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 AND BLUE SHIELD OF MICHIGAN,

Defendant-Appellee.

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

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

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UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit
Case Number: 21-1226 Case Name: Saginaw Chippewa v Blue Cross

Name of counsel: Herman D. Hofman

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

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

No

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

No

CERTIFICATE OF SERVICE

I certify that on March 12, 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/Herman D. Hofman
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This statement is filed twice: when the appeal is initially opened and later, in the principal briefs, immediately preceding the table of contents. See 6th Cir. R. 26.1 on page 2 of this form.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT
CIVIL APPEAL STATEMENT OF PARTIES AND ISSUES

Case No: 21-1226 Case Manager: Ryan E. Orme

Case Name: Saginaw Chippewa Indian Tribe of Michigan v Blue Cross Blue Shield of Michigan

Is this case a cross appeal? ☐ Yes ☑ No
Has this case or a related one been before this court previously? ☑ Yes ☐ No
If yes, state:
Case Name: Same as above Citation: 17-1932 and 18-1170
Was that case mediated through the court's program? ☑ Yes ☐ No

Please Identify the Parties Against Whom this Appeal is Being Taken and the Specific Issues You Propose to Raise:

Appeal taken by Plaintiffs against Defendant Blue Cross Blue Shield of Michigan.

Issues that may be raised include, but are not limited to:

1. Whether the District Court erroneously dismissed Plaintiffs' claims under Fed. R. Civ. P. 56 based on its opinion that the MLR regulations only apply to services exclusively funded by the Tribe's CHS program when the District Court's decision: (1) failed to apply the plain language of the MLR regulations, instead creating an additional condition to MLR eligibility by improperly deferring to select passages on a page linked to the IHS website; and (2) declined to enforce statutory and regulatory mandates to increase health services available to tribes, instead imposing an unduly restrictive interpretation of the MLR regulations inconsistent with the Tribe's self-determined status.

This is to certify that a copy of this statement was served on opposing counsel of record this 12th day of March, 2021.

/s/ Herman D. Hofman
Name of Counsel for Appellant

TABLE OF CONTENTS

TABLE OF AUTHORITIES viii

STATEMENT REGARDING ORAL ARGUMENT xii

STATEMENT OF JURISDICTION 1

STATEMENT OF ISSUE PRESENTED FOR REVIEW 2

STATEMENT OF THE CASE 4

I. FACTUAL BACKGROUND 5

A. BCBSM HAS A DECADES-OLD HISTORY OF DEFRAUDING ITS SELF-INSURED CUSTOMERS AND BREACHING ITS FIDUCIARY DUTIES 5

B. BCBSM PREVIOUSLY ADMINISTERED THE TRIBE'S HEALTHCARE BENEFIT PLANS 6

C. BCBSM HAD DISCRETIONARY AUTHORITY AND CONTROL OVER ALL FUNDING PAID BY SCIT FOR ITS PLANS 7

D. IN 2007, DHHS ENACTS REGULATIONS MANDATING THAT ALL SERVICES FURNISHED BY MEDICARE-PARTICIPATING HOSPITALS AND AUTHORIZED BY A TRIBE'S CHS PROGRAM BE PAID AT MLR OR LOWER 8

E. BCBSM ALWAYS KNEW ABOUT THE TRIBE'S PURCHASE ORDER/REFERRAL AUTHORIZATION PROCESS FOR HEALTHCARE CLAIMS ELIGIBLE FOR CONTRACT HEALTH SERVICES 11

F. INTERNALLY, BCBSM ACKNOWLEDGED THAT ITS TRIBAL CLIENTS WERE ELIGIBLE FOR MLR DISCOUNTS AND THAT BCBSM "HELD THE KEYS" TO UNLOCKING MLR DISCOUNTS FOR THE TRIBES 14

G. BCBSM KNEW ITS TRIBAL CLIENTS WOULD SAVE MILLIONS OF DOLLARS IN HEALTHCARE COSTS IF THEY ACCESSED MLR DISCOUNTS, BUT OBSTRUCTED ITS

TRIBAL CLIENTS' ACCESS TO THOSE DISCOUNTS TO MAINTAIN ITS OWN REVENUE STREAMS....16

1. BCBSM swindles the GTB Tribe out of MLR discounts after GTB insists BCBSM provide MLR discounts....16

2. BCBSM fends off efforts by SCIT and its agent to obtain MLR discounts....18

3. BCBSM continues obstructing its tribal clients' efforts to access MLR with full knowledge of the massive overpayments it was making using these tribes' funds....21

II. PROCEDURAL HISTORY....22

A. THE DISTRICT COURT DISMISSED PLAINTIFFS' MLR CLAIMS BASED ON THE PREMISE THAT THE MLR REGULATIONS DO NOT REFERENCE ERISA....22

B. ON APPEAL, BCBSM ARGUED THE MLR REGULATIONS DO NOT APPLY TO ITS ADMINISTRATION OF SCIT'S SELF-FUNDED PROGRAM, RELYING ON AN FAQ....23

C. THIS COURT REVERSES THE DISTRICT COURT'S DECISION AND REJECTED BCBSM'S POSITION, INTERPRETING THE TEXT OF THE MLR REGULATIONS BASED ON ITS PLAIN MEANING AND REMANDING FOR RESOLUTION OF CERTAIN CIRCUMSCRIBED FACTUAL ISSUES....23

D. ON REMAND, BCBSM AGAIN MOVES TO DISMISS PLAINTIFFS' MLR CLAIMS, BUT THE DISTRICT COURT SENT THE PARTIES TO DISCOVERY, EMPHASIZING THE IMPORTANCE FACTUAL DEVELOPMENT WOULD HAVE ON PLAINTIFFS' CLAIMS....25

E. THE DISTRICT COURT GRANTS BCBSM'S MOTION FOR SUMMARY JUDGMENT, HOLDING THE MLR REGULATIONS DO NOT APPLY TO THE HEALTHCARE SERVICES AT ISSUE AS A MATTER OF LAW BASED ON FAQS FROM IHS'S WEBSITE....26

SUMMARY OF THE ARGUMENT 30

ARGUMENT 32

I. STANDARDS OF REVIEW 32

II. BCBSM BREACHED ITS FIDUCIARY DUTIES TO THE TRIBE BY SYSTEMATICALLY SQUANDERING TRIBAL PLAN ASSETS 32

A. THE DISTRICT COURT ERRED BY NOT APPLYING THE PLAIN LANGUAGE OF THE MLR REGULATIONS AND BY CREATING A NEW CONDITION TO MLR ELIGIBILITY NOT FOUND IN THE REGULATIONS 33

1. Authorization by a tribal CHS program and the hospital's participation in Medicare are the only two requirements for MLR eligibility 33

2. The plain language of the MLR regulations does not predicate eligibility for MLR discounts on a showing that the claims were paid for only with IHS funds.....35

B. THE DISTRICT COURT FAILED TO APPLY RELEVANT TOOLS OF STATUTORY AND REGULATORY CONSTRUCTION.....39

C. THE DISTRICT COURT'S DECISION IMPROPERLY DEFERRED TO BCBSM'S SELF-SERVING INTERPRETATION OF SNIPPETS OF FAQS IT PLUCKED FROM A PAGE LINKED TO IHS'S WEBSITE 41

D. THE DISTRICT COURT'S DECISION UNDERMINES THE MLR REGULATIONS' PURPOSE OF INCREASING HEALTHCARE SERVICES AVAILABLE TO TRIBAL MEMBERS AND SUBVERTS THE TRIBE'S SELF-DETERMINED STATUS 47

1. The District Court's decision contradicts the purpose of the authorizing statutes and implementing regulations 47

2. The District Court's decision subverts the Tribe's self-governed and self-determined status 49

3. The Rancheria opinion is premised on tribal self-determination and fully supports the Tribe's position 51

III. BCBSM VIOLATED ERISA, THE HFCA, AND ITS MICHIGAN COMMON LAW FIDUCIARY DUTIES.....53

CONCLUSION.....58

CERTIFICATE OF COMPLIANCE.....60

CERTIFICATE OF SERVICE 61

DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS 62

TABLE OF AUTHORITIES

Cases

Bay Mills Indian Cmty. v. Whitmer, 794 F. App'x 485 (6th Cir. 2019)..... 41

Bostock v. Clayton Cnty., 140 S. Ct. 1731 (2020)..... 38

Calhoun Cnty. v. BCBSM, 297 Mich. App. 1, 824 N.W.2d 202 (2012)..... 57, 58

Cf. United States v. Hawley, 619 F.3d 886 (8th Cir. 2010)..... 55

Christensen v. Harris Cnty., 529 U.S. 576 (2000) 43

Citizens Ins. Co. of America v. Federated Mut. Ins. Co., 199 Mich. App. 345, 500 N.W.2d 773 (1993)..... 58

County of Yakima v. Confederated Tribes & Bands of Yakima Indian Nation, 502 U.S. 251 (1992)..... 40

Gonzales v. Oregon, 546 U.S. 243 (2006)..... 44

Good Samaritan Hosp. v. Shalala, 508 U.S. 402 (1993)..... 33

Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002)..... 35

Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan, 751 F.3d 740 (6th Cir. 2014) 6, 7

Intel Corp. Inv. Policy Comm v. Sulyma, --U.S.—140 S. Ct. 768 (2020)..... 54

Iowa Mut. Ins. Co. v. LaPlante, 480 U.S. 9 (1987) 50

Kisor v. Wilkie, 139 S. Ct. 2400 (2019)..... passim

Little River Band v. BCBSM, 183 F. Supp. 3d 835 (2016)..... 35

Martinez v. Larose, 968 F.3d 555 (6th Cir. 2020)..... 32

Memphis Biofuels, LLC v. Chickasaw Nation Indus., Inc., 585 F.3d 917 (6th Cir. 2009) 41

Merrion v. Jicarilla Apache Tribe, 455 U.S. 130 (1982) 49, 50

Michigan v. Bay Mills Indian Cmty., 572 U.S. 782 (2014) 50, 53

Montana v. Blackfeet Tribe, 471 U.S. 759 (1985) 40

Navajo Nation v. Dep't of Health & Human Servs., Sec'y, 325 F.3d 1133 (9th Cir. 2003) 48

Oak Point Partners, LLC v. Blue Cross Blue Shield of Michigan, 446 F. Supp. 3d 195 (E.D. Mich. 2020) 6

OfficeMax, Inc. v. U.S., 428 F.3d 583 (6th Cir. 2005) 44

Ramah Navajo Chapter v. Lujan, 112 F.3d 1455 (10th Cir. 1997) 49

Rancheria v. Hargan, 296 F. Supp. 3d 256 (D.D.C. 2017) ..... passim

S. Ute Indian Tribe v. Sebelius, 657 F.3d 1071 (10th Cir. 2011) 40

Santa Clara Pueblo v. Martinez, 436 U.S. 49 (1978) 53

SCIT v. BCBSM, 748 F. App'x 12 (6th Cir. 2018) ..... passim

Solomon v. Interior Reg'l Hous. Auth., 313 F.3d 1194 (9th Cir. 2002) 49

State ex rel. Gurganus, No. 299997, 2013 WL 238552 56

Tennessee Hosp. Assoc. v. Azar, 908 F.3d 1029 (6th Cir. 2018) 41

United States ex rel. Morsell v. Symantec Corp., 130 F. Supp. 3d 106 (D.D.C. 2015) 56

United States v. Douglas, 634 F.3d 852 (6th Cir. 2011) 34, 36

United States v. Havis, 927 F.3d 382 (6th Cir. 2019) 29, 42, 43

United States v. Riccardi, 989 F.3d 476 (6th Cir. 2021) 43

Universal Health Servs., Inc. v. United States, __U.S.__, 136 S. Ct. 1989 (2016) 56

