UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

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

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 15-cv-13708

Honorable David M. Lawson

PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

Statutes

Rules

I. INTRODUCTION

Except for the argument that Plaintiffs' state law claims, pleaded in the alternative, are preempted by the Employee Retirement Insurance Security Act ("ERISA"), 29 U.S.C. §1001 *et seq.*, the motion filed by Defendant Blue Cross Blue Shield of Michigan ("BCBSM") lacks merit and should be denied.

Plaintiffs have pleaded claims under ERISA. To fall outside of ERISA, substantially all of the participants in the tribal plan must be engaged in essential governmental functions that are not commercial activities. Here, Plan members include casino, resort, and convenience store employees.

Regarding Plaintiffs' Medicare-Like Rate ("MLR") claims, BCBSM argues that the Complaint fails to establish "a number of federal statutory and regulatory conditions precedent." However, under Fed. R. Civ. P. 9(c), conditions precedent need only be alleged generally. Plaintiffs' Complaint satisfies this requirement, as it only addresses claims that were MLR-eligibile. Moreover, BCBSM misconstrues the MLR eligibility requirements and ignores that BCBSM had a fiduciary obligation to ensure that any conditions for MLR eligibility were being met. In any event, whether a particular claim among the thousands administered by BCBSM should have been paid at MLR rates or contractual rates is a fact-intensive inquiry not appropriate for adjudication on a motion to dismiss under Fed. R. Civ. P. 12(b)(6).

Finally, ignoring the fact that ERISA applies, the intermediate appellate decision in *Calhoun County v. BCBSM* does not require dismissal of the state law claims. Plaintiffs' Complaint includes factual allegations that were not before the court in *Calhoun County*, and raises legal theories never considered by the Michigan Court of Appeals.

II. STANDARD OF REVIEW

BCBSM has moved for dismissal pursuant to Fed. R. Civ. P. 12(b)(6). "The purpose of Rule 12(b)(6) is to allow a defendant to test whether, as a matter of law, plaintiff is entitled to legal relief if all the facts and allegations in the complaint are taken as true." *Bowlers' Alley, Inc. v. Cincinnati Ins. Co.*, 32 F. Supp. 3d 817, 820 (E.D. Mich. 2014) (Lawson J.) (quotation omitted). "Under Rule 12(b)(6), the complaint is viewed in the light most favorable to the plaintiff, the allegations in the complaint are accepted as true, and all reasonable inferences are drawn in the plaintiff's favor." *Id*. (quotations omitted).

"To survive a motion to dismiss, plaintiff must plead enough factual matter that, when taken as true, states a claim for relief that is plausible on its face. Plausibility requires showing more than the sheer possibility of relief, but less than a probable entitlement to relief." *Id*. at 821 (quotations omitted). "As long as a court can draw the reasonable inference that the defendant is liable for the

misconduct alleged, plaintiff's claims must survive a motion to dismiss." *Id.* (quotations omitted).

Regarding the sufficiency of the MLR allegations, "in pleading conditions precedent, it suffices to allege generally that all conditions precedent have occurred or been performed." *Id.* (quoting Fed. R. Civ. P. 9(c)).

III. THE PLAN IS GOVERNED BY ERISA

A. CONGRESS EXPRESSLY PROVIDED THAT ERISA APPLIES TO TRIBAL PLANS UNLESS SUBSTANTIALLY ALL COVERED INDIVIDUALS ARE ENGAGED IN ESSENTIAL GOVERNMENTAL FUNCTIONS THAT ARE NOT COMMERCIAL ACTIVITIES.

With limited exceptions, ERISA applies to a welfare benefit plan 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) by both." 29 U.S.C. § 1003(a)(1)-(3). Congress excluded from the scope of ERISA certain governmental plans. 29 U.S.C. § 1003(b)(1).

