UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

LITTLE RIVER BAND OF OTTAWA INDIANS
AND ITS EMPLOYEE WELFARE PLAN,

Plaintiffs,

Case No. 15-cv-13708
Hon. David M. Lawson

v.

BLUE CROSS BLUE SHIELD
OF MICHIGAN,

Defendant.

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DEFENDANT'S MOTION TO DISMISS PLAINTIFFS' COMPLAINT PURSUANT TO FRCP 12(B)(6) FOR FAILURE TO STATE A CLAIM

Defendant Blue Cross Blue Shield of Michigan ("BCBSM"), by its attorneys Dickinson Wright PLLC, moves this Court pursuant to Fed. R. Civ. P. 12(b)(6) for dismissal of Plaintiffs' Complaint in its entirety with prejudice.

In support of this Motion, BCBSM relies upon and incorporates by reference the facts, arguments, and legal authority set forth in the accompanying Brief in Support, as well as the pleadings on file with the Court.

Pursuant to LR 7.1, concurrence in the instant relief was requested from opposing counsel during a conference call occurring on December 11, 2015, but no such concurrence was obtained.

WHEREFORE, BCBSM respectfully requests that this Court enter an Order granting this Motion dismissing Plaintiffs' Complaint in its entirety with prejudice, and awarding BCBSM such other relief as the Court deems just and proper.

Respectfully submitted,

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By: /s/ Brandon C. Hubbard

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DEFENDANT'S BRIEF IN SUPPORT OF ITS MOTION TO DISMISS PLAINTIFFS' COMPLAINT PURSUANT TO FRCP 12(B)(6) FOR FAILURE TO STATE A CLAIM

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ISSUES PRESENTED

1. Should Plaintiffs' two ERISA claims be dismissed pursuant to Rule 12(b)(6) because Plaintiffs failed to plead facts supporting their legal conclusion that the underlying employee welfare plan is in fact governed by ERISA?

BCBSM answers: Yes.

Plaintiffs answer: No.

2. Should the "Access Fee" portion of Plaintiffs' seven state-law claims be dismissed pursuant to Rule 12(b)(6) because those claims are governed by the Michigan Court of Appeals' decision in *Calhoun County v. BCBSM*, which dispositively held that the actions allegedly taken by BCBSM in this case were contractually permitted?

BCBSM answers: Yes.

Plaintiffs answer: No.

3. Should the "Medicare-like rate" portion of Plaintiffs' claims (ERISA and state law) be dismissed pursuant to Rule 12(b)(6) because Plaintiffs' "Medicare-like rate" allegations fail to establish that Plaintiffs satisfied a number of federal statutory and regulatory conditions precedent?

BCBSM answers: Yes.

Plaintiffs answer: No.

4. Alternatively, and to the extent it is found that the underlying employee welfare plan is governed by ERISA, should Plaintiffs' seven state law claims be dismissed because they are preempted by ERISA?

BCBSM answers: Yes.

Plaintiffs answer: No.

I. INTRODUCTION

This lawsuit pertains to Plaintiff Little River Band of Ottawa Indians' ("LRB") self-insured employee benefit plan ("Plan"),[1] for which Defendant Blue Cross Blue Shield of Michigan ("BCBSM") at one time served as the third-party administrator.

Plaintiffs assert against BCBSM two federal law claims and seven state law claims, each of which relates to BCBSM's alleged failure to properly process healthcare claims under the parties' Administrative Services Contract. Plaintiffs' two federal law claims arise under the Employee Retirement Income Security Act ("ERISA"): Breach of Fiduciary (Count I) and Prohibited Transaction Under ERISA (Count II). Plaintiffs' seven state law claims arise out of the same operative facts as (and thus relate to) Plaintiffs' two ERISA claims, and assert the following:

- Count III: Violation of Michigan's Nonprofit Health Care Act
- Count IV: Violation of Health Care False Claims Act
- Count V: Breach of Contract, And Alternatively, Covenant Of Good Faith And Fair Dealing
- Count VI: Breach of Common Law Fiduciary Duty
- Count VII: Conversion
- Count VIII: Fraud / Misrepresentation
- Count IX: Silent Fraud

While Plaintiffs' Complaint alleges nine causes of action and is comprised of 215 paragraphs, Plaintiffs' lawsuit is premised on just two factual assertions: (1) BCBSM impermissibly added fees to healthcare claims processed by BCBSM,

[1] LRB and the Plan are at times collectively referred to as "Plaintiffs."

artificially inflating Plaintiffs' healthcare claims without disclosing to Plaintiffs the actual cost of same (hereinafter, "Access Fees"); and (2) BCBSM improperly processed and paid certain healthcare claims without first obtaining (or applying) less costly "Medicare-like rates" ("MLR"), to which Plaintiffs claim entitlement because of their Indian Tribe status under federal law. BCBSM now seeks dismissal of each of claim pursuant to FRCP 12(b)(6) for failure to state a claim.