Williams v Int'l Paper Co., 227 F.3d 706 (6th Cir. 2000) 32

Wysocki v. Int'l Bus. Mach. Corp., 607 F.3d 1102 (6th Cir. 2010) 39

Statutes

25 U.S.C. § 13 48

25 U.S.C. § 1621a(d)(5) 38

25 U.S.C. § 1642 ..... 48, 49

25 U.S.C. § 450 44

25 U.S.C. § 458aaa-16e 44

25 U.S.C. § 5321(a)(1) 49

25 U.S.C. § 5324(j) 49

25 U.S.C. § 5325(o) 49

25 U.S.C. § 5329(c) 44

25 U.S.C. 1603(h) 10

25 U.S.C. 450 10

25 U.S.C. 5301 9

28 U.S.C. § 1291 1

28 U.S.C. § 1331 1

28 U.S.C. § 1362 1

29 U.S.C. § 1002(1) 41

42 U.S.C. § 2001 48

MCL 752.1001, *et seq.* 22

Other Authorities

1988 U.S.C.C.A.N. 2620 52

Rules

Fed. R. App. P. 34(a) xii

Fed. R. Civ. P. 12(b)(6).....25

Regulations

42 C.F.R. 136 36

42 C.F.R. 136.1 ..... 33, 36

42 C.F.R. 136.11-136.12.....8

42 C.F.R. 136.12(a).....8

42 C.F.R. 136.22(a)(6) 8

42 C.F.R. 136.23 8

42 C.F.R. 136.23(a).....8

42 C.F.R. 136.24(b) 11

42 C.F.R. 136.24(e).....39

42 C.F.R. 136.30(a).....37

42 C.F.R. 136.30(b) 10, 37

42 C.F.R. 136.30(c).....10

42 C.F.R. 136.30(d) 10

42 C.F.R. 136.30(e).....10

42 C.F.R. 136.30(f) 10, 37

42 C.F.R. 136.31(g)(2)..... 11, 37

42 C.F.R. 136.61 8

42 U.S.C. 1395cc(a)(1)(U)(i).....36

STATEMENT REGARDING ORAL ARGUMENT

This matter involves the fundamental rights of self-determination and self-governance of Native American tribal nations and is of significant importance. *See* Fed. R. App. P. 34(a). Moreover, the proper resolution of this appeal is of interest not just to Native American tribes, but also to thousands of their members and employees. Further, considering the importance and complexity of the issues involved in this appeal, Appellants believe that oral argument will assist the Court in its review. Accordingly, Appellants respectfully request oral argument.

STATEMENT OF JURISDICTION

The District Court exercised jurisdiction under 28 U.S.C. §§ 1331 and 1362. This Court's jurisdiction is based on 28 U.S.C. § 1291. The District Court entered final judgment on August 7, 2020. Appellants timely filed their Motion to Alter or Amend Judgment on September 1, 2020, which the District Court denied on February 2, 2021. Appellants timely filed their Notice of Appeal on March 3, 2021.

STATEMENT OF ISSUE PRESENTED FOR REVIEW

Promulgated with the remedial purpose of improving Native American tribes' access to healthcare, the Medicare-Like Rate ("MLR") regulations set forth in 42 C.F.R. §§ 136.30-136.32 make discounted pricing available for healthcare services (1) authorized by a Tribe's Contract Health Services ("CHS") program and (2) provided by a Medicare-participating hospital.

All healthcare services at issue in this case were authorized by the Contract Health Services program of Plaintiff/Appellant Saginaw Chippewa Indian Tribe (the "Tribe" or "SCIT"). In addition, all healthcare services at issue in this case were provided by a Medicare-participating hospital. Neither of these fundamental facts is in dispute.

Blue Cross Blue Shield of Michigan ("BCBSM") breached its fiduciary duties in administering SCIT's health care plans by depriving the Tribe of MLR discounts, which resulted in SCIT paying millions more for healthcare services than necessary. The District Court allowed BCBSM to escape liability for its breaches of fiduciary duty by creating an additional condition to MLR eligibility not found in the MLR regulations by requiring that, for each instance in which a tribal member received healthcare services, the funds used to pay for the healthcare services be traceable to funds received by SCIT from the Indian Health Service ("IHS"). The issue presented

for review is whether the District Court erred when it granted BCBSM's Motion for Summary Judgment on that basis.

STATEMENT OF THE CASE

This case concerns BCBSM's concerted and systematic effort to block tribal clients from obtaining MLR discounts for healthcare services expressly promised by federal regulations to Native American tribal nations. BCBSM's selfish motive was to preserve its lucrative pricing arrangements with providers and increase its own revenue.

Enacted in 2007, the MLR regulations entitle Native American tribes to pay the lower of a Medicare-Like Rate or contracted rate for healthcare services, so long as the services were (1) authorized by a tribal CHS program; and (2) provided by a Medicare-participating hospital.

BCBSM was the fiduciary for SCIT's self-insured healthcare plans for both SCIT employees and tribal members. BCBSM knew about the benefits the MLR regulations offered to its tribal clients. Any prudent person managing SCIT's healthcare plans would have taken advantage of the millions of dollars in savings the MLR regulations offered to SCIT. But instead of taking advantage of MLR discounts available to the tribe, BCBSM engaged in an extended campaign to conceal the benefit of these discounts from its tribal clients and thwart their access to MLR discounts. BCBSM–with its discretionary authority and control over tribal plan assets–squandered millions of dollars of SCIT's money as a result to preserve its own profit-making pricing arrangements with hospitals.

SCIT brought this lawsuit after discovering BCBSM's fiduciary breaches and self-dealing in charging the Tribe Hidden Fees and causing it to overpay millions of dollars for healthcare services. BCBSM previously sought to dismiss the Tribe's MLR claims, arguing that healthcare services are only eligible for MLR discounts if the claims are paid for exclusively with funds from the IHS. This Court rejected BCBSM's position previously and remanded the case for further proceedings. *SCIT v. BCBSM*, 748 F. App'x 12, 20-21 (6th Cir. 2018).

On remand, BCBSM repackaged the same argument previously rejected by this Court and convinced the District Court to once again dismiss the Tribe's claims on this same basis. The District Court's erroneous decision to judicially rewrite the MLR regulations to add a condition to MLR eligibility not included in the plain language of the MLR regulations contradicts well-established canons of regulatory interpretation. Further, it infringes on the Tribe's self-determined status by retroactively requiring the Tribe to follow a narrow, judicially-created plan design to obtain MLR discounts.

I. FACTUAL BACKGROUND

A. BCBSM HAS A DECADES-OLD HISTORY OF DEFRAUDING ITS SELF-INSURED CUSTOMERS AND BREACHING ITS FIDUCIARY DUTIES.

The largest health insurance company in Michigan, BCBSM also provides third-party claims administration services to self-funded welfare benefit plans across the state, including SCIT's welfare benefit plans. This action is one of a long line of

successful actions against BCBSM by self-insured entities for BCBSM's breaches of fiduciary duties and self-dealing. *See Oak Point Partners, LLC v. Blue Cross Blue Shield of Michigan*, 446 F. Supp. 3d 195, 196 (E.D. Mich. 2020) ("Blue Cross Blue Shield of Michigan has been sued successfully a number of times for overcharging companies for whom it had agreed to process healthcare claims for their self-funded employee health plans."). The seminal lawsuit culminated in the Sixth Circuit's decision in *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751 F.3d 740 (6th Cir. 2014), which conclusively established BCBSM's liability as an ERISA fiduciary for charging, collecting, and fraudulently concealing a variety of fees from its customers. Earlier in this case, a partial Judgment was entered against BCBSM related to BCBSM's fraudulently charging and collecting certain fees against tribal plan assets. 7/14/17 Judgment, (RE 113, PageID#6233).

B. BCBSM PREVIOUSLY ADMINISTERED THE TRIBE'S HEALTHCARE BENEFIT PLANS.

SCIT is a federally recognized Indian Tribe that employs both non-tribal and tribal members. Vogel Dep. 25:3-24, (RE 81-10, PageID#4104). From 2004 forward, BCBSM administered medical claims for SCIT's plan participants through a self-funded arrangement. Sprague Decl. at ¶ 10, (RE 81-13, PageID#4159); Cronkright Dep. 26:15-18, (RE 81-14, PageID#4165). This meant that, instead of paying insurance premiums to BCBSM in return for coverage, SCIT paid the cost of health care benefits from its own funds; BCBSM administered and paid those claims

using tribal funds. Reger Decl. at ¶¶ 3-6, (RE 97-7, PageID#5829-5830). SCIT paid BCBSM a fee for administering the plans.

BCBSM administered claims pursuant to two Administrative Services Contracts ("ASCs"). SCIT tribal members were designated as Group 52885 (the "Member Plan"). SCIT employees were designated as Group 61672 (the "Employee Plan"). Cronkright Dep. 26:23-27:11, 30:9-20, (RE 81-14, PageID#4165-4166).

C. BCBSM HAD DISCRETIONARY AUTHORITY AND CONTROL OVER ALL FUNDING PAID BY SCIT FOR ITS PLANS.

During the relevant time period, BCBSM obtained funds for the Employee Plan out of the Tribe's Fringe Internal Service Fund. In contrast, BCBSM obtained funding for the Member Plan out of the Tribe's Government Trust (subsequently the Gaming Trust). 7/14/17 Op. & Order, (RE 112, PageID#6203); 4/26/19 Order (RE 146, PageID#7787). Funds SCIT received from the IHS were held in the Government Trust that funded the Member Plan. Reger Dep. 21-24 (RE 199-2, PageID#12694-12697). In other words, IHS funds used to pay healthcare claims for the Member Plan were held in the same trust and same bank account as SCIT funds used for that purpose. *Id.* at 23:14-24:02 (RE 199-2, PageID#12695-12696).

At all relevant times, BCBSM had discretionary authority and control over the funds paid for SCIT's plans and was SCIT's fiduciary with respect to those funds. *See Hi-Lex Controls*, 751 F.3d at 745-747.

D. IN 2007, DHHS ENACTED REGULATIONS MANDATING THAT ALL SERVICES FURNISHED BY MEDICARE-PARTICIPATING HOSPITALS AND AUTHORIZED BY A TRIBE'S CHS PROGRAM BE PAID AT MLR OR LOWER.

IHS offers medical services to persons of Native American descent at IHS facilities across the country—just as veterans receive medical treatment at VA facilities. 42 C.F.R. 136.11-136.12. To serve Native Americans who do not live near an IHS facility, Congress directed IHS to offer Contract Health Services, through which a Native American can be authorized by IHS to go to a private hospital or doctor for treatment when an IHS facility is not reasonably available. 42 C.F.R. 136.23.[1] IHS pays the cost of such services as the "payor of last resort" after "alternate resources" such as Medicare have been exhausted. 42 C.F.R. 136.61.

Contract Health Services are available "to persons of Indian descent belonging to the Indian community served by the local facilities and program." 42 C.F.R. 136.12(a). Such services are provided to Native Americans "when necessary health services by an Indian Health Service facility are not reasonably accessible or available" and the patient lives within the CHS delivery area. 42 C.F.R. 136.23(a).[2]

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

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

Under the Indian Self-Determination and Education Assistance Act of 1975 ("ISDEAA"), 25 U.S.C. 5301 *et seq.*, self-determined Indian tribes may carry out a CHS program for eligible Native Americans living near the tribe's reservation. SCIT is a self-determined Indian tribe and has carried out a CHS program for tribal members living near the SCIT reservation since 1997. SCIT Contract Health Service Eligibility Criteria, (RE 177-2, PageID#10872).

In July 2007, "Subpart D" of the IHS regulations governing Indian Health went into effect. These new regulations are entitled "Limitation on Charges for Services Furnished by Medicare-Participating Hospitals to Indians" and are codified at 42 C.F.R. 136.30-136.32 (the "MLR regulations").[3]

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

> §136.30 Payment to Medicare-participating hospitals for authorized Contract Health Services.
>
> (b) *Applicability.* **The payment methodology under this section applies to all levels of care furnished by a Medicare-participating hospital**, whether provided as inpatient, outpatient, skilled nursing facility care, as other services, of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) that is

[3] The MLR regulations are a subset of the regulations on Indian Health relevant to this dispute. Most of the regulations governing CHS programs date back to 1999, well before the MLR regulations were enacted.

> authorized under part 136, subpart C by a contract health service (CHS) program of the Indian Health Service (IHS); **or authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act**, as amended, Pub. L. 93-638, 25 U.S.C. § 450 *et seq.;* or authorized for purchase under § 136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h))(hereafter "I/T/U").