Prior to 2006, ERISA was silent as to whether it applied to welfare benefit plans maintained by Indian tribal governments. In 2006, Congress amended section 1002(32) of ERISA to say the "governmental plan" exception to ERISA excludes certain types of tribal benefit plans from ERISA. By definition, Congress expressly determined that tribal benefit plans not excluded by §1002(32) are subject to ERISA. A "governmental plan" is:

> 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).

A tribal plan is only exempted from ERISA if "substantially all" employment services of plan participants "are in the performance of essential governmental functions *but not in the performance of commercial activities*." *Id.* (emphasis added). Where many of the employees covered by the plan are engaged in commercial activities, the plan is subject to ERISA – even if those commercial activities might *also* be essential governmental functions. *Id.; see also Bolssen v. Unum Life Ins. Co. of Am.*, 629 F. Supp. 2d 878 (E.D. Wis. 2009) ("employee plans established and maintained by an Indian tribal government are exempt [from ERISA] only if substantially all of the employees' services are in the performance of essential government functions, as opposed to commercial activities – even if the commercial activities are essential government functions").[1]

[1] The express statement by Congress that ERISA governs tribal plans including employees engaged in commercial activities, "whether or not [those commercial activities also constitute] an essential government function," is very significant. The gaming activities of the Little River Band of Ottawa Indians ("LRBOI") undoubtedly have a commercial aspect. However, these gaming

Indeed, when Congress amended the definition of "governmental plan" in 2006, the Joint Committee on Taxation explained that a "governmental plan would not include a plan covering tribal employees who are employed by a hotel, casino, service station, convenience store, or marina operated by a tribal government." Joint Committee on Taxation, *Technical Explanation of H.R. 4, the "Pension Protection Act of 2006" as passed by the House on July 28, 2006, and considered by the Senate on August 3, 2006* (JCX-38-06), August 3, 2006, 109th Cong., 2nd Sess., at 244 (2006), **Ex. 1.** Congress expressly intended for ERISA to cover tribal plans that include employees of a casino.

Courts that have addressed this issue have also held that tribal plans covering casino employees are subject to ERISA. For example, in *Bolssen*, the Eastern District of Wisconsin determined that an Oneida tribal plan covering all employees was not exempt from ERISA because a number of employees worked in business enterprises for the tribe - a hotel, farm, retail store, and casino.

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activities are also *essential* to LRBOI's self-governance. Under the Indian Gaming Regulatory Act, net revenues from the casino must be used to fund the Tribe's governmental operations or programs, provide for the general welfare of the LRBOI and its members, promote Tribal economic development, support charities, or support the operations of local government. *See* 25 U.S.C. § 2710(b)(2)(B).

Congress has determined that, so long as many plan participants are engaged in commercial activities, the plan is governed by ERISA – even if those commercial activities are essential to the LRBOI's governmental function (such as its gaming activities).

Bolssen, 629 F. Supp. 2d at 882 (holding that a tribal plan with 1,324 business enterprise employees and 1,225 government employees was governed by ERISA)*; see also Dobbs v. Anthem Blue Cross & Blue Shield*, 600 F.3d 1275, 1285 (10th Cir. 2010)(noting that, in determining whether a tribal plan is exempt from ERISA, "the court must determine whether all plan participants are employees substantially all of whose services . . . are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential governmental function").

B. IT CANNOT BE INFERRED FROM THE COMPLAINT THAT SUBSTANTIALLY ALL INDIVIDUALS COVERED BY THE PLAN ARE ENGAGED IN ESSENTIAL GOVERNMENTAL FUNCTIONS THAT ARE NOT COMMERCIAL ACTIVITIES.

Plaintiffs "offer[] health care benefits to over 1,000 employees, other tribal members, elected officials, Little River Casino Resort employees, and Little River Trading Post employees through the Plan." Compl. ¶ 11 [Dkt #1]. The Plan includes casino (Little River Casino Resort) and convenience store (Little River Trading Post) employees and their dependents. *See id.*

Under a plain reading of the Complaint, many members of the Plan are employed to perform commercial activities. Indeed, this Court would have to make numerous implausible inferences in favor of BCBSM to conclude that substantially all of the Tribe's employees are engaged in essential governmental

functions that are not commercial activities. There is neither a factual or legal basis for this Court to do so.

