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

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

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INTRODUCTION

ERISA protects healthcare plan assets (including tribal plan assets) from being squandered by fiduciaries (like Blue Cross Blue Shield of Michigan). In fact, ERISA requires fiduciaries to act affirmatively to preserve plan assets.

The MLR regulations gave BCBSM a powerful tool to preserve plan assets. As this Court ruled previously, those regulations extended discounted pricing for all services at Medicare-participating hospitals authorized by tribes carrying out CHS programs. BCBSM studied the MLR regulations. It knew the deep discounts MLR pricing offered bested its own rates. But instead of taking advantage of those discounts to preserve tribal plan assets, BCBSM lied to the Tribe and overpaid claims using tribal plan assets. It knowingly overpaid claims using tribal plan assets to improve its own economic position, contrary to its fiduciary obligations.

BCBSM excuses putting its own interests ahead of the Tribe's by inventing a "tracing of funds" precondition to MLR eligibility. No such precondition exists in the regulatory text. Nor does such a precondition make sense, because adding such a requirement would undermine federal Indian health and self-governance policies established by Congress. As this Court previously held, BCBSM was a fiduciary when it made discretionary payment decisions, and it breached its fiduciary duties by putting its interests ahead of the Tribe's.

ARGUMENT

I. BCBSM BREACHED ITS FIDUCIARY DUTIES BY SQUANDERING TRIBAL PLAN ASSETS.

BCBSM does not dispute the facts this Court has already said are sufficient to sustain the Tribe's ERISA claim, namely that BCBSM: (1) was aware of the MLR regulations and the pricing discounts it promised to the Tribe's plans, yet (2) refused to provide the Tribe's plan access to the MLR discounts, resulting in overpayments for healthcare claims with tribal plan assets. *See SCIT v. BCBSM*, 748 F. App'x 12, 21 (6th Cir. 2018) (whether "the MLR regulations are applicable to BCBSM's administration of the Tribe's ERISA plan" turns on whether "BCBSM was aware of the MLR regulations" and whether it "failed to ensure that the Tribe paid no more than MLR for MLR-eligible services"). BCBSM claims it can escape liability for its fiduciary breaches by creating an additional precondition to MLR eligibility not found in the regulatory text. BCBSM's argument is baseless.

A. The MLR regulations apply to BCBSM's administration of the Plans.

The text of the MLR regulations requires that payments be capped at MLR or lower for "all levels of care furnished by a Medicare-participating hospital," regardless of the source of the funding, so long as the services are authorized by a tribe carrying out a CHS program. 42 C.F.R. § 136.30(b). The "*Applicability*" provision for "the payment methodology" is broadly worded, applying to "all"

services so long as they are (1) provided by a Medicare-participating hospital and (2) authorized by a Tribe carrying out a CHS program. *See id.*; *see also SCIT*, 748 F. App'x at 20 (describing Medicare participation by the provider and authorization by the tribe as the two preconditions for MLR applicability).

Services provided by a Medicare-participating hospital to persons covered by a Tribe's self-insured plan administered by BCBSM are quite naturally encompassed by this broad definition. *See Little River Band v. BCBSM*, 183 F. Supp. 3d 835, 842-44 (E.D. Mich. 2016) (the MLR regulations "plainly require that payments be capped at 'Medicare-Like Rates' for all qualifying services, regardless of source of funds . . . ."); *Grand Traverse Band v. BCBSM*, No. 14-CV-11349, 2017 WL 3116262, at *5 (E.D. Mich. July 21, 2017) (the MLR "regulations . . . directly affect how [BCBSM] administers and manages plan assets" for a tribe's self-funded plan). The district court tacitly conceded the plain text of the MLR regulations favors the Tribe's interpretation, observing that the text provides "no further explanation" of any requirement for a "source of IHS funding" precondition to MLR eligibility. 2/1/2021 Order (RE 202, PageID#12790).

B. The MLR regulations do not have a "tracing" requirement.

BCBSM claims it discovered a "source of funding" requirement in the provisions describing how payment is calculated: 42 C.F.R. § 136.30(e)-(g). BCBSM Resp. Br. at 17-18, 23. Without citing any support, BCBSM declares the

term "I/T/U," as used in those provisions, "means tribal CHS programs," and concludes that, therefore, the MLR regulations impose a requirement that tribes trace each "payment" to "CHS funds" for MLR discounts to apply. *Id.* at 18, 23-24.

BCBSM's reading is contradicted by the plain text of the MLR regulations. The contention that "I/T/U" means a "tribal CHS program" conflicts with the definition of that term. The regulation defines "I/T/U" as "IHS," "an Indian Tribe carrying out a Contract Services program," or "an urban Indian organization." 42 C.F.R. § 136.30(b). Correctly defining this term matters, because all funds at issue were contributed by a "Tribe carrying out a Contract Services program."

The applicability of the MLR regulations does not turn on an artificial "separat[ion]" among "payors" or BCBSM's pretended ability to "distinguish between" "payments by an I/T/U" and "payments by all other payors," as BCBSM argues. BCBSM Resp. Br. at 24-25. The "*Scope*" and "*Applicability"* provisions of the MLR regulations govern their scope and applicability; of course, BCBSM's brief gives those provisions short shrift. *See id.* Because the "*Scope*" and "*Applicability*" provisions say the MLR regulations apply to "all" services authorized by the Tribe, the "payment calculation" and "[c]oordination of benefits" provisions BCBSM references (Subsections 136.30(e)-(g)) still required it to coordinate benefits available to the Plans' participants and ensure that the payment (from tribal plan assets) did "not exceed" MLR "or the contracted amount . . . whichever is less." *Id.*

§ 136.30(g)(4). Subsections 136.30(e)-(g) of the MLR regulations speak to the *order* of payment for authorized claims, not *whether* MLR discounts apply in the first place. *Id.* § 136.30(e)-(g). They set forth additional requirements BCBSM was obligated to perform, not broad exemptions allowing it to bilk the Tribe out of MLR discounts.[1] *See id.* And although BCBSM's litigation position is otherwise, it acknowledged internally the MLR regulation applied to its administration of the Tribe's plans. *See, e.g.*, 12/13/11 BCBSM E-mail, (RE 177-20, PageID#11662) ("All tribal groups are eligible to receive MLR when paying for services at our hospitals . . . .").