42 C.F.R. 136.30(b)(emphasis added).

Neither the enabling statute nor the regulations state that the hospital services authorized by a tribe's CHS program must be exclusively paid for with IHS funds to be eligible for MLR discounts. Authorization of the hospital services by the Tribe's CHS program, not payment with IHS funds, is the regulatory predicate for services provided by a Medicare-participating hospital to be eligible for MLR pricing under 42 C.F.R. 136.30(b). *See id.*

The "payment methodology under this section" for hospital claims authorized by a CHS program is based on what "the Medicare program would pay under a prospective payment system" with some minor additional charges, thus the phrase "Medicare-Like Rates." 42 C.F.R. 136.30(c)-(e). Notably, the MLR regulations say the Tribe "will pay the lesser of the payment amount determined under [the MLR regulations] or the amount negotiated with the hospital or its agent." 42 C.F.R. 136.30(f) (emphasis added). A tribe's CHS program is the "payor of last resort" and must coordinate benefits with any third-party payers, with the CHS program paying

for services only after other "alternate resources" such as Medicare and Medicaid have paid. 42 C.F.R. § 136.31(g)(2).

E. BCBSM ALWAYS KNEW ABOUT THE TRIBE'S PURCHASE ORDER/REFERRAL AUTHORIZATION PROCESS FOR HEALTHCARE CLAIMS ELIGIBLE FOR CONTRACT HEALTH SERVICES.

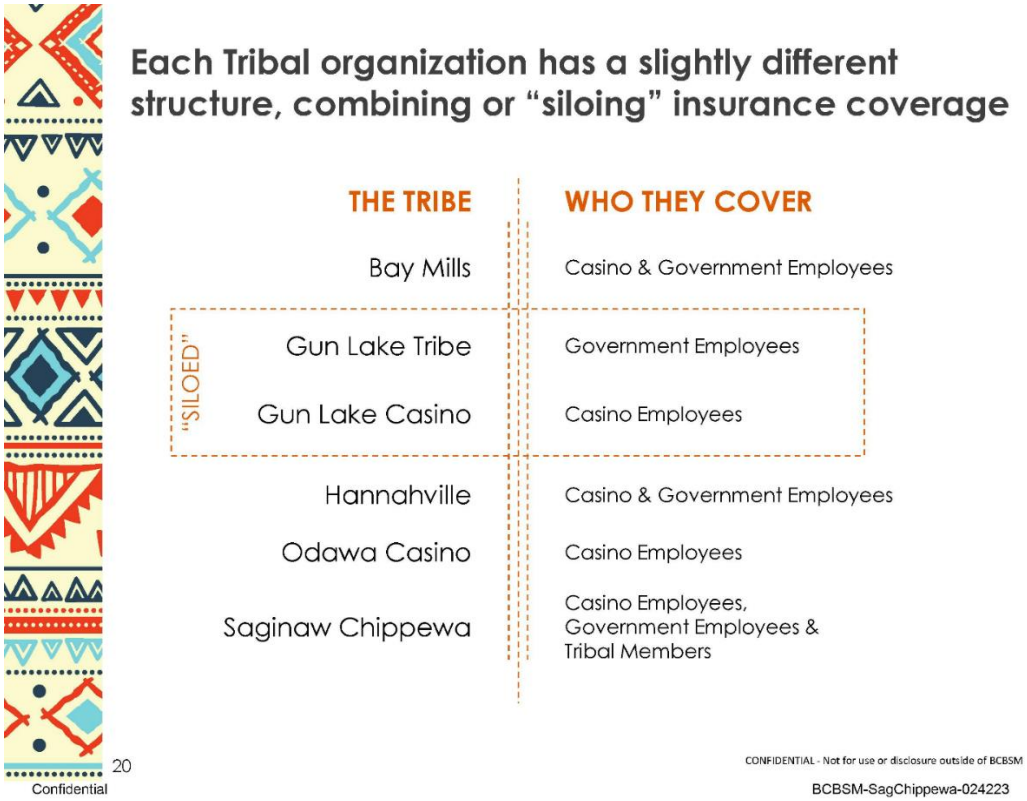
SCIT's CHS program authorized all healthcare claims at issue in this lawsuit.[4] A patient authorized to receive healthcare services by SCIT's CHS program was required to present the purchase order/referral issued by the CHS program to the healthcare provider at the time of service. *See* Robinson Dep. 20:21-21:1 (RE 177-6, PageID#10980-10981); Fox Dep. 34:24-35 (RE 177-7, PageID#11055-11056).

[4] Two requirements must be met for a CHS program to authorize a Native American's healthcare:

- Before receiving treatment, the patient must "supply information that the ordering official [the tribe's CHS program] deems necessary to determine the relative medical need for services and the individual's eligibility."[4] 42 C.F.R. 136.24(b); and
- After reviewing that information, a "purchase order" must be issued by the tribe's CHS program evidencing that the tribe's CHS program has determined that (a) the patient is eligible for contract health services; and (b) the patient is authorized to receive the specific services described in the purchase order. 42 C.F.R. 136.24(a).

These requirements were met for each of the healthcare services at issue in this lawsuit. *See, e.g.*, 6/12/15 Referral, (RE 177-4, PageID#10883); Raphael Dep. 11:19-24, (RE 177-5, PageID#10895); Robinson Dep. 11:3-12:15 (RE 177-6, PageID#10971-10972).

BCBSM knew the healthcare plans it was managing for its tribal clients, such as SCIT, included "tribal Contract Health groups" eligible for MLR discounts. *See, e.g.*, Deiss Dep. 102:23-103:24 (RE 177-16, PageID#11551-11552); 8/22/07 E-mail, (RE 177-11, PageID#11240) (discussing MLR applicability to "tribal Contract Health groups"). BCBSM also knew that each of its tribal clients, as self-determined tribal nations, had somewhat "different" structures, as demonstrated from BCBSM's October 29, 2014 internal PowerPoint presentation regarding "Tribal Healthcare Decisionmakers" it produced in this case:



Indeed, BCBSM discussed with other BCBS member companies in other states the logistics of how to confirm that healthcare services had been authorized

by its tribal clients' CHS programs in order to identify those claims eligible for MLR discounts. *See, e.g.*, 4/12/13 BCBSM internal E-mail, (RE 177-33, PageID#11705-11708) ("[W]ould the Indian Health Services/Tribal Clinic enter an authorization for its specific services, or is the activation of medical eligibility [] the only authorization of services required?"); 7/16/13 E-mail, (RE 177-34, PageID#11709) (BCBSM Product Consultant Jeffrey Tenerowicz discussing "operational requirements to administer MLRs" in the context of the "precertification process" and how, in Michigan, "tribes have their own method of IHS referrals or PO-equivalents.").

BCBSM also knew that, to obtain MLR for its tribal clients, it would have to implement a process to confirm those services had been authorized by the tribe's CHS program. *See* Root Dep. 74:25-76:7, 122:25-123:1-8 (RE 177-15, PageID#11327-11329, 11375-11376); Deiss Dep. 95:14-18, 102:23-103:24 (RE 177-16, PageID#11544, 11551-11552); Kamai Dep. 52:12-53:18, 64:1-66:7 (RE 177-51, PageID#11842-11843, 11854-11856).

In fact, for healthcare services provided outside of Michigan, BCBSM was *required* by the National Blue Cross Blue Shield Association ("BCBSA") to obtain purchase order authorizations from either the CHS program or from the healthcare provider to ensure the Tribe paid the lower of MLR or the BCBSM contract price. *See* Nat'l. Business Requirements–MLR, § 6.8, (RE 177-9, PageID#11211-11219).

Accordingly, BCBSM always fully understood that, as part of implementing MLR pricing, it—not SCIT—had the responsibility to obtain purchase order authorizations from the CHS programs of its self-insured tribal customers, including SCIT. *See* Root Dep. 74:25-76:7, 122:25-123:1-8 (RE 177-15, PageID#11327-11329, 11375-11376); Nat'l. Business Requirements–MLR, § 6.8, (RE 177-9, PageID#11211-11219). From SCIT's side, if BCBSM had only provided access to the MLR discounts, SCIT "would have done everything they could to try to [align] their internal systems to provide that data" to BCBSM. Kamai Dep. 56:15-57:1 (RE 177-51, PageID#11846-11847). But BCBSM deliberately chose not to obtain purchase order authorizations from SCIT's CHS program or from healthcare providers because it did not want SCIT to access MLR discounts. BCBSM was making too much money off its own pricing arrangements with providers. 2/17/15 E-mail, (RE 177-44, PageID#11734) (BCBSM's Regional Sales Manager Chris Staub stating that he understood why "[BCBSM's President of West Michigan Operations Jeff Connolly] would not want to undertake this [MLR] project unless there are enough members or revenue at stake for BCBSM.").

F. INTERNALLY, BCBSM ACKNOWLEDGED THAT ITS TRIBAL CLIENTS WERE ELIGIBLE FOR MLR DISCOUNTS AND THAT BCBSM "HELD THE KEYS" TO UNLOCKING MLR DISCOUNTS FOR THE TRIBES.

BCBSM knew of the MLR regulations within a few "months" after they went into effect. Deiss Dep. 12:25-14:5 (RE 177-16, PageID#11461-11463). BCBSM

repeatedly acknowledged internally that its tribal clients were eligible for the MLR discounts the regulations promised, and that BCBSM "h[e]ld the keys" for the tribes to access the MLR discounts. 2/17/15 E-mail, (RE 177-44, PageID#11733) (BCBSM's Regional Sales Manager Chris Staub e-mail to the Tribe's Account Manager Lynne Harvey wondering whether MLR was "critical for [BCBSM] going forward" because BCBSM "h[e]ld the keys to this, at this point.").

By 2007, BCBSM described the MLR regulations internally as follows:

> Do you have any tribal Contract Health groups? The IHS has ruled that they pay Medicare or lower at the hospital.

8/22/07 E-mail, (RE 177-11, PageID#11240) (emphasis added). While externally obstructing access to MLR, BCBSM continued to admit internally that its tribal clients were entitled to MLR:

> Medicare Like Rates (MLR) – All tribal groups are eligible to receive MLR when paying for services at our hospitals . . . .

12/13/11 E-mail, (RE 177-20, PageID#11662) (emphasis added). In July 2013, BCBSM again admitted internally that

> "[T]he non-employed tribal groups (CHS–Contract Health Services) are unquestionably entitled to Medicare-like rates and act as the tribes insurer of last resort . . . ."

7/17/13 E-mail, (RE 177-31, PageID#11699) (emphasis added).

Despite what it always admitted internally, BCBSM's efforts externally were to obstruct its tribal clients' efforts to access MLR discounts (see below).

G. BCBSM Knew its Tribal Clients Would Save Millions of Dollars in Healthcare Costs if They Accessed MLR Discounts, But Obstructed its Tribal Clients' Access to Those Discounts to Maintain its Own Revenue Streams.

Despite knowing that SCIT: (1) operated a CHS program; (2) authorized CHS-eligible healthcare claims; (3) was eligible for the MLR discounts; and (4) would save millions of dollars in healthcare costs by utilizing the MLR discounts, BCBSM as SCIT's plan administrator and fiduciary failed to obtain these discounts for SCIT. BCBSM went even further: it actively obstructed access to the MLR discounts to avoid diminishing its pricing arrangements and losing revenue. *See* Root Dep. 85:9-87:7, 89:24-91:3 (RE 177-15, PageID#11338-11340, 11342-11344).

1. BCBSM swindled the GTB Tribe out of MLR discounts after GTB insisted BCBSM provide MLR discounts.

Soon after the MLR Regulations went into effect in July 2007, the Grand Traverse Band of Ottawa and Chippewa Indians ("GTB"), insisted on BCBSM providing access to the MLR discounts provided by the regulations. *See* 10/25/07 E-mail, (RE 177-13, PageID#11251). BCBSM admitted that its Blue Care Network (BCN) system could process claims at MLR and identified this as "corporate project." *Id.* ("BCN can process claims like Medicare") *Id*. Yet, BCBSM never provided GTB (or any tribe) with the MLR discounts. *See* Root Dep. 96:5-13 (RE 177-15, PageID#11349).

BCBSM's refusal to provide its tribal clients with the MLR discounts was not because of any inability to do so. Already in January 2008, Blue Cross Blue Shield of Minnesota was providing its tribal clients MLR discounts and offered to assist BCBSM in doing so for BCBSM's tribal clients:

> Our affiliate, CCStpa, is offering to reprice claims as a service to Indian Tribes. Most of the tribes have little or no chance of figuring out what a Medicare-like rate might be, so CCStpa is offering to perform that service on a service bureau basis.