This Court may also take judicial notice from the Sixth Circuit's decision in *Nat'l Labor Relations Bd. v. Little River Band of Ottawa Indians Tribal Gov't*, 788 F.3d 537 (6th Cir. 2015) ("*NLRB*") that 905 employees work for the casino and 245 employees work for the Tribe's other governmental departments. *NLRB*, 788 F.3d at 540. There is no dispute that many Plan participants are engaged in commercial activities.[2]

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[2] In *NLRB*, the Sixth Circuit found that LRBOI's casino is a commercial activity. *NLRB* 788 F.3d at 553. LRBOI has petitioned the United States Supreme Court for a writ of certiorari in *NLRB*. By citing *NLRB*, Plaintiffs do not suggest that the holding of *NLRB* – that the National Labor Relations Act ("NLRA") applies to employees working at LRBOI's casino – was correct.

In fact, the present case is distinguishable from *NLRB* on two important grounds. First, in amending the "governmental exception" to ERISA in 2006, Congress *expressly* abrogated tribal sovereignty over the regulation of tribal self-insured employee benefit plans that do not meet the "governmental exception," providing that ERISA applies to such plans. 29 U.S.C. §1002(32). This is in direct contrast to *NLRB*, which involved the applicability of the National Labor Relations Act ("NLRA") lacking any express statutory language evidencing congressional intent to regulate Indian tribes. *See NLRB*, 788 F.3d at 556 ("all agree that the [NLRA], the exclusive basis for the [NLRB's] exercise of jurisdiction in this case, is silent as to Indian tribes")(McKeague, J., dissenting); *compare Michigan v. Bay Mills Indian Cmty.*, ___ U.S. ___, 134 S. Ct. 2024, 2031-32 (2014)(enforcing the "enduring principle of Indian law" that Congress must "unequivocally express" its intent to limit tribal sovereignty).

Second, LRBOI has not made any legislative enactments governing health care benefit, so applying ERISA to the LRBOI's Plan does not infringe upon any Tribal enactment. In stark contrast, the LRBOI has enacted an extensive Fair

Taking all allegations in the Complaint as true, along with all reasonable inferences from those allegations, Plaintiffs have pleaded sufficient facts for this Court to conclude that its benefit plan is not excluded from ERISA.

IV. ERISA PREEMPTS STATE LAW CLAIMS

Plaintiffs agree with BCBSM's "alternative" argument that ERISA preempts Plaintiffs' state law claims. Other courts in this district have held that ERISA preempts hidden access fee claims brought by self-insured plans against BCBSM. *See Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, Nos. 11-12565, 11-12557, 2012 WL 3887438, at *4 (E.D. Mich. Sept. 7, 2012) (holding that *Calhoun County* was "irrelevant" to plaintiff's claims because plaintiff's claims were governed by ERISA, which pre-empted plaintiff's state law claims); *Lumberman's Inc. v. Blue Cross Blue Shield of Michigan*, No. 12-cv-15606, 2013 WL 1976157, at *4 (E.D. Mich. May 13, 2013) (same); *East Jordan Plastics, Inc. v. Blue Cross Blue Shield of Michigan*, No. 12-cv-15621, 2013 WL 1876117, at *5 (E.D. Mich. May 3, 2013) (same).[3]

Employment Practices Code ("FEPC") that directly conflicts with the NLRA in a number of areas, such that application of the NLRA to the Tribe directly infringes on the sovereignty of the Tribe. *NLRB* at 540-541.

Accordingly, this Court can hold that ERISA applies to the Plan without adopting the Sixth Circuit's holding in *NLRB*.

[3] Plaintiffs' state law claims were pleaded in the alternative, in case this Court were to conclude that the Plan is not governed by ERISA.