Plaintiffs' two ERISA claims must be dismissed because Plaintiffs do not allege sufficient facts demonstrating that the Plan is governed by ERISA. Under ERISA, a "governmental plan" is expressly *excluded* from ERISA regulation. And the defined meaning of "governmental plan" includes tribal plans. Here, Plaintiffs fail to plead any facts establishing that the Plan falls outside the meaning of a "governmental plan." And because it is axiomatic that a plaintiff cannot assert an ERISA claim when the underlying plan is not governed by ERISA, Plaintiffs' two ERISA claims must be dismissed pursuant to FRCP 12(b)(6).

Separately, the Access Fee portion of Plaintiffs' state-law claims must be dismissed because those claims are governed by the Michigan Court of Appeals' decision in *Calhoun County v. BCBSM*, which dispositively held that the actions allegedly taken by BCBSM in this case were contractually permitted. And under the *Erie* doctrine, the Michigan Court of Appeals' decision controls this case, in turn requiring dismissal of each state law claim as it relates to Access Fees.

Additionally, the MLR-portion of Plaintiffs' Complaint must be dismissed because Plaintiffs' MLR allegations fail to establish that Plaintiffs satisfied a number of federal statutory and regulatory conditions precedent, thereby

warranting dismissal under FRCP 12(b)(6). Before a tribal member is entitled to a "Medicare-like rate," the tribal member must satisfy—as a condition precedent—a myriad of federal statutory and regulatory requirements. Plaintiffs' Complaint contains no allegations establishing that these conditions precedent were in fact satisfied. Rather than assert such allegations, Plaintiffs' Complaint glosses over the applicable conditions precedent, and erroneously assumes that MLR-status should be automatically afforded to all healthcare claims simply because of Plaintiffs' Indian Tribe status. But federal law requires otherwise, making Plaintiffs' Complaint woefully deficient, in turn warranting dismissal of the MLR-portion of Plaintiffs' Complaint—which includes Plaintiffs' ERISA and state law claims.

Finally, in the alternative and to the extent it is found that the Plan is governed by ERISA, Plaintiffs' seven state law claims must be dismissed because they are preempted by ERISA. Plaintiffs' state law claims arise out of the same operative facts as Plaintiffs' two ERISA claims, and it is well-settled that Congress pre-empted such state law claims when it enacted the ERISA provision providing that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a), (b)(2)(B).

For these and other reasons, BCBSM now seeks to dismiss the entirety of Plaintiffs' Complaint.

II. LEGAL ARGUMENT

A. FRCP 12(b)(6) Standard of Review

"[A] complaint must contain sufficient factual matter . . . to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). If a complaint's "well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged – but it has not show[n] – that the pleader is entitled to relief." *Id.* at 679. The court "need not accept as true legal conclusions or unwarranted factual inferences." *DirectTV Inc. v. Treesh*, 487 F.3d 471, 476 (6th Cir. 2007).

B. Plaintiffs' Two ERISA Claims Must Be Dismissed Because Plaintiffs' Complaint Fails To Plead Facts Demonstrating That The Plan Is Governed By ERISA

ERISA applies to "any employee benefit plan if it is established or maintained (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) both." 29 U.S.C. § 1003(a)(1)-(3). The broad application of ERISA notwithstanding, a "governmental plan" is expressly *excluded* from ERISA. *See* 29 U.S.C. § 1003(b)(1).

ERISA's definition of "governmental plan" includes tribal plans. *See* 29 U.S.C. § 1002(32). Specifically, ERISA provides:

> The term "governmental plan" includes a plan which is established and maintained by an Indian tribal government (as defined in section 7701(a)(40) of Title

> 26), a subdivision of an Indian tribal government (determined in accordance with section 7871(d) of Title 26), or an agency or instrumentality of either, and all of the participants of which are employees of such entity substantially all of whose services as such an employee are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential government function). [29 U.S.C. § 1002(32).]

Accordingly, a tribal plan is not governed by ERISA if "substantially all" of the participants perform services that are "essential governmental functions but not in the performance of commercial activities." *Id.*

In this case, Plaintiffs allege that LRB "has created an ERISA-governed benefit plan." (Pls' Complaint, at ¶ 6). But that allegation is a legal conclusion not supported by any alleged facts. To be sure, Plaintiffs allege that LRB "is a federally recognized Indian tribe . . . with its Tribal Government headquarters in Manistee, Michigan," and that "LRB offers health care benefits to over 1,000 employees," including "tribal members" and "elected officials." *Id.* at ¶¶ 3, 6, 11. But a review of Plaintiffs' Complaint provides no factual basis to conclude whether (or even infer that) "substantially all" of the Plan's participants perform services that are "in the performance of commercial activities." 29 U.S.C. § 1002(32). This defect is fatal: Plaintiffs' allegation that "LRB has created an ERISA-governed benefit plan" is nothing more than a "legal conclusion[ ] unsupported by the pleaded facts." *Llewellyn-Jones v. Metro Prop. Group, LLC*, 22 F. Supp. 3d 760, 790 (E.D. Mich. 2014) (citation omitted).

