No. 24-1367

IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS; and the GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS EMPLOYEE WELFARE FUND,

Plaintiffs-Appellants,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant-Appellee.

On Appeal from the United States District Court for the Eastern District of Michigan, Case No. 5:14-cv-11349 Hon. Judith E. Levy

DEFENDANT-APPELLEE BLUE CROSS BLUE SHIELD OF MICHIGAN'S BRIEF

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DISCLOSURE OF CORPORATE AFFILIATIONS
AND FINANCIAL INTEREST

Pursuant to 6th Cir. Rule 26.1, Defendant-Appellee Blue Cross Blue Shield of Michigan states as follows:

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.

/s/ *Phillip J. DeRosier*
Phillip J. DeRosier

Dated: September 9, 2024

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STATEMENT REGARDING ORAL ARGUMENT

While Defendant-Appellee Blue Cross Blue Shield of Michigan ("BCBSM") disagrees with Plaintiffs' characterization of the district court's decisions, it agrees that the Court would likely benefit from oral argument in this matter.

COUNTER-STATEMENT OF ISSUES

1. Did the district court properly dismiss as time-barred Plaintiffs' ERISA and common-law breach of fiduciary duty claims, when Plaintiffs had actual knowledge of the key "fact" supporting their claims—that BCBSM was not processing their claims using Medicare-like rates (MLR)—more than three years before filing suit, and when Plaintiffs failed to plead any facts supporting a claim for fraud or concealment?

2. Did the district court properly grant summary judgment to BCBSM on Plaintiffs' claim under Michigan's Health Care False Claim Act ("HCFCA"), when that claim was premised upon a violation of MLR regulations that do not apply directly to BCBSM?

3. Does Plaintiffs' lack of statutory standing provide an alternative ground for affirming the district court's dismissal of Plaintiffs' HCFCA claim, where the Tribe was not "providing health care benefits to its employees" when it was paying claims for "health care benefits" on behalf of the Tribe's *non-employee* members?

I. COUNTER-STATEMENT OF THE CASE

A. The Framework

There are two health plans subject to this litigation: (i) the Tribe's Employee Plan (Group 1019), which offered coverage to employees; and (ii) the Tribe's Member Plan (Group 1020), which offered coverage to tribal members.

As explained in *Saginaw Chippewa Indian Tribe of Michigan v. BCBSM*, 748 F. App'x. 12, 16-19 (6th Cir. 2018) (*"SCIT I"*), the Employee Plan is governed by ERISA because participation depended entirely on being an employee. Any state law claims relative to the Employee Plan were thus pre-empted by ERISA, a point the Tribe[1] concedes. As also explained in *SCIT I*, ERISA does not govern the Member Plan "since coverage depended entirely on whether an individual was a member of the Tribe" (as opposed to an employee) (*id.* at 19), meaning ERISA did not preempt any state law claims regarding the Member Plan.

Understanding that framework is critical to analyzing this case, as it informs this Court about which claims apply to which Plan, i.e., the ERISA claim applies to only the Employee Plan, while the HCFCA and common law fiduciary duty claims apply to only the Member Plan.

[1] "Tribe," "Plaintiff," and "Plaintiffs" are used interchangeably throughout this brief.

B. The Tribe Operates A CHS Program—Three Individuals Oversaw It During The Relevant Timeframe

Indian Health Services ("IHS") is an agency within the United States Department of Health and Human Services and is responsible for providing federal health services to American Indians.[2] IHS provides direct, on-site health services when possible—through IHS and tribally-operated hospitals, clinics, and health stations.[3] When services are not available on-site, patients are referred to off-site providers. This is known as Contract Health Services (or, "CHS"), i.e., "health services provided at the expense of [IHS] from public or private medical or hospital facilities." 42 C.F.R. § 136.21(e).[4]

The 1975 Indian Self-Determination and Education Assistance Act ("ISDEAA") created a framework for tribes to enter into contracts with the United States to take on responsibility for their own CHS programs. *See Rancheria v. Hargan*, 296 F. Supp. 3d 256, 260 (D.D.C. 2017). The Tribe did that here,

[2] *See* IHS Agency Overview, Ex. A, *available at* https://www.ihs.gov/aboutihs/overview/ (last accessed on July 19, 2024).

[3] The Tribe's on-site location is the "Medicine Lodge." *See* Plaintiffs' Website at http://www.gtbindians.org/contracthealth.asp (last accessed on July 19, 2024). The Medicine Lodge, however, "is not a hospital, such that there are many instances in which the clinic cannot provide the level of care needed by Tribal members." (FAC, RE 90, ¶45, PageID#2550 n.1).

[4] The Consolidated Appropriation Act of 2014 (Pub. L. 113-76, 128 Stat. 5) renamed CHS to Purchased/Referred Care ("PRC"), but everything otherwise remains the same. For consistency, BCBSM uses "CHS" where "PRC" would also be appropriate.

choosing since 1980 to design and operate its own CHS Program, a fact the Tribe made clear in its First Amended Complaint ("FAC"): "the Tribe stands in the shoes of IHS in administering Contract Health Services for Tribal members." (FAC, RE 90, ¶ 45, PageID#2550).

For the period relevant to this lawsuit, three Tribal employees oversaw the CHS Program. Ms. Ruth Bussey served as the Health Director (the Program's highest position) from 1981-2000 and from 2007-2010. She "really laid the ground work for the health program," e.g., she "developed contracts and agreements and set in place the impetus of the health program for the [T]ribe." (Bussey Dep., RE 154-3, PageID#3814). When Ms. Bussey retired in 2010, Ms. Loi Chambers took over as Health Director (later called "Division IV Manager"), holding the position until 2014. (*Id.*; see also Chambers Dep., RE 154-4, PageID#3830). Ms. Jeanne Harter worked as the Program's "Contract Health specialist" (later called "CHS case manager") for 31 years, from 1980 until approximately 2011, reporting to Mss. Bussey and Chambers. (Harter Dep., RE 154-5, PageID#3839-3840).

As discussed below, Mss. Bussey, Chambers, and Harter provided dispositive testimony as to what the Tribe knew regarding BCBSM's processing of claims at network rates instead of MLR.

C. The Tribe Contracted With BCBSM In The Early 2000's To Save Money By Utilizing BCBSM's Network Rates

In the 1980's and 1990's, the Tribe's CHS Program paid whatever rates health providers charged (without any discount), referring to that as the "market rate." (Bussey Dep., RE 154-3, PageID#3816-3817). Because each year the market rate imposed financial strain (*id.*), Ms. Bussey desired to hire a third-party administrator (or, "TPA") to gain access to the TPA's "negotiate[d] rates with providers" and "manage that budget shortfall." (*Id.*, PageID#3815-3817).

Around this same time (2000), the Tribe's Employee Plan entered into an Administrative Services Contract ("ASC") with BCBSM to secure access to BCBSM's network of providers and corresponding network rates, while providing coverage to employees. (2000 ASC, RE 45-2, PageID##1343-1359). The Tribe shortly thereafter did the same thing for the Member Plan, executing a separate ASC in 2001 and providing coverage to tribal members. (2001 ASC, RE 45-3, PageID##1361-1374). As Ms. Bussey explained, the Tribe was "trying to do a businesslike operation … as far as budgetary containment." (Bussey Dep., RE 154-3, PageID#3815).

Each ASC provides that "BCBSM shall administer [the Tribe's] health care Coverage(s) in accordance with BCBSM's standard operating procedures." (ASCs, RE 45-2 and 45-3, Article II.A, PageID##1344 and 1362). BCBSM's "standard operating procedures" include the processing and payment of claims at discounted

"network rates" negotiated by BCBSM with its network of healthcare providers (*e.g.,* hospitals). (Root Dec., RE 154-6, PageID#3845).

D. MLR Became Available To CHS Programs In 2007

"In July of 2007, federal regulations went into effect implementing Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [("MMA")], Pub. L. 108-173, ratified at 42 U.S.C. § 1395cc(1)(U)." (FAC, RE 90, ¶5, PageID##2540). As described by the Tribe: "Under the regulations, [in certain circumstances] Medicare-participating hospitals are required to accept [MLR] for health care services provided to tribal members[.]" (*Id.*; see also 42 C.F.R. § 489.29; 42 C.F.R. § 136.30(b)).

The regulations do not impose requirements upon, nor do the regulations speak to, TPAs (e.g., BCBSM) processing and paying medical claims. As the district court properly explained:

> Under the plain language of the MLR regulations cited by the parties, these regulations impose obligations on Medicare-participating hospitals to ensure they follow a particular payment regime when billing federally recognized tribes, in order to continue participating in Medicare. These regulations do not impose a separate obligation on TPAs like Defendant BCBSM to ensure that federally recognized tribes pay MLR for MLR-eligible claims.

(8/3/22 Order, RE 196, PageID#5896).

Nevertheless, the Tribe maintains on appeal that "BCBSM acknowledged its obligation to pay CHS-eligible claims at the lower of MLR or its contractual

rates," and that "BCBSM admitted it must pay claims for Plaintiffs at MLR or lower." (Tribe Br. 3) In making those statements, the Tribe cites to BCBSM's internal, non-binding (and non-legal) communications. (*Id.*). Those communications, however, are irrelevant. As the district court properly held:

> Plaintiffs' attempt to use contemporary communications internal to Defendant BCBSM in support of the argument that Defendant BCBSM is governed by the MLR regulations is unavailing. [W]hat matters here is what the regulations require—not how Defendant BCBSM interpreted them at the time.

(8/3/22 Order, RE 196, PageID#5889).

E. The Tribe Always Knew That BCBSM Did Not Apply MLR

The Tribe admitted during discovery—in writing—that it "knew by October 1, 2007" that "BCBSM had not adopted an MLR pricing process." (Plfs' Resp. to BCBSM's RFA No. 60, RE 154-7, PageID#3849). Consistent with that admission, the Tribe's own FAC alleged that the Tribe knew BCBSM did not apply MLR: "Because [in 2007] BCBSM was already administering" claims, "Plaintiffs asked BCBSM to ensure that Plaintiffs were obtaining Medicare-Like Rate discounts" and BCBSM "replied that it could not adjust its entire system to calculate MLR on those claims eligible for MLR discounts." (FAC, RE 90, ¶¶ 50-51; PageID##2551-2552).