V. PLAINTIFFS MADE SUFFICIENT MEDICARE-LIKE RATES" ALLEGATIONS

A. BCBSM MISCHARACTERIZES PLAINTIFFS' COMPLAINT REGARDING THE "MEDICARE-LIKE RATES" CLAIMS.

Plaintiffs' self-insured health care plan covers more than 1,000 employees, along with their spouses and other dependents. Compl. ¶ 11 [Dkt #1]. BCBSM has administered the Plan since March 1, 2005. *Id*. ¶ 17. Thus, each year since 2005, BCBSM has administered many hospital claims for Plaintiffs.

Since July 5, 2007, federal law has required Medicare-participating hospitals to accept no more than "Medicare-Like Rates" ("MLR") for services authorized by a tribe carrying out a Contract Health Services program of the Indian Health Service. *See e.g.* 42 C.F.R. § 136.30; 42 U.S.C. § 1395cc(a)(i)(U); Compl. ¶ 133 [Dkt #1]. Plaintiffs carry out a Contract Health Services program for its Tribal citizens that live within the nine-county service area where the Tribe is authorized to provide Contract Health Services. Compl. ¶¶ 1, 4 [Dkt #1].

Plaintiffs are not alleging that BCBSM overpaid a few hospital claims since 2007. Rather, they allege a systematic failure on BCBSM's part to administer *any* hospital claims at lower MLR payment rates. *See* Compl. ¶ 135 [Dkt #1] ("Plaintiffs allege that "BCBSM failed to ensure that Plaintiffs paid no more than MLR for MLR-eligible services, instead using Plan assets to pay standard contractual rates on services that were eligible for lower MLR payment rates").

BCBSM continually failed to even consider whether any hospital expenses paid by the Plan should have been paid at the lower MLR rates.

Plaintiffs did not need to allege (and could not practically allege) the factual details regarding each hospital claim improperly administered by BCBSM. Factual development of specific claims will be necessary for Plaintiffs to prove the damages to which they are entitled. But such detail is not necessary in a complaint.

B. THE ALLEGED CONDITIONS PRECEDENT TO PLAINTIFFS' MLR CLAIMS HAVE BEEN SUFFICIENTLY PLED.

BCBSM argues that "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)." BCBSM Br. at 2-3 [Dkt #14]. The "myriad of federal statutory and regulatory requirements" BCBSM says are "condition[s] precedent" to Plaintiffs' claims include the following: (1) that each individual who received hospital treatment was a Tribal member residing within the nine-county service area; (2) that the hospital services were authorized by a "purchase order" from an "appropriate ordering official" representing the Tribe; and (3) that other "alternate resources" which might have covered the hospital claims had been exhausted.

BCBSM's argument ignores the liberal pleading rules regarding conditions precedent. "In pleading conditions precedent, it suffices to allege generally that all

conditions precedent have occurred or been performed." *Bowlers Alley, Inc.*, 32 F. Supp. 3d at 821 (quoting Fed.R.Civ. P. 9(c)). Plaintiffs' Complaint, taken as a whole, only seeks recovery for those hospital claims meeting MLR regulatory requirements. *See, e.g.*, Compl. ¶ 1 [Dkt #1] ("Since July 5, 2007, Plaintiff should have been paying no more than Medicare-Like Rates ('MLR') for levels of care furnished by Medicare-Participating hospitals *authorized by Plaintiffs'* carrying out of a Contract Health Services ('CHS') program") (emphasis added); ¶ 2 ("BCBSM has been collecting more than the Plaintiffs are required to pay *for MLR-eligible claims* and has paid Medicare-Participating hospital amounts in excess of MLR for such claims") (emphasis added); ¶ 135 ("BCBSM failed to ensure that Plaintiffs paid no more than MLR *for MLR-eligible services*, instead using Plan assets to pay standard contractual rates that were eligible for lower MLR payment rates"); ¶ 136 ("As a result, since July 5, 2007, Plaintiffs have been *overpaying for services eligible for lower MLR payment rates*"); ¶ 137 ("Plaintiffs did not discover that BCBSM had failed to ensure that Plaintiffs were paying no more than MLR *for MLR-eligible services* until 2015") (emphasis added).