1/21/08 E-mail, (RE 177-14, PageID#11252) (emphasis added). BCBSM never took BCBS of Minnesota up on its offer because (again) it did not want to lose its lucrative pricing arrangements with providers. *See* Root Dep. 85:9-87:7, 89:24-91:3 (RE 177-15, PageID#11338-11340, 11342-11344). And following the law took effort: it wasn't "worth keeping the business and not getting any money for it[.]" 7/28/13 E-mail, (RE 177-30, PageID#11697).

GTB continued to insist that BCBSM provide it with MLR discounts. *See* 2/17/15 E-mail, (RE 177-44, PageID#11733) (noting how GTB had "pushed" BCBSM "hard on MLR . . . in prior years"). BCBSM refused to do so, but to placate GTB, BCBSM eventually promised GTB an additional 8% discount on claims at Munson hospital approved by GTB's CHS program. Deiss Dep. 32:19-33:12, 34:9-13, 35:25-36:12 (RE 177-16, PageID#11481-11482, 11483-11485). BCBSM (falsely) represented to GTB that the net amount paid by GTB's self-insured member plan for those claims was "close to" MLR pricing. *See id.* BCBSM ultimately failed

to honor even this commitment, and its breaches and false representations to GTB are currently the subject of pending, parallel litigation in Michigan. *See GTB v. BCBSM*, No. 14-CV-11349, (E.D. Mich.).

2. BCBSM fended off efforts by SCIT and its agent to obtain MLR discounts.

Thereafter, SCIT's insurance broker, Gallagher Benefits Services, challenged BCBSM's refusal to take advantage of MLR discounts available to SCIT:

> Unfortunately, BCBS MI doesn't coordinate any of these [MLR] discounted rates so the Tribes are losing money. Since we at GBS are the agents for the majority of the MI Tribes, we need to make sure that the carriers are capturing every discount available to the [Native American] community.

1/7/11 E-mail, (RE 177-17, PageID#11630). Gallagher introduced BCBSM executives to HealthSmart, the company that developed the program BCBS of Arizona used for MLR pricing. 8/12/11 E-mail, (RE 177-18, PageID#11657-11658). Gallagher urged BCBSM to partner with HealthSmart as an "eas[y]" way to provide tribes with access to MLR discounts. *Id.*; *see also* 7/6/11 E-mail, (RE 177-19, PageID#11659-11660). BCBSM never implemented this "easy" option. *See* Kamai Dep. 35:12-37:9 (RE 177-51, PageID#11825-11827). Instead, BCBSM continued to refuse its tribal clients MLR discounts, deciding it did not want to devote any IT resources to it. *See* 10/19/11 E-mail, (RE 177-21, PageID#11663-11665).

In September 2012, Gallagher again sought to address BCBSM's refusal to provide its tribal clients MLR discounts and its corresponding concealment of (what was later discovered to be) overpayments by BCBSM's tribal clients:

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

9/4/12 E-mail, (RE 177-22, PageID#11666-11667).

BCBSM responded by (falsely) representing to Gallagher that BCBSM's network discounts were better than or at least not significantly different than MLR discounts. *See* Brooks Dep. 58:16-60:16 (RE 177-52, PageID#11966-11968) (BCBSM "had said that their rates, their contract rates, . . . the contract rates that they pay their doctors and facilities would not yield any significant changes if paid under Medicare-like repricing."). Gallagher wanted proof:

> [B]elieve me, I'm not looking past the discounts that BCBSM has here in Michigan and I'm not entirely sure that Medicare-like rates will be much different than those discounts. But, I'm sure you can understand that we can't just make that assertion and hope for the best. Our mutual

> clients are going to want proof and at the very least, know that BCBSM is investigating who they can accommodate processing claims at Medicare-Like Rates.

10/5/12 E-mail, (RE 177-23, PageID#11668-11673); *see also* 1/9/13 E-mail (RE 177-26, PageID#11681) (BCBSM's representations about being the "best fit" for tribes were "contradict[ed]" by other out-of-state TPAs who were "saving these Tribes millions and leveraging that success here in MI").

Gallagher further requested BCBSM's decision (not to provide MLR discounts) "in writing" to both "protect [BCBSM]" and "inoculate our Tribes." *Id.*, (RE 177-26, PageID#11681). BCBSM never provided anything in writing. *See* Brooks Dep. 60:22-62:2 (RE 177-52, PageID#11968-11970); *see also* 10/9/12 E-mail (RE 177-24, PageID#11674-11679) (Gallagher stating that BCBSM's feigned MLR effort "is going nowhere fast").

Upon learning that BCBSM would not commit to provide MLR discounts to its tribal clients, Gallagher warned BCBSM: "[I]f it's discovered that BCBSM's legal interpretation is wrong and the Tribes could have been saving millions [with MLR pricing], it will look bad for BCBS." 1/9/13 E-mail, (RE 177-26, PageID#11681). BCBSM decided to gamble, ordering its directors and managers to "see where the cards fall" on the issue. Root Dep., at 93:17-25 (RE 177-15, PageID#11346) (March 21, 2013 directive from BCBSM President of West Michigan Operations Jeff

Connolly to Regional Sales Director Kelley Root and Regional Manager Frank Smith).

3. BCBSM continued obstructing its tribal clients' efforts to access MLR with full knowledge of the massive overpayments it was making using these tribes' funds.

Gallagher continued to pressure BCBSM to provide its tribal clients with MLR discounts. In June 2015, Gallagher asked BCBM about "where things stand with BCBS implementing MLR for tribal claims?" 6/25/15 E-mail, (RE 177-46, PageID#11742-11744). BCBSM's internal reaction was "Oh boy . . . see below." *Id*.

It was known within BCBSM that the difference between MLR pricing and BCBSM's network pricing was massive:

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

8/7/15 E-mail, (RE 177-47, PageID#11773-11775) (emphasis added).

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

With full knowledge of this, BCBSM's obstructionism continued through 2015. In an e-mail to BCBSM's Account Manager for SCIT, BCBSM's Regional Sales Manager said he was "most concerned about SagChips [SCIT's]" attempts to

obtain MLR discounts "since they have the Tribal Council most concerned about overall cost–plus they seem to be the ones who feel there is 'something else' out there that could benefit the Tribe/Casino that hasn't yet been discovered . . . ." 2/17/15 E-mail, (RE 177-44, PageID#11733). In that same e-mail, BCBSM's Regional Sales Manager further noted that he understood why "[BCBSM's President of West Michigan Operations] would not want to undertake this [MLR] project unless there are enough members or revenue at stake for BCBSM." *Id.* at PageID#11734.

II. PROCEDURAL HISTORY

A. THE DISTRICT COURT DISMISSED PLAINTIFFS' MLR CLAIMS BASED ON THE PREMISE THAT THE MLR REGULATIONS DO NOT REFERENCE ERISA.

After being swindled out of MLR discounts and defrauded with Hidden Fees, SCIT sued BCBSM in January 2016. 1/29/16 Compl., (RE 1). SCIT's remaining MLR claims are for: (1) ERISA breach of fiduciary duty (related to the Employee Plan); (2) violation of Michigan's Health Care False Claims Act, MCL 752.1001, *et seq.*, ("HCFCA") (related to the Member Plan); and (3) Common law breach of fiduciary duty (also related to the Member Plan) ("MLR Claims"). Amended Compl., (RE 7, PageID#60-103).

BCBSM moved to dismiss the portion of the Amended Complaint relating to MLR. BCBSM's Mtn. to Dismiss, (RE 14). On August 3, 2016, the District Court granted BCBSM's motion. 8/3/16 Op. & Order, (RE 22). Plaintiffs appealed.

B. ON APPEAL, BCBSM ARGUED THE MLR REGULATIONS DO NOT APPLY TO ITS ADMINISTRATION OF SCIT'S SELF-FUNDED PROGRAM, RELYING ON AN FAQ.

In its response brief on appeal, BCBSM argued (among other things) that Plaintiffs' MLR claims were barred because the MLR regulations do not apply to BCBSM's administration of SCIT's plans. Resp. Br. of Appellee BCBSM, Case No. 17-1932, (Doc. # 19, Page 46-48). Specifically, BCBSM argued that hospitals are only required to accept MLR rates when services are purchased by a CHS program and traced to IHS funds. *See id.* at p. 38. BCBSM argued that because it did not pay SCIT's claims only with IHS funds, its payments of healthcare claims (using tribal plan assets) were not subject to the MLR regulations. *Id.* at p. 40. BCBSM based its position on its reading of an FAQ response on IHS's website. *Id.*

C. THIS COURT REVERSED THE DISTRICT COURT'S DECISION AND REJECTED BCBSM'S POSITION, INTERPRETING THE TEXT OF THE MLR REGULATIONS BASED ON ITS PLAIN MEANING AND REMANDING FOR RESOLUTION OF CERTAIN CIRCUMSCRIBED FACTUAL ISSUES.

Reversing the District Court's dismissal of Plaintiffs' fiduciary duty claim based on the MLR regulations, this Court held that it was actionable under ERISA. *SCIT v. BCBSM*, 748 F. App'x 12, 20-21 (6th Cir. 2018). This Court identified Section 136.30 of the MLR regulations as the authority underlying Plaintiffs' MLR claim. *Id.* at 20 ("The Tribe bases its MLR claim on 42 C.F.R. § 136.30."). It gave the text its plain meaning as requiring "Medicare-participating hospitals to accept payment for services at a rate that is no more than what those services would cost

under Medicare[.]" *Id.* This Court identified two conditions to applicability of the aforementioned MLR regulations: (1) that the services are provided by a Medicare-participating hospital; and (2) "that the services are authorized by a Tribe that is carrying out a Contract Health Service ('CHS') program on behalf of the Indian Health Service ('IHS')." *Id.* (citing 42 C.F.R. 136.30(a), (b)).

This Court also rejected BCBSM's "alternative reason for affirming the district court's dismissal" discussed above: namely, that BCBSM's "administration of the Tribe's plan . . . is not subject to the MLR regulations" because those regulations "apply only to the expenditure of IHS funds and do not limit the payment that hospitals must accept from a third-party payor, such as BCBSM, which is not expending IHS funds." *Id.* at 21. This Court construed BCBSM's argument as contending "that the Tribe cannot show, as a factual matter, that the regulations apply to its ERISA plan." *Id.* This Court rejected BCBSM's position, instead holding: if the Tribe established "as a factual matter" that "BCBSM was aware of the MLR regulations, that BCBSM failed to ensure that the Tribe paid no more than MLR for MLR-eligible services, and that all other conditions precedent were met," the MLR regulations would be "applicable to BCBSM's administration of the Tribe's ERISA plan."[5] *Id.* at 21-22.

[5] This Court concluded its opinion by adding the obvious point that it was expressing "no opinion on the ultimate merits of the Tribe's MLR claim." *Id.* at 22.

D. ON REMAND, BCBSM AGAIN MOVED TO DISMISS PLAINTIFFS' MLR CLAIMS, BUT THE DISTRICT COURT SENT THE PARTIES TO DISCOVERY, EMPHASIZING THE IMPORTANCE FACTUAL DEVELOPMENT WOULD HAVE ON PLAINTIFFS' CLAIMS.

Upon reinstatement of Plaintiffs' MLR claims on remand, and despite this Court's decision that such claims presented "factual matter[s]" not resolvable as a matter of law, BCBSM immediately moved (again) under Fed. R. Civ. P. 12(b)(6) to dismiss Plaintiffs' MLR claims. BCBSM's Mtn. to Dismiss (RE 142). The District Court denied BCBSM's Motion to Dismiss without prejudice and directed the parties to conduct discovery. *See* 4/26/19 Order (RE 146). The District Court emphasized the importance "factual development" would have on "the merits of SCIT's MLR claim[s]." *Id.* at PageID#7802.

After discovery, BCBSM moved for judgment as a matter of law (yet again). BCBSM's Mtn. for S.J. (RE 173). This motion did not challenge Plaintiffs' claims on any factual issues identified by this Court, namely that BCBSM was aware of the MLR regulations; that the MLR rates were on average substantially lower than BCBSM's network rates; or that SCIT authorized all claims at issue in its lawsuit. *Compare SCIT v. BCBSM*, 748 F. App'x at 21-22 *with* BCBSM's Mtn. for S.J. (RE 173). Instead, along with secondary arguments, BCBSM focused on the same argument it had previously made to this Court during the prior appeal—that the MLR regulations did not apply, as a matter of law, to BCBSM's administration of SCIT's plans because the claims were not paid solely with funds traceable to IHS. *See id.*

at PageID#8910-15. Once again, BCBSM did not tie its argument to the plain language of the MLR regulations or any language from the Sixth Circuit's decision. *Id.* at PageID#8897. Instead, as if cutting and pasting from its losing brief to the Sixth Circuit, BCBSM again based its position on its self-serving interpretation of a FAQ response found on IHS's website. *Id.* at PageID#8910.