Based on the foregoing, and due to Plaintiffs' failure to allege facts sufficient to support Plaintiffs' legal conclusion that LRB "created an ERISA-governed benefit plan," dismissal of Plaintiffs two ERISA claims (Counts I and II) is required under FRCP 12(b)(6). *Id.*

C. Plaintiffs' Seven "Access Fee" State Law Claims Are Governed By The Michigan Court Of Appeals' Decision In *Calhoun County v. BCBSM* And Must Therefore Be Dismissed

Relative to the Access Fee portion of Plaintiffs' seven state law claims, this Court is, respectfully, bound under the *Erie* doctrine to follow *Calhoun County v. BCBSM*, 297 Mich. App. 1, 824 N.W.2d 202 (2012), which held that BCBSM did no wrong in charging the alleged Access Fees. *Hicks v. Feiock*, 485 U.S. 624, 630 n. 3 (1988); *Wieczorek v. Volkswagenwerk*, 731 F.2d 309, 310 (6th Cir. 1984) (noting that "Michigan intermediate courts … are binding authority in federal courts in the absence of any Michigan Supreme Court precedent."). To this end, and in an analogous 2012 case, this Court already held that "*Calhoun County* would control any surviving state law claims" to the extent that a lawsuit, as here, "was improperly brought under ERISA." *Hi-Lex Controls, Inc. v. BCBSM,* Nos. 11-12565; 11-12557, 2012 WL 3887438 at *4 (E.D. Mich. Sept. 7, 2012).[2]

The facts of *Calhoun County* are nearly identical to the facts in this case and demonstrate that Plaintiffs "unequivocally agreed to the payment of access fees."

[2] The state law claims asserted by the Borroughs Corporation were identical to the state law claims asserted by LRB in this case. *See* Case No. 2:11-cv-12565-VAR-PJK, Dkt. #1, Filed 06/13/11.

Calhoun County, 297 Mich. App. at 17. In *Calhoun County*, BCBSM served as a third-party administrator for the plaintiff county's self-insured health care plan. The plaintiff, a governmental entity having an ERISA-excluded "governmental plan," brought an action against BCBSM alleging breach of contract and breach of fiduciary duty, among other state law claims, premised upon the argument that the "parties had not agreed to a price for the access fee and, even if they had, [BCBSM] unilaterally charged excessive fees in violation of the parties' agreement." *Id.* at 8. The trial court granted summary disposition for the plaintiff, but the Michigan Court of Appeals reversed.

In finding that the plaintiffs agreed to pay the access fees, the Michigan Court of Appeals first held that, "[c]ontrary to plaintiff's argument, the language of the ASC expressly provided for the collection of additional fees beyond the administrative charge and stop-loss coverage." *Calhoun County,* 297 Mich. App. at 15. Specifically, the language, which is identical to the language in the ASC in this case, states that the "Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner . . . will be reflected in the hospital claims cost in Amounts Billed." *Id.* at 15-16. The court found the Schedule A in *Calhoun County* equally conclusive, noting that, "since at least January 2007," the Schedule A has "reflected the parties' agreement that . . . a portion of your hospital savings has been retained by BCBSM to cover the ASC Access Fee." *Id.* The court found that, as a result of these provisions, the plaintiff "unequivocally agreed to the payment of the access fee, what it covered, and how it would be paid." *Id.* at 17.

The court likewise found that the plaintiff's breach of fiduciary duty claim failed where, "[e]ven assuming that [BCBSM] owed a fiduciary duty to plaintiff, as a result of our holding that [BCBSM] was authorized by the contract to charge the access fee, plaintiff cannot maintain its breach of fiduciary duty claim." *Id.* at 20-21. Indeed, because the alleged breach of fiduciary "duty resulted from [BCBSM's] charging a fee that it was contractually entitled to charge, that allegation should … have been dismissed on [BCBSM's] motion for summary disposition." *Id.* at 21. Considering these facts, the court reversed the trial court's order granting the plaintiff's motion for summary disposition. *Id.*