It is clear from these allegations that Plaintiffs are seeking money for hospital claims that were "MLR eligible" (*i.e.*, for which all conditions precedent in the MLR regulations for MLR eligibility had been met). Plaintiffs are not

required to specifically allege each condition precedent for MLR eligibility in the Complaint.[4]

BCBSM's argument with regard to exhausting "alternate resources" is particularly unfounded. Exhaustion of "alternate resources" is an exception to MLR payment rates that is an affirmative defense, comparable to failure to mitigate damages or failure to exhaust administrative remedies. If some hospital claims among the thousands at issue in the Complaint could have been paid by "alternate resources" of insurance, they will come to light during discovery. It is not Plaintiffs' obligation to plead an absence of alternate resources for every claim at issue. Therefore, dismissing the Complaint under Rule 12(b)(6) is inappropriate.

C. BCBSM MISINTERPRETS THE CONDITIONS PRECEDENT TO A CLAIM BEING ELIGIBLE FOR MLR.

1. BCBSM Overstates the Significance of the "Purchase Order" Provision of 42 C.F.R. §136.24.

BCBSM reads the so-called "purchase order" provision of 42 C.F.R. § 136.24 too broadly and contrary to the context of the MLR regulations as a whole. Federal law states that MLR payment rates "appl[y] to all levels of care furnished by a Medicare-participating hospital . . . authorized by a Tribe or Tribal

[4] If the Court believes the Complaint would more clearly comply with Fed.R.Civ.P. 9(c) if it included a separate, general allegation that "all conditions precedent have occurred or been performed," Plaintiffs can easily amend the Complaint to include such a general allegation without having to delay adjudication of Plaintiffs' claims.

organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Pub. L. 93-638, 25 U.S.C. 450 *et seq*." 42 C.F.R. § 136.30(b). The only two conditions for MLR eligibility set forth in 42 C.F.R. § 136.30(b) are that (1) the services were provided at a Medicare-participating hospital; and (2) the services were authorized by a Tribe carrying out a CHS program.

Plaintiffs are suing to recover overpayment on hospital claims "*furnished by Medicare-Participating hospitals authorized by Plaintiffs'* carrying out of a Contract Health Services ('CHS') program." Compl. ¶1 [Dkt #1] (emphasis added); *see also id.* ¶5, 133 [Dkt #1]. The two conditions for MLR eligibility in 42 C.F.R. § 136.30(b) are alleged in the Complaint.

Moreover, the provision in 42 C.F.R. § 136.24 relating to purchase order authorizations does not require, as BCBSM suggests, that a purchase order authorizing services be issued by the Tribe before service is rendered. Nor do the regulations define what constitutes a "purchase order." Rather, Section 136.24 simply states that the Tribe's CHS administrator has to be notified that services are needed before services are provided or within 72 hours after the beginning of treatment in certain circumstances, and that a "purchase order" (an undefined term) must be issued before payment is made to the hospital. 42 C.F.R. § 136.24(a).

In any event, whether notice was provided and a "purchase order" issued regarding any particular claim, among the thousands of hospital claims administered by BCBSM, is a factual question that cannot be evaluated at this juncture.[5]

2. BCBSM Misconstrues the "Alternate Resource" Exception in 42 C.F.R. §136.61.

BCBSM also asserts that the Tribe's self-insured plan (or more accurately the Tribal dollars set aside to provide health care for Tribal employees) is itself an "alternate resource" that must be exhausted before MLR payment rates apply. This Court need not decide this issue in denying BCBSM's motion, but in any event the issue is not nearly as clear as BCBSM suggests.