While not relevant to the dismissal of Plaintiffs' ERISA and common-law breach of fiduciary duty claims on statute of limitations grounds (which was based

solely on Plaintiffs' FAC), additional record evidence also establishes the Tribe's knowledge. In September 2007, BCBSM's in-house lawyer advised the Tribe's in-house lawyer via e-mail that "it does not appear that the new [MLR] regulations apply to BCBSM or its ASC arrangement with the Tribe." (2007 E-mail, RE 154-9, PageID##3862-3863). In November 2008, BCBSM employee Dan Deiss, who was the account manager for the Tribe (Deiss Dep., RE 154-10, PageID#3867), e-mailed Mss. Bussey and Harter, stating: "Due to systems, software and legal issues BCBSM has not yet been able to process [hospital] claims at Medicare like rates." (2008 E-mail, RE 154-11, PageID#3871). Ms. Bussey testified that she understood that e-mail to mean that BCBSM was processing the Tribe's claims at the rates it negotiated with providers, and not MLR. (Bussey Dep., RE 154-3, PageID##3815, 3819).

In October 2009, Ms. Harter advised IHS (the federal agency charged with overseeing MLR) in an e-mail that "[t]he GTB [Tribe] has a contract with BC/BS…so the Tribe is currently paying BC/BS rates." (2009 E-mail, RE 154-12, PageID#3873). And during her deposition, Ms. Harter explained that—in that e-mail—she was "reaffirming that [she] knew at the time [October 2009] that the Tribe was getting Blue Cross's rates and not Medicare-like rates." (Harter Dep., RE 154-5, PageID#3841). Ms. Chambers also knew—through conversations with Mr. Deiss—that BCBSM did not apply MLR. (Chambers Dep., RE 154-4,

PageID#3832 ("I don't recall the exact conversation, but I know that it couldn't be done.")).

The Tribe was also well-aware that MLR rates offered "significant savings." The Tribe's Chairman, Derek Bailey, sent a letter to BCBSM's CEO in 2008 acknowledging as much. In that letter, Bailey referenced the Tribe's "repeated attempts to discuss with BCBS the [MLR] regulations," because the "federal law [MLR] … would have *significant savings* for the [Tribe]." (Chairman Ltr., RE 154-13, PageID#3877) (emphasis added). Ms. Bussey similarly answered "[a]bsolutely" when asked about whether she "thought at the time [2007] that Medicare like rates would provide a benefit to the [T]ribe by way of monetary savings." (Bussey Dep., RE 154-3, PageID#3820). And tribal employee Donna Swallows, who oversaw "the funding that came in through the CHS [P]rogram" (Swallows Dep., RE 154-14, PageID#3883), likewise testified that the "Tribe was very excited about Medicare-like rates" "[b]ecause it was going to make [the Tribe's] limited funds go further" (*Id.,* PageID#3884).

Thus, in the Tribe's own words, it "knew BCBSM was not pricing claims using Medicare-Like Rates" (Plaintiffs' Resp. to BCBSM's Mot. to Dismiss FAC, RE 96, PgID#2665 fn. 4), and that MLR "would have significant savings for the [Tribe]." (Chairman Ltr., RE 154-13, PageID#3877).

F. Munson, The Tribe, And BCBSM Execute The FCPA In 2009

Though BCBSM regularly advised the Tribe that it did not provide MLR, BCBSM still endeavored to address the Tribe's MLR requests. As Mr. Deiss explained, "this was a concern of theirs [the Tribe], so it was a concern of mine." (Deiss Dep., RE 154-10, PageID#3868). The parties therefore entered into a Facility Claims Processing Agreement ("FCPA") in connection with the Member Plan, effective March 1, 2009, for services provided to tribal members by Munson Medical Center. As the Tribe's Rule 30(b)(6) designee testified, the FCPA "is an agreement with Blue Cross/Blue Shield because they [BCBSM] were not able to do Medicare-like rates." (Woods Dep., RE 154-8, PageID#3859). Or, as the district court observed, "plaintiffs entered into the FCPA *because* they knew they were not receiving MLR." (7/21/17 Order, RE 99, PageID#2938.)

Munson, GTB, and BCBSM "evidence[d] their intent in executing th[e] Agreement," stating "that th[e] Agreement be construed in a manner consistent with the [Agreement's] Recitals." (FCPA, RE 154-16, PageID#3897). Three such Recitals are important. First, that "effective July 5, 2007, …[the MLR] regulations … went into effect." (*Id.*). Second, "Munson desire[d] to afford GTB most of the pricing benefits under the [MLR] Regulations for services … from Munson Medical Center." (*Id.*). Third, "BCBSM [was] willing to accommodate the desire of both Munson and GTB by processing [Munson's] claims … at a price they

believe is close to that which would be payable under the [MLR] Regulations." (*Id.*).

It is significant that the FCPA still required BCBSM to "process Munson Claims in the normal course of business using the BCBSM Rate," i.e., the network rate. (*Id.* ¶ 3, PageID#3898). After processing claims at the network rate, the FCPA called for a formulaic, percentage discount each quarter. (*Id.*). The FCPA identified those calculations as the "Prospective Differential" and the "Quarterly Reduction," respectively, with the agreed-upon Prospective Differential for 2009 being eight percent (8%). (*Id.*).

G. The Tribe Terminated BCBSM Shortly After Signing The FCPA Because It Wanted To Build Its Own Network Of Providers

Even though the Tribe executed the FCPA effective March 1, 2009, that same month the Tribe recommended internally that it "change the current administration [of claims] which is Blue Cross/Blue Shield to the Grand Traverse Band Health Staff." (March 2009 Slide Deck, RE 154-19, PageID#3910). That is because the Tribe desired to bring claims processing "in-house." As Ms. Bussey testified, "the tribe CHS department [was] trying to build out its own network of providers." (Bussey Dep., RE 154-3, PageID#3821). The Tribe therefore "sent out [its own] Preferred Provider Agreements" to more than 30 local providers,

including to Munson. (*Id.*; Provider Letters List, RE 154-20, PageID##3913-3914).

Ms. Bussey further explained that, "to save money," "we as a self-governance tribe should" "at some point divorce [ourselves] from Blue Cross." (*Id.*, PageID#3822). And "in terms of bringing it in house," Ms. Bussey "consider[ed] utilization of Medicare like rates as one of the ways in which [the Tribe] could have saved money." (*Id.*, PageID#3822). Those statements again confirmed that the Tribe: (1) knew BCBSM did not provide MLR; and (2) believed MLR to be better than BCBSM's network rates.

In light of the Tribe's decision to build its own network, on April 29, 2009, the Tribe's Chairman sent to BCBSM's CFO a termination letter for the Member Plan, "effective May 31, 2009 at 11:59p.m.," i.e., just three months after the FCPA's effective date. (Termination Letter, RE 154-22, PageID##3921-3922). The Tribe, however, quickly realized two fundamental problems.

First, the Tribe did not have the human resources to process its large volume of claims. As Ms. Bussey explained, the Tribe was "really short staffed to do all of that." (Bussey Dep., RE 154-3, PageID#3822). Second, as reflected in a June 2009 internal memorandum, the Tribe still wanted to take advantage of BCBSM's network rate in the interim:

> By using the BCBSM network we [the Tribe] will obtain their [BCBSM's] already negotiated discounts.

(June 2009 Memorandum, RE 154-23, PageID##3924-3925). When reviewing that memorandum during her deposition, Ms. Bussey confirmed that the Tribe "decided to stay with Blue Cross Blue Shield of Michigan for the time being so that it [the Tribe] could continue to take advantage of the Blue Cross Blue Shield network rates." (Bussey Dep., RE 154-3, PageID#3821).

Ultimately, the Tribe "didn't get to the point where [it] could negotiate discounts," so it stayed with BCBSM. (*Id.*, PageID#3821).

H. The Tribe Terminated BCBSM Again In 2013, Hired A New Vendor To Replace BCBSM, And Then Sued BCBSM In 2014

On February 12, 2013, the Tribe's Chairman sent BCBSM another termination notice, advising that, because of the "inability of BCBS to code Medicare like rates for eligible services under its existing software system," the Tribe decided to go with a "new vendor to code Medicare like rates." (Feb. 2013 Ltr., RE 154-24, PageID#3930-3931). That "new vendor" was Forest County Potawatomi Insurance Department ("Forest County"), located in Wisconsin. Very much *unlike* its ASC with BCBSM, the Tribe's contract with Forest County stated that Forest County "shall provide [MLR] repricing for … CHS-eligible Program Participants." (Forest County Contract, RE 154-26, ¶3.2.7.1, PageID#3942).

After hiring Forest County, the Tribe sued BCBSM. The Tribe filed its original Complaint on April 1, 2014 (Complaint, RE 1, PageID#1), and its FAC on

January 24, 2017 (FAC, RE 90, PageID#2538). The FAC asserted six claims: (1) Breach of Fiduciary Duty–ERISA; (2) Violation of the Michigan Health Care False Claim Act (HCFCA), Mich. Comp. Laws § 752.1001 *et seq*.; (3) Breach of Contract (FCPA); (4) Breach of Common Law Fiduciary Duty; (5) Fraud/Misrepresentation; and (6) Silent Fraud. (FAC, RE 90, ¶¶65-108, PageID##2554-2560).[5]

I. The District Court Dismissed Plaintiffs' ERISA And Common Law Breach Of Fiduciary Duty Claims Under Rule 12(b)(6) As Time-Barred

In July 2017, the district court dismissed all counts except for a component of Count III—an alleged breach of the FCPA. (7/21/17 Order, RE 99, PageID#2918). Among other things, the court held that Plaintiffs' ERISA claim was time-barred by ERISA's three-year, "actual knowledge" statute of limitations, reasoning that "plaintiffs entered into the FCPA [in 2009] *because* they knew they were not receiving MLR" and "the claim should have been brought by March 1, 2012" (making the 2014 Complaint untimely). (*Id.*, PageID##2937-2938 (emphasis in original)). The parties and the court also recognized at that time that the state

[5] On the first two pages of its brief, the Tribe discusses "hidden fees" and cites to this Court's 2014 decision in *Hi-Lex Controls Inc. v. BCBSM*, 751 F.3d 740 (6th Cir. 2014). Tribe's Br. at 1-2. Any "hidden fees" have nothing to do with this appeal, nor are they referenced in the Tribe's First Amended Complaint (the operative pleading). Any further discussion of same is thus superfluous.

law claims were preempted by ERISA (except for the breach of FCPA claim). (*Id.*, PageID#2939).