But even if Subsections 136.30(e)-(g) were to be read as imposing a "tracing" requirement, the MLR regulations still apply to BCBSM's administration of the Tribe's plans because all services at issue were paid with tribal plan assets, contributed by a "Tribe carrying out a Contract Services program." The Tribe is undisputedly "an Indian Tribe carrying out a Contract Services program." 42 C.F.R. § 136.30(b). The plan assets at issue entrusted to BCBSM for both plans (and from

[1] BCBSM falsely claims that *Amici* "acknowledge that 'a health insurance plan (or other third-party payor' may pay 'amounts equal to or more than the MLR' when paying for authorized contract health services." *See* BCBSM Resp. Br. at 18, 25-26, 30. BCBSM omits the sentence immediately following the quoted portion of the *Amici*'s brief, which states that the "MLR payment cap" is still "imposed" on such a "health insurance plan" or "third-party payor" payment when the service is authorized. *Amici* Br. at 9. All payments here were authorized by a Tribe carrying out a CHS program and should have been paid at MLR or lower. Tribe Br. at 11.

which BCBSM discretionarily paid claims) consisted entirely of tribal funds contributed by the Tribe. 7/14/17 Op. & Order (RE 112, PageID#6203-04); 4/26/19 Order (RE 146, PageID#7787). Accordingly, because BCBSM's payments of claims for services provided to participants of the Employee Plan and Member Plan were always from tribal plan assets contributed by a "Tribe carrying out a Contract Services program," the MLR regulations apply even if BCBSM's imagined "tracing" idea were to be deemed into existence.

BCBSM references additional ancillary provisions, claiming they "confirm that the only payments capped under the regulation are payments by a CHS program using CHS funds." BCBSM Resp. Br. at 28. Not so. Each provision references ancillary matters of no consequence here. They do not impose BCBSM's elaborate "tracing" requirement.

For example, Section 136.21(e) defines "Contract Health Services" as "health services provided at the expense of the Indian Health Service." That definition says nothing about MLR requirements, much less requires tribes to trace payments to IHS funding as a precondition for application of MLR. *See id.* Contrary to BCBSM's attempt to silo tribal funds into strict categories and apply its preferred labels to each, the Tribe receives block grants from IHS and has complete discretion on how to spend those funds. Reger Decl. (RE 97-7, PageID#5830).

Section 136.61 discusses the services IHS "will not be responsible for or authorize payment for," including "private insurance." 42 C.F.R. § 136.61. But the Tribe is not IHS and the Tribe's self-funded insurance plan is not "private insurance," so this provision is inapplicable. *See Redding Rancheria v. Hargan*, 296 F. Supp. 3d 256, 271 (D.D.C. 2017) ("[T]ribally-funded self-insured plans are not to be considered an alternate resource under IHS's Payor of Last Resort Rule."). In any event, the Tribe authorized all services at issue here, satisfying MLR's relevant precondition for "applicability." Tribe Br. at 11.

Section 489.29a(2) is a regulation separate from the MLR regulation that requires Medicare-participating hospitals to accept MLR "as payment in full for . . . [a] CHS program . . . carried out by an Indian Tribe or Tribal organization." 42 C.F.R. § 489.29(a)(2). Here, all payments at issue were "for . . . [a] CHS program" because they were authorized by the Tribe, who carries out a CHS program. Tribe Br. at 11. Section 489.29a(2) does not require tribes to trace payment to IHS funding as a precondition for MLR.

Finally, 42 U.S.C. § 1395cc(a)(1)(U)(i) merely establishes one way for a *healthcare facility* to qualify for the Medicare program. It says nothing about how a *tribe* with a CHS program qualifies for MLR pricing. *See id.*

C. BCBSM's interpretation of IHS guidance neither applies nor supports BCBSM's position.

Lacking support in the MLR regulations' text, BCBSM relies on a self-serving interpretation of what it calls "IHS guidance." BCBSM Resp. Br. at 18, 27-28. The so-called "IHS guidance" is inapplicable for numerous reasons.

First, the plain language of the regulatory text, covering "all" services at issue, controls the question of applicability. *See* 42 C.F.R. § 136.30(b); *see also Kisor v. Wilkie*, 139 S. Ct. 2400, 2410-14 (2019) ("If the law gives an answer . . . then a court has no business deferring to any other reading"). BCBSM's interpretation of alleged agency commentary cannot expand the MLR regulation's preconditions. *See United States v. Havis*, 927 F.3d 382, 386-87 (6th Cir. 2019). Second, even if the MLR regulations were ambiguous, the Indian canon requires that they be construed to the Tribe's benefit, regardless of alleged "IHS guidance." *County of Yakima v. Confederated Tribes & Bands of Yakima Indian Nation*, 502 U.S. 251, 269 (1992) (where "two possible constructions" of the MLR regulation's applicability exist, the Indian canon dictates "the choice between them"). Third, the Tribe is not subject to the "IHS guidance" at issue. *See* 25 U.S.C. § 5397(e) (tribes operating ISDEAA programs "shall not be subject to any agency circular, policy, manual, guidance or rule adopted by [IHS]"); 25 U.S.C. § 5329(c). Fourth, for the reasons discussed by *Amici*, IHS's "guidance" supports the Tribe's position. *See Amici* Br., at 16-20. Fifth, this Court should not adopt BCBSM's convenient litigation position adopted after

previously admitting (internally, when there was no reason to posture) that its administration of the Tribe's plans is subject to the MLR regulations. *See* Tribe Br. at 45-46; *see also Kisor*, 139 S. Ct. at 2417-18. Sixth, BCBSM's interpretation of "IHS guidance" contravenes tribal self-governance and Indian Health statutes and policies. *See* Tribe Br. at 47-53; *Amici* Br. at 20-27.