42 C.F.R. § 136.61 is silent on whether Tribal funds are an "alternate resource." Indian Health Services has interpreted this regulation in a way that contradicts the argument advanced by BCBSM. In a document entitled "Medicare-Like Rates for CHS services (consolidated) FAQ" issued by IHS in May 2008, shortly after the MLR regulations went into effect, IHS specifically addressed the situation where a Tribe adds its own self-insured funds to federal funds provided to

[5] Indeed, in a similar case, *The Grand Traverse Band of Ottawa and Chippewa Indians and its Employee Welfare Plan v. BCBSM*, Case No. 14:cv-11349 (Levy, J.), the parties agreed to conduct discovery before presenting their competing perspectives on the meaning of the applicable MLR regulations through motions and supporting briefs. *See* **Ex. 2**.

the Tribe and pays health care claims from this pool of money. IHS advised Tribes that MLR rates would apply to all payments by the Tribe, "as long as the CHS pays for the services and follows the regulations that applies to CHS and client eligibility (42 C.F.R. Part 136)." 5/10/08 Medicare-Like Rates for CHS Services (Consolidated) FAQ, ¶ 11, **Ex. 3**.

Similarly, in a 2013 federal GAO report about expanding Medicare-Like Rates to non-hospital services that was reviewed and approved by IHS prior to publication, the GAO stated that "certain tribally funded insurance plans are not considered alternative resources and the CHS program must pay for care before billing the tribally funded insurance plan . . . ." *Indian Health Service – Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services*, at 11 n. 27, April 2013, http://www.gao.gov/products/GAO-13-272, **Ex. 4**.[6]

Requiring other tribal funds to be exhausted before hospital expenditures would be subject to MLR payment rates would be nonsensical. The federal government has a strong public policy interest in encouraging tribal governments to use their own financial resources to help pay healthcare expenses when tribal members do not have access to an IHS hospital. This is particularly true for tribes

[6] This statement in the GAD Report did not say that the Tribal plan must have an "exclusionary clause" rendering the plan "residual to IHS" in order to not be considered a "alternate resource."

such as LRBOI who have successful casino activities that could be used to help fund such expenses.

The federal government has limited resources to provide to tribal member who are not in close proximity to an IHS hospital. It therefore wants to encourage tribes to spend their tribal dollars on healthcare, both to minimize the financial burden on the federal government and to maximize the benefits available to tribal members who do not live close to an IHS hospital.

The interpretation advanced by BCBSM would do exactly the opposite. It would discourage tribes from using their own financial resources to help pay for healthcare rendered to tribal members, and would encourage tribes to rely solely on federal funding for such services.

In any event, the "alternate resource" issue again turns on the facts. It is not a purely legal issue. Accordingly, there is no basis to dismiss Plaintiffs' Complaint on this ground.

D. AS A FIDUCIARY, BCBSM WAS OBLIGATED TO ENSURE THAT THE PLAN COMPLIED WITH ANY CONDITIONS PRECEDENT TO MLR ELIGIBILITY TO PRESERVE PLAN ASSETS.

BCBSM ignores the significant fiduciary duties it owed to Plaintiffs in administering the Plan and preserving plan assets. "The duties charged to an ERISA fiduciary are the highest known to the law." *Chaw v. Hall Holding Co.*, 25 F.3d 415, 426 (6th Cir. 2002). ERISA imposes "strict fiduciary standards of care

in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries." *Acres v. Palmer*, 71 F.3d 226, 229 (6th Cir. 1995). This includes the "prudent person fiduciary obligation" from a fiduciary duty "which requires a plan fiduciary to act with the card, skill, prudence, and diligence of a prudent person acting under similar circumstances." *Pipefitters Local 636 Ins. Fund v. BCBSM*, 722 F.3d 861, 867 (6th Cir. 2013). Among the fiduciary duties BCBSM had as plan administrator was to "inform when the trustee knows that its silence might be harmful" to the plan. *Krohn v. Huron Mem'l Hosp.*, 173 F.3d 542, 551 (6th Cir. 1999).

