UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

SAGINAW CHIPPEWA INDIAN TRIBE OF MICHIGAN, and ITS WELFARE BENEFIT PLAN,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 1:16-cv-10317-TLL-PTM

Hon. Thomas L. Ludington

BLUE CROSS BLUE SHIELD OF MICHIGAN'S MOTION TO DISMISS

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, with prejudice, of Counts I, IV and VI of Plaintiffs' First Amended Complaint (Dkt. #7), which on remand assert claims regarding only "Medicare-like rates."

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, BCBSM sought concurrence in the instant relief and Plaintiffs denied the same.

WHEREFORE, BCBSM respectfully requests that this Court enter an Order granting this Motion and awarding to BCBSM such other relief as the Court deems just and proper.

Respectfully submitted,

DICKINSON WRIGHT PLLC

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Dated: January 29, 2019

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BRIEF IN SUPPORT OF BLUE CROSS BLUE SHIELD OF MICHIGAN'S MOTION TO DISMISS

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ISSUES PRESENTED

1. Should Plaintiffs' ERISA claim (Count I) be dismissed because it is time-barred under ERISA's six-year statute of repose?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

2. Should Plaintiffs' Health Care False Claim Act claim (Count IV) be dismissed where: (a) Plaintiffs do not have statutory standing; (b) it is undisputed that BCBSM did not "present or cause to be presented" any "claims" to Plaintiffs—a condition precedent to any possible liability; and (c) the Legislature enacted the HCFCA to protect BCBSM, not to impose liability upon BCBSM, and Plaintiffs' interpretation to the contrary produces an absurd result?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

3. Should Plaintiffs' Breach of Common Law Fiduciary Duty claim (Count VI) be dismissed where the parties' Administrative Services Contract authorized BCBSM to process claims at something *other than* MLR?

   BCBSM answers: Yes.

   Plaintiffs answer: No.

CONTROLLING OR MOST APPROPRIATE AUTHORITY

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

McGuire v. Metro. Life Ins. Co., 899 F. Supp. 2d 645 (E.D. Mich. 2012)

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Statutes

I. INTRODUCTION

This Court knows well the history of this case, including: (a) the difference between the Member Plan and the Employee Plan; (b) Plaintiffs' claims regarding BCBSM's alleged failure to apply Medicare-like rates ("MLR"); (c) the Sixth Circuit's decision affirming this Court's holding that ERISA does not apply to the Member Plan because the Tribe established and maintained it for tribal members regardless of their employment status; and (d) the Sixth Circuit's holding that Plaintiffs stated a cognizable ERISA claim relative to the Employee Plan and MLR.

In light of the Sixth Circuit's decision, Plaintiffs are proceeding on remand with three claims—one ERISA claim (applicable to only the Employee Plan) and two state-law claims (applicable to only the Member Plan), each bearing upon BCBSM's alleged failure to apply MLR:

- Breach of Fiduciary Duty – ERISA (Count I)
- Health Care False Claim Act (Count IV)
- Breach of Common Law Fiduciary Duty (VI)

See Dkt. # 141. BCBSM now seeks dismissal of each.

Plaintiffs' ERISA claim must be dismissed because it is barred by ERISA's six-year statute of repose. 29 U.S.C. § 1113(1). Here, Plaintiffs assert that, "since July 5, 2007," they "have been overpaying for services eligible for lower MLR

payment rates" because BCBSM—in ostensibly breaching its fiduciary duty—made a decision not to apply MLR once available. Plaintiffs' First Amended Complaint ("FAC"), Dkt. #7, at ¶¶ 134-139. But under ERISA's six-year statute of repose, Plaintiffs thus had until July 5, 2013 to file their lawsuit. That makes Plaintiffs' January 29, 2016 lawsuit untimely. Dismissal of Count I is thus required.

Plaintiffs' Health Care False Claim Act ("HCFCA") claim must be dismissed for three independent reasons. First, Plaintiffs do not have statutory standing under the HCFCA because Plaintiffs are not "health care insurers." Second, it is undisputed that BCBSM did not "present or cause to be presented" any "claims" to Plaintiffs—a condition precedent to any possible liability under the HCFCA. Rather, BCBSM "administer[ed] the Plan by paying . . . health care claims," *i.e.*, "BCBSM would process and pay" claims, not present them. Plaintiffs' FAC, Dkt. #7, at ¶¶ 20-21. Third, the Legislature enacted the HCFCA to *protect* BCBSM, not to impose liability upon BCBSM. Plaintiffs' interpretation to the contrary produces an absurd result not intended by the Legislature.