In August 2018, this Court issued its opinion in *SCIT I*. That decision impacted this case relative to the Member Plan and it not being governed by ERISA. *SCIT I*, 748 F. App'x. at 19. The district court thus reinstated two of the previously-dismissed state law claims relative to the Member Plan—namely, the HCFCA and breach of common law fiduciary duty claims—essentially recognizing each as not preempted by ERISA. (Order, RE 116, PageID#3163).

BCBSM then moved to dismiss both reinstated claims. (Mot. to Dismiss, RE 117, PageID#3167). The district court dismissed the common law fiduciary duty claim (also time barred), but not the HCFCA claim (holding the Tribe had statutory standing, which is addressed below). (5/20/19 Order, RE 122, PageID#3249). Thus, only the HCFCA and FCPA claims remained as of May 2019, with each claim relating only to the Member Plan. In 2022, the parties settled the FCPA claim. (Stip., RE 194, PageID#5828).

J. The District Court Granted Summary Judgment To BCBSM On Plaintiffs' Remaining HCFCA Claim, Rejecting Their Effort To Mischaracterize The HCFCA Claim That They Actually Pled

BCBSM thereafter sought summary judgment on the HCFCA claim. (BCBSM's MSJ, RE 154, PageID#3762). As alleged in their FAC, Plaintiffs' HCFCA claim is premised upon BCBSM's alleged failure to follow the MLR

regulations when paying discounted "network rates" instead of MLR, ostensibly making the claims "false":

> BCBSM was well aware of the MLR regulations. However, when processing claims for payment from Medicare-participating hospitals …, BCBSM systematically failed to take advantage of MLR discounts available to Plaintiffs. Instead, BCBSM [paid] the contractual rate negotiated with the hospital by BCBSM.
>
> ***
>
> The amount charged by BCBSM for paying the claims was false ***because*** Plaintiffs were not required to pay more than Medicare-Like Rates on a number of claims administered by BCBSM….

(FAC, RE 90, ¶¶7, 74, PageID##2540, 2556 (emphasis added)). In support of this allegation, Plaintiffs' FAC alleged a specific example:

> [O]n October 8-9, 2012, a Plan participant in Group #01020 received services at Munson…. Blue Cross paid Munson $3,608.67 … for the hospital claim…. [T]he Medicare-Like Rate for that claim was only $1,936.09, such that Munson should only have been paid $1,936.09 from Plan assets.

(*Id.,* ¶58, PageID#2553).[6]

[6] The Tribe also confirmed during discovery that BCBSM's failure to apply MLR was the basis for its HCFCA claim. BCBSM requested in a 2019 interrogatory that the Tribe identify "each fact" supporting the allegation that "BCBSM knowingly presented or caused to be presented claims which contained one or more false statements," *i.e.,* BCBSM tracked word-for-word the Tribe's allegation in its HCFCA claim. (*See* BCBSM's MSJ, Exhibit Z, RE 154-27, PageID#3946.) Consistent with how the Tribe actually alleged the HCFCA claim in its FAC, the Tribe answered: "BCBSM presented claims to [the Tribe] that were eligible for MLR but wer[e] priced at BCBSM's standard contractual rates." (*Id.*, PageID#3947). The Tribe made no mention of any alleged misrepresentation. If the HCFCA claim was actually premised on an alleged misrepresentation—as the Tribe *now* says—the Tribe would have been required to state as much when answering that interrogatory in 2019.

The problem is that after BCBSM filed its motion for summary judgment, the Tribe endeavored to rewrite its allegations in its response brief by asserting that Paragraph 74 of the FAC instead contained the following, different allegation:

> ***Because*** of Blue Cross's ***false representations***, the amounts charged by BCBSM for paying the claims was false. ***Further***, Plaintiffs were not required to pay more than Medicare-Like Rates on a number of claims administered by BCBSM.

(Plfs. Resp., RE 164, PageID#4996 (citing FAC, RE 90, ¶74, PageID#2556) (emphasis added) (quotations omitted)). The Tribe made the same assertion during a hearing that took place shortly before filing that response brief. (Trans., RE 162, PageID##4947-4948 ("Our claim…is that Blue Cross…misrepresented to the tribe that its network rates were better than Medicare-like rates. And when…that was rendered untenable, it said, 'Oh, actually, our network rate is only within a certain percentage of Medicare-like rates.' So that's the tribe's complaint.").

During oral argument on the parties' respective motions for summary judgment, Plaintiffs again tried to revise what they actually alleged in their FAC—much to the district court's surprise:

> THE COURT: Wait. Say that again.
>
> [TRIBE'S COUNSEL]: We have not alleged that Blue Cross Blue Shield of Michigan is liable for breaching this [MLR] regulation.
>
> THE COURT: But that's exactly what the first amended complaint says. It says every bill submitted that is [not] MLR is false because it doesn't comply with the regulation…. That's why I think

> you pivoted in your brief because I think you figured out that's not going to work. But go ahead.
>
> ***
>
> [BCBSM'S COUNSEL]: Never before them [Plaintiffs] filing [their] summary judgment motion [in 2021] did I see anything saying that Blue Cross promised that they were going to provide better than or equal to MLR. No amount of scrutiny by this Court or anybody else looking at that first amended complaint will find that allegation because it doesn't exist.
>
> ***
>
> THE COURT: …I did not understand until getting the briefing that it was a different claim.

(Summ. Judgment Hrg., RE 189, PageID##5793, 5795, 5797-5798, 5811).[7]

In granting summary judgment to BCBSM, the district court rejected Plaintiffs' effort to expand their HCFCA claim beyond the scope of their FAC, concluding that it merely alleged that the claims presented to it for payment were false because they were supposed to be paid at MLR. Period. The district court thus properly held that it would "not permit Plaintiffs to advance this new theory of liability on summary judgment, and [would] evaluate Plaintiffs' HCFCA claim as

[7] The Tribe's brief says that "[t]he FAC alleges BCBSM misrepresented to GTB that BCBSM's contractual discounts were better than or at least close to those Plaintiffs were entitled to under the MLR regulations" (Tribe's Br. at 29), and then uses the phrase "better than" 10-plus times throughout. But as explained by BCBSM's counsel at the hearing, no amount of scrutiny in looking at the FAC will find that allegation because it simply does not exist.

articulated in the complaint." (8/3/22 Order, RE 196, PageID#5882).[8] As discussed in more detail below, the court held that, as alleged, Plaintiffs' HCFCA claim failed because the MLR regulations do not impose any obligations directly on BCBSM. (*Id.,* PageID#5896). Thus, Plaintiffs "failed to allege derivative violations of the HCFCA." (*Id.*).

The district court denied reconsideration on March 29, 2024 (Order, RE 203, PageID#5986), and entered its final judgment that same day. (Judgment, RE 204, Page ID#6023).

II. SUMMARY OF ARGUMENT

As an initial matter, the district court appropriately recognized that the untimeliness of Plaintiffs' ERISA and common law breach of fiduciary duty claims begins and ends with their actual knowledge—which they had since at least March 1, 2009, when they entered into the FCPA—that BCBSM was not processing claims for payment at Medicare-like rates. As that was the key "fact" constituting BCBSM's alleged breach of its fiduciary duty, and because the statute of

[8] The Tribe points to statements by BCBSM's counsel at a June 2017 hearing as suggesting that "BCBSM's counsel acknowledged Plaintiffs' claims, including the HCFCA claim, turned on BCBSM's misrepresentations." Tribe's Br. at 40. A review of the transcript shows that this is simply not true. (June 7, 2017 Tr., RE 98, PageID#2873. The hearing largely concerned BCBSM's motion to dismiss Plaintiffs' ERISA claim and some of their state law claims. The HCFCA claim, however, was not even at issue because the parties agreed that, at the time, it was preempted and had to be dismissed. (Order, RE 99, PageID#2939).

limitations for each of Plaintiffs' breach of fiduciary duty claims is three years, they should have filed suit by 2012. But they did not file until 2014. Both breach of fiduciary duty claims are therefore time-barred.

The district court was also correct in granting summary judgment to BCBSM with respect to Plaintiffs' claim under the HCFCA. First, Plaintiffs lack standing even to assert such a claim because the Tribe was not acting as a "health care insurer," as defined in the statute, because the Tribe was not "providing health care benefits to its employees." Second, even if they had standing, Plaintiffs' HCFCA claim fails because it is premised upon an alleged failure to obtain Medicare-like rates. As the district court recognized, because the MLR regulations do not directly apply to BCBSM, it could not have violated them.

III. STANDARD OF REVIEW

BCBSM agrees that this Court reviews *de novo* the district court's dismissal of Plaintiffs' ERISA and common law breach of fiduciary duty claims as barred by the statute of limitations. *Cataldo v. U.S. Steel Corp*., 676 F.3d 542, 547 (6th Cir. 2012). BCBSM adds that "[d]ismissal of a complaint because it is barred by the statute of limitations is proper when 'the statement of the claim affirmatively shows that the plaintiff can prove *no* set of facts that would entitle him to relief.'" *Dimond Rigging Co., LLC v. BDP Int'l, Inc.*, 914 F.3d 435, 441 (6th Cir. 2019) (citations and some quotations omitted).