Following *Calhoun County*, the Michigan Court of Appeals has repeatedly struck down claims based upon facts very similar to the alleged facts in this case. *See City of Battle Creek v. BCBSM,* No. 311872, 2014 WL 547613, at *4 (Mich. Ct. App. Feb. 11, 2014) (affirming dismissal of the plaintiff's access fee claims where the court concluded that "*Calhoun Co* does control this case, and [BCBSM] was contractually authorized to charge the access fee in this case"); *County of Bay v. BCBS,* No. 307447, 2013 WL 6670894, at *2 (Mich. Ct. App. Dec. 17, 2013) (reversing the trial court's jury verdict for the plaintiff in an access fee case where the court previously held that the "parties agreed to enter into a binding contract, the ASC included a provision that allowed [BCBSM] to collect fees in addition to the administrative charge and stop-loss coverage, [and] article III of the ASC provides that those additional fees will be included in the "Amounts Billed . . . .").[3]

[3] *See also, BCBSM v. Genesee County Road Comm'n,* Nos. 305512, 313023, 2013 WL 2662806, at *2 (Mich. Ct. App. June 13, 2013) (affirming dismissal of the

Here, as in *Calhoun County,* Plaintiffs allege that BCBSM violated the parties' agreements and committed numerous torts because Plaintiffs allegedly never agreed to pay the Access Fees, and BCBSM had no contractual right to charge them. But the Michigan Court of Appeals, in examining provisions identical to those in this case, held just the opposite: "According to [the ASC], the parties agreed that [Plaintiffs] would be charged for additional fees beyond the administrative charge and stop-loss coverage, and that those fees would be reflected in the hospital claims cost contained in 'Amounts Billed.'" *Calhoun County,* 297 Mich. App. at 16. The Schedule A is also definitive on this point, noting that, "since at least January 2007," a "portion of [Plaintiffs'] hospital savings has been retained by BCBSM to cover the ASC Access Fee." *Id.* As in *Calhoun County,* here, BCBSM undeniably maintained the contractual right to charge the Access Fees.

In short, the Michigan Court of Appeals already decided this case. In the absence of contrary precedent, its "judgment is not to be disregarded by a federal court." *Mich. First. Credit Union v. Cumis Insurance Society, Inc.,* 641 F.3d 240, 252 (6th Cir. 2011). Plaintiffs here, like in *Calhoun County; Creek; County of Bay; Genesee County Rd Comm'n;* and *County of Midland*, *supra*, "unequivocally agreed to the payment of the access fee, what it covered, and how it would be

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plaintiff's access fee claims where the court's "interpretation of the contracts in *Calhoun Co* is directly applicable to the interpretation of the contracts in this case"); *County of Midland v. BCBS,* No. 303611, 2013 WL 2494983, at *3 (Mich. Ct. App. June 11, 2013) (reversing judgment in favor of the plaintiff against BCBSM where the court was "bound to follow *Calhoun Co* in the instant appeal and conclude that BCBSM was contractually authorized to charge the access fee").

paid." Accordingly, the Access Fee portion of Plaintiffs' seven state law claims should, respectfully, be dismissed in light of the fact that BCBSM was contractually permitted to charge the Access Fees at issue in this case.

D. The MLR Portion Of Plaintiffs' Claims (Both ERISA And State Law) Must Be Dismissed Because Plaintiffs' Complaint Fails To Plead Facts Establishing That Plaintiffs Were Entitled To "Medicare-Like Rates"

1. Federal law creation of "Medicare-like rates" (a/k/a "MLR")

The federal government, through the Indian Health Service ("IHS"), provides two types of health care services to American Indians and Alaska Natives.

The first type of health care service is direct health care services delivered by an IHS facility (e.g., clinic or hospital) to a tribal member, most of which are located on or near reservations. For American Indians and Alaskan Natives covered by direct IHS health care programs, treatment at an IHS facility is free. The second type of health care service is called Purchased Referred Care ("PRC"). PRC is a federal program funded by annual, fixed appropriations from IHS that pays for health care services that are purchased from, and provided by, non-IHS providers or facilities. Each delivery type has distinct eligibility requirements under federal law, and failure to meet the eligibility requirements results in a denial of MLR.

In this case, the closest IHS facility to LRB is located in Bemidji, Minnesota, which explains LRB's reliance on healthcare purchased from *non*-IHS healthcare providers in Michigan. And relevant to this case is 42 C.F.R. § 489.29,

which requires hospitals and critical access hospitals in Michigan—as a condition of maintaining their provider agreement to participate in Medicare—to "accept the payment methodology and no more than the rates of payment established under 42 C.F.R. part 136, subpart D as payment in full for [the PRC program]." This means that non-IHS providers that participate in Medicare must accept "Medicare-like rates" for those healthcare services that are provided to PRC-eligible American Indians and Alaskan Natives, and that are payable through a PRC program administered in accordance with 42 C.F.R. Part 136.