BCBSM's position, unfortunately adopted by the district court, suffers from additional flaws. Beyond misconceptions of how the *Rancheria* tribe structured its healthcare programs, the district court and BCBSM fail to explain how their hypothetical "tracing" requirement might work in practice for tribes seeking to take advantage of the MLR regulation's discounts. *See generally* 8/7/2020 Op. & Order (RE 197, PageID#12652-56); 2/1/2021 Order (RE 202, PageID#12786-94); *see also* BCBSM Resp. Br. at 35-36 (conceding the district court did not "address . . . details"). This is an additional reason for reversing the district court's decision. *See United States v. Cooley*, 141 S. Ct. 1638, 1645 (2021) (reversing the Ninth Circuit Court of Appeals' decision limiting tribal authority in part because of "doubts about the workability of the standards that the Ninth Circuit set out"). As shown by at least 41 tribes and six tribal organizations representing more than 300 tribes who, as *Amici* for the Tribe, support the Tribe's interpretation, allowing the district court and BCBSM's position to become controlling law will drastically limit the ability of tribes to protect the health and welfare of their members, worsening the Native

American healthcare crisis. *See Amici* Br. at 10-12, 20. The Supreme Court recently reaffirmed that in cases affecting sensitive issues of internal tribal "health or welfare," tribal interests should be protected, not harmed. *See Cooley*, 141 S. Ct. at 1643 (tribes retain inherent authority to protect the "health or welfare of the tribe").

II. BCBSM'S ATTEMPT TO RE-LITIGATE ITS FIDUCIARY STATUS IS UNAVAILING.

A. This Court has repeatedly reaffirmed BCBSM's fiduciary status over its conduct at issue here.

BCBSM may not re-litigate this Court's finding that it is a "fiduciary." To start, it is law of the case that BCBSM is a fiduciary with respect to the activity at issue here: paying claims using tribal plan assets. As this Court noted in its prior opinion, fiduciary status is "a threshold question in every case charging breach of ERISA fiduciary duty." *SCIT*, 748 F. App'x at 22. Accordingly, this Court's prior description of BCBSM as a fiduciary is dispositive. *See id.* at 20 (recognizing BCBSM's "duties under ERISA to act prudently and with the best interests of the Tribe in mind when administering the plan").

BCBSM's arguments merely re-package positions previously addressed and rejected by this Court in *Pipefitters Local 636 Ins. Fund v. BCBSM*, 722 F.3d 861, 866 (6th Cir. 2013), and *Hi-Lex Controls, Inc. v. BCBSM*, 751 F.3d 740 (2014), under analogous facts. An entity is an ERISA fiduciary if it "exercises any discretionary authority or discretionary control respecting management of such plan

or exercises any authority or control respecting management or disposition of its assets." 29 U.S.C. § 1002(21)(A)(i). "ERISA fiduciary status is broadly triggered with any control over plan assets." *Pipefitters Local 636 Ins. Fund*, 722 F.3d at 866 (cleaned up).

As it did in *Hi-Lex* and *Pipefitters*, BCBSM uses *Seaway Food Town, Inc. v. Medical Mutual of Ohio*, 347 F.3d 610 (6th Cir. 2003), to downplay its payment decisions as merely "adher[ence] to the parties' agreement" and thus not a fiduciary act. *Compare* BCBSM Resp. Br. at 39-43 with *Hi-Lex*, 751 F.3d 744-746, and *Pipefitters*, 722 F.3d at 866-67. This Court rejected BCBSM's identical position in *Hi-Lex* and *Pipefitters*, distinguishing *Seaway*'s holding as inapplicable to the arrangements BCBSM uses for self-funded clients like the Tribe. *Hi-Lex*, 751 F.3d at 744-45; *Pipefitters*, 722 F.3d at 866-67 ("Unlike in *Seaway*, the ASC between Plaintiff and Defendant contains no such analogous language."). This Court rejected BCBSM's "attempt[] to characterize its arrangement with [the self-funded plan sponsor] as a service agreement between two companies—with no thought toward ERISA and its protections" as "unavailing." *Hi-Lex*, 751 F.3d at 746. This Court reasoned that, unlike the conduct at issue in *Seaway*, which was expressly authorized by the parties' agreement, the fees at issue in *Hi-Lex* and *Pipefitters* were discretionarily imposed and the ASC did not "set forth the dollar amount for the . . . fee or even a method by which the . . . fee is to be calculated." *Pipefitters*, 722 F.3d

at 866; *see also Hi-Lex*, 751 F.3d at 744-45. Therefore, BCBSM was a fiduciary with respect to the employers' self-funded plans. *See id.*