The Court also reviews the grant of summary judgment and dismissal of Plaintiffs' HCFCA claim *de novo*, *K.V.G. Properties, Inc. v. Westfield Ins. Co.*, 900 F.3d 818, 821 (6th Cir. 2018), along with their related (but not fully-developed) argument that the district court erred in denying their request for leave to amend. *Colvin v. Caruso*, 605 F.3d 282, 294 (6th Cir. 2010).[9]

"Faced with a properly supported motion for summary judgment, the non-movant may force a trial by 'set[ting] forth specific facts showing that there is a genuine issue for trial.'" *K.V.G. Properties,* 900 F.3d at 822 (citation omitted). "[B]ut its threadbare assertion of a material dispute does not make it so." *Id*. Moreover, "a party may not avoid summary judgment by resorting to 'speculation, conjecture, or fantasy.'" *Id*. at 823 (citation omitted).

IV. ARGUMENT

A. The District Court Properly Dismissed As Untimely Plaintiffs' ERISA And Common Law Breach Of Fiduciary Duty Claims.

1. Plaintiffs had actual knowledge, more than three years before filing suit, that BCBSM was not processing claims at MLR.

ERISA's statute of limitations for breach of fiduciary claims is set out in 29 U.S.C. § 1113:

[9] As discussed further below, while Plaintiffs accuse the district court of denying a request for leave to add factual allegations supporting *their HCFCA claim* (Tribe's Br. at 34-36), their motion for leave to file a second amended complaint actually pertained solely to *their ERISA breach of fiduciary duty claim*, which was dismissed five years earlier. (Mtn. for Leave to Amend, RE 102, PageID#2966).

> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—
>
> > (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
> >
> > (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
>
> except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

Thus, "[t]he basic ERISA limitation period of six years begins on the date of the breach or violation." *Wright v. Heyne*, 349 F.3d 321, 327 (6th Cir. 2003). "However, this period may be shortened to three years where the victim had 'actual knowledge of the breach or violation.'" *Id.* (citing 29 U.S.C. §1113(2)); *see also Intel Corp. Investment Policy Comm. v. Sulyma*, 589 U.S. 178, 180 (2020). Michigan common law similarly provides for a three-year limitation period for breach of fiduciary duty claims. *Prentis Family Found. v. Barbara Ann Karmanos Cancer Inst.*, 698 N.W.2d 900, 908 (Mich. 2005); Mich. Comp. Laws § 600.5805(2).[10]

[10] Mich. Comp. Laws § 5805(2) (formerly Section 5805(10)) is Michigan's "catch all" provision, and provides that "the period of limitations is 3 years after the time of the death or injury for all actions to recover damages for the death of a person or for injury to a person or property."

In *Wright*, after surveying the approaches taken by other circuits, this Court adopted the following standard for what constitutes "actual knowledge" under § 1113(2):

> [T]he relevant knowledge required to trigger the statute of limitations under 29 U.S.C. § 1113(2) is knowledge of the facts or transaction that constituted the alleged violation; it is not necessary that the plaintiff also have actual knowledge that the facts establish a cognizable legal claim under ERISA in order to trigger the running of the statute.

Wright, 349 F.3d at 330. The Court found this standard to "furthe[r] the policies underlying statutes of limitations. Among the basic policies served by statutes of limitations is preventing plaintiffs from sleeping on their rights and prohibiting the prosecution of stale claims." *Id*.[11] In *Sulyma*, the Supreme Court clarified that

[11] Plaintiffs cite *Rogers v. Millan*, 902 F.2d 34, 1990 WL 61120, at *4 (6th Cir. 1990) (unpublished table decision), for its statement that "[t]he actual knowledge exception applies only if [the plaintiff['had specific knowledge of the actual breach of duty upon which he sues.'" (quoting *Brock v. Nellis*, 809 F.2d 753, 755 (11th Cir. 1987)). That is misleading because, as *Rogers* went on to explain, and as the Court in *Wright* later clarified, the three-year limitation period begins to run when the plaintiff learns of the "*facts* that support his allegation that the [defendant] breached [its] fiduciary duties." *Id*. It is *not* when the plaintiff learns that those facts could amount to an ERISA violation. *Wright*, 349 F.3d at 331 ("Although the actions complained of in this case may not themselves 'communicate the existence of an underlying breach,' the extrinsic facts of which the Plaintiffs had actual knowledge demonstrate that Plaintiffs must have known that they had been wronged long before they consulted with an attorney.").

"actual knowledge" means "when a plaintiff is actually aware of the relevant facts, not when he should be." 589 U.S. at 778.[12]

Meanwhile, under Michigan's common law, "[a] claim of breach of fiduciary duty or breach of trust accrues when the beneficiary knew or should have known of the breach." *Prentis Family Found.*, 698 N.W.2d at 908 (citation and quotations omitted). "[A] plaintiff is deemed to be aware of a possible cause of action when he becomes aware of an injury and its possible cause." *Id*. (citation and quotations omitted).

In this case, the district court properly concluded that Plaintiffs' own allegations and admissions demonstrated that they had "actual knowledge" beginning in 2009 that BCBSM was not obtaining Medicare-like rates, which was the alleged "fact" constituting Plaintiffs' claim that BCBSM had both violated ERISA and breached its common law fiduciary duty. (7/21/17 Order, RE 99, PageID#2935-2938; 5/20/19 Order, RE 122, PageID#3269-3271).

In their FAC, Plaintiffs alleged that although BCBSM "was well aware of the MLR regulations," it "systematically failed to take advantage of MLR discounts available to Plaintiffs," instead "processing claims for payment from Medicare-participating hospitals" based on the "contractual rate negotiated with

[12] Plaintiffs also cite the Supreme Court's admonition in *Sulyma*, that "§ 1113(2) requires more than evidence of disclosure alone" (Tribe's Br. at 20), 589 U.S. at 186, but that has no application here. BCBSM has never argued, and the district court did not hold, that Plaintiffs' actual knowledge came from "disclosure alone."

the hospital by BCBSM." (FAC, ¶7, RE 90, PageID#2540). Plaintiffs alleged that "BCBSM's failure to take advantage of MLR discounts available to Plaintiffs when processing claims for payment was a breach of BCBSM's fiduciary duties under ERISA" as well as Michigan's common law. (*Id*., ¶¶10, 86-88, PageID#2540, 2557-2558).

Plaintiffs, however, admitted knowing all of this at least as of March 1, 2009, when they entered into the FCPA with BCBSM and Munson. (*Id*., ¶52, PageID#2552). According to Plaintiffs' FAC, they agreed to enter into the FCPA because, after requesting that BCBSM "ensure that Plaintiffs were obtaining Medicare-Like Rate discounts as part of BCBSM's administration of Plaintiffs' self-insured Plan," BCBSM informed Plaintiffs "that it could not adjust its entire system to calculate MLR on those claims eligible for MLR discounts." (*Id*., ¶¶50-51, PageID#2551-2552). Under the FCPA, "BCBSM agreed to process Plaintiffs' claims for services at Munson at a discount (the 'FCPA Discount') on top of the BCBSM standard contractual rate." (*Id*., ¶52, PageID#2552; FCPA, RE 90-4, PageID#2589-2592).

Given this backdrop, *as alleged by Plaintiffs*, the district court appropriately determined that Plaintiffs "had actual knowledge by March 1, 2009 that they were not receiving MLR" discounts for either Plan and, therefore, "that [BCBSM] was violating its fiduciary duty under ERISA" as well as under Michigan's common

law. (7/21/17 Order, RE 99, PageID#2935-2938; 5/20/19 Order, RE 122, PageID#3269-3271). As the district court explained:

> Plaintiffs admit that in 2009, they had actual knowledge that defendant was violating its fiduciary duty. (Dkt. 119 at 116.) In 2000, the parties signed the ASC, establishing a fiduciary relationship. (Dkt. 90-2 at 15.) After the 2007 regulations went into effect, "BCBSM[] fail[ed] to take advantage of MLR discounts … [and this] was a breach of BCBSM's fiduciary duties under ERISA" (Dkt. 90 at 4–5), and the parties do not dispute these duties are identical to common law fiduciary duties. Then plaintiffs learned in 2009 that they were not receiving MLR discounts, i.e. that defendant was violating its fiduciary duty under ERISA. Defendant's conduct at this point, whether it be characterized as not offering competitive rates, preserving plan assets, etc. or offering rates close to MLR, breached its common law fiduciary duties to prudently manage funds and act with plaintiffs' best interests in mind….

(5/20/19 Order, RE 122, PageID#3270). As a result, Plaintiffs had three years under both ERISA and Michigan law—or until 2012—to file suit. Because Plaintiffs did not do so until 2014, the district court properly held that their breach of fiduciary duty claims were time-barred.

Plaintiffs argue that they "did not actually know about BCBSM's fiduciary breaches until 2013," when an audit "revealed that, contrary to BCBSM's representations, Plaintiffs were not paying anything 'close to MLR' on claims eligible for the FCPA Discount." (Tribe's Br. at 21-22 (citing FAC, ¶¶56-57, 69-70, 90-91, RE 90, PageID#2552-2555, 2558) (some quotations omitted)). That argument lacks merit for several reasons:

First, the FCPA is irrelevant to the Tribe's Employee Plan (Group 1019) because the FCPA only applied to the Member Plan (Group 1020), so Plaintiffs could not plausibly have relied on any alleged representations made in the FCPA. While Plaintiffs acknowledged as much in seeking reconsideration of the district court's decision,[13] they ignore that distinction in their brief on appeal.

Second, Plaintiffs mischaracterize what the FCPA actually says. It merely states BCBSM's willingness to "accommodate" Munson and the Tribe by processing claims at a price "they," i.e., Munson and the Tribe, "believe is close to [MLR]." (FCPA, RE 90-4, PageID#2589). Nowhere in the FCPA is there any representation by BCBSM that the discount was in fact "close to" MLR.