2. Plaintiffs' failure to plead facts establishing compliance with MLR's strict regulatory requirements warrants dismissal of Plaintiffs' MLR claims

There is no federal law entitling American Indians or Alaskan Natives to receive, and non-IHS hospitals to provide, health care services at "Medicare-like rates" *across the board*. Rather, tribal members must first satisfy a number of federal statutory and regulatory requirements.

Critically, in order for an individual to be eligible for MLR, the individual must:

> (1) Be eligible for direct care as defined in 42 CFR § 136.12
>
> (2) Reside within the U.S. on a Federally-Recognized Indian reservation; or
>
> (3) Reside within a [contract health service delivery area] and;

> (4) Be a member of the Tribe or Tribes located on that reservation; or
>
> (5) Maintain close economic and social ties with that Tribe or Tribes.

42 C.F.R. § 136.23(a); 42 C.F.R. § 136.12. And an individual is eligible due to his or her close economic ties with a tribe if:

> (1) The person is employed by a Tribe whose reservation is located within a CHSDA in which the person lives;
>
> (2) The person is married to or is the child of . . . an eligible member of the Tribe; or
>
> (3) The Tribe where the person resides determines and certifies that the person has close economic and social ties with the Tribe whose reservation is located within the CHSDA.

See, Indian Health Manual; Chapter 3- Contract Health Services, 2-3.6(C), INDIAN HEALTH SERVICE, *available at* http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p2c3#2-3.5C.

The requirements do not stop there. Becoming eligible for MLR is akin to seeking a referral from a primary care physician before seeing a specialist. That is, the MLR regulations utilize what is commonly referred to as a "purchase order system," which requires a tribal member to first obtain from a physician (or here, an "ordering official") a "purchase order" for the care and services to-be-rendered. Having the "purchase order" from the "ordering official" and presenting the same to a *non*-IHS facility (i.e., the treating hospital) then places the *non*-IHS facility on notice that the tribal member is entitled to MLR. And a failure to follow the

foregoing "purchase order" requirements makes it such that no payment will be made at a "Medicare-like rate."

More specifically, the regulations provide: "No payment will be made for medical care and services obtained from non-[IHS] providers or in non-[IHS] facilities unless the applicable requirements . . . have been met *and a purchase order for the care and services has been issued by the appropriate ordering official to the medical care provider*." 42 C.F.R. § 136.24(a) (emphasis added). In this case, the participants or beneficiaries did not receive healthcare treatment at IHS facilities (i.e., in Bemidji, Minnesota), otherwise the healthcare would have been free. Therefore, the participants and beneficiaries are presumed to have received their healthcare at *non*-IHS facilities in Michigan. As a result, all of the participants and beneficiaries were required to follow the foregoing "purchase order" regulations.

Further to the "purchase order" requirement, the applicable regulations state:

> In nonemergency cases, a sick or disabled Indian, an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if:
>
> > (1) Such notice and information are provided within 72 hours after the beginning of treatment or admission to a health care facility; and

> (2) The ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.
>
> In emergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services. The 72–hour period may be extended if the ordering official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply. [42 C.F.R. § 136.24(b), (c).]

In sum, and as the foregoing establishes, the Plan's participants and beneficiaries in this case were required to follow strict "purchase order" requirements before being considered eligible for MLR rates.

Here, Plaintiffs completely fail to allege that they met *any* of the foregoing requirements. For example, Plaintiffs do not allege that the participants received from the "appropriate ordering official" a "purchase order for the care and services." 42 C.F.R. § 136.24(a). And it is believed that Plaintiffs cannot make any such allegation. Instead of alleging facts that would allow this Court to conclude that Plaintiffs complied with federal law, Plaintiffs engage in a rote discussion of the enactment of the federal regulations applicable to MLR, alleging only:

> Since July 5, 2007, federal law has provided that Medicare-participating hospitals must accept as payment in full, for all levels of care furnished, no more than "Medicare-Like Rates" … as outlined in federal regulations, for services authorized by a Tribe or Tribal organization carrying out a … program of the IHS. [*See* Pls' Complaint, at ¶ 133].

Immediately following the foregoing allegation, Plaintiffs allege only that "BCBSM was aware" of these regulations and that BCBSM somehow "failed to ensure that Plaintiffs paid no more than MLR for MLR-eligible services." (*See* Pls' Complaint, at ¶134-135). This Court need not accept Plaintiffs' threadbare allegations as stating a claim.

Ultimately, Plaintiffs' allegations are entirely insufficient to establish that *Plaintiffs* met the requirements for MLR. Without alleging that they met federal requirements to be entitled to MLR, or even *discussing* those requirements, Plaintiffs fail to state a claim for which relief can be granted. Fed. R. Civ. P. 12(b)(6).