Hi-Lex and *Pipefitters* directly apply and preclude BCBSM's renewed attempt to escape fiduciary status. *See Varnum LLP v. United States Dep't of Lab.*, No. 1:18-CV-1156, 2021 WL 1387773, at *1 (W.D. Mich. Mar. 15, 2021) ("In *Hi-Lex Controls*, the Sixth Circuit affirmed a finding that BCBSM is an [ERISA] fiduciary for self-funded administrative services contracts."). Under ASC terms identical to the *Hi-Lex* ASC, BCBSM possessed and controlled tribal plan assets. ASC, Art. III, ¶ B (RE 79-4, PageID#3186-87). BCBSM decided whether to pay each healthcare claim, and when it did pay a claim, it decided how much to pay. *Id.* at Art. II, ¶ A, C (PageID#3181-82). Like the *Hi-Lex* and *Pipefitters* ASCs, which did not "set forth the dollar amount for the OTG fee or even a method by which the OTG fee [was] calculated," *Pipefitters*, 722 F.3d at 867, here the ASC did not mandate any particular payment rates or even articulate the method by which those rates were calculated. ASC, Art. II, ¶¶ A, C (RE 79-4, PageID#3181-82). That was left to BCBSM's discretion. *See id.*

Like it did in *Hi-Lex* and *Pipefitters*, BCBSM relies on opaque language in its ASCs to try to absolve itself of responsibility. BCBSM Resp. Br. at 39-43. But BCBSM's vague "standard operating procedures" language confirms it had discretion to decide which claims to pay, or at what rates to pay those claims. *See*

ASC, Art. II, ¶¶ A, C (RE 79-4, PageID#3180); *see also Pipefitters*, 722 F.3d at 867. Any "standard operating procedures" were BCBSM's procedures. And as a practical matter, this language cannot excuse BCBSM's decision to swindle the Tribe out of MLR discounts because the ASC was drafted and signed years before the MLR regulations were promulgated in July 2007. *See* ASC (RE 79-4, PageID#3181-3182). Plus, BCBSM cannot retroactively "contract around" its fiduciary obligations or diminish those duties by distorting a vague ASC term. *Hi-Lex*, 751 F.3d at 746, n.7 ("A fiduciary is established under ERISA by a party's functional role and that responsibility cannot be abrogated by contract."); *Pfahler v. Nat'l Latex Prod. Co.*, 517 F.3d 816, 836-37 (6th Cir. 2007) (ERISA "prohibits agreements that diminish the statutory obligations of a fiduciary." (cleaned up)).

BCBSM admitted its discretionary authority in an internal e-mail, stating that it "h[e]ld the keys" to unlock the MLR discounts for the Tribe. 2/17/15 BCBSM E-mail (RE 177-44, PageID#11733) (BCBSM's Regional Sales Manager Chris Staub questioning whether MLR was "critical for [BCBSM] going forward" because BCBSM "h[e]ld the keys to this, at this point"). Like BCBSM's discretionary imposition of fees in *Hi-Lex* and *Pipefitters*, BCBSM exercised discretionary authority with respect to paying claims. With full knowledge of the MLR regulations and the discounts they offered, BCBSM refused to take advantage of the available MLR discounts, consistently paying claims using tribal funds at inflated

rates. *See* Tribe Br. at 11-22. Yet, it promised to pay claims for another tribal client (The Grand Traverse Band) at rates "close to" MLR. Deiss Dep. 32:19-33:12, 34:9-13, 35:25-36:12 (RE 177-16, PageID#11481-11482, 11483-11485). BCBSM squandered plan assets by overpaying claims it knew were eligible for lower MLR discounts, and that violated its fiduciary obligations. *SCIT v. BCBSM*, 748 F. App'x at 22 (squandering plan assets implicates fiduciary concerns); *DeLuca v. BCBSM*, 628 F.3d 743, 747-48 (6th Cir. 2010) (same).

Finally, BCBSM argues it can escape fiduciary status because the funds at issue are "CHS funds" not eligible for ERISA protection as plan assets. BCBSM Resp. Br. at 29-34. BCBSM conflates the Tribe's CHS program authorizing the referral for outside hospital services with payment for the hospital services. The Tribe is not arguing BCBSM squandered "CHS funds." [2] The funds BCBSM squandered are the kind at issue in *Hi-Lex* and *Pipefitters*, namely contributions to a self-funded plan. Reger Decl. at ¶¶ 3-7 (RE 97-7, PageID#5829-30). BCBSM had discretionary authority and control over those funds, and those funds were

[2] For the same reason, BCBSM's feigned concern about employees being held liable for contract health services, BCBSM Resp. Br. at 32, is misplaced. Besides the irony of BCBSM's alleged concern about excessive spending after squandering millions of dollars in tribal plan assets (including employee contributions), no one is arguing that employee funds should be used to pay for contract health services.

undisputedly entitled to ERISA protection. *See Hi-Lex*, 751 F.3d at 745-46; *Pipefitters Loc. 636 v. BCBSM*, 213 F. App'x 473, 477-78 (6th Cir. 2007).

B. BCBSM's contrived ignorance regarding "CHS eligibility" does not excuse its fiduciary breaches.

Citing out-of-circuit cases *Gordon v. CIGNA Corp.*, 890 F.3d 463 (4th Cir. 2018), and *Fink v. Union Cent. Life Ins. Co.*, 94 F.3d 489 (8th Cir. 1996), BCBSM argues its breaches of fiduciary duty should be excused because it was supposedly ignorant regarding which claims were eligible for MLR pricing. BCBSM Resp. Br. at 43-45. BCBSM's position is meritless because it rests on a false premise, and because it fundamentally mischaracterizes the scope of its fiduciary duties and the Tribe's ERISA claim.