Last, Plaintiffs' Breach of Common Law Fiduciary Duty claim must be dismissed because the parties' Administrative Services Contract ("ASC") authorized BCBSM to process claims at something *other than* MLR. Under

Michigan law, that contractual authorization bars a state-law, breach of fiduciary duty claim.

For these reasons, and as further articulated below, this Court should, respectfully, grant BCBSM's Motion.

II. LEGAL ARGUMENT

A. Standard Of Review

A party may move to dismiss a claim when a plaintiff failed "to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). In ruling on a motion to dismiss, the Court "must construe the complaint in a light most favorable to [the] plaintiffs" and "accept all well-pled factual allegations as true." *Bishop v. Lucent Techs., Inc.*, 520 F.3d 516, 519 (6th Cir. 2008).

"To state a valid claim, a complaint must contain either direct or inferential allegations respecting all the material elements to sustain recovery under some viable legal theory." *League of United Latin Am. Citizens v. Bredesen*, 500 F.3d 523, 528 (6th Cir. 2007). "While a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations, . . . a plaintiff's obligation to provide the 'grounds' of his 'entitle[ment] to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555; 127 S. Ct. 1955; 167 L. Ed. 2d 929 (2007).

B. Plaintiffs' ERISA Claim Is Barred By ERISA's Statute Of Repose

"A statute of repose does not focus on the injured party; instead it measures time from a culpable act of the putative defendant." *Dykema Excavators, Inc. v. BCBSM*, 77 F. Supp. 3d 646, 653 (E.D. Mich. 2015) (citation omitted) (Lawson, J.). "It establishes a cutoff, which is in essence an absolute bar on a defendant's temporal liability." *Id.* (citation and quotation omitted).

Applicable here is ERISA's six-year statute of repose, which provides:

> No action may be commenced . . . with respect to a fiduciary's breach of any responsibility, duty, or obligation . . . *six years after . . . the date of the last action which constituted a part of the breach or violation.*

29 U.S.C. § 1113(1) (emphasis added). This statute of repose "effects a legislative judgment that a defendant should be free from liability after the legislatively determined [six-year] period of time." *Dykema Excavators*, 77 F. Supp. 3d at 655. (citation and quotation omitted).

Notably, ERISA's six-year statute of repose "runs from the original wrongful act and is not restarted each time a plaintiff suffers incremental, additional injury flowing from the same event." *McGuire v. Metro. Life Ins. Co.*, 899 F. Supp. 2d 645, 662 (E.D. Mich. 2012) (Ludington, J.) (adopting this analysis as "sound"). Or, in the words of the Sixth Circuit, "a continuing violation [for which a defendant can be held liable] is occasioned by continual unlawful acts, *not*

continual ill effects from an original violation." *Medical Mut. of Ohio v. k. Amalia Enters. Inc.*, 548 F.3d 383, 394 (6th Cir. 2008) (emphasis added).

Critical to this case is the Sixth Circuit's recognition that "individual medical claims [do] not count as discrete wrongs" where they "merely perpetuate[ ] the harm from the original wrong." *Id.* With that in mind, the Sixth Circuit concluded in *Medical Mut. of Ohio* that the "claim accrued when [the insurer] first began paying out benefits for . . . treatment," and rejected the "argument that several of the relevant payments [still] fell within the limitations period." *Id.*; *Accord, McGuire*, 899 F. Supp. 2d at 662 ("The fact that Defendant calculated dividends each later year uniformly applying the new methodology does not constitute a new violation."); *Olivo v. Elky*, 646 F. Supp. 2d 95, 102 (D.C.D.C. 2009) ("The Court concludes that a continuing violation [under ERISA] should not be recognized where, as here, there was no clear affirmative duty that was breached multiple times, but instead only continuing effects of an initial breach.") (citations omitted). Simply put, incremental, additional injury flowing from a single event does not re-start ERISA's statute of repose.