Finally, even as it pertains to the Member Plan (Group 1020), the district court correctly recognized that, in any event, all that matters is that Plaintiffs "knew they were not getting MLR in March 2009." (12/26/17 Order, RE 107, PageID#3134). That was the only "relevant fac[t]" of which they needed to have actual knowledge relative to a potential breach of BCBSM's fiduciary duty. *Wright*, 349 F.3d at 328.

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[13] *See* Plaintiffs' Mot. for Recon., RE 101, PageID#2963 ("Plaintiffs believed that the FCPA Discount was making the Plan whole for hospital claims at Munson for members of Group #01020. As such, as of March 2009, Plaintiffs had no reason to believe that BCBSM was breaching its fiduciary duties for hospital claims at Munson for members of Group #01020.").

Plaintiffs respond that the district court used an "incorrect framing" of their claim, i.e., they claim that it was not "about a mere 'failure to provide MLR.'" (Tribe's Br. at 22 (citing 12/26/17 Order, RE 107, PageID#3132-3134)). According to Plaintiffs, this "reflects a misunderstanding of the [MLR regulations]," which Plaintiffs assert do not necessarily require applying MLR if the negotiated contractual rate is lower. (*Id*. at 22-23). Plaintiffs therefore claim that they "had to know: (1) what MLR was; (2) what BCBSM's pricing was; and (3) the difference between the two, on average." (*Id*.).

Not so. Plaintiffs' own allegations show that they knew full well that BCBSM's pricing was overall higher than MLR and that BCBSM was either unwilling or unable to "adjust its entire system to calculate MLR on those claims eligible for MLR discounts," which is precisely why Plaintiffs entered into the FCPA with BCBSM and Munson. (FAC ¶51, RE 90, PageID#2552). As the district court explained: "[Plaintiffs] knew what they were getting was, by definition, not MLR, and was going to be higher than MLR." (12/26/17 Order, RE 107, PageID#3134).

Despite Plaintiffs' suggestion, it was not necessary for them "to have knowledge of every last detail of a transaction, or knowledge of its illegality." *Wright*, 348 F.3d at 328 (citation and quotations omitted). As the district court once again aptly explained, Plaintiffs' insistence that they did not know that

BCBSM was allegedly squandering plan assets until the 2012 audit is flawed because "Plaintiffs do not allege that they did not know of the facts or transaction that constituted the violation—their 2009 agreement to pay an amount above, but 'close to,' MLR—they allege that they did not know those facts *supported their claim for a breach of fiduciary duty*." (12/26/17 Order, RE 107, PageID#3135 (emphasis in original)). Plaintiffs certainly knew more than that "something was awry." *Rogers*, 920 F.2d 34, 1990 WL 61120, *4.

Because Plaintiffs failed to file suit within three years of their actual knowledge of the facts that constituted BCBSM's alleged breach of fiduciary duty, the district court correctly held their ERISA and common law breach of fiduciary duty claims to be time-barred.[14]

2. Plaintiffs failed to plausibly allege fraud or concealment.

The district court was also correct in rejecting Plaintiffs' reliance both on the "fraud or concealment" exception to ERISA' statute of limitations, as well as

[14] Plaintiffs cite this Court's decision in *Saginaw Chippewa Indian Tribe of Michigan v. Blue Cross Blue Shield of Mich.*, 32 F.4th 548, 564-65 (6th Cir. 2022), as "precedent" that requires reversal of the district court's "opposite conclusion" in this case. (Tribe's Br. at 24). It does no such thing. First of all, the Court did not foreclose application of the statute of limitations even in that case; it simply recognized the statute of limitations as something the district court needed to address in the first instance—which it has yet to do. *Saginaw Chippewa Indian Tribe of Michigan*, 32 F.4th at 564-65. Second, and more important, the Court did not say anything about the statute of limitations that has even a remote bearing on the facts of this case, in which Plaintiffs, based on their own allegations, had actual knowledge of the facts establishing their breach of fiduciary duty claims.

Michigan's "fraudulen[t] conceal[ment]" tolling statute. (7/21/17 Order, RE 99, PageID#2936-2938; 12/26/17 Order, RE 107, PageID#3133-3136; 5/20/19 Order, RE 122, PageID#3272-3274).

When applicable, ERISA's "fraud or concealment" exception provides that an action "may be commenced not later than six years after the date of discovery of such breach or violation." 29 U.S.C. § 1113. Michigan law similarly provides that the statute of limitations is tolled if the defendant "fraudulently conceals the existence of the claim." Mich. Comp. Laws § 600.5855. In a case of fraudulent concealment, the plaintiff is permitted to bring suit "at any time within 2 years after the [plaintiff] … discovers, or should have discovered, the existence of the claim." *Id*.

This Court has explained that ERISA's "fraud or concealment" exception requires plaintiffs to show that "despite their exercise of due diligence or care, they were not on notice of [a defendant's] breach of duty." *Brown v. Owens Corning Investment Review Comm.*, 622 F.3d 564, 574 (6th Cir. 2010), *abrogated on other grounds by Intel Corp. Investment Policy Comm. v. Sulyma,* 589 U.S. 178 (2020) (citation and quotations omitted); *see also Med. Mut. of Ohio v. k. Amalia Enterprises Inc*., 548 F.3d 383, 391 (6th Cir. 2008) ("In the context of fraud, we have 'imposed upon the plaintiff a positive duty to use diligence in discovering the existence of a cause of action.' We have also held that '[i]nformation sufficient to

alert a reasonable person to the possibility of wrongdoing gives rise to a party's duty to inquire into the matter with due diligence.'") (citations omitted).

Michigan law imposes a similar hurdle. In *Doe v. Roman Catholic Archbishop of Archdiocese of Detroit*, 692 N.W.2d 398 (Mich. Ct. App. 2004), the Michigan Court of Appeals observed that "[i]f there is a known cause of action there can be no fraudulent concealment which will interfere with the operation of the statute, and in this behalf a party will be held to know what he ought to know …. For a plaintiff to be sufficiently apprised of a cause of action, a plaintiff need only be aware of a possible cause of action." *Id*. at 643 (citations and quotations omitted). Thus, if the plaintiff "knew or should have known" of the facts giving rise to its claimed injury, there can be no fraudulent concealment. *Id.*

That is precisely the case here. The district court correctly determined that Plaintiffs' actual knowledge that BCBSM was not processing claims at MLR—which was *the* fact at the heart of their breach of fiduciary duty claims—necessarily defeats any reliance on a fraud or concealment theory. *See Brown*, 622 F.3d at 574 ("Defendants could not have engaged in fraud to conceal from the Plaintiffs what the Plaintiffs already knew"); *Doe*, 692 N.W.2d at 405 ("If there is a known cause of action there can be no fraudulent concealment[.]").

In addressing Plaintiffs' ERISA claim as it pertained to the Tribe's Employee Plan (Group 1019), the district court correctly observed that although "plaintiffs

asked defendant to ensure they were receiving MLR [in March 2009], and … 'BCBSM replied that it could not adjust its entire system[,]' [n]othing in the complaint shows that defendant represented to plaintiff at that time or at a later date that it would pursue MLR for Group #01019." (7/21/17 Order, RE 99, PageID#2936-2937). Nor did Plaintiffs "plead facts in the complaint that would plausibly indicate they lacked actual knowledge in 2009." (*Id*., PageID#2937).

As for the Tribe's Member Plan (Group 1020), the court acknowledged Plaintiffs' argument that BCBSM had represented in the FCPA that it would pay "close to" MLR, but appropriately determined that this could not possibly constitute "fraud or concealment" because the FCPA itself stated "that plaintiffs would not receive MLR." (12/26/17 Order, RE 107, PageID#3135). Thus, "Plaintiffs did not and do not demonstrate how this separate contract, which still states that plaintiffs would not receive MLR, constitutes fraud or concealment of a breach of a fiduciary duty that consisted of obtaining MLR." (*Id*.).

The court correctly applied the same analysis in dismissing Plaintiffs' claim for breach of fiduciary duty with respect to Group 1020 (the non-employee Tribal members) under Michigan's common law: "[P]laintiffs argue that defendant failed to disclose a material fact, its breach of fiduciary duties after it signed the FCPA, which amounts to fraudulent concealment in Michigan…. But this argument is subsumed by the Court's earlier analysis; plaintiffs already knew of the breach, and

Michigan courts do not permit tolling under § 600.5855 once the party knows of a cause of action." (5/20/19 Order, RE 122, PageID#3272 (citing *Doe*, 264 Mich. App. at 643)).[15]

Plaintiffs argue that the district court "incorrectly held this exception inapplicable," asserting that while the district court "speculated 'Plaintiffs knew they were not getting MLR in 2009,'" they "actually believed the opposite." (Tribe's Br. at 26). But Plaintiffs cite no support for that assertion, which contradicts Plaintiffs' own prior statements in this very case. For example, in responding to BCBSM's motion to dismiss their FAC, Plaintiffs conceded that they "knew BCBSM was not pricing claims using Medicare-Like Rates prior to March of 2009." (Plaintiffs' Resp. to BCBSM's Mot. to Dismiss FAC, RE 96, PageID#2665 n. 4).

Plaintiffs will no doubt respond that what they really meant was that they did not know how BCBSM's pricing under the FCPA "compared to MLR" (Tribe's Br. at 26), which is what they argued in the district court, i.e., that they "did not know

[15] The court also cited Plaintiffs' failure to allege that BCBSM engaged in any intentional deception "intended to prevent discovery of the claim." (*Id*., PageID#3273). Plaintiffs do not address this aspect of the district court's analysis, so the Court is well within its discretion to consider Plaintiffs' challenge to the dismissal of their state law breach of fiduciary duty claim as forfeited. *See Rees v. W.M. Barr & Co., Inc*., 736 F. App'x 119, 125 (6th Cir. 2018) ("[W]here a plaintiff fails to address the district court's reasoning in disposing of a claim on summary judgment or motion to dismiss, we have deemed the claim forfeited."). In any event, this is yet another fatal flaw in Plaintiffs' allegations that provides additional support for the district court's decision.

whether BCBSM's contractual reimbursement rates were higher than, the same as, or lower than the Medicare-Like Rates for the same service." (Plaintiffs' Resp. to BCBSM's Mot. to Dismiss FAC, RE 96, PageID#2665 n. 4). But that argument does not work either. As the district court pointed out, Plaintiffs' own allegations showed that they knew full well that a rate "close to" MLR under the FCPA would still be "above" the MLR amount. (12/26/17 Order, RE 107, PageID#3135).

