as the ASC required—according to its standard operating procedures, by applying its discounted network rates. RE79-3, PageID#3163, RE173-2, PageID#8935-36. Unlike the plaintiffs in *United States ex rel. Morsell* and *State ex rel. Gurganus*, the Tribe contends that BCBSM should have paid claims at rates *different* from what the contract prescribed. But the Tribe knew throughout the parties' relationship that BCBSM paid healthcare claims as set forth in the ASC, and BCBSM's processing of claims in the manner it had contracted to is not "false."

The Tribe cannot satisfy the other requirements for an HCFCA claim either. For one, BCBSM did not "present[ ] or cause[ ] to be presented" any claim to the Tribe for payment within the meaning of the HCFCA. *See* Mich. Comp. Laws Ann. § 752.1009. As the Tribe's benefits manager and the Tribe's controller both testified, BCBSM did not present medical claims to the Tribe. RE173-3, PageID#8963. Rather, healthcare providers presented claims to BCBSM for payment, BCBSM paid those claims pursuant to the terms of the ASC, and the Tribe periodically made lump-sum payments to BCBSM for the aggregate amounts owed. RE173-3, PageID#8961-63; RE173-4, PageID#8991-92; *see also* RE79-18,

PageID#3431-37; RE79-3, PageID#3164. In other words, it was healthcare providers who "presented" healthcare claims for payment—not BCBSM. Again, this conclusion is confirmed by the Tribe's own authority, *United States v. Hawley*, 619 F.3d 886, 892-93 (8th Cir. 2010), which held that the presentment requirement was satisfied when the defendant submitted false claims for crop reimbursement to an insurance company.

Finally, on top of the other holes in its HCFCA claim, the Tribe has not identified any particular false claims presented to it, as required under Michigan law. *See State ex rel. Gurganus*, 852 N.W.2d at 112 (under HCFCA, false claims must be identified "with particularity"). Throughout this litigation, the Tribe has not identified a single "false" claim to support its theory. *See, e.g.,* RE173-36, PageID#9445-46. *See supra*, n.8. For these reasons, the Tribe's HCFCA claim fails.

III. The Tribe's Common Law Breach of Fiduciary Duty Claim Fails.

The Tribe's MLR-based common law breach of fiduciary duty claim as to the Member Plan fails for the reasons already discussed. As the Tribe concedes, its common law fiduciary duty claim cannot succeed if its ERISA claim fails. Tribe Br. 56 (arguing "the same reasons" in support of the two claims). Therefore, just as the Tribe cannot establish that BCBSM breached any fiduciary duty under ERISA, it cannot establish that BCBSM breached any common law fiduciary duty either.

Indeed, Michigan law is clear that where the parties' contract authorizes particular conduct, there can be no claim that engaging in that conduct constitutes breach of a fiduciary duty. *Calhoun Cnty. v. Blue Cross Blue Shield of Mich.*, 824 N.W.2d 202, 213 (Mich. Ct. App. 2012) ("Even assuming that defendant owed a fiduciary duty to plaintiff, as a result of our holding that defendant was authorized by the contract to charge the access fee, plaintiff cannot maintain its breach-of-fiduciary-duty claim."). Here, because BCBSM was "authorized by the [ASC]" to process claims pursuant to its standard network rates, the Tribe "cannot maintain its breach-of-fiduciary-duty claim" based on BCBSM's adherence to the parties' contract. *Id.*; *cf. Thompson v. Cmty. Ins. Co.*, 213 F.R.D. 284, 301 (S.D. Ohio 2004).

The Tribe attempts to distinguish *Calhoun County* by arguing that "BCBSM cannot point to any provision in the ASCs authorizing BCBSM to deprive the Tribe of its legally entitled MLR discounts." Tribe Br. 57. This is specious: The ASC authorized BCBSM to process healthcare claims according to its standard operating procedures, which it did. The Tribe elsewhere asserts that "BCBSM cannot contract away its legal obligations under the MLR regulations." *Id.* at 58 (citing *Citizens Ins. Co. of Am. v. Federated Mut. Ins. Co.*, 500 N.W.2d 773, 774 (Mich. Ct. App. 1993)). This, too, is specious: The MLR regulations facially do not prohibit a claims processor from paying healthcare claims in the manner prescribed

by contract. Indeed, the only entities on whom the MLR regulations impose legal obligations are "Medicare-participating hospitals," which are required to accept "I/T/U payments" at MLR as payment in full. *See* 42 C.F.R. § 136.30(a). If the Tribe believes that Medicare-participating hospitals violated this regulatory requirement by refusing to accept MLR-capped payments from the Tribe's CHS program, its recourse lies with those hospitals—not with BCBSM. *See* 42 C.F.R. § 136.32(a) ("If it is determined that a hospital has submitted inaccurate information for payment, . . . [a Tribe] may *** [d]isallow costs previously paid . . . .").

Finally, for the reasons stated with respect to the Tribe's ERISA claim, the Tribe's common law fiduciary duty claim is also time-barred. The Tribe's common law fiduciary duty claim is subject to a similar three-year statute of limitations accruing "when [the Tribe] knew or should have known of the breach." *Grand Traverse Band of Ottawa and Chippewa Indians v. Blue Cross Blue Shield of Mich.*, 391 F. Supp. 3d 706, 717 (E.D. Mich. 2019); Mich. Comp. Laws Ann. § 600.5805(2). Because the Tribe knew that BCBSM was not processing claims at MLR no later than 2008, but did not file suit until 2016, the Tribe's state law claim is untimely.

CONCLUSION

For the foregoing reasons, the judgment should be affirmed.

Dated: June 30, 2021

Respectfully submitted,

/s/ *Tacy F. Flint*

Tacy F. Flint
Abigail B. Molitor
Rebecca B. Shafer
SIDLEY AUSTIN LLP
One South Dearborn
Chicago, Illinois 60603

Attorneys for
Blue Cross Blue Shield of Michigan

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because, according to the word-count feature of Microsoft Word, this brief contains 12,784 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Office Word in Times New Roman 14 point font.

Dated: June 30, 2021

Respectfully submitted,

/s/ *Tacy F. Flint*

Tacy F. Flint
Abigail B. Molitor
Rebecca B. Shafer
SIDLEY AUSTIN LLP
One South Dearborn
Chicago, Illinois 60603

Attorneys for
Blue Cross Blue Shield of Michigan

CERTIFICATE OF SERVICE

I hereby certify that on June 30, 2021, I electronically filed the foregoing document using the ECF system which will send notification of such filing to all counsel of record.

Respectfully submitted,

/s/ *Tacy F. Flint*

Tacy F. Flint
Abigail B. Molitor
Rebecca B. Shafer
SIDLEY AUSTIN LLP
One South Dearborn
Chicago, Illinois 60603

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