In its role as fiduciary for the Plan, BCBSM knew about the MLR regulations and the Plan's entitlement to pay the lower of MLR payment rates or BCBSM's standard contractual rates for certain hospital claims. Compl. ¶134 [Dkt #1]. If Plaintiffs failed to perform or satisfy a condition precedent for MLR eligibility, that does not relieve BCBSM from liability. BCBSM had a fiduciary obligation to preserve plan assets, and thus to ensure that Plaintiffs were satisfying the conditions precedent for MLR eligibility, or at least to inform Plaintiffs that plan assets could be preserved if additional conditions for MLR eligibility were met.[7]

[7] This is particularly true if the condition precedent for MLR eligibility that was not met was something as simple as adding "magic words" to the plan documents to indicate that plan assets were residual to IHS. *See, e.g.*, BCBSM Br.

BCBSM's assertion that Plaintiffs did not meet all conditions precedent does not relieve BCBSM from liability for breach of fiduciary duty under ERISA. It actually demonstrates BCBSM breached its fiduciary duties in that regard. Thus, BCBSM's motion should be denied.

VI. ***CALHOUN COUNTY* IS INAPPLICABLE.**

This Court should not dismiss Plaintiffs' state law claims based on the Michigan Court of Appeals' decision in *Calhoun County v. Blue Cross Blue Shield of Mich.*, 297 Mich. App. 1 (2012). Under the *Erie* doctrine, when interpreting state law, the federal court must apply state law in accordance with decisions of the highest state court. *Erie R.R. Co. v. Tompkins*, 304 U.S. 64 (1938). If the state's highest court has not ruled on an issue, the federal court must decide the issue based on how it believes that court would rule. *Meridian Mutual Ins. Co. v. Kellman*, 197 F.3d 1178, 1181 (6th Cir. 1999). This Court may look to state intermediate court opinions and other federal court opinions for guidance; however, it is not bound by those courts' rulings. *Rutherford v. Columbia Gas*, 575 F.3d 616, 620 (6th Cir. 2009).

Calhoun County does not involve a novel legal issue. Rather, it applies well-established legal principles to the particular facts that were before the court in that particular case. In *Calhoun County*, the plaintiff, a governmental entity,

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at 16-17 [Dkt #14].

contracted with BCBSM to manage its self-insured healthcare plan. *Calhoun County*, 297 Mich. App. at 4. The court's attention in *Calhoun County* was on whether access fees could not be charged because the ASC did not identify a specific dollar amount or specific formula for calculating access fees. *Id.* at 17–19.[8]

In finding the access fee provision in the ASC enforceable, the Michigan Court of Appeals stated that "[a]lthough the contract does not have a specific price for the access fee, it is nonetheless binding on the parties because the promises and performances to be rendered by each party are set forth with reasonable certainty." *Id.* at 18 (quotation omitted). Specifically, the court found that both parties had agreed to the access fees because the ASC referred to calculating the access fee amounts in conformity with BCBSM's "standard operating procedures." *Id.* at 19. Although not expressly stated in the ASC (or Schedule A attachment to the ASC), the court found that, if the plaintiff wanted to determine the access fee amount, it could do so by reference to BCBSM's standard operating procedures. *Id.*

The premise underlying *Calhoun County* is that BCBSM's access fees were permissible because the methodology for calculating them, while not defined

[8] The ASC also has a supplement, referred to as a Schedule A, that is updated annually to reflect adjustments to the fees for BCBSM's administration services plan. The Schedule A's do not reference a specific dollar amount or methodology for calculation of access fees. *Calhoun County*, 297 Mich. App. at 17-19.

anywhere in the ASC, was defined in an outside document, -- BCBSM's standard operating procedures. Significantly, the plaintiff in *Calhoun County* did not contest whether BCBSM had "standard operating procedures" from which the amount of the access fees could be calculated. *Id.* at 20.

In stark contrast, Plaintiffs vigorously contest whether BCBSM had any standard operating procedures from which the access fees charged to Plaintiffs could be calculated. In fact, on the *same day* the intermediate appellate court issued its decision in *Calhoun County*, counsel for Plaintiffs deposed a corporate representative of BCBSM in the *Hi-Lex* matter. Counsel specifically questioned BCBSM as to whether BCBSM had any "standard operating procedures" from which the amount of the access fees could be calculated.