In this case, Plaintiffs allege that, "since July 5, 2007, Plaintiffs have been overpaying for services eligible for lower MLR payment rates," reasoning that BCBSM made a decision not to apply MLR once MLR became available. Plaintiffs' FAC, Dkt. #7, at ⁋ 139. For example, Plaintiffs have argued:

> Choosing to pay for health care claims at the rate BCBSM negotiated with the hospital, rather than the lower Medicare-Like Rate available to the Plan, was a decision BCBSM made on behalf of the Plan. BCBSM's decision was imprudent and not in Plaintiffs' best interest. [Plaintiffs' Brief in Support of Motion for Reconsideration, Dkt. #24, at p. 17].
>
> BCBSM was fully aware of the Medicare-Like Rate discounts available to Plaintiffs, yet routinely and systematically caused Plaintiffs to pay higher standard contractual rates [for claims] that were eligible for a lower Medicare-Like Rate from the providing hospital. BCBSM squandered millions of dollars of Plan assets as a result. [Plaintiffs' Brief on Appeal, Dkt. #17, at p. 49.]

In short, Plaintiffs posit that BCBSM's decision not to apply MLR caused "a systematic and repeated overpayment of health care claims." Plaintiffs' Brief in Support of Motion for Reconsideration, Dkt. #24, at p. 2.

In applying ERISA's six-year statute of repose and cases interpreting same, it becomes clear that Plaintiffs' claim accrued in July 2007. That is when: (a) MLR became available; and (b) notwithstanding MLR's availability, BCBSM continued to uniformly process claims "at the rate BCBSM negotiated with hospitals" (instead of at MLR). Under this Court's decision in *McGuire*, "[t]he fact that [BCBSM] calculated [medical claims] each later year uniformly applying the [rate negotiated with the hospitals] does not constitute a new violation." *McGuire*, 899 F. Supp. 2d at 662. That is, the "individual medical claims [do] not count as discrete wrongs." *Medical Mut. of Ohio*, 548 F.3d at 394. Accordingly,

Plaintiffs had until July 2013 to file their lawsuit, *i.e.*, six years after: (a) MLR became available; and (b) BCBSM nevertheless continued to process claims at something other than MLR. Because Plaintiffs did not file until January 2016, Plaintiffs' claim is time-barred.

Based on the foregoing, Count I is time-barred by ERISA's statute of repose and must be dismissed. 29 U.S.C. § 1113(1). To hold otherwise would be to count each individual medical claim as a "discrete wrong," which is inconsistent with the law in this Circuit.[1]

[1] 29 U.S.C. § 1113(2) also permits an action to be brought within "three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation." However, the statute expressly requires application of the "earlier" of the three-year "actual knowledge" or six-year repose periods. Thus, even if Plaintiffs did not have "actual knowledge" until after the six-year repose period expired, that would not save their ERISA claim (because the "earlier" period would still be the six-year statute of repose). And while there is an exception "in the case of fraud or concealment," allowing the action to be "commenced not later than six years after the date of discovery of such breach or violation," Plaintiffs do not allege "fraud or concealment" with respect to MLR. *See* Plaintiffs' FAC, Dkt. #7, at ¶¶ 134-41. Rather, they allege only that BCBSM "fraudulently concealed" that it charged the so-called "Hidden Fees" at issue in *Hi-Lex Controls, Inc., v. BCBSM*, No. 11-cv-12557 (E.D. Mich.). *See* Plaintiffs' FAC, Dkt. #7, at ¶ 148 (citing Judge Roberts' findings of fact and the Sixth Circuit's opinion in *Hi-Lex*). *Hi-Lex* has nothing to do with BCBSM's alleged failure to apply MLR to Plaintiffs' medical claims.

C. Plaintiffs' HCFCA Claim Must Be Dismissed For Three Independent Reasons

1. Plaintiffs lack statutory standing

When the Michigan Legislature enacted the HCFCA, the Legislature expressly limited the possible plaintiffs to "health care corporation[s]" and "heath care insurer[s]":

> . . . 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 heath care insurer* for the full amount of the benefit or payment made. [M.C.L. § 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.*, 481 Mich. 601, 607; 751 N.W.2d 463 (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.* (internal quotations, modifications and citations omitted).