But even if Plaintiffs had actually alleged otherwise, it does not matter because both ERISA's "fraud or concealment" exception and Michigan's statute of limitations tolling provision require the exercise of reasonable diligence in the face of a possible cause of action, which Plaintiffs did not exercise—despite their contrary assertions. *See Brown*, 622 F.3d at 574; *Med. Mut. of Ohio*, 548 F.3d at 391; *Doe*, 692 N.W.2d at 405. Once again, the district court aptly explained Plaintiffs' failure in this regard:

> In 2009, it appears that plaintiffs chose not to pursue legal action for defendant's breach of fiduciary duty, and instead gave defendant the benefit of the doubt and let it attempt to cure its deficient conduct. Shrewdly, plaintiffs entered into the FCPA and imposed more specific requirements upon the relationship to see if matters improved…. However, it will not be able to turn back the clock on the breach of fiduciary duty claim that it knew of in 2009.

(5/20/19 Order, RE 122, PageID#3274).

Even in seeking reconsideration of the dismissal of their ERISA breach of fiduciary duty claim and for leave to further amend their complaint, Plaintiffs

never argued "that it was diligent to wait over three and a half years to audit their agreement with BCBSM, or that the information they gained from that audit did anything more than reveal the extent of the breach of BCBSM's fiduciary duty, rather than the existence of that breach." (12/26/17 Order, RE 107, PageID#3135-3136). That lack of diligence is fatal to Plaintiffs' reliance on the "fraud or concealment" exception.[16]

In sum, because BCBSM did not conceal anything from Plaintiffs, the timeliness of their ERISA and common law breach of fiduciary duty claims depends solely on when Plaintiffs knew that BCBSM was not processing healthcare claims at MLR. As the district court recognized, Plaintiffs knew as much in 2009, and thus were required to file suit by 2012. Because Plaintiffs did not sue until 2014, their breach of fiduciary duty claims were untimely and properly dismissed.

[16] At pages 25-26 of their brief, Plaintiffs once again mischaracterize this Court's decision in *Saginaw Chippewa Indian Tribe of Michigan*, 32 F.4th 548. Again, the Court simply remanded the statute of limitations issue for the district court to consider; it did not make any determination as to the application of the "fraud or concealment" exception. In any event, whether the exception is ultimately found to apply in that case has nothing to do with this one. Plaintiffs' reliance on *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Mich.*, 751 F.3d 740 (6th Cir. 2014), is likewise without merit for the simple reason that it is a different case based on different facts.

B. The District Court Properly Granted Summary Judgment To BCBSM On Plaintiffs' HCFCA Claim.

1. The HCFCA and its purpose.

The HCFCA provides in relevant part:

> [A] person who knowingly presents or causes to be presented a claim which contains a false statement, shall be liable to the health care corporation or health care insurer for the full amount of the benefit or payment made.

Mich. Comp. Laws § 752.1009. "The Legislature enacted the HCFCA to extend to private insurers … protections against fraud," and the HCFCA is considered to be an anti-fraud statute. *People v. Motor City Hosp. and Surgical Supply, Inc.*, 575 N.W.2d 95, 98 (Mich. Ct. App. 1997).

With little case law interpreting the HCFCA, courts have at times turned to the federal False Claims Act ("FCA"), reasoning that the FCA is "analogous to the … HCFCA." *State ex rel. Gurganus v. CVS Caremark Corp.*, Nos. 299997, 299998, 299999, 2013 WL 238552, at *10 (Mich. App. Jan. 22, 2013), *rev. on other grounds, State ex rel. Gurganus v. CVS Caremark Corp.,* 852 N.W.2d 103 (Mich. 2014).

2. Plaintiffs lack standing under the HCFCA.

Although the district court disagreed with BCBSM's standing argument (*see* 5/20/19 Order, RE 122, PageID#3249), Plaintiffs' lack of standing to assert an HCFCA claim provides an additional ground to affirm summary judgment in BCBSM's favor. *Autumn Wind Lending, LLC v. Est. of Siegel by & through*

Cecelia Fin. Mgmt., LLC, 92 F.4th 630, 638 (6th Cir. 2024) (An appellee "may 'urge in support of a decree any matter appearing in the record, although his argument may involve an attack upon the reasoning of the lower court.'") (citations omitted).

The Michigan Legislature limited the possible plaintiffs under the HCFCA to "health care corporation[s]" and "heath care insurer[s]." Mich. Comp. Laws § 752.1009 (emphasis added). That "the Legislature may permissibly limit the class of persons who may challenge a statutory violation" is axiomatic—a plaintiff suing under a statute must always have "statutory standing." *Miller v. Allstate Ins. Co.*, 751 N.W.2d 463, 467 (Mich. 2008). "Statutory standing simply entails statutory interpretation: the question it asks is whether the Legislature has accorded this injured plaintiff the right to sue the defendant to redress his [alleged] injury." *Id.* (quotations, modifications and citations omitted).

In an effort to establish their statutory standing, Plaintiffs alleged that they "are *health care insurers* as defined by M.C.L. § 752.1009." (Plaintiffs' FAC ¶72, RE 90, PageID#2556 (emphasis added)). To be a "health care insurer," however, Plaintiffs must be a "legal entity which is self-insured and providing health care benefits to *its employees*." Mich. Comp. Laws § 752.1002(f) (emphasis added). That is not the case here, as the allegedly false claims related to the Tribe's *Member Plan*. That has nothing to do with "employees" because under the

Member Plan, Plaintiffs are only providing health care benefits to "Members of the Tribe *who are not employed by the Tribe*." (FAC ¶2(b), RE 90, PageID#2539 (emphasis added)). Plaintiffs therefore lack standing to sue under the HCFCA, warranting dismissal of the HCFCA claim. *Roberts v. Hamer*, 655 F.3d 578, 581 (6th Cir. 2011).

The district court disagreed, reasoning that it does not matter whether the allegedly false claims relate to the Member Plan or the Employee Plan. According to the court, "as long as plaintiffs are continuously supplying health care benefits to employees, they are health care insurers for all purposes under the HCFCA." (5/20/19 Order, RE 122, PageID#3259). Such an interpretation, however, takes the term "health care insurer" out of its statutory context, which is not permitted.

The HCFCA governs false "claims." The statute defines a "claim" as "any attempt to cause a … *health care insurer* to make the payment of a *health care benefit.*" Mich. Comp. Laws § 752.1002(a) (emphasis added). A "health care benefit," in turn, is "the right under a contract … to have a payment made by a … health care insurer *for a specified health care service*." Mich. Comp. Laws § 752.1002(d) (emphasis added). Reading these definitions together shows that an entity is only "providing health care benefits to its employees" to the extent that it is making payment "for a specified health care service" *on behalf of those employees*.

Any other reading of the phrase "legal entity which is self-insured and providing health care benefits to its employees," Mich. Comp. Laws. § 752.1002(f), ignores statutory context in which the term "health care insurer" is used. Yet it is well established that a "strained reading of an excerpt of one sentence must yield to context." *Speicher v. Columbia Twp. Bd. of Trustees*, 860 N.W.2d 51, 57 (Mich. 2014). Relatedly, "[w]ords in a statute should not be construed in the void, but should be read together to harmonize their meaning." *Rock v. Crocker*, 884 N.W.2d 227, 236 (Mich. 2016) (quotation and citation omitted). The only way to do that here is to recognize that because the allegedly false "claims" did not relate to Plaintiffs "providing health care benefits to [the Tribe's] employees," the Tribe's HCFCA claim fails as a matter of law.

3. Lack of standing aside, because BCBSM is not required to comply with the MLR regulations, its processing of claims at network rates instead of MLR could not have been "false" for purposes of the HCFCA

a) The MLR regulations only govern Medicare-participating hospitals

In defining their "Scope," the MLR regulations expressly state that they apply only to Medicare-participating hospitals: "All *Medicare-participating hospitals* … that furnish inpatient services must accept no more than the rates of payment under the methodology described in this section...." 42 C.F.R. § 136.30(a) (emphasis added). Thus, on their face, the MLR regulations do not in

any way govern TPAs like BCBSM. *Accord SCIT I*, 748 F. App'x. at 20 (the "MLR [regulation] requires *Medicare-participating hospitals* to accept payment for services at a rate that is no more than what those services would cost under Medicare.") (emphasis added).[17] As IHS has explained: "'Medicare-participating hospitals that furnish inpatient services must accept the rate methodology established under this regulation as a condition of participation in the Medicare program.'" *Saginaw Chippewa Indian Tribe of Michigan, et al*, 477 F. Supp. 3d at 606 (citation omitted). The MLR regulations have nothing to do with BCBSM.

b) The Tribe's HCFCA claim fails because it is impossible for the Tribe to establish that BCBSM actually violated the MLR regulations

The inapplicability to BCBSM of the MLR regulations is fatal to the Tribe's HCFCA claim because in order for the Tribe to succeed on that claim, it must first establish that BCBSM actually violated obligations imposed upon it by the MLR regulations. *State ex rel. Gurganus v. CVS Caremark Corp*., 852 N.W.2d 103, 114 (Mich. 2014). And because the Tribe cannot do that, its HCFCA claim fails as a matter of law.