3. Dismissal is also required because the Plan is an "alternative resource" that must first be "exhausted" before participants and beneficiaries are deemed eligible for "Medicare-like rates"

Assuming a patient is in fact PRC-eligible (i.e., able to establish compliance with all federal law requirements), all of the patient's "alternate resources" must first be exhausted because, under federal law, the PRC program is the payor of last resort. 42 C.F.R. § 136.61. This means that the PRC program serves as a

supplemental payor for PRC-eligible patients who have other health insurance benefits available.

Federal regulations define "alternate resources" as follows:

> Alternate resources means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, *and private insurance*. [42 C.F.R. § 136.61 (emphasis added).]

Self-insured plans properly fall within the category of "private insurance" (emphasized immediately above), with even the IHS recognizing that "tribal self-insurance can be billed as an [alternative resource], unless the insurance plan contains an exclusionary clause designating it as residual to IHS." *Frequently Asked Questions*, Indian Health Service, http://www.ihs.gov/chs/index.cfm?module=chs_faq.[4] Accordingly, absent an "exclusionary clause" designating a plan as "residual" to IHS, a tribal self-insured

[4] A Tribal self-insurance plan is defined as "[a] health plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes payment for health services covered under the plan either directly or through an administrator." *See, Indian Health Manual; Chapter 3- Contract Health Services, 2-3.1(E)(22),* Indian Health Service*, available at http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p2c3#2-3.1E*. That is the situation here. (Pls' Complaint, at ¶¶ 6, 11).

healthcare plan is considered an "alternative resource" under federal regulations. *Id.*[5]

In this case, Plaintiffs fail to allege that the Plan contains an "exclusionary clause" designating the Plan as "residual" to IHS, and it is believed that Plaintiffs cannot make any such allegation for the reason that it would not be true. In turn, the Plan must first be "exhausted" (at *non*-MLR rates). For this reason, standing alone, Plaintiffs fail to state a claim for which relief can be granted. Fed. R. Civ. P. 12(b)(6).[6]

E. In The Alternative, And To The Extent The Plan Is Deemed To Be Governed By ERISA, Plaintiffs' State-Law Claims Are Preempted By ERISA

1. ERISA preemption

BCBSM asserts this argument in the alternative. That is, to the extent that it is found that the Plan is governed by ERISA, Plaintiffs' state law claims should be

[5] IHS' interpretation of its own regulation is "controlling unless plainly erroneous or inconsistent with the regulation," which is not the case here. *Auer v. Robbins*, 519 U.S. 452, 461; 117 S.Ct. 905 (1997) (citations and quotation marks omitted).

[6] Even if the Plan's beneficiaries and participants were in-fact entitled to MLR because they satisfied all federal-law requirements, and even if the Plan is not an "alternative resource," BCBSM could never be deemed a "fiduciary" within the meaning of ERISA. That is, BCBSM's processing of potentially MLR-eligible healthcare claims amounted to nothing more than "number crunching," which under the law does not give rise to a fiduciary duty. *See, Redall Indus., Inc. v. Wiegand,* 878 F. Supp. 1026, 1031 (E.D. Mich. 1995). Simply put, BCBSM never had the ability to determine whether each participant and beneficiary, when submitting a healthcare claim, followed all of the federal law requirements and was in-fact eligible for MLR.

dismissed because each state law claim parrots, relates-to, and/or relies exclusively upon the ERISA claims and is therefore preempted.

Congress enacted ERISA preemption to "avoid conflicting federal and state regulation and to create a nationally uniform administration of employee benefit plans." *Penny/Ohlmann/Neiman, Inc. v. Miami Valley Pension Corp.,* 399 F.3d 692, 698 ("*PONI*") (6th Cir. 2005). Both the Supreme Court and the Sixth Circuit have emphasized the broad scope of ERISA's "expansive pre-emption provision[]." *Aetna Health, Inc. v. Davilla,* 542 U.S. 200, 208 (2004). Indeed, "*virtually all* state law claims *relating* to an employee benefit plan are preempted by ERISA." *Cromwell v. Equicor-Equitable HCA Corp.,* 944 F.2d 1272, 1276 (6th Cir. 1991) (emphasis added). To accomplish such wide-ranging preemption, ERISA mandates that its provisions "shall supersede *any and all* State laws insofar as they . . . relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a), (b)(2)(B) (emphasis added).

In determining whether state-law claims "relate to" a covered plan, the Sixth Circuit "consider[s] the kind of relief that plaintiffs seek, and its relation to the pension plan." *Ramsey v. Formica Corp.,* 398 F.3d 421, 424 (6th Cir. 2005). The Sixth Circuit holds that state laws and their corollary causes of action relate to ERISA plans if they:

> (1) mandate employee benefit structures or their administration; (2) *provide alternative enforcement mechanisms*; or (3) bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself.