BCBSM's position is premised on the (false) assertion that the Tribe never indicated which Employee Plan claims were authorized by the Tribe's CHS program. BCBSM Resp. Br. at 33, 43. BCBSM previously told the District Court exactly the opposite. In briefing attaching multiple "key" and "highly relevant" e-mails between the Tribe's benefits manager Connie Sprague and BCBSM representatives, BCBSM represented to the District Court that in "an April 15, 2010 e-mail . . . Ms. Sprague relayed information to . . . [a] BCBSM representative regarding what claims were paid for by the Tribe using CHS/IHS dollars." BCBSM's Mtn. for Reconsideration (RE 193, PageID#12571) (emphasis added). In another e-mail BCBSM attached to briefing below, BCBSM "verif[ied] with [the Tribe] . . . the number of Contract

Health eligible members in the Sag Chips group (both Employees and Tribal members combined)." *See* 3/5/13 BCBSM E-mail (RE 163-7, PageID#8675). BCBSM verified this data for its "Medicare Like Rate product." (*Id.* at PageID#8676). BCBSM's argument is contradicted by its own representations to the District Court and the documentary evidence it relied on below. (*Id.*).

In any event, BCBSM's cases are inapplicable because they involved claims for breach of fiduciary duty based on the insurer's alleged failure to "notify" the employer of eligibility status for participants of fully insured plans and "train" the employer to take advantage of that status. *See Gordon*, 890 F.3d at 470-76; *Fink*, 94 F.3d at 492. This case does not involve a fully insured plan. Nor are Plaintiffs' claims about a "failure to notify" or "train" on BCBSM's part. Rather, BCBSM had a "prudent person fiduciary obligation" to preserve tribal funds (plan assets) it held in trust for the Tribe's self-funded healthcare plans, and it breached that fiduciary obligation by not taking advantage of MLR discounts when it paid claims using tribal plan assets. *See SCIT*, 748 F. App'x at 20-21. This difference is key, as BCBSM's own case emphasizes in distinguishing *Hi-Lex*.[3] *See Gordon*, 890 F.3d at

[3] BCBSM also cites the out-of-circuit, unpublished District of Alabama decision in *Birmingham Plumbers and Steamfitters Local Union No. 91 Health and Welfare Tr. Fund v. Blue Cross Blue Shield of Ala.*, No. 2:17-cv-00443, 2018 WL 1210930, at *3 (N.D. Ala. Mar. 8, 2018), as supposedly "analogous." BCBSM Resp. Br. at 44. The Magistrate Judge in that case focused on the parties' ASC, which he read as "unambiguously provid[ing] that BCBS's fiduciary duty with respect to administering claims is limited by the eligibility information the Employer

472 ("There is a critical distinction between this case and *Hi-Lex*: *Hi-Lex* involved a self-funded plan.").

Moreover, BCBSM cannot bootstrap its supposed ignorance of "CHS eligibility" into an excuse for its fiduciary breaches because it deliberately chose not to obtain purchase order authorizations from the Tribe and healthcare providers. BCBSM did not want its tribal clients to access MLR discounts because those discounts would mean diminished pricing arrangements with providers and less revenue for BCBSM. Tribe Br. at 14, 16; 2/17/15 BCBSM 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").

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provides." *Birmingham Plumbers*, No. 2:17-cv-00443, 2018 WL 1210930, at *5. BCBSM's ASC does not address MLR eligibility (as opposed to an individual plan member's eligibility for benefits). *See* ASC (RE 79-4, PageID#3181-94). It could not, because the MLR regulation was promulgated after the ASC was signed. In any event, the Magistrate Judge's decision conflicts with binding Sixth Circuit case law to the extent that decision meant to hold that ERISA fiduciaries may contract around their fiduciary obligations or otherwise diminish those duties through contractual agreements. *See Hi-Lex*, 751 F.3d at 746, n.7 ("A fiduciary is established under ERISA by a party's functional role and that responsibility cannot be abrogated by contract."); *Pfahler*, 517 F.3d at 836-37 (ERISA "prohibits agreements that diminish the statutory obligations of a fiduciary." (cleaned up)).

BCBSM was aware of the MLR regulations and the benefits they promised for tribal clients. Deiss Dep. 12:25-14:5 (RE 177-16, PageID#11461-11463). BCBSM also knew the Tribe carried out a CHS program through which it authorized claims for healthcare services—the only prerequisite for payment at MLR or lower under the MLR regulations. *See id.* at 102:23-103:24 (RE 177-16, PageID#11551-11552); *see also* 8/22/07 BCBSM E-mail (RE 177-11, PageID#11240) (discussing MLR applicability to "tribal Contract Health groups").

BCBSM always knew that, as part of implementing MLR pricing, it—not the Tribe—had the responsibility to obtain purchase order authorizations from the CHS programs of its self-insured tribal customers. *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). Indeed, BCBSM discussed with other BCBS affiliates the logistics of how to confirm that healthcare services had been authorized by its tribal clients' CHS programs to identify claims eligible for MLR discounts. *See, e.g.*, 4/12/13 BCBSM E-mail (RE 177-33, PageID#11705-11708); 7/16/13 BCBSM E-mail (RE 177-34, PageID#11709). If BCBSM had only provided access to the MLR discounts, the Tribe "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).

With that knowledge, it was imprudent—even reckless—for BCBSM to block the Tribe's access to MLR discounts. BCBSM's disingenuous concerns about "CHS-eligibility" for certain claims are just that, and even legitimate concerns would not absolve it of liability for paying the Tribe's claims at rates it knew were inflated.