[17] "The regulation also provide[s] a mechanism for Indian organizations to recover *from hospitals* that did not apply the required MLR rates." *Saginaw Chippewa Indian Tribe of Michigan, et al v. BCBSM*, 477 F. Supp. 3d 598, 606-607 (E.D. Mich. 2020) (citing 42 C.F.R. § 136.32). Instead of recovering from the hospitals (i.e., from those that actually presented for payment claims in excess of MLR), the Tribe elected to sue BCBSM, the claims *administrator*.

The Michigan Supreme Court's decision in *Gurganus* controls. There, the plaintiffs alleged that certain pharmacists (Rite Aid, CVS, etc.) violated the HCFCA because they first violated a separate statute: Mich. Comp. Laws § 333.17755(2). 852 N.W.2d at 105. "Under [§ 17755(2)], when a pharmacist receives a prescription for a brand-name drug and instead dispenses the generic equivalent, the pharmacist must 'pass on the savings in cost to the purchaser.'" *Id.* The *Gurganus* plaintiffs contended that, in violating § 17755(2) by failing to pass on the savings, the pharmacists "necessarily … violat[ed] the … HCFCA." *Id.*

The Michigan Supreme Court affirmed dismissal of the plaintiffs' case because they could not *first* establish a violation of § 17755(2). The court reasoned:

> Assuming for the sake of argument that claims under the HCFCA … *may* be derived from violations of § 17755(2), plaintiffs' failure to sufficiently allege violations of § 17755(2) necessarily means that they fail to allege derivative violations of the false claim ac[t].
>
> … Any discussion of these remaining derivative claims [under the HCFCA] would constitute dicta....
>
> ***
>
> Because plaintiffs have failed to allege sufficient facts to state a violation of § 17755(2), plaintiffs' remaining derivative claims under the HCFCA … are unsustainable.

Id. at 66-68 (emphasis in original).

Just as in *Gurganus*, the Tribe here cannot *first* establish that BCBSM violated the MLR regulations for the simple reason that the MLR regulations do not govern BCBSM and do not impose any obligations on it. They instead govern *Medicare-participating hospitals* and impose certain obligations on *them*. Indeed, as noted above, the MLR regulations provide to the Tribe a legal mechanism to recover from hospitals (*see* 42 C.F.R. § 136.32), and the Tribe even admits that it already "obtained [from hospitals] some recoveries on some overpayments pursuant to" that process. (Plfs' Resp. to BCBSM's RFA 25, Seventh Set, RE 154-30, PageID##3959-3960).

In any event, the Tribe is legally incorrect when arguing that "[t]he MLR regulations required BCBSM to pay at the lesser of the Medicare-Like Rate or the contract rate negotiated with the hospital." Tribe's Br. at 15. In turn, because the Tribe cannot establish "a violation of" the MLR regulations by BCBSM, the Tribe's "remaining derivative claim under the HCFCA [is] unsustainable." *Gurganus*, 852 N.W.2d at 114. Thus, the district court properly held:

> [T]he HCFCA claim as articulated requires a finding that BCBSM has violated the MLR regulations such that Plaintiffs could sustain a derivative violation of the HCFCA....
>
> ***
>
> Ultimately, the underpinning logic of Plaintiffs' argument is that … BCBSM must be beholden to the MLR regulations. But Plaintiffs' argument would require the Court to improperly impose an

> obligation on Defendant BCBSM that is not included in the text of [the MLR regulations]….
>
> ***
>
> Under the plain language of the MLR regulations cited by the parties, these regulations impose obligations on Medicare-participating hospitals to ensure they follow a particular payment regime when billing federally recognized tribes, in order to continue participating in Medicare. These regulations do not impose a separate obligation on TPAs [third party administrators] like Defendant BCBSM to ensure that federally recognized tribes pay MLR for MLR-eligible claims. Because Plaintiffs have failed to demonstrate that Defendant BCBSM can violate [the MLR regulations], this necessarily means that they have failed to allege derivative violations of the HCFCA. Accordingly, Defendant BCBSM is entitled to summary judgment on the HCFCA claim.

(8/3/22 Order, RE 196, PageID##5883, 5895-5896).

c) The applicability of the MLR regulations is an element of Plaintiffs' HCFCA claim, not an affirmative defense

Because Plaintiffs could not first establish that BCBSM violated the MLR regulations, Plaintiffs could not prove a necessary element of the HCFCA claim. *See Gurganus, supra*. (8/3/22 Order, RE 196, PageID#5896.)

Plaintiffs respond that this is really an "affirmative defense" that BCBSM somehow waived. Tribe's Br. at 43-46. Not so. First, as the district court correctly recognized in denying Plaintiffs' motion for reconsideration (3/29/24 Order, RE 203, PageID#6019-6020), Plaintiffs never raised this argument during

summary judgment and it is improper to do so now. *Leisure Caviar, LLC v. U.S. Fish and Wildlife Service*, 616 F.3d, 612, 616 (6th Cir. 2010).

But nevertheless, "[a]n affirmative defense … is a defense that does not negate the elements of the plaintiff's claim, but instead precludes liability even if all of the elements of the plaintiff's claim are proven." *Roberge v. Hannah Marine Corp.*, 124 F.3d 199, 1997 WL 468330, at *3 (6th Cir. 1997) (unpublished table decision) (rejecting plaintiff's argument that the defendant waived an affirmative defense that was really an element of the claim). That is plainly not the case here. As the district court explained, where, as here (and like in *Gurganus*), liability under the HCFCA is premised upon a statutory or regulation violation, that is an element of the claim. (3/29/24 Order, RE 203, PageID#6019).

4. The district court properly declined the Tribe's effort to recast its HCFCA claim to avoid summary judgment

Despite Plaintiffs' assertions, the district court was also correct in rejecting their effort to use their summary judgment briefing to change their HCFCA claim into something that was never alleged.

a) Pleading with particularity

Rule 9(b)—pleading with particularity—governs Plaintiffs' HCFCA claim, with the Michigan Supreme Court making that clear in *Gurganus*, 852 N.W.2d at 112 (2014) ("Because plaintiffs' [HCFCA] claims are based on alleged fraudulent

activity, the heightened pleading standard for fraud claims applies"). The particularity requirement "serves an important purpose … by alerting defendants to the *precise* misconduct with which they are charged." *United States ex rel. Prather v. Brookdale Senior Living Cmtys., Inc.*, 838 F.3d 750, 771 (6th Cir. 2016) (quotations omitted) (emphasis added).

Because Plaintiffs did not allege as part of their HCFCA claim that BCBSM had promised rates that were "better than MLR" or "close to MLR," the district court was correct in preventing Plaintiffs from using their summary judgment briefing to try to recast their HCFCA claim as being based on such allegations. (8/3/22 Order, RE 196, PageID#5881-5882). *See Hubbard v. Select Portfolio Servicing, Inc.*, No. 16-CV-11455, 2017 WL 3725475, at *3 (E.D. Mich. Aug. 30, 2017), *aff'd*, 736 F. App'x 590 (6th Cir. 2018) (holding that a plaintiff could not "simply includ[e] new factual allegations in his briefing in opposition to the motions for summary judgment," as it "would throw the rules of civil procedure into disarray, and would be fundamentally unfair to Defendants"); *Samuels v. Wilder*, 871 F.2d 1346, 1350 (7th Cir. 1989) ("The court correctly prevented plaintiffs' attempted bypass of Rule 9(b) … and concentrated only on the averments of fraud originally pleaded"); *Pooshs v. Philip Morris USA, Inc.*, 904 F. Supp. 2d 1009, 1027 (N.D. Cal. 2012) ("plaintiff cannot oppose a motion for

summary judgment … on allegations of fraud that were never pled with particularity in the first place").

The Tribe's "incorporation-by-reference" argument is equally unavailing. Tribe's Br. at 32. As an initial matter, Plaintiffs never made that argument until seeking reconsideration under Rule 59, so they should be precluded from doing so now. *Exxon Shipping Co. v. Baker*, 554 U.S. 471, 485 n. 5 (2008); *Robinson v. Capital One Bank*, No. 19-2275-DDC-KGG, 2021 WL 351421, at *3 (D. Kan. Feb. 2, 2021) ("Rule 59(e) does not provide litigants an encore performance[.]").

In any event, Plaintiffs' "incorporation-by-reference" argument fails because it violates Rule 9(b)'s particularity requirement. In their FAC, Plaintiffs identified with particularity the basis for the alleged falsity: "The amount charged by BCBSM for paying the claims was false ***because*** Plaintiffs were not required to pay more than Medicare-Like Rates on a number of claims administered by BCBSM." (FAC, RE 90, ¶74, PageID#2556 (emphasis added)). Rule 9(b) does not permit Plaintiffs to allege with precision the purported falsity, and then apply an "incorporation-by-reference" approach that leaves BCBSM guessing as to the *key* element of Plaintiffs' HCFCA claim. *Cf. In re Metro. Sec. Litig.*, 532 F. Supp. 2d 1260, 1279 (E.D. Wash. 2007) ("A complaint is deficient for the purposes of Rule 9(b) when it relies on 'shotgun' or 'puzzle' pleading," and "[s]hotgun pleadings are those that incorporate every antecedent allegation by reference into each

subsequent claim[.]"); *Ill. Nat'l. Ins. Co. v. Nordic PCL Constr., Inc.*, 870 F. Supp. 2d 1015, 1037-38 (D. Haw. 2012) (holding that the plaintiff used insufficient particularity for its fraud claim under Rule 9(b) by realleging "the allegations contained in all of the foregoing paragraphs as if fully set forth herein"). As the district court below aptly explained:

> While Plaintiffs are correct that their HCFCA claim incorporated all preceding paragraphs, it also included the amended complaint's delineation between MLR and the FCPA that Plaintiffs articulated in ¶ 16. Plaintiffs cannot ignore these distinctions now because they are inconvenient. Thus, the factual allegations regarding the FCPA on which Plaintiffs rely (see ECF No. 198, PageID.5922–5924) have no bearing on their HCFCA claim based on MLR. As such, Plaintiffs' attempts to expand their claim at summary judgment to include misrepresentations and fraudulent inducement related to the FCPA are inconsistent with the amended complaint.