In contrast, SCIT responded by citing this Court's prior guidance and the plain language of the MLR regulations. Response to BCBSM's Mtn. for S.J. (RE 177, PageID#10829-31, 10845). Relying on this Court's prior interpretation of the MLR regulations, SCIT demonstrated that the regulations unambiguously contain only two conditions to eligibility: (1) the services were provided by a Medicare-participating hospital; and (2) the services were authorized by the Tribe's CHS program. *Id.* at PageID#10830-31, 10845. The plain language of the regulations does not precondition eligibility for MLR discounts on showing exclusive IHS funding for the healthcare services. *Id.*

E. THE DISTRICT COURT GRANTED BCBSM'S MOTION FOR SUMMARY JUDGMENT, HOLDING THE MLR REGULATIONS DO NOT APPLY TO THE HEALTHCARE SERVICES AT ISSUE AS A MATTER OF LAW BASED ON FAQS FROM IHS'S WEBSITE.

The District Court granted BCBSM's motion and entered judgment in BCBSM's favor on Plaintiffs' MLR claims. 8/7/20 Op. & Order, (RE 197); 8/7/20 Judgment, (RE 198). Although the District Court had said factual development would be important, its decision dismissed the entire case based only on what it saw

as "the purely legal question of the applicability of MLR[.]" 8/7/20 Op. & Order (RE 197, PageID#12656). And although this Court previously stated that only two conditions exist for applicability of MLR, the District Court heeded BCBSM's demand to create an additional condition found nowhere in the regulations: exclusive IHS funding for the healthcare services. *Id.* at PageID#12655.

The District Court's decision relied on the same reasoning BCBSM unsuccessfully advanced before this Court in the prior appeal. *Id.* at PageID#12651-12655. The District Court also relied on a distorted interpretation of an out-of-circuit, district court case, *Rancheria v. Hargan*, 296 F. Supp. 3d 256 (D.D.C. 2017). *Id.* at PageID#12651-12655. Ignoring SCIT's self-governed and self-determined status, the District Court opined that SCIT could have qualified for MLR discounts only if it had adopted what the District Court believed was the *Redding Rancheria* tribe's model for structuring its self-funded welfare benefit plan. *See id.*

The District Court's decision was also based on a factual error, which it later corrected on reconsideration. The District Court incorrectly assumed the Tribal Member Plan is funded in the same way the Employee Plan is. *Id.* at PageID#12649. Thus, it only analyzed the Employee Plan funding.[6] *Id.* The District Court had

[6] Previously, the District Court ruled that "the Member Plan and the Employer Plan should be analyzed separately...." 7/14/17 Op. & Order, (RE 112, PageID#6214).

previously found that the Employee Plan and Tribal Member Plan are funded from different sources. *See* 7/14/17 Op. & Order (RE 112, PageID#6203) ("The two groups are also funded from different sources."); 4/26/19 Order (RE 146, PageID#7787) (same).

Given the District Court's errors, SCIT moved under Rule 59(e) to alter or amend the Judgment. BCBSM's Mtn. to Alter or Amend Judgment, (RE 199). In addition to the factual error discussed above, SCIT's Motion pointed out that the District Court's decision had erroneously: (1) ignored the plain language of the MLR regulations; (2) disobeyed recognized rules of statutory and regulatory construction; (3) deferred to BCBSM's interpretation of select passages from FAQ responses on a page linked to IHS's website; (4) contradicted the purpose of the authorized statutes and implementing regulations; and (5) subverted the Tribe's self-governed and self-determined status. *Id.* at PageID#12668-12690.

The District Court denied SCIT's Motion to Alter or Amend. 2/1/21 Order, (RE 202). Brushing aside SCIT's argument that it should have analyzed the plain language of the MLR regulations and used applicable tools of statutory construction, the District Court reasserted its position that BCBSM's interpretation of select passages from FAQs linked to IHS's website controlled its decision. *Id.* at PageID#12784-12790. The District Court gave short shrift to the Sixth Circuit precedent relied on by SCIT, characterizing the Sixth Circuit's unanimous *en banc*

holding in *United States v. Havis*, 927 F.3d 382 (6th Cir. 2019) that commentary cannot expand statutory or regulatory provisions beyond their plain language as "not binding" because "[t]his is not a criminal case." 2/1/21 Order, (RE 202, PageID#12790). The District Court found no impediment for its prior decision in SCIT's self-governed and self-determined status. 2/1/21 Order, (RE 202, PageID#12791, 12794). Instead, it re-emphasized its prior opinion that the only way SCIT could qualify for MLR discounts was if it re-built its self-funded insurance policy to conform to the District Court's preferred model (what it believed was the *Rancheria* tribe's approach). *See id.*

Finally, the District Court addressed BCBSM's inconsistent position on interpretation of the MLR regulations, finding it was "not dispositive" and somehow "not relevant to this case." *Id.* at PageID#12792. The District Court failed to address Plaintiffs' actual argument on that issue, that deference to BCBSM's interpretation of certain IHS commentary is impermissible where BCBSM's interpretation is nothing more than a convenient litigating position. *See Kisor v. Wilkie*, 139 S. Ct. 2400, 2417-2418 (2019) ("[A] court should decline to defer to a merely convenient litigating position or post hoc rationalization advanced to defend past . . . action against attack.").

SUMMARY OF THE ARGUMENT

The District Court's decision looked beyond the plain language of the MLR regulations and eschewed well-established rules of interpretation to let BCBSM escape its fiduciary duties and squander tens of millions of dollars of tribal plan assets. The District Court wrongly tethered its decision on a debatable interpretation of "FAQs" BCBSM plucked from a page linked to the IHS website. In so doing, the District Court created a new condition for MLR eligibility not found in the authorizing statute or implementing regulations.

The plain text of the MLR regulations provide that MLR discounts "appl[y] to all levels of care furnished by a Medicare-participating hospital . . . authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act . . . ." 42 C.F.R. § 136.30(b) (emphasis added). Accordingly, only two preconditions for the MLR discounts to apply to healthcare services exist: (1) the healthcare provider's participation in Medicare; and (2) authorization by a Tribe or Tribal organization carrying out a CHS program. *See id.*

The MLR regulations do not allow the District Court or BCBSM to interpose a new precondition that SCIT exclusively use IHS funds to pay the healthcare claims at issue. The District Court's interpretation that SCIT must somehow trace each healthcare claim payment to IHS funds rewrites the regulations.

The regulatory text's plain meaning is what matters. This Court need go no further than to confirm that basic proposition. But even if the MLR regulations' text left any doubt, the plain meaning of the MLR regulations' text is concordant with (1) well-established canons of construction; (2) the purpose of the MLR regulations; (3) basic principles of tribal sovereignty; (4) applicable case law; and (5) the positions the BCBSA, other Blue Cross entities, and even BCBSM itself (at least internally) espoused prior to this litigation.

Further, any ambiguity in the MLR regulations must necessarily be resolved in SCIT's favor under the Indian canon of construction. BCBSM's appeal to deference to its interpretation of select FAQs on an IHS website fails; the Indian canon trumps any possible deference that could possibly be afforded to any debatable interpretation of an FAQ. The MLR regulations–promulgated with the remedial purpose of improving Native American tribes' access to healthcare–must be construed in favor of SCIT, not an insurance company like BCBSM.

The District Court's ruling further undermines ISDEAA by ignoring SCIT's self-determined status. As a self-determined sovereign nation, SCIT is entitled to flexibility in how it administers its federally supported healthcare program. SCIT's decision to provide healthcare benefits to tribal members differently than the District Court's judicially-designed preference does not negate SCIT's entitlement to MLR discounts for hospital services authorized by its CHS program. The District Court's

decision deprives SCIT of millions of dollars in discounts the MLR regulations expressly provide and flies in the face of those regulations' purpose: to address the long history of inadequate funding for Native Americans' healthcare. By forcing an inflexible approach to eligibility for MLR discounts, the District Court contravenes SCIT's self-determined status and worsens the Native American healthcare crisis.

For these reasons, this Court should reverse the District Court's entry of summary judgment in BCBSM's favor and remand for a trial on SCIT's claims.

ARGUMENT

I. STANDARDS OF REVIEW

This Court "review[s] the district court's grant of summary judgment in an action involving an ERISA claim *de novo*." *Williams v Int'l Paper Co.*, 227 F.3d 706, 710 (6th Cir. 2000). "Statutory interpretation is a question of law that is also subject to de novo review." *Martinez v. Larose*, 968 F.3d 555, 558 (6th Cir. 2020).

II. BCBSM BREACHED ITS FIDUCIARY DUTIES TO THE TRIBE BY SYSTEMATICALLY SQUANDERING TRIBAL PLAN ASSETS.

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

> (1) the duty of loyalty, which requires "all decision regarding an ERISA plan … be made with an eye single to the interests of the participants and beneficiaries"; (2) the "prudent person fiduciary obligation," which requires a plan fiduciary to act with the "care, skill, prudence, and diligence of a prudent person acting under similar circumstances," and

(3) the exclusive benefit rule, which requires a fiduciary to "act for the exclusive purpose of providing benefits to plan participants." *Id.* at 20.

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

Instead of addressing the facts unearthed in discovery showing that BCBSM breached of fiduciary duty, the District Court dismissed SCIT's claims as a matter of law by adding a new condition to MLR eligibility not found in the regulatory text. That is error, as set forth below.

A. THE DISTRICT COURT ERRED BY NOT APPLYING THE PLAIN LANGUAGE OF THE MLR REGULATIONS AND BY CREATING A NEW CONDITION TO MLR ELIGIBILITY NOT FOUND IN THE REGULATIONS.

1. Authorization by a tribal CHS program and the hospital's participation in Medicare are the only two requirements for MLR eligibility.

Courts "begin . . . interpretation of the regulation with its text," not commentary as the District Court did here. *Green v. Brennan*, 578 U. S. __, __, 136 S. Ct. 1769, 1776 (2016). The District Court did not follow the plain language of the MLR regulations, 42 C.F.R. § 136.1, *et seq*.

The text of the MLR regulations is clear and unambiguous. The "*Applicability*" provision states that MLR payment methodology "applies to all levels of care furnished by a Medicare-participating hospital . . . authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act . . . ." 42 C.F.R. § 136.30(b) (emphasis added). Accordingly, the only requirements for the MLR discounts to apply to healthcare services are: (1) the healthcare provider's participation in Medicare; and (2) authorization by a Tribe or Tribal organization carrying out a CHS program. *See id.* Because the MLR regulation's language is clear and unambiguous, the plain and ordinary meaning of that language "should also be the ending point" of the inquiry. *United States v. Douglas*, 634 F.3d 852, 858 (6th Cir. 2011) (citation and internal quotation marks omitted).

This is how this Court previously set forth the MLR regulations' requirements: "42 C.F.R. § 136.30 . . . requires Medicare-participating hospitals to accept payment for services at a rate that is no more than what those services would cost under Medicare, provided that the services are authorized by a Tribe that is carrying out a Contract Health Service ('CHS') program on behalf of the Indian Health Service ('IHS')." *SCIT*, 748 F. App'x at 20. This Court did not add to the plain language of the MLR regulations and require SCIT to prove that each healthcare claim was paid for entirely with IHS funds, as the District Court did. *See* 8/7/20 Op. & Order, (RE

197). After all, if DHHS had wanted to impose a tracing requirement in the MLR regulations, it "could simply have said that." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 218 (2002).

The District Court's decision also conflicts with the Eastern District of Michigan's prior published decision in *Little River Band v. BCBSM*, 183 F. Supp. 3d 835 (2016), where the court rejected BCBSM's identical position.[7] In *Little River Band*, the court analyzed the plain language of the "governing [MLR] regulations," interpreting it to "plainly require that payments be capped at 'Medicare-Like Rates' for *all* qualifying services, regardless of the source of funds, as long as the services were authorized by the rules of the federally-funded Indian Health Services 'Direct Care' or 'Contract Health Services' programs." *Id.* at 842-44.