III. THE TRIBE'S BREACH OF FIDUCIARY DUTY CLAIMS ARE TIMELY.

The Tribe's ERISA and common law breach of fiduciary duty claims are not time-barred.[4] The Supreme Court recently addressed ERISA's "actual knowledge" statute of limitations in *Intel Corp. Inv. Pol'y Comm. v. Sulyma*, 140 S. Ct. 768 (2020), a case BCBSM's brief ignores. ERISA's "actual knowledge" statute of limitations begins "when the plaintiff gains 'actual knowledge' of the breach." *Id.* at 774. The "actual knowledge" standard requires that the plaintiff in fact know of all "material facts upon which [Plaintiffs'] claims for breach of ERISA fiduciary duties are based." *Wright v. Heyne*, 349 F.3d 321, 331 (6th Cir. 2003); *see also Intel Corp.*, 140 S. Ct. at 776 (to have "actual knowledge" of a piece of information, one must in fact be aware of it").

The Tribe's ERISA claim against BCBSM is based on BCBSM's "overpaying for services eligible for lower MLR payment rates." Pls' First Am. Compl., at ¶ 136,

[4] The parties agree that Plaintiffs' ERISA and common law breach of fiduciary duty claims are subject to the "actual knowledge" limitation period. BCBSM Resp. Br. at 54. Accordingly, the same analysis applies for both claims.

139 (RE 7, PageID#88); *see also id.* at ¶ 146 (PageID#90) (BCBSM breached its ERISA fiduciary duties by "[p]aying excess claim amounts to Medicare-participating hospitals for services authorized by a tribe or tribal organization carrying out a CHS program."). This Court previously characterized Plaintiffs' claim that way too: "BCBSM failed to preserve plan assets by consistently causing the Tribe to overpay on claims that were eligible for a lower, Medicare-Like Rate." *SCIT*, 748 F. App'x at 20-21. Plaintiffs' claim is not, as BCBSM seeks to frame it, about "processing healthcare claims at standard network rates instead of at MLR." BCBSM Resp. Br. at 45-49.

The material facts underlying BCBSM's fiduciary breaches are (1) BCBSM's willful ignorance over whether it was squandering plan assets by refusing to apply MLR (or lower) pricing; (2) BCBSM's lack of prudence by not applying MLR (or lower) pricing; and (3) resulting repeated and systematic overpayments (using Plan assets) on claims eligible for MLR prices. *SCIT*, 748 F. App'x at 21 (Plaintiffs' ERISA claim turns on whether "BCBSM was aware of the MLR regulations" and whether it "failed to ensure that the Tribe paid no more than MLR for MLR-eligible services").

Plaintiffs did not know BCBSM had been squandering plan assets and overpaying MLR-eligible claims at amounts in excess of MLR until the Tribe learned in November 2014 that GTB had been overpaying on hospital claims for

tribal members administered by BCBSM and had secured substantial savings by switching to a different third-party administrator who priced claims using MLR methodology. *See* Sprague Decl. at ¶¶ 8-9 (RE 177-50, PageID#11786-11789). For example, the Tribe's Executive Director for its health care clinic testified that she did not know MLR pricing was lower than BCBSM network pricing. *See* Fox Dep. 144:3-145:5 (RE 177-7, PageID#11165-66). Gallagher representatives (the Tribe's insurance broker) testified they did not know whether MLR pricing was lower than BCBSM network pricing, despite repeatedly asking BCBSM for such information. Kamai Dep. 57:3-22, 59:9-60:10, 62:8-63:5, 79:14-21, 80:6-16 (RE 177-51, PageID#11847-53, 11869-70); Brooks Dep. 58:16-61:20 (RE 177-52, PageID#11966-11969). BCBSM has admitted Plaintiffs' lack of actual knowledge in this regard (RE 173, PageID#8907) ("The Tribe did not necessarily know the MLR dollar amount for any particular claim . . . compared . . . with BCBSM's network rate.").

BCBSM's twisting of Plaintiffs' claim as being about a mere "failure to apply MLR" cannot support BCBSM's statute of limitations "defense" for additional reasons. For one, "apply[ing] MLR" is not even what the MLR regulations required; they instead required BCBSM to pay MLR or its contractual rate, whichever was lower on a claim-by-claim basis. 42 C.F.R. § 136.30(f)-(g). Moreover, BCBSM's effort to describe its misconduct as a mere failure to apply MLR unravels as a

practical matter. Imagine that BCBSM's network rate for a medical procedure is $50, but the MLR price is $100. In that scenario, BCBSM does not breach its fiduciary duty by paying its network rate and not applying MLR pricing methodology. But imagine the reverse is true—BCBSM's network rate is $100, but the available MLR price is $50. In the latter case, BCBSM squanders plan assets and breaches its fiduciary duty by not using due care to take advantage of the lower MLR price. This case is not just about applying MLR, and BCBSM may not reframe this case to avoid liability. *See Stockwell v. Hamilton*, 163 F. Supp. 3d 484, 488 (E.D. Mich. 2016) ("Courts have found that Congress evidently did not desire that those who violate ERISA fiduciary trust could easily find refuge in a time bar." (cleaned up)).

Judge Levy's unpublished decision in *GTB v. BCBSM*, No. 14-CV-11349, 2017 WL 6594220, at *2-3 (E.D. Mich. Dec. 26, 2017), does not help BCBSM. The conclusion in that case about what another tribe knew under different circumstances does not prove that the Tribe in this case actually knew about BCBSM's fiduciary breaches. *See Intel Corp.*, 140 S. Ct. at 776 ("[T]o have 'actual knowledge' of a piece of information, one must in fact be aware of it."). BCBSM's brief fails to mention that Judge Levy's statute of limitations decision relied on a separate agreement BCBSM had with GTB, whereby BCBSM promised to provide that tribe rates "close

to" MLR. *GTB*, No. 14-CV-11349, 2017 WL 6594220, at *2-3. No such agreement exists in this case.