(3/29/24 Order, RE 203, PageID#5999-6000).[18]

[18] The cases relied upon by Plaintiffs in their brief (Plaintiffs' Br. at 33-39) are completely inapposite and do not even address Rule 9(b) and pleading with particularity. *See generally Dassault Systemes, SA v. Childress*, 828 Fed. Appx. 229 (6th Cir. 2020) (unpublished); *CMFG Life Ins. Co. v. RBS Secs., Inc.*, 799 F.3d 729 (7th Cir. 2015); *Bard v. Brown Cty, Ohio*, 970 F.3d 738 (6th Cir. 2020); *Johnson v. City of Shelby, Miss.*, 574 U.S. 10 (2014); *Boshaw v. Midland Brewing Co*, 32 F.4th 598 (6th Cir. 2022); *Lunneen v. Village of Berrien Springs, Mich.*, Nos. 22-2044; 22-2046, 2023 WL 6162876 (6th Cir. 2023); *Dibrell v. City of Knoxville, Tenn.*, 984 F.3d 1156 (6th Cir. 2021); *Chessie Logistics Co. v. Krinos Hldgs., Inc.*, 867 F.3d 852 (7th Cir. 2017). The two cases cited by Plaintiffs that actually do reference Rule 9(b) have no bearing on the circumstances here, *i.e.*, Plaintiffs' effort to oppose a motion for summary judgment with allegations of fraud that were never pled with particularity in the first place. *See generally Ballan v. Upjohn Co.*, 814 F. Supp. 1375 (W.D. Mich. 1992); *JAC Hldg. Enters., Inc. v. Atrium Capital Partners, LLC*, 997 F. Supp. 2d 710 (E.D. Mich. 2014).

Plaintiffs also did not need "detail learned from discovery" to allege with particularity the supposed misrepresentations (Tribe's Br. at 37), as they "should have first-hand knowledge of what was said." *Lesniak v. Mission Essential Pers., LLC*, No. 2:12–cv–1041, 2013 WL 6008912, at *4 (S.D. Ohio November 13, 2013) (rejecting as "disingenuous" the plaintiff's assertion "that any deficiency in his pleadings [concerning alleged misrepresentations] should be excused until after he can conduct discovery").

Notwithstanding Plaintiffs' attempt to portray their summary judgment position as having merely "refine[d] their HCFCA claim at summary judgment" because they "develop[ed] [the] claim with discovery materials" (Tribe's Br. at 37-38), the district court was right in concluding that "Plaintiffs' characterization of their HCFCA claim on summary judgment diverges from the complaint." (8/3/22 Order, RE 196, PageID#5875). And there can be no question that BCBSM would suffer prejudice if Plaintiffs new allegations of fraud were allowed, notwithstanding Plaintiffs saying "BCBSM was not prejudiced." (Tribe's Br. at 39). As the district court properly recognized, BCBSM was prejudiced for the simple reason that it "ultimately fil[ed] a motion for partial summary judgment regarding the HCFCA claim as pleaded in the complaint." (8/3/22 Order, RE 196, PageID#5881).

Finally, while Plaintiffs briefly allude to the district court's denial of their motion for leave to file a second amended complaint (Tribe's Br. at 34-36), which they say was to expand their HCFCA claim, this is yet another argument that they never made in responding to BCBSM's motion for summary judgment—as the district court pointed out in denying reconsideration. (3/29/24 Order, RE 203, PageID#6003).

Moreover, their request for leave to amend and proposed amendment did not, contrary to Plaintiffs' assertion, relate to their HCFCA claim, but rather their ERISA claim. That much is apparent from their motion (RE 102, PageID#2966)), BCBSM's response (RE 104, PageID#3706), and the court's order denying leave to amend (RE 107, PageID#3127). Indeed, when Plaintiffs sought leave to amend, which was in August 2017, it was obviously in response to the court's July 21, 2017 dismissal of their ERISA claim. (*See* 7/21/17 Order, RE 99, PageID#2918).

For Plaintiffs to now claim that their request for leave to amend in July 2017 was somehow an effort to shore up their HCFCA claim, which the district court did not dispose of on summary judgment until August 2022 (8/3/22 Order, RE 196, PageID#5863), is eyebrow-raising. The district court summed it up well:

> [P]laintiffs' argument is disingenuous. In their August 4, 2017 motion to file a second amended complaint, Plaintiffs made no mention of their HCFCA claim whatsoever. (*See* ECF No. 102.) As discussed further below, *see infra* pp. 27–28, this is likely because the parties agreed at the time that Plaintiffs' HCFCA claim was preempted under ERISA. (*See* ECF No. 94, PageID.2624–2626; ECF No. 96,

> PageID.2678–2679.) Plaintiffs' motion instead sought "to present the additional facts relevant to the statute of limitations analysis" and offer a "more explicit and clear … description of Plaintiffs' ***ERISA claims***." (ECF No. 102, PageID.2971–2972 (emphasis added); *see also id*. at PageID.2972–2975 (discussing the "two types of changes" in the proposed second amended complaint).) In denying the motion, the Court explained: "The amended complaint would be futile, because the amended ***ERISA breach of fiduciary claim*** could not withstand a motion to dismiss." (ECF No. 107, PageID.3141 (emphasis added).) Plaintiffs' assertion—more than five years later—that their proposed second amended complaint was intended to clarify their then-dismissed HCFCA claim is without merit.

(3/29/24 Order, RE 203, PageID#6003-6004 (emphasis in original)).

b) Neither the "implied certification" theory nor the "fraudulent inducement" theory save Plaintiffs' HCFCA claim

As they did in seeking summary judgment in their own favor, Plaintiffs rely on the "implied certification" and "fraudulent inducement" theories under the FCA. (Plfs' MSJ, RE 155, PageID##3997-4003). Both fail.

Before the "implied certification" theory can even be considered, it must be established that the "claim for payment … rests on a false representation of compliance with an applicable federal statute, federal regulation, or contractual term." (*Id.*, PageID#3998-3999). Or, as the Supreme Court articulated: "first, the claim [for payment] makes specific representations about the goods or services provided; and second, the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those

representations misleading half-truths." *Universal Health Servs. v. U.S.*, 579 U.S. 176, 190 (2016).

Plaintiffs cannot establish such a claim here because, as the district court recognized, the FCPA "explicitly stated [that the Tribe] would not receive MLR," and that "what [it was] getting was, by definition, not MLR[.]" (12/26/17 Order, RE 107, PageID##3133-3144). That proper conclusion, coupled with the testimony of the Tribe's own in-house lawyer, John Petoskey, that—before even executing the FCPA—Mr. Deiss told him that Plaintiffs "were not receiving Medicare-like rates" (Petoskey Dep., RE 165-8, PageID#5310-5311), establishes that the "implied certification" theory is plainly inapplicable. Far from implicitly representing compliance with the MLR regulations—BCBSM *expressly* stated to the contrary, and the Tribe knew it.

Plaintiffs' "fraudulent inducement" theory, which according to Plaintiffs applies when "a defendant … obtains a contract 'through false statements or fraudulent contract,'" fails for the same reason. Tribe's Br. at 49-50. Plaintiffs claim that the theory applies here because "BCBSM fraudulently concealed the true nature of its network rates vis-à-vis MLR prices during and after negotiations of the FCPA and renewals of the ASC, misrepresenting it was giving Plaintiffs 'close to' or 'better than' MLR when BCBSM knew that was false." Tribe's Br. at 51. But as explained above, Plaintiffs' new narrative does not in any way comport

with the record in this case—even setting aside Plaintiffs' failure to plead supposed misrepresentations regarding the formation of the FCPA as being a component of their HCFCA claim.

In short, the Tribe sued BCBSM under the HCFCA—an "anti-fraud statute"—for doing the very thing the Tribe consciously hired BCBSM to do: apply network rates while knowing full well that BCBSM did not apply MLR. Yet "fraud is not perpetrated upon one who has full knowledge." *Montgomery Ward & Co. v. Williams*, 47 N.W.2d 607, 611 (Mich. 1951). Under Michigan law and authorities interpreting the analogous FCA, the Tribe's HCFCA claim therefore fails as a matter of law. *Accord U.S. ex rel. Durcholz v. FKW Inc.*, 189 F.3d 542, 545 (7th Cir. 1999) ("[T]he government not only knew that [the] proposal and invoices contained excavation line-items, it directed FKW to use those pricing numbers. In essence, then, [plaintiff] is alleging that the government was defrauded by the very activities that its agents ordered…. In this case, the government's knowledge is an effective bar to [plaintiff's] FCA claim."); *U.S. ex rel. Owens v. First Kuwaiti Gen. Trading & Contracting Co*, 612 F.3d 724, 729 (4th Cir. 2010) ("Evidence that the government officials were aware of any alleged defects and accepted [the] work anyway effectively negates the fraud or falsity required by the FCA.") (citations and quotations omitted); *United States ex rel. Spay v. CVS Caremark Corp.*, 875 F.3d 746, 756 (3rd Cir. 2017) ("A classic

example of the government knowledge inference occurs when the government, with knowledge of the facts underlying an allegedly false claim, authorizes a contractor to make that claim.") (citations and quotations omitted).

V. CONCLUSION

For all of these reasons, BCBSM respectfully requests that the Court affirm.

Dated: September 9, 2024

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 12,596 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2016 in 14-point Times New Roman font.

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Dated: September 9, 2024

CERTIFICATE OF SERVICE

I hereby certify that on September 9, 2024, I electronically filed the foregoing paper with the Clerk of the Court using the ECF system, which will send notification of such filing to registered users.

By: */s/ Phillip J. DeRosier*
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ADDENDUM – DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

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96	Plaintiffs' Response to Defendant's Motion to Dismiss First Amended Complaint	2650-2775
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203	March 29, 2024 Opinion and Order Denying Plaintiffs' Motion for Reconsideration	5986-6022
204	March 29, 2024 Judgment	6023-6024