Plaintiffs here erroneously seek to satisfy statutory standing by alleging that they "are *health care insurers* as defined by M.C.L. § 752.1009." Plaintiffs' FAC, Dkt. #7, at ¶ 166 (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*." M.C.L. § 752.1002(f) (emphasis added). That is why

Plaintiffs' HCFCA claim fails: In the context of the Member Plan – the only Plan at issue regarding the HCFCA claim – Plaintiffs are *not* providing health care benefits to individuals due to their "employee" status. Rather, as the Sixth Circuit explained:

> The stumbling block for the Tribe is that it did not establish or maintain the Member [Plan] with the intent of providing benefits to its employees. As we have already noted, the employment status of the individuals who received coverage under this policy was irrelevant, since coverage depended entirely on whether an individual was a member of the Tribe. [*Saginaw Chippewa Indian Tribe of Michigan v. BCBSM*, No. 17-1932, 2018 WL 4183717, *5 (6th Cir. Aug. 30, 2018).]

Notwithstanding the foregoing, Plaintiffs will certainly argue that they enjoy statutory standing because certain of the individuals within the Member Plan also happen to be employees.[2] But that analysis would improperly distort the HCFCA's "employee" requirement.

As this Court knows, "[i]n reviewing [a] statute's language, every word should be given meaning, and [courts] should avoid a construction that would render any part of the statute surplusage or nugatory." *Wickens v. Oakwood*

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[2] The record in this case established the undisputed fact that employees accounted for only approximately 5% to 9% of the participants in the Member Plan from 2007 to 2014. *See* BCBSM's Motion for Partial Summary Judgment, Dkt. #79, at Exhibit 22 (Analysis of Non-Employee Members in Member Plan). *Cf. Saginaw Chippewa Indian Tribe of Michigan, et al v. BCBSM*, No. 16-cv-10317, 2017 WL 3007074, *12 (E.D. Mich. July 14, 2017) ("The vast majority of participants in the Member Plan are not Tribe employees.").

Healthcare Sys., 465 Mich. 53, 60; 631 N.W.2d 686 (2001) (citation omitted). Michigan also recognizes "the principal of *expressio unius est exclusio alterious* — express mention in a statute of one thing implies the exclusion of other similar things." *Stowers v. Wolodzko*, 386 Mich. 119, 133; 191 N.W.2d 355 (1971). Application of these principles requires perspicacious attention to both the meaning and the placement of the following words contained in the HCFCA's definition of *health care insurer*: "providing health care benefits to its employees." M.C.L. § 752.1002(f) (emphasis added).

Analysis of both the meaning and the placement of "to its employees" leaves but one conclusion: In the context of a "health care insurer," the "claims" at issue must be for "health care benefits" provided to "employees," *i.e., not* "persons" irrespective of employment status. Indeed, that the Legislature used the word "employees" instead of "persons" is no accident. "Person" is defined by the HCFCA to mean an "individual," without limitation on the individual's employment status. M.C.L. § 752.1002(i). And, the Legislature used "person" 49 different times in the HCFCA (excluding the definition itself). Conversely, the Legislature used "employees" just once – when defining "health care insurer." M.C.L. § 752.1002(f). Stated differently, the Legislature's express mention of "employees" implies the exclusion of other similar things, *i.e.,* other "persons." *Stowers*, 386 Mich. at 133.

Also illustrative is that the HCFCA defines "claim" as "any attempt to cause a . . . *health care insurer* to make the payment of a health care benefit." M.C.L. § 752.1002(a) (emphasis added). The HCFCA similarly defines "health care benefit" as "the right under a contract . . . to have a payment made by a . . . *health care insurer* for a specified health care service." M.C.L. § 752.1002(d) (emphasis added). As this Court will notice, embedded within the definition of both "claim" and "health care benefit" is the emphasized, statutorily-defined term "health care insurer." Thus, the HCFCA's definitions of "claim" and "health care benefit" actually contain the "employees" limitation:

"Claim"

> [A]ny attempt to cause [any legal entity which is self-insured and providing health care benefits **to its employees**] to make the payment of a health care benefit.

M.C.L. § 752.1002(a) (emphasis added).

"Health Care Benefit"

> [T]he right under a contract . . . to have a payment made by [any legal entity which is self-insured and providing health care benefits **to its employees**] for a specified health care service.

M.C.L. § 752.1002(d) (emphasis added).

Indeed, M.C.L. § 752.1009, the statutory provision upon which Plaintiffs ostensibly rely to hold BCBSM liable, thrice has embedded within it the

"employees" limitation through its own use of "claim," "benefit," and "health care insurer":

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

M.C.L. § 752.1009 (emphasis added).