PONI, 399 F.3d at 698 (emphasis added).

Considering these principles, courts hold that a "state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Aetna Health, Inc.* 542 U.S. at 209. Accordingly, ERISA preempts state law claims that "implicate the relations among the traditional ERISA plan entities, including the principals, *the employer*, the plan, the plan fiduciaries, and the plan beneficiaries." *Lerner v. EDS Corp.,* No. 07-1730, 2009 WL 579345, at *5 (6th Cir. Mar. 9, 2009) (emphasis added). Ultimately, ERISA preempts claims when plaintiffs seek to enforce ERISA through "alternative enforcement mechanisms." *PONI,* 399 F.3d at 698*; see also Gresham v. Lumbermen's Mut. Cas. Co.,* 404 F.3d 253, 258 (4th Cir. 2005) (noting that "when a state law claim may fairly be viewed as an alternative means of recovering benefits allegedly due under ERISA, there will be preemption").

2. ERISA preempts Plaintiffs' statutory state law claims

Plaintiffs' statutory state law claims are subject to ERISA preemption because they arise out of the same operative facts as Plaintiffs' ERISA claims.

With respect to Count III of Plaintiffs' Complaint, Plaintiffs allege a violation of the Nonprofit Health Care Act, particularly citing Mich. Comp. Laws § 550.1211 and Mich. Comp. Laws § 550.1402. But courts in the Eastern District of Michigan have long held that such claims are expressly preempted under ERISA.

See, e.g., Foster v. BCBSM, 969 F. Supp. 1020, 1028 (E.D. Mich. 1997) ("Section 550.1402 … relates to an ERISA plan and is not saved from preemption.").

The same is true for Plaintiffs' claim under the Health Care False Claims Act (Count IV). *See Alma Products I, Inc. v. BCBSM,* No. 14-cv-13066; 2015 WL 1498881, at *6 (E.D. Mich. Mar. 31, 2015) (dismissing such a claim, noting: "as every court in this district to address the issue has found, these state-law claims 'arise out of the same operative facts as the ERISA claims,' and 'seek relief for the same conduct through 'alternative enforcement mechanisms.'")(citing *Hi-Lex Controls, Inc.* Nos. 11-12565; 11-12557, 2012 WL 3887438 at *10); *see also Dykema Excavators, Inc. v. BCBSM,* 77 F. Supp. 3d 646, 659 (E.D. Mich. 2015) (finding that the statutory state law claims, in addition to the rest of the plaintiffs' state law claims, "arise out of the same operative facts as the ERISA claims").

Accordingly, it is clear that ERISA preempts Plaintiffs' statutory state law claims such that they must now be dismissed. FRCP 12(b)(6).

3. ERISA preempts Plaintiffs' breach of contract/good faith and fair dealing claim

Count V of Plaintiffs' Complaint alleges that BCBSM breached the Administrative Services Contract and related Schedule A's by "(1) charging Hidden fees … (2) not reporting or otherwise disclosing the actual claims paid and administrative compensation it received; (3) overcharging administrative and stop-loss fees; and (4) submitting false and misleading quarterly and annual settlements." (Pls' Complaint, at ¶ 173). Plaintiffs cite the same alleged breaches to support their meritless claim for a breach of the "duty of good faith and fair

dealing." (Pls' Complaint, at ¶ 177). As Plaintiffs' breach of contract/good faith and fair dealing claims do nothing more than re-state their ERISA claims, they are preempted by ERISA.

Courts in the Sixth Circuit routinely dismiss breach of contract and good faith and fair dealing claims in ERISA actions, finding that such claims are at the very core of ERISA's regulation. For example, in *Cromwell,* 944 F.2d at 1275, employees who were participants of an employee benefit plan brought an action against the administrator of the plan alleging, among other claims, "breach of contract" and "breach of good faith." The Sixth Circuit was unequivocal in holding that ERISA preempted such claims, observing that the "appellants' state law claims are *at the very heart of issues within the scope of ERISA's exclusive regulation,* and if allowed, would affect the relationship between plan principals . . . ." *Id.* at 1276 (emphasis added). "Clearly," the court held, the "appellants' claims are preempted by ERISA." *Id. See also, Ciaramitaro v. Unum Life Ins. Co. of Am.,* No. 09-CV-13492, 2009 WL 3757046 (E.D. Mich. Nov. 6, 2009) (dismissing breach of contract / good faith and fair dealing claims because they were preempted by ERISA); *Bonewitz v. Cigna Corp.,* No. 3:14-cv-02281, 2015 WL 5794549, at *8 (M.D. Tenn. Oct. 2, 2015) (finding that the plaintiff's breach of contract claim was preempted where it "unmistakably relate[d] to the Plan because adjudication of this claim would require the court to assess the Plan and [the defendant's] performance pursuant to it").