Next, BCBSM exaggerates the narrow "willfully blind" exception by asserting the Tribe "accepted the risk" of being cheated out of MLR by BCBSM because it was "aware that BCBSM's network rate would sometimes be higher than MLR." BCBSM Resp. Br. at 46-47. The Tribe never "accepted" any risk, but in any event "accepting the risk" does not establish willful blindness. *Global-Tech Appliances, Inc. v. SEB S.A.*, 563 U.S. 754, 769-70 (2011) ("[A] willfully blind defendant is one who takes deliberate actions to avoid confirming a high probability of wrongdoing and who can almost be said to have actually known the critical facts."). The "willful blindness" standard requires conduct by the Tribe surpassing recklessness, which BCBSM does not allege, much less establish. *See id.* at 769 ("[T]hese requirements give willful blindness an appropriately limited scope that surpasses recklessness and negligence."). "Willful blindness" is an "inference the jury *may* make, not a rule of law that *must* be applied." *See Fish v. GreatBanc Trust Co.*, 749 F.3d 671, 685 (7th Cir. 2014) (emphasis in original).

Finally, ERISA's six-year "fraud or concealment" limitations period means Plaintiffs' ERISA claim is timely.[5] *See* 29 U.S.C. § 1113. BCBSM falsely

[5] Contrary to BCBSM's argument, Plaintiffs did not "waive" this argument by "failing to develop it" below. BCBSM Resp. Br. at 48. In addition to the footnote in Plaintiffs' summary judgment briefing, Plaintiffs briefed the issue extensively to

represented to the Tribe and its agents that there was no meaningful difference between its payment rates and MLR, tricking the Tribe into believing it was acting prudently to preserve the Tribe's plan assets. Kamai Dep. 57:3-22, 59:9-60:10, 62:8-63:5, 79:14-21, 80:6-16 (RE 177-51, PageID#11847-53, 11869-70); Brooks Dep. 58:16-61:20 (RE 177-52, PageID#11966-11969). BCBSM concealed its over-payments by consistently refusing to provide the Tribe and its agents with proof of the difference between its payment rates and MLR, despite repeated requests by the Tribe's agent. *See id.* Accordingly, the "fraud or concealment" limitations period applies. *See Hi-Lex*, 751 F.3d at 748 (fraud or concealment exception to ERISA statute of limitations applied where BCBSM misrepresented and omitted material information about its pricing practices in documents).

IV. BCBSM VIOLATED THE HCFCA AND ITS COMMON LAW FIDUCIARY DUTIES.

Regarding Plaintiffs' state law claims, BCBSM's brief repeats in conclusory fashion the arguments addressed above. BCBSM Resp. Br. at 49-54. Those

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the District Court in multiple pages of argument responding to BCBSM's Motion to Dismiss Plaintiffs' MLR claims. Pls.' Brief in Opp. to Mot. To Dismiss (RE 144, PageID#7716, 7722-23). Moreover, the District Court considered the issue in its Opinion denying BCBSM's Motion to Dismiss without prejudice. 4/26/2019 Op. & Order at 16 (RE 146, PageID#7797). Plaintiffs definitely developed this argument below. *See Harris v. Klare*, 902 F.3d 630, 635 (6th Cir. 2018) (plaintiff did not forfeit argument on appeal where general argument presented to district court provided sufficient notice of the issue to the defendant and district court).

arguments fail for the same reasons discussed in detail above, in the Tribe's original brief, and in the *Amici*'s brief, as well as for the additional points noted below.

One basis for holding BCBSM liable under the HCFCA is under the implied certification theory of liability, which BCBSM's brief ignores entirely. Under this theory, claims that contain "half-truths" or fail to disclose violations of statutory or regulatory provisions violate the analogous "false claims" provision of the FCA. *Universal Health Servs., Inc. v. United States*, __U.S.__, 136 S. Ct. 1989, 1999-2000 (2016). All that is required is a "show[ing] that the contractor withheld information about its noncompliance with material contractual [or regulatory] requirements." *United States v. Sci. Applications Int'l Corp.*, 626 F.3d 1257, 1266 (D.C. Cir. 2010). Here, BCBSM implied (falsely) its compliance with the MLR regulations to the Tribe by representing (again falsely) to the Tribe and its agents that there was no meaningful difference between its payment rates and MLR, thereby tricking the Tribe into believing it was acting prudently to preserve the Tribe's plan assets. Kamai Dep. 57:3-22, 59:9-60:10, 62:8-63:5, 79:14-21, 80:6-16 (RE 177-51, PageID#11847-53, 11869-70); Brooks Dep. 58:16-61:20 (RE 177-52, PageID#11966-11969). BCBSM further withheld information from the Tribe about its noncompliance by consistently refusing to provide the Tribe and its agents with proof of the difference between its payment rates and MLR, despite repeated requests by the Tribe and its agents. *See id.*

BCBSM further "presented" or "caused to be presented" false claims to the Tribe through reimbursement requests in invoices and monthly claims listings. Reger Decl. ¶¶ 6-9 (RE 177-54, PageID#12043-12045); Sprague Decl. ¶¶ 6-8 (RE 177-50, PageID#11786-11789). BCBSM's brief does not dispute that this settlement and reconciliation process occurred regularly. BCBSM Resp. Br. at 51-52. That process easily falls within the HCFCA's broad description of "presentment" of a "claim" for payment. *See* MCL § 752.1002(a) (defining a "claim" as "any attempt to cause a health care corporation or health care insurer to make the payment of a health care benefit."); *see also United States v. Hawley*, 619 F.3d 886, 893 (8th Cir. 2010) (annual settlement and reconciliation process where government determined whether any payments it made should be recouped from insurance company was "presentment" under analogous FCA provision).