2. <u>The plain language of the MLR regulations does not predicate eligibility for MLR discounts on a showing that the claims were paid for only with IHS funds.</u>

The District Court adopted BCBSM's policy suggestion that an additional, unwritten precondition to MLR applicability be recognized, one that requires a tribe to trace each IHS dollar it spends to each healthcare service received for an MLR

[7] The District Court itself recognized this, stating "it reached the opposite conclusion from Judge Lawson" in *Little River Band*. 2/1/21 Order, (RE 202, PageID#12788). The sole reason proffered by the District Court for its contrary conclusion was "the existence of the additional FAQ passages." *Id.* As explained below, the plain language of the MLR regulations controls, not BCBSM's interpretation of select FAQ responses linked to an IHS website.

discount to apply. *See* 8/7/20 Op. & Order, (RE 197, PageID#12655); 2/1/21 Order, (RE 202, PageID#12786). No tracing requirement exists in the regulations. *See generally* 42 C.F.R. § 136.1, *et seq*. Inventing a new requirement is clear error. *See Douglas*, 634 F.3d at 858; *see also United States v. Sonmez*, 777 F.3d 684, 688 (4th Cir. 2015) ("We will not construe the statute in such a manner, because we are required to interpret statutory language as written and are not permitted to add words of our own choosing.").

Against SCIT's straightforward reading of the MLR regulations, BCBSM falls back on a grab-bag of statutory and regulatory excerpts having nothing to do with the MLR regulations' applicability. *See* BCBSM's Reply re Mtn. for S.J. (RE 178, PageID#12131-12132). Beyond that, the ancillary provisions BCBSM cited below do not impose any requirement on tribes to trace fungible IHS dollars to each healthcare claim for MLR discounts to apply. For example, 42 U.S.C. § 1395cc(a)(1)(U)(i) merely speaks to the requirement that a healthcare facility be a participating provider "under the contract health services program funded by [IHS] . . . ." That provision says nothing about CHS program payment, much less that the services be paid for exclusively with funds provided by IHS. *See id.*

BCBSM also relied on provisions in 42 C.F.R. § 136 referencing "I/T/Us," *id.* (RE 178, PageID#12132). "I/T/U" stands for IHS, an Indian Tribe carrying out a Contract Services program, or an urban Indian organization. *See* 42 C.F.R.

136.30(b). Accordingly, to the extent those provisions require authorization or payment by an I/T/U, they support SCIT's position because all services were paid with IHS funds or Tribal funds. *See* Reger Decl. at ¶¶ 3-6, (RE 97-7, PageID#5829-5830).

BCBSM's attempt to transform the MLR regulations' claims processing procedures into additional preconditions for MLR applicability is unfaithful to the regulations' text. BCBSM relies on "coordination of benefits" and "alternate resources" provisions in 42 C.F.R. §§ 136.30(f)-(g), but those provisions simply speak to the order of payment for healthcare claims, not whether MLR discounts apply to the claims. *See id.* In other words, whether SCIT's self-insured plans pay first or SCIT's CHS program pays first is entirely irrelevant to whether the MLR discounts apply to the healthcare services at issue. MLR discounts apply to all levels of care provided by a Medicare-participating hospital authorized by a tribe carrying out a CHS program, without reference to (1) what type of funds (IHS, tribal funds, or a mix) paid for the authorized care or (2) the order of payment. *See* 42 C.F.R. § 136.30(a)-(b).

Even assuming MLR discounts do not apply to "alternate resources," SCIT's self-insured plans are not "alternate resources" to its CHS program because SCIT's self-insured plans are fully funded by tribal dollars. As explained in detail by the District Court in *Redding Rancheria*, "[c]onsistent with congressional intent not to

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

Ultimately, BCBSM's attempt to add a requirement for MLR applicability "fall[s] back to the last line of defense for all failing statutory interpretation arguments: naked policy appeals." *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1753 (2020). BCBSM argued below that, unless payment is traced to IHS funds, the scope of health care services a tribal CHS program can authorize is potentially unlimited. *See* BCBSM's Reply re Mtn. for S.J. (RE 178, PageID#12129). BCBSM's concerns are misdirected and, in any event, provide no basis for rewriting regulatory text. BCBSM overlooks that the CHS regulations require a tribe's CHS program to establish a priority schedule for the types of health care services the CHS program will authorize for outside referral. This ensures that Native Americans with the

greatest relative medical need for outside medical services always obtain authorization from the tribe's CHS program and have those medical services paid for by some source of coverage. 42 C.F.R. § 136.24(e).

SCIT followed the CHS regulations, adopting priority levels that limited the types of health care services its CHS program authorized for outside referral. *See* SCIT CHS/PRC Policies, (RE 177-53, PageID#12011-12042) (defining the scope of services SCIT's CHS program authorized for various types of medical care); Raphael Dep. 23:3-5 (RE 177-5, PageID#10907); Nimkee Clinic PowerPoint (RE 177-8, PageID#11183). All hospital claims at issue met the priority levels established by SCIT's CHS program and were authorized for referral to an outside hospital by that program.

B. THE DISTRICT COURT FAILED TO APPLY RELEVANT TOOLS OF STATUTORY AND REGULATORY CONSTRUCTION.

Unambiguous language requires no interpretation. To go beyond the text of the MLR regulations, the District Court first should have identified some ambiguity. *See Wysocki v. Int'l Bus. Mach. Corp.*, 607 F.3d 1102, 1106 (6th Cir. 2010) ("In matters of statutory interpretation, we look first to the text and, if the meaning of the language is plain, then the sole function of the courts—at least where the disposition required by the text is not absurd—is to enforce it according to its terms.") (quotation omitted). The District Court did not identify any ambiguous words in the MLR

regulations it purported to construe. *See* 8/7/20 Op. & Order (RE 197); 2/1/21 Order, (RE 202). There are none.

But even if it had identified an ambiguity in the regulations, the District Court should have employed established tools of textual construction to resolve it. *See Kisor*, 139 S. Ct. at 2415 ("[B]efore concluding that a rule is genuinely ambiguous, a court must exhaust all the 'traditional tools' of construction.").

In this case, the Indian canon requires that any ambiguity involving regulatory text affecting Indian affairs be resolved in favor of protecting tribal interests. *Montana v. Blackfeet Tribe*, 471 U.S. 759, 766 (1985). "Statutes are to be construed liberally in favor of the Indians with ambiguous provisions interpreted to their benefit." *Id.* Under this precedent, even were there "two possible constructions" of the MLR regulations' applicability, the Indian canon would dictate "the choice between them" and compel SCIT's reading. *County of Yakima v. Confederated Tribes & Bands of Yakima Indian Nation*, 502 U.S. 251, 269 (1992).

Thus, any regulatory ambiguity should have been resolved in SCIT's favor; adding conditions for MLR eligibility not found in the regulations interpreted the regulations to SCIT's (and other tribes) detriment.[8] *See Memphis Biofuels, LLC v.*

[8] The canon of construction favoring American Indian tribes "controls over more general rules of deference to an agency's interpretation of an ambiguous statute." *S. Ute Indian Tribe v. Sebelius*, 657 F.3d 1071, 1078 (10th Cir. 2011).

Chickasaw Nation Indus., Inc., 585 F.3d 917, 921 (6th Cir. 2009) (the canon of construction in favor of Indians is a "directive to favor tribes"). The District Court's creation of a new eligibility condition diminishing SCIT's legal rights was a clear error of law. *See Bay Mills Indian Cmty. v. Whitmer*, 794 F. App'x 485, 488 (6th Cir. 2019) (reversing district court's summary judgment grant in part because "the district court should [have] consider[ed] the proper interpretation of [the statute] as a whole and in context.").

C. THE DISTRICT COURT'S DECISION IMPROPERLY DEFERRED TO BCBSM'S SELF-SERVING INTERPRETATION OF SNIPPETS OF FAQS IT PLUCKED FROM A PAGE LINKED TO IHS'S WEBSITE.

The District Court's Opinion relies heavily on "FAQs" linked to IHS's website. 8/7/20 Op. & Order, (RE 197, PageID#12652). Where, as here, regulatory text is clear and unambiguous as a "threshold matter," the District Court is bound to apply the plain language and end its inquiry. *See Tennessee Hosp. Assoc. v. Azar*, 908 F.3d 1029, 1044 (6th Cir. 2018) ("If the regulation is not ambiguous, the court must forego deference and apply the plain language of the regulation as written."). No FAQs can be considered (much less deferred to) in such a case. *See id.* (deference to commentary "unwarranted" where the regulation was unambiguous).[9]

[9] Previously in this litigation, the District Court refused to defer to the Department of Labor's interpretation of ERISA on the grounds that it was "at odds with the clear language" of the statutory section at issue there, namely 29 U.S.C. § 1002(1). *See* 7/14/17 Op. & Order, (RE 112, PageID#6224).

The Supreme Court has emphasized there is "no plausible reason for deference" to agency statements where a regulation is clear; instead, the "the court must give [the regulation] effect." *See Kisor*, 139 S. Ct. at 2415 (emphasis added). "A court has no business deferring to any other reading" where the regulation's plain language is clear. *Id.* Doing otherwise permits the opposing party or agency "under the guise of interpreting a regulation, to create de facto a new regulation." *Id.* That is exactly what the District Court did. It created a *de facto* new regulation by requiring tribes to trace every dollar spent on healthcare claims to somehow establish that only IHS funds were used to pay for the services before the services qualified for MLR discounts under 42 C.F.R. 136.30. *See* 8/7/20 Op. & Order (RE 197, PageID#12655) ("MLR is only applicable to those services funded by CHS.").

This Court, in a unanimous *en banc* ruling, recently reaffirmed this fundamental principle: agency commentary cannot expand statutory or regulatory provisions. *See United States v. Havis*, 927 F.3d 382, 386–87 (6th Cir. 2019) (en banc) (per curiam) ("The Commission's use of commentary to add attempt crimes to the definition of 'controlled substance offense' deserves no deference. The text of § 4B1.2(b) controls, and it makes clear that attempt crimes do not qualify as controlled substance offenses."). Notably, this Court's ruling in *Havis* involved the United States Sentencing Commission's authoritative Guidelines, not mere FAQs linked to an agency's web page.

The District Court erroneously dismissed this Court's *Havis* ruling as "not binding," opining that it is somehow limited to criminal cases. *See* 2/1/21 Order, (RE 202, PageID#12790). That is wrong. The principle that agency commentary cannot expand statutory or regulatory provisions beyond their plain language is not limited to criminal cases. *See, e.g.*, *Kisor v. Wilkie*, 139 S. Ct. 2400, 2410-2414 ("[I]f the law gives an answer . . . then a court has no business deferring to any other reading, no matter how much the agency insists it would make more sense. Deference in that circumstance would permit the agency, under the guise of interpreting a regulation, to create de facto a new regulation.") (citations and internal punctuation omitted). In fact, this Court recently linked interpretation of the Sentencing Guidelines in criminal cases (*Havis*) with interpretation of regulations in civil cases (*Kisor*), holding the principles established in those cases "appl[y] just as much to . . . the Commission's guidelines as [they do] to *Auer* (and an agency's regulations)." *United States v. Riccardi*, 989 F.3d 476, 485 (6th Cir. 2021).

The District Court's error goes beyond the reflexive deference condemned by *Kisor* and *Havis*: The District Court improperly deferred to BCBSM's interpretation of the FAQs, which has not even been supported—much less adopted—by any agency. Interpretations in informal agency materials such as FAQs are entitled to deference "only to the extent that [they] have the power to persuade." *Christensen v. Harris Cnty.*, 529 U.S. 576, 587 (2000). To be assigned any weight, there must

be "thoroughness evident in [the agency's] consideration" and its reasoning must be valid. *Gonzales v. Oregon*, 546 U.S. 243, 268 (2006). BCBSM's interpretation of the FAQs reflects the opposite of reasoned consideration for multiple reasons.

First, no evidence suggests the FAQs at issue are IHS's words, much less its formal position. *See* MLR for CHS Services (RE 173-27, PageID#9274-9285). The FAQs' title contains an acknowledgement to the California Rural Indian Health Board for "developing this document," which suggests IHS did not even write the passages relied upon by the District Court. *Id.* at PageID#9274. There is no indication IHS agrees with or endorses BCBSM's interpretation, 8/7/20 Op. & Order (RE 197, PageID#12651), making reliance upon them error. *See OfficeMax, Inc. v. U.S.*, 428 F.3d 583, 598 (6th Cir. 2005) ("*Skidmore* deference does not apply to a line of reasoning that an agency could have, but has not yet, adopted.").