Ultimately, Plaintiffs' breach of contract/good faith and fair dealing claims "duplicate[], supplement[], [and] supplant[]," their request for ERISA civil

remedies in this case. *Girl Scouts of Middle Tennessee, Inc. v. Girl Scouts of the U.S.A.,* 770 F.3d 414, 419 (6th Cir. 2015). They are accordingly preempted by ERISA.

4. ERISA preempts Plaintiffs' common law tort claims

ERISA similarly preempts Plaintiffs' common law tort claims. Count VI of Plaintiffs' Complaint alleges a breach of "common law fiduciary duty;" Count VII of Plaintiffs' Complaint alleges "conversion;" Count VIII of Plaintiffs' Complaint alleges "fraud/misrepresentation;" and Count IX of Plaintiffs' Complaint alleges "silent fraud." All of these claims necessarily relate to and duplicate Plaintiffs' ERISA-based allegations. Under Sixth Circuit precedent, it is "well-established that such state law tort claims are preempted by [ERISA]." *Ramsey,* 398 F.3d at 425.

Plaintiffs' "common law fiduciary duty" claim, which replicates all of their ERISA fiduciary duty allegations, is no exception. (*See* Pls' Complaint, at ¶ 183). Indeed, the Sixth Circuit regularly dismisses duplicative "fiduciary duty" claims. *See Cataldo v. United States Steel Corp.,* 676 F.3d 542, 557 (6th Cir. 2012) (finding that the plaintiffs' fiduciary duty claim, among other state law claims, was subject to preemption where the claims related to the pension plan and would "require the court to consider the plan documents to determine whether there had been any breaches of these state-law duties, a further indication that ERISA preempts these claims"); *Girl Scouts of Middle Tennessee,* 770 F.3d at 419

(affirming the dismissal of the plaintiffs' fiduciary duty claims where they "necessarily relate[d] to the ERISA benefit plan").

Plaintiffs' conversion claim, based on identical allegations as their ERISA claims, meets a similar fate, as the Sixth Circuit has held that such claims fall comfortably within the confines of ERISA preemption. *See Briscoe v. Fine,* 444 F.3d 478, 500 (6th Cir. 2006) (noting that this "court held that the conversion claim was preempted, explaining the plaintiff had 'merely attach[ed] new, state-law labels to the ERISA claims for breach of fiduciary duty and recovery of benefits, for the apparent purpose of obtaining remedies that Congress has chosen not to make available under ERISA" (citations omitted)). As Plaintiffs' "conversion" claim adopts the allegations housed in their ERISA claims, it is subject to preemption.

ERISA likewise preempts Plaintiffs' fraud and misrepresentation claims. For example, in *Briscoe,* 444 F.3d at 478, former employees in an ERISA plan brought an action against officers and directors of the employer, as well as the third-party administrator of the employer's health care plan, alleging that they violated their fiduciary duty under ERISA and committed "fraud, misrepresentation, and concealment," as well as conversion under state law. The defendants argued that ERISA preempted the plaintiffs' state law claims, and the court agreed, noting that the "torts of fraud, misrepresentation, and concealment" were simply "alternative enforcement mechanisms" of ERISA rights. *Id.* at 498 (citing *PONI,* 399 F.3d at 698)). "Perhaps most revealing" to the court was the "manner in which the plaintiffs ma[de] these allegations in their . . . complaint –

they simply 'incorporate[] by reference' the conduct that they claim violates ERISA." *Id.* at 498-499.

Here, and like the Plaintiffs' claims for "common-law fiduciary duty" and "conversion," Plaintiffs' "fraud/misrepresentation" (Count VIII) and "silent fraud" (Count IX) claims mirror the precise allegations of their ERISA claims. (*See e.g.* ¶ 198 of Pls' Complaint (alleging that BCBSM represented that it was "charging a smaller administrative fee than it was actually charging"); ¶ 210 of Pls' Complaint (alleging that BCBSM failed to disclose "it was charging 'Hidden Fees.'")). These are the exact claims which comprise Plaintiffs' ERISA claims and go "to the very heart of issues within the scope of ERISA's exclusive regulation." *PONI,* 399 F.3d at 701 n5. Plaintiffs' fraud and misrepresentation claims are therefore preempted under ERISA.

III. CONCLUSION

For the foregoing reasons, BCBSM respectfully requests that this Court dismiss Plaintiffs' Complaint in its entirety.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on December 14, 2015, I electronically filed the foregoing paper with the Clerk of the Court using the ECF system which will send notification of such filing to counsel of record.

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