The foregoing analysis makes it readily apparent that, in the context of a "health care insurer," statutory standing exists only for "claims" relating to "health care benefits" provided "to employees." Why else include the term "employees"?

In short, because here Plaintiffs' HCFCA claim is contingent entirely upon the providing of health care benefits to *tribal members* irrespective of employment status (otherwise there could be no MLR), Plaintiffs do not have statutory standing. Plaintiffs thus failed to state a claim upon which relief can be granted, warranting dismissal of Count IV. *Roberts v. Hamer*, 655 F.3d 578, 581 (6th Cir. 2011) ("Where a plaintiff lacks statutory standing to sue, her claim should be dismissed for failure to state a claim upon which relief can be granted.").

2. BCBSM did not "present or cause to be presented" any claim(s)

Even if Plaintiffs could clear their statutory-standing hurdle, Plaintiffs' HCFCA claim still fails because Plaintiffs admit that BCBSM did not "present or cause to be presented a claim," which is required before liability can be triggered

under M.C.L. § 752.1009. *See* M.C.L. § 752.1009 (requiring that a "person . . . knowingly present[ ] or cause[ ] to be presented a claim which contains a false statement.")

It is here undisputed that BCBSM – not Plaintiffs – processed and paid the claims in question. Put differently, the claims were "presented" *to* BCBSM by medical providers / participants / beneficiaries, and BCBSM thereafter paid them. Under the parties' ASC, Plaintiffs were then obligated to *reimburse* BCBSM for the claims paid:

> BCBSM will *process and pay*, and [Plaintiffs] will *reimburse* BCBSM for [the amount Plaintiffs owe in accordance with BCBSM's standard operating procedures for payments] related to [Plaintiffs'] claims. [**Exhibit 1**, at Art. II, ¶ C.][3]

Consistent with this framework, Plaintiffs' FAC alleges the following:

> . . . BCBSM agreed to administer the Plan by paying . . . health care claims on behalf of the Plan, using money provided to it by SCIT.
>
> . . . The parties agreed that BCBSM would process and pay, and SCIT would reimburse BCBSM for all . . . claims.
>
> ***
>
> Plaintiffs *reimbursed* BCBSM for health care services [BCBSM] paid on behalf of [Plaintiffs]. [Plaintiffs' FAC, Dkt. #7, at ¶¶ 20, 21, and 167 (emphasis added).]

[3] The ASC is properly considered by this Court under Rule 12(b)(6) because Plaintiffs' FAC makes multiple references to same. *Ohio Pub. Emps. Ret. Sys. v. Fed. Home Loan Mortg. Corp.*, 830 F.3d 376, 383 (6th Cir. 2016).

Thus, according to Plaintiffs' own pleading, BCBSM did not "present or cause to be presented" any claims to Plaintiffs, and thus cannot be liable under the express terms of the statute. Count IV of Plaintiffs' FAC must thus be dismissed.

3. Holding BCBSM liable under the HCFCA would be an absurd result

It is a well-established principle that "statutes must be construed to prevent absurd results." *People v. Tennyson*, 487 Mich. 730, 741; 790 N.W.2d 354 (2010) (citation and quotations omitted). "The absurd results rule demonstrates a respect for the coequal Legislative Branch, which [courts] assume would not act in an absurd way." *Id.* at n.6 (citation and quotations omitted).

Important here is that "[t]he Legislature enacted the HCFCA to extend to private insurers and health care corporations . . . protections against fraud." *People v. Motor City Hosp. and Surgical Supply, Inc.*, 227 Mich. App. 209, 213; 575 N.W.2d 95 (1997). That is to say, the Legislature enacted the HCFCA to *protect* BCBSM (a health care corporation) from unscrupulous providers, not to impose liability upon BCBSM. Indeed, when opining on the HCFCA's intent, the *Motor City* court relied upon and cited the House Legislative Analysis used to support enactment of the HCFCA, which itself makes express reference to BCBSM:

> Private insurance companies and health care corporations *(Blue Cross-Blue Shield,* health maintenance organizations, etc.) are also victims of fraudulent claims, but their only remedies [before enactment of the HCFCA] are civil actions or attempts to prosecute under

> general fraud statutes. Some people think that these institutions should have the same protections afforded to the [Department of Social Services under the already-enacted Medicaid False Claim Act]. [House Legislative Analysis, HB 5102 & 5103, December 19, 1984, attached as **Exhibit 2** (emphasis added); *Motor City*, 227 Mich. App. at 213.]