BCBSM's corporate representative testified that there were no separate "standing operating procedures" governing access fees, and that the only BCBSM document governing access fees was the ASC and Schedule A, neither of which included any amount or methodology for calculating access fees:

> Q. But in my experience it's common for an employer or an organization to have standard operating procedures that are written down somewhere, kept in a book, maybe in the president's office or in the H.R. director's office, or whatever, that are the rules that apply to that company. Is there anything like that relative to the issue of access fees?
>
> A. It's in the Schedule A.
>
> Q. Okay.

A. As well as the ASC contract.

Q. Okay. So whatever the standard operating procedures are, whether they are truly standard or whether they are unique for a particular customer in a particular year, they will be in the combination of the ASC and the Schedule A?

A. That is correct.

Q. I don't need to look anywhere else?

A. That's correct.

Q. Okay.

A. That's the document that's signed by the customer.

6/5/12 Corporate Deposition of BCBSM in *Hi-Lex Controls Inc. v. Blue Cross Blue Shield of Michigan*, 23:19-24:14, **Ex. 5**.[9]

In short, Plaintiffs are prepared to present facts to this Court that are fundamentally different than the facts before the court in *Calhoun County* and the other cases cited by BCBSM. These Michigan intermediate court opinions do not address or consider the additional facts alleged by Plaintiffs in this case that were not alleged by the plaintiffs in *Calhoun County* or the other Michigan Court of Appeals cases cited by BCBSM. At a minimum, whether the access fees charged to Plaintiffs by BCBSM constitutes a breach of contract or fiduciary duty is a fact

[9] Indeed, the federal courts that have interpreted the ASC, have had a very different view of whether the ASC included any amout or methodology for calculating access fees. *See*, *e.q.*, *Hi-Lex Controls Inv. V. BCBSM*, No. 2:11-cv-12557, Corrected Findings of Fact and Conclusions of Law at 11, ¶ 33 ("BCBSM had complete discretion to determine the amount of the Disputed Fees, as well as which of its customers paid them")(Roberts, J.), **Ex. 6**.

question to be resolved at trial (or on summary judgment), not a legal question to be resolved on a motion to dismiss pursuant to Fed. R. Civ. P. 12(b)(6).

Moreover, the *Calhoun County* decision does not address a number of the legal theories in Plaintiffs' Complaint. Plaintiffs alleged a number of state law claims, including violations of the Nonprofit Health Care Act (Count III) and Health Care False Claims Act (Count IV), and breaches of the duty of good faith and fair dealing (Count V), conversion (Count VII), fraud/misrepresentation (Count VIII), and silent fraud (Count IX), that were not considered in Calhoun County or the other cases cited by BCBSM. Plaintiffs' Complaint also includes a host of factual allegations supporting these counts that were not made by the plaintiffs in *Calhoun County* or the other cases cited by BCBSM.

The Michigan Court of Appeals opinions cited by BCBSM are devoid of any discussion, much less any holdings, concerning these other legal theories upon which Plaintiffs base their claims. The decisions of the Michigan Court of Appeals in *Calhoun County* and the other cases cited by BCBSM, which relied on *Calhoun County*, do not warrant dismissal of Plaintiffs' claims in this case.

VII. CONCLUSION

For the foregoing reasons, Defendant's Motion to Dismiss should be granted in part and denied in part. Defendant's Motion should be granted in part on its

"alternative" grounds, as Plaintiffs' claims are governed by and preempted by ERISA. In all other respects, Defendant's Motion to Dismiss should be denied.[10]

Respectfully submitted,

VARNUM

Attorneys for Plaintiffs

Dated: January 14, 2016

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CERTIFICATE OF SERVICE

I hereby certify that on January 16, 2016, 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.

By: s/ Bryan R. Walters

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[10] In the alternative, Plaintiffs should be afforded the opportunity to file an amended complaint to address any deficiencies the Court identifies in the Complaint.