BCBSM misleadingly cites its attempt to elicit legal conclusions from the Tribe's lay witnesses about whether *providers* ever presented medical claims to *BCBSM* (RE 173, PageID#8896, 8928). But those transactions are not the false claims at issue. After all, the MLR regulations do not regulate the amount providers may charge, only what providers must accept as payment in full. 42 C.F.R. § 136.30(a).

Contrary to its feigned ignorance, BCBSM knows the false claims at issue. *See* 11/6/19 E-mail, (RE 173-36, PageID#9445-9448).[6] In addition, Plaintiffs' preliminary expert report provided a detailed sampling of the "false claims" at issue, *i.e.*, claims BCBSM should have paid from the Tribe's assets at MLR pricing because MLR was less than BCBSM's network rate. Plaintiffs' Preliminary Expert Report (RE 177-56, PageID#12123-25).

Finally, the opaque language BCBSM points to in its ASC does not excuse it from liability under the HCFCA or for breach of its common law fiduciary duties. As to Plaintiffs' HCFCA claims, courts regularly find claims to be false when, as here, the amounts charged under a contract were inflated because the defendant, like BCBSM here, violated regulations, resulting in overcharges. *See United States ex rel. Shemesh v. CA, Inc.*, 89 F. Supp. 3d 36, 46 (D.D.C. 2015) (contractor violated analogous FCA provision by providing inaccurate discounts, resulting in the plaintiff paying higher prices than it was entitled to under regulations and contract).

The ASC says nothing about MLR or BCBSM's network prices. It most certainly does not purport to immunize BCBSM from fiduciary breaches. The ASC was entered by the parties before the MLR regulations went into effect, rendering

[6] BCBSM's argument is all the more disingenuous because it has exclusive possession of Plaintiffs' claims data, key components of which it delayed turning over until right before summary judgment briefing was due. *See* 3/23/20 E-mail, (RE 177-57, PageID#12126).

BCBSM's argument a practical impossibility. In any event, BCBSM cannot contract out of its fiduciary obligations to preserve plan assets. *See Citizens Ins. Co. of America v. Federated Mut. Ins. Co.*, 199 Mich. App. 345, 347, 500 N.W.2d 773 (1993) (insurer was "not permitted to contract away its statutory obligation").

BCBSM's last-gasp argument is to assert, without authority, that "[t]he MLR regulations facially do not prohibit a claims processor from paying healthcare claims in the manner prescribed by contract." BCBSM Resp. Br. at 54. BCBSM ignores the MLR regulation's provisions governing its conduct at issue: "payment" of claims using tribal plan assets. *See* 42 C.F.R. § 136.30(c)-(f). Those provisions expressly required BCBSM to pay at MLR or its contractual rate whichever was lower on a claim-by-claim basis. 42 C.F.R. § 136.30(f)-(g). Accordingly, the MLR regulation governs BCBSM's conduct at issue here. *See Band*, No. 14-CV-11349, 2017 WL 3116262, at *5 ("[The MLR] regulations . . . directly affect how [BCBSM] administers and manages plan assets[.]").

CONCLUSION

Plaintiffs request that this Court 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 remand the matter to the District Court for further proceedings and a trial on those claims.

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Respectfully submitted,

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Attorneys for Appellants

Date: August 18, 2021

By: */s/ Herman D. Hofman*

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CERTIFICATE OF COMPLIANCE

Pursuant to FRAP 32(a)(7)(C), I hereby certify that the foregoing Reply Brief (exclusive of content excluded pursuant to FRAP 32(a)(7)(B)(iii) and 6th Cir. R. 32(b)) contains 6,695 words, per the word processing software used to prepare the brief.

Date: August 18, 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 18th day of August, 2021, I electronically filed the foregoing document with the Clerk of the Court using the ECF system.

Date: August 18, 2021 By: */s/ Herman D. Hofman*
Herman D. Hofman (MI Bar #P81297)

DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

Appellants state that all 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#
7	Amended Compl.	60-112
79-4	ASC	3179-3210
97-7	Reger Decl.	5828-5831
112	7/14/17 Op. & Order	6200-6232
144	Pls.' Brief in Opp. to Mot. To Dismiss	7710-7736
146	4/26/19 Order	7782-7802
163-7	3/5/13 BCBSM E-mail	8674-8676
173	BCBSM's Mtn. for S.J.	8882-8931
177-7	Fox Dep	11021-11167
177-9	Nat'l. Business Requirements–MLR, § 6.8	11210-11219
177-11	8/22/07 BCBSM E-mail	11240-11242
177-15	Root Dep.	11254-11449
177-16	Deiss Dep.	11450-11629
177-20	12/13/11 BCBSM E-mail	11662
177-33	4/12/13 BCBSM internal E-mail	11705-11708

177-34	7/16/13 BCBSM E-mail	11709-11710
173-36	11/6/19 E-mail	9445-9448
177-44	2/17/15 BCBSM E-mail	11730-11737
177-50	Sprague Dec.	11786-11789
177-51	Kamai Dep.	11790-11908
177-52	Brooks Dep.	11909-12010
177-54	Reger Decl.	12043-12045
177-56	Plaintiffs' Preliminary Expert Report	12123-12125
177-57	3/23/20 E-mail	12126-12127
193	BCBSM's Mtn. for Reconsideration	12560-12593
197	8/7/20 Op. & Order	12635-12656
202	2/1/21 Order	12775-12795

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