Based on the foregoing, it is no coincidence that when enacting the HCFCA the Legislature included BCBSM within the definition of a "health care corporation," *i.e.,* the Legislature vested BCBSM with statutory standing: "a consolidated hospital service corporation and medical care corporation incorporated or reincorporated under Act No. 350 of the Public Acts of 1980." M.C.L. § 752.1002(e). BCBSM indisputably held that defined legal status: (a) in 1985 when the Legislature enacted the HCFCA; and (b) at all "times relevant to [Plaintiffs'] Complaint," a fact alleged by Plaintiffs. Plaintiffs' FAC, Dkt. #7, at ‖ 8. The Legislature also defined "claim" as an "attempt to cause a *health care corporation [BCBSM]* . . . to make the *payment* of a *health care benefit*." M.C.L. § 752.1002(a) (emphasis added). That is what BCBSM did in this case—paid health care benefits (claims).

A "[c]ourt reads the provisions of statutes reasonably and in context," and "nothing may be read into a statute that is not within the manifest intent of the Legislature as derived from the act itself." *Detroit Pub Schs v. Conn*, 308 Mich. App. 234, 248-49; 863 N.W.2d 373 (2014) (citation and quotations omitted).

Again, the Legislature enacted the HCFCA to protect BCBSM, not to impose liability upon it. What Plaintiffs now seek is opposite of that. Because holding BCBSM liable under the HCFCA would lead to an absurd result, Plaintiffs failed to state a claim and Count IV should be dismissed.

D. Plaintiffs' Breach Of Common Law Fiduciary Duty Claim Must Be Dismissed Because The Parties' ASC Authorized BCBSM To Process Claims At Something *Other Than* MLR

Plaintiffs failed to state a cognizable common law, breach of fiduciary duty claim because the parties' ASC authorized BCBSM to process claims at something *other than* MLR, *i.e.,* by "pay[ing] standard contractual rates." Plaintiffs' FAC, Dkt. #7, at ⁋ 136.

Under Michigan law, if the parties' contract authorizes the conduct at issue, no breach of fiduciary duty can lie. *Calhoun Cnty v. BCBSM*, 297 Mich. App. 1, 5, 21; 824 N.W.2d 202 (2012) ("The ASC is the central contract for the insurance arrangement, and it determines the rights and obligations of each party. . . . [A]s 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."). *Cf. Thompson v. Cmty. Ins. Co.*, 213 F.R.D. 284, 301 (S.D. Ohio 2002) ("Because [Anthem] was permitted to take these actions, its conduct cannot constitute a breach of fiduciary duty.").

Here, Plaintiffs allege that "BCBSM was in a fiduciary relationship with Plaintiffs because . . . [BCBSM] was reposed with trust and confidence by Plaintiffs *under the ASC*." Plaintiffs' FAC, Dkt. #7, at ⁋ 184 (emphasis added). But critically, the ASC provides:

> BCBSM shall administer [Plaintiffs'] health care Coverages *in accordance with BCBSM's standard operating procedures for comparable coverage(s) offered under a BCBSM underwritten program*, any operating manual provided to [Plaintiffs], and this Contract.
>
> ***
>
> BCBSM will *process and pay*, and [Plaintiffs] will *reimburse* BCBSM for [the amount Plaintiffs owe in accordance with BCBSM's standard operating procedures for payments] related to [Plaintiffs'] claims. [**Exhibit 1**, at Art. II, ⁋⁋ A, C. (emphasis added).]

It is undisputed that BCBSM's "standard operating procedure" is to administer claims at rates negotiated by BCBSM with its network of providers, *i.e.*, something *different than* MLR. Plaintiffs do not allege otherwise. *See, e.g.*, Plaintiffs' FAC, Dkt. #7, at ⁋ 136 ("BCBSM . . . us[ed] Plan assets to pay standard contractual rates on services that were eligible for lower MLR payment rates."). *Accord,* Plaintiffs' Brief in Support of Motion for Reconsideration, Dkt. #24, at p. 7 