Second, the ISDEAA expressly exempts tribal contractors (such as SCIT) from being bound by IHS guidance unless the tribe specifically agrees to it. *See* 25 U.S.C. § 5329(c) (Title I model agreement, at Sec. 1(b)(11)) ("Except as specifically provided in the [ISDEAA] (25 U.S.C. § 450 *et seq.*) the Contractor is not required to abide by program guidelines, manuals, or policy directives of the Secretary, unless otherwise agreed to by the Contractor and the Secretary, or otherwise required by law."); 25 U.S.C. § 458aaa-16e (Title V). Here SCIT does not agree with the District Court's formulation of IHS's so-called "policy."

Third, other FAQ passages contradict BCBSM's position, underscoring that BCBSM's interpretation is not IHS's position and that BCBSM's interpretation is the opposite of reasoned consideration necessary for deference. For example, FAQ No. 11 states that MLR discounts apply where CHS funds are not exclusively used, like here where SCIT supplements its CHS funds. MLR for CHS Services (RE 173-27, PageID#9276). FAQ No. 17 provides that MLR discounts apply where a tribe pays "with Tribal funds" alone "as long as they meet CHS eligibility requirements within the regulations and services are authorized by the CHS program." *Id.* at PageID#9277. FAQ No. 28 states that a hospital must accept MLR payment based on two preconditions alone: "if the hospital is a Medicare participating hospital, and if [the tribe's] CHS program has authorized payment for the services." *Id.* at PageID#9278. FAQ No. 39 indicates that MLR discounts apply even if "another insurance" is involved in paying for the services. *Id.* at PageID#9281.

Fourth, BCBSM's interpretation is merely a convenient litigating position adopted after previously admitting (internally) on multiple occasions that SCIT is entitled to MLR discounts. "[A] court should decline to defer to a merely convenient litigating position or post hoc rationalization advanced to defend past . . . action against attack." *Kisor*, 139 S. Ct. at 2417-18. Moreover, a court may "not to give deference to . . . interpretations advanced for the first time in legal briefs." *Id.* at 2418 n.6 (citation omitted). The sincerity of BCBSM's interpretation of the FAQs

is belied by the fact that, before this lawsuit, it repeatedly admitted (internally) MLR discounts apply to SCIT's healthcare claims at issue. *See*, *e.g.*, 12/13/11 E-mail, (RE 177-20, PageID#11662) ("Medicare Like Rates (MLR) – All tribal groups are eligible to receive MLR when paying for services at our hospitals . . . ."); 7/17/13 E-mail, (RE 177-31, PageID#11699) ("[T]he non-employed tribal groups (CHS–Contract Health Services) are unquestionably entitled to Medicare-like rates and act as the tribes insurer of last resort . . . .").

The National Association to which BCBSM belongs has policies that contravene BCBSM's position. BCBSA's policy for member companies (including BCBSM) says authorization (not payment) by a tribe's CHS program is the only condition for application of MLR pricing to claims for services rendered by a Medicare-participating facility to a Native American member. Nat'l. Business Requirements–MLR, § 6.8 (RE 177-9, PageID#11210-11219); BSBSA Nat'l. Programs 2014 Overview (RE 177-10, PageID#11220-11227). Multiple other Blue Cross entities across the country acknowledge that "ALL [tribal] members are entitled to MLR whether they have other coverage or not." 4/10/13 E-mail (RE 177-29, PageID#11695) (emphasis added). The District Court was wrong to ignore these facts, 8/7/20 Op. & Order (RE 197), because doing so contravened the Supreme Court's express command. *See Kisor*, 139 S. Ct. at 2417-18 ("[A] court should

decline to defer to a merely convenient litigating position or post hoc rationalization advanced to defend past . . . action against attack.").

D. THE DISTRICT COURT'S DECISION UNDERMINES THE MLR REGULATIONS' PURPOSE OF INCREASING HEALTHCARE SERVICES AVAILABLE TO TRIBAL MEMBERS AND SUBVERTS THE TRIBE'S SELF-DETERMINED STATUS.

The District Court's judicially-created condition for MLR eligibility is inconsistent with Congress' intent to expand tribal access to federal resources, programs, and benefits; and it subverts SCIT's self-determined status expressly conferred on SCIT by the federal government pursuant to ISDEAA.

1. The District Court's decision contradicts the purpose of the authorizing statutes and implementing regulations.

The District Court rationalized its decision by adopting BCBSM's theory that its interpretation "conserve[s] IHS funds." 8/7/20 Op. & Order, (RE 197, PageID#12655); 2/1/21 Order, (RE 202, PageID#12791). There is irony in BCBSM championing conservation of IHS funds after squandering millions of dollars in tribal plan assets, including IHS funds. Regardless, BCBSM's view that IHS-only payment conserves IHS funds is wrong because SCIT receives block grants from IHS and has complete discretion on how to spend those funds. Reger Decl., (RE 97-7, PageID#5830).

Beyond that, the authorizing statutes' purpose is not to conserve IHS funds as the District Court believed, but to spend those funds to improve Native Americans'

healthcare. The statutes authorizing the MLR regulations are the Snyder Act, 25 U.S.C. § 13, and the Transfer Act of 1954, 42 U.S.C. § 2001, 8/7/20 Op. & Order (RE 197, PageID#12645-12646). The Snyder Act actually expressed the purpose of spending federal funds for Indian healthcare needs: the administering agency "shall . . . expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes: . . . . For relief of distress and conservation of health . . . ." 25 U.S.C. § 13; *see also Navajo Nation v. Dep't of Health & Human Servs., Sec'y*, 325 F.3d 1133, 1138 (9th Cir. 2003) ("[T]he Snyder Act is directed solely to Indian welfare."). The Transfer Act transferred these responsibilities to the federal government. *See* 42 U.S.C. § 2001(b) (transferring "the maintenance and operation of hospital and health facilities for Indians . . . to . . . the United States Public Health Service.").

Related statutory provisions also contradict the District Court's view of legislative "purpose." In the American Indian provisions of the Affordable Care Act, Congress specifically authorized tribes to provide health coverage to their members using federal funds, including CHS funds, through self-insured plans. *See* 25 U.S.C. § 1642. The District Court's interpretation of the MLR regulations disqualifies from MLR eligibility hospital services provided to an individual covered under a plan funded in part by CHS dollars. 8/7/20 Op. & Order, (RE 197, PageID#12655).

Congress wanted to encourage tribes to leverage federal program dollars, not disqualify them from assistance when SCIT uses its own resources to enhance healthcare benefits for Native Americans. *See* 25 U.S.C. § 1642.

2. The District Court's decision subverts the Tribe's self-governed and self-determined status.

The District Court failed to properly consider the statutory and regulatory text concerning SCIT's self-determination and self-government rights, which supports the Tribe's interpretation of the MLR regulations. There is a "federal policy of Native American self-determination." *Ramah Navajo Chapter v. Lujan*, 112 F.3d 1455, 1462 (10th Cir. 1997). "[A] proper respect both for tribal sovereignty itself and for the plenary authority of Congress in th[e] area [of Indian affairs] cautions that [courts] tread lightly in the absence of clear indications of legislative intent." *Merrion v. Jicarilla Apache Tribe*, 455 U.S. 130, 149 (1982).

Although the District Court noted SCIT's CHS program and IHS funding originate from the ISDEAA, it failed to consider that "Congress' stated purpose in enacting the ISDEAA was to increase Indian tribal autonomy in running federally administered programs." *Solomon v. Interior Reg'l Hous. Auth.*, 313 F.3d 1194, 1199 (9th Cir. 2002) (emphasis added). The ISDEAA authorizes self-determined tribes to not only "administer," but also "redesign" services taken over from IHS administration and "rebudget" funds to target their communities' specific healthcare needs. 25 U.S.C. §§ 5321(a)(1); 5324(j); 5325(o) (providing tribes with right to

contract for funds and responsibilities for programs, redesign programs, and reallocate funds awarded in a contract).

The District Court's decision gave short shrift to SCIT's self-governed and self-determined status, even after recognizing that SCIT's Member Plan was created "in the Tribe's capacity as a sovereign." 7/14/17 Op. & Order, (RE 112, PageID#6222). SCIT's sovereign and self-determined status is critical to interpreting the statutory and regulatory framework at issue.[10] *See Merrion*, 455 U.S. at 149 (requiring courts to interpret statutes with a "proper respect" for "tribal sovereignty").

The above foundational principles of federal Indian law dictate that the MLR regulations be interpreted so that SCIT's "sovereign power . . . remains intact" and it retains the authority to design its healthcare programs and allocate funding. *Iowa Mut. Ins. Co. v. LaPlante*, 480 U.S. 9, 18 (1987). The District Court's ruling that only one "right" way exists to design, operate, and fund SCIT's CHS program violates these fundamental principles. *See Michigan v. Bay Mills Indian Cmty.*, 572 U.S. 782, 790 (2014) ("an enduring principle of Indian law" is that "courts will not lightly assume that Congress . . . intends to undermine Indian self-government.")

[10] Not all tribes have self-determination rights under the ISDEAA, and some that do have such rights nevertheless choose not to administer a CHS program for their members.

3. The *Rancheria* opinion is premised on tribal self-determination and fully supports the Tribe's position.

The District Court's opinion relied heavily on BCBSM's misreading of select excerpts from an out-of-circuit district court case: *Rancheria v. Hargan*, 296 F. Supp. 3d 256 (D.D.C. 2017). *See* 8/7/20 Op. & Order, (RE 197, PageID#12652-12655). But *Rancheria*'s facts and holdings actually support SCIT's position.

Like SCIT's attempt to hold BCBSM accountable for squandering the Tribe's plan assets, *Rancheria* addressed "the Redding Tribe's attempt to create a tribally-funded self-insurance program and coordinate its benefits with those available from the Indian Health Service to make efficient use of all available services." *Rancheria*, 296 F. Supp. 3d at 260. While in this case BCBSM bilked SCIT out of MLR, in *Rancheria* IHS repeatedly refused to grant that tribe's reimbursement requests. *Id.*

Both BCBSM here and IHS in *Rancheria* disputed "the legitimacy of the Tribe's coordination of federal benefits with its self-insurance program" under federal IHS regulations. *Id.* at 260. Almost identical to BCBSM's position on MLR discounts here, "IHS took the position that the CHEF applications could not be processed because CHEF cannot reimburse payments to a tribal self-insurance plan, but can only reimburse valid CHS payments." *Id.* at 262; *see also id.* at 263, 268 ("IHS contends that the definitions inevitably rob a tribe's self-insurance program of similar status [under the statute] as self insurance is neither funded nor administered

by IHS."). The *Rancheria* tribe's position, like SCIT's here, was that no "statutory or regulatory requirement" supported the defendant's position. *Id.*

The *Rancheria* Court sided with the tribe. *Id.* at 274. That court "first determine[d] whether Congress ha[d] specifically spoken to the question at issue, in other words, whether the statutory text is plain and unambiguous." *Id.* at 265. It then rejected IHS's interpretation of various statutory and regulatory provisions (including CHS regulations) as "inconsistent with a plain reading of the statue and congressional intent." *Id.* at 260, 268, 272. The *Rancheria* court adopted an interpretation "favoring the Tribe" under "the canon that statutes are to be construed liberally in favor of the Indians." *Id.* at 266 (emphasis added) (citation and quotation marks omitted). The court based its holding on "principles of statutory interpretation" and "statutory text and purpose," *id.* at 272, not the nature of the tribe's "insurance policy" as the District Court apparently believed. *See* 8/7/20 Op. & Order, (RE 197, PageID#12654-12655) ("The tribe's insurance policy in *Rancheria* is not legal authority but . . . supports a finding that the use of CHS funds are necessary to obtain MLR.").

Self-determined status (as granted by the ISDEAA) gives tribes flexibility to spend appropriated funds on pressing local health concerns and needs. *See* S. Rep. No. 100-274, at 1 (1987) *reprinted in* 1988 U.S.C.C.A.N. 2620, 2620-21 (noting Congress's policy of allowing tribes to assume control over service delivery of

federally funded programs); *see also* Reger Decl., (RE 97-7, PageID#5830) (SCIT has complete discretion on how to spend funds). The District Court's view that the authorizing statutes and MLR regulations prescribe the only way to administer a healthcare plan to qualify for MLR discounts (what it viewed as the *Rancheria* tribe model) flies in the face of the Supreme Court's admonition that "courts [should] not lightly assume that Congress in fact intends to undermine Indian self-government." *Bay Mills*, 572 U.S. at 790. The District Court should not have endorsed BCBSM's interpretation of the MLR regulations, which undermines SCIT's authority to design and maintain its own healthcare plans and programs. *See Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 64 (1978) (declining to add statutory language to Indian Civil Rights Act because it would "undermine the authority" of tribal self-government and "impose serious financial burdens on already financially disadvantaged tribes." (citation and quotation marks omitted)).

Far from supporting the District Court's decision, the *Rancheria* decision actually undermines BCBSM's position and supports reversal of the District Court's ruling.

III. BCBSM VIOLATED ERISA, THE HCFCA, AND ITS MICHIGAN COMMON LAW FIDUCIARY DUTIES.

The District Court disregarded the MLR regulations' text, failed to apply well-established tools of regulatory construction, and undermined SCIT's self-determined and self-governed status as a sovereign nation. But the District Court also entirely

ignored fully-briefed issues on SCIT's claims against BCBSM for violation of ERISA, the HCFCA, and breach of common law fiduciary duty, 8/7/20 Op. & Order (RE 197), 2/1/21 Order (RE 202).

As demonstrated by SCIT below, its ERISA claim is not time-barred because it did not actually know that BCBSM had been squandering plan assets and causing Plaintiffs to overpay claims eligible for MLR at inflated rates until November 2014 or later. *See* Sprague Dec. ¶¶ 8-9 (RE 177-50, PageID#11786-11789). BCBSM admitted Plaintiffs' lack of actual knowledge in this regard: "The Tribe did not necessarily know the MLR dollar amount for any particular claim . . . compared . . . with BCBSM's network rate." BCBSM's Mtn. for S.J. (RE 173, PageID#8907). Because SCIT did not actually know these material facts until 2014 or later, its 2016 ERISA claim was timely filed. *See Intel Corp. Inv. Policy Comm v. Sulyma*, __ U.S. __, 140 S. Ct. 768, 776-77 (2020) ("To meet § 1113(2)'s 'actual knowledge' requirement, however, the plaintiff must in fact have become aware of that information.").

Moreover, BCBSM is liable under the HCFCA for cheating Plaintiffs out of MLR discounts. SCIT is a healthcare insurer protected by the HCFCA against BCBSM's misconduct. *See Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross & Blue Shield of Michigan*, 391 F. Supp. 3d 706, 713 (E.D. Mich. 2019) (Indian tribe that offered health care benefits to employees continuously was

a "health care insurer" with statutory standing under HCFCA as to non-employee tribe members).

BCBSM "presented" false claims to SCIT through reimbursement requests to the Tribe for amounts BCBSM paid to providers. Reger Dec. ¶¶ 6-9 (RE 177-54, PageID#12043-12045). That process alone is sufficient to establish "presentment" of claims under the HCFCA. *Cf. United States v. Hawley*, 619 F.3d 886, 893 (8th Cir. 2010) ("presentment" of claims established under analogous FCA provision where "requests for payment" were "forwarded in some form" to the government, including through electronic communications that triggered release of funds and through "reimbursement" requests). Another way BCBSM "presented" false claims to SCIT was through the "monthly claims listing" BCBSM was contractually required to provide the Tribe under the parties' contract. Sprague Decl. ¶¶ 6-8 (RE 177-50, PageID#11786-11789). This settlement and reconciliation process is also evidence of "presentment" of false claims to SCIT under the HCFCA. *Cf. Hawley*, 619 F.3d at 893-94 (annual settlement and reconciliation process where government determined whether any payments it made should be recouped from insurance company was "presentment" under analogous FCA provision).

The claims BCBSM presented to SCIT were false. Under the MLR regulations, SCIT was entitled to pay hospitals MLR rates or lower on eligible claims, but BCBSM knowingly misled SCIT about the nature of its rates, causing

Plaintiffs to pay at materially higher rates than they were entitled to. Sprague Dec. ¶¶ 6-8 (RE 177-50, PageID#11786-11789). Under analogous scenarios under the federal False Claims Act, courts have held that schemes like BCBSM's misrepresentation of the difference between its network rates vis-à-vis the MLR rates are consummate False Claims Act violations. *See United States ex rel. Morsell v. Symantec Corp.*, 130 F. Supp. 3d 106, 120 (D.D.C. 2015) (plaintiff stated presentment claim under analogous FCA provision where contractor implied it was offering government lowest price, but contractor failed to disclose more favorable pricing and adjust government's price accordingly). BCBSM is liable under the HCFCA for presenting claims to SCIT in this false and deceptive manner. *State ex rel. Gurganus v. CVS Caremark Corp.*, No. 299997, 2013 WL 238552, at *8 (Jan. 22, 2013), judgment rev'd in part, vacated in part on other grounds, 496 Mich. 45, 852 N.W.2d 103 (2014) (presentation of claims for payment in a manner that violates regulations "entails omission of a material fact" and thereby meets HFCA's "deceptive" claim definition); *see also Universal Health Servs., Inc. v. United States*, __U.S.__, 136 S. Ct. 1989, 1999-2000 (2016) (claims that contain "half-truths" or fail to disclose violations of statutory or regulatory violations are encompassed by the analogous "false claims" provision of the FCA).

Finally, for the same reasons BCBSM is liable under ERISA, it is liable under Michigan common law for its breaches of fiduciary duty. BCBSM mistakenly relied

below on *Calhoun Cnty. v. BCBSM*, 297 Mich. App. 1, 824 N.W.2d 202 (2012) for the proposition that the ASCs somehow authorized BCBSM to swindle SCIT out of MLR discounts it was legally entitled to receive.

Calhoun County is inapplicable. That case involved a breach of fiduciary duty claim against BCBSM for its charging of an access fee to the county. *Calhoun Cnty.*, 297 Mich. App. at 4-8. The Michigan Court of Appeals held the access fee charges were not a fiduciary breach because "[t]he agreed-upon terms of the ASC allowed for the collection of the access fee." *Id.* at 16. In contrast, BCBSM cannot point to any provision in the ASCs authorizing BCBSM to deprive the Tribe of its legally entitled MLR discounts. Unlike *Calhoun County*, SCIT did not "unequivocally agree" that BCBSM could disregard the MLR regulations by squandering the Tribe's funds through overpayments.

While it is now apparent that BCBSM systematically fleeced SCIT out of MLR discounts, the ASCs never disclosed—much less authorized—that misconduct. The ASC's "standard operating procedures" language that BCBSM points to says nothing about MLR pricing, much less broadly immunizes BCBSM from its fiduciary breaches, as BCBSM theorizes. ASCs, (RE 79-3 and 79-4, PageID#3163, 3181). Moreover, while the amount of the access fee was "reasonably ascertainable" in *Calhoun County*, BCBSM never identified or incorporated the MLR rates into its procedures for the Tribe. *See* 1/21/08 E-mail, (RE 177-14,

PageID#11252) ("[M]ost of the tribes have little or no chance of figuring out what a Medicare-like rate might be"). In any event, BCBSM cannot contract away its legal obligations under the MLR regulations. *See Citizens Ins. Co. of America v. Federated Mut. Ins. Co.*, 199 Mich. App. 345, 347, 500 N.W.2d 773 (1993) (insurance company was "not permitted to contract away its statutory obligation"). BCBSM's overwrought interpretation of *Calhoun County* should be rejected.

CONCLUSION

The District Court re-wrote the MLR regulations by adding an eligibility condition found nowhere in the text: namely, for MLR discounts to apply, tribes must trace IHS block grants to each healthcare claim. The District Court's judicial legislation masquerades as deference to a regulatory agency, which is ironic because no agency has adopted this position. Instead, the District Court adopted BCBSM's self-serving interpretation of the MLR regulations, allowing it to escape its fiduciary violations while squandering tribal plan assets totaling millions of dollars. Plaintiffs ask this Court to reverse the District Court's August 7, 2020 and February 1, 2021 Opinions and Orders granting summary judgment to BCBSM on Plaintiffs' MLR claims, and to remand the matter to the District Court for a trial of those claims.

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Dated: May 3, 2021

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CERTIFICATE OF COMPLIANCE

Pursuant to FRAP 32(a)(7)(C), I hereby certify that the foregoing Appeal Brief (exclusive of content excluded pursuant to FRAP 32(a)(7)(B)(iii) and 6th Cir. R. 32(b)) contains 12,646 words, per the word processing software used to prepare the brief.

Dated: May 3, 2021

By: s/ Herman D. Hofman
Herman D. Hofman (MI Bar #P81297)

CERTIFICATE OF SERVICE

I, Herman D. Hofman, do hereby certify that on this 3rd day of May, 2021, I electronically filed the foregoing document with the Clerk of the Court using the ECF system.

Dated: May 3, 2021

By: s/ Herman D. Hofman
Herman D. Hofman (MI Bar #P81297)

DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

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

RECORD ENTRY #	DESCRIPTION OF DOCUMENT	PAGE ID#
1	1/29/16 Compl.	1-53
7	Amended Compl.	60-112
14	BCBSM's Mtn. to Dismiss	129-161
22	8/3/16 Op. & Order	455-464
81-10	Vogel Dep.	4102-4105
81-13	Sprague Decl.	4156-4160
81-14	Conkright Dep.	4161 - 4171
97-7	Reger Decl.	5828-5831
112	7/14/17 Op. & Order	6200-6232
113	7/14/17 Judgment	6233-6234
142	BCBSM's Mtn. to Dismiss	7661-7708
146	4/26/19 Order	7782-7802
173	BCBSM's Mtn. for S.J.	8882-8931
173-27	MLR for CHS Services	9273-9285
177	Response to BCBSM's Mtn. for S.J.	10816-10866

RECORD ENTRY #	DESCRIPTION OF DOCUMENT	PAGE ID#
177-2	SCIT Contract Health Service Eligibility Criteria	10872
177-4	6/12/15 Referral	10883
177-5	Raphael Dep.	10884-10960
177-6	Robinson Dep.	10961-11020
177-7	Fox Dep	11021-11167
177-8	Nimkee Clinic PowerPoint	11168-11209
177-9	Nat'l. Business Requirements–MLR, § 6.8	11210-11219
177-10	BSBSA Nat'l. Programs 2014 Overview	11220-11227
177-11	8/22/07 E-mail	11240-11242
177-13	10/25/07 E-mail	11251
177-14	1/21/08 E-mail	11252-11253
177-15	Root Dep.	11254-11449
177-16	Deiss Dep.	11450-11629
177-17	1/7/11 E-mail	11630-11656
177-18	8/12/11 E-mail	11657-11658
177-19	7/6/11 E-mail	11659-11661
177-20	12/13/11 E-mail	11662
177-21	10/19/11 E-mail	11663-11665
177-22	9/4/12 E-mail	11666-11667
177-23	10/5/12 E-mail	11668-11673
177-24	10/9/12 E-mail	11674-11679

RECORD ENTRY #	DESCRIPTION OF DOCUMENT	PAGE ID#
177-26	1/9/13 E-mail	11681-11688
177-29	4/10/13 E-Mail	11695
177-30	7/28/13 E-mail	11696-11698
177-31	7/17/13 E-mail	11699-11702
177-33	4/12/13 BCBSM internal E-mail	11705-11708
177-34	7/16/13 E-mail	11709-11710
177-44	2/17/15 E-mail	11730-11737
177-46	6/25/15 E-mail	11742-11772
177-47	8/7/15 E-mail	11773-11775
177-50	Sprague Dec.	11786-11789
177-51	Kamai Dep.	11790-11908
177-52	Brooks Dep.	11909-12010
177-53	SCIT CHS/PRC Policies	12011-12042
177-54	Reger Dec.	12043-12045
178	BCBSM's Reply re Mtn. for S.J.	12128-12188
197	8/7/20 Op. & Order	12635-12656
198	8/7/20 Judgment	12657-
199	BCBSM's Mtn. to Alter or Amend Judgment	12658-12691
199-2	Reger Dep.	12693-12697
202	2/1/21 Order	12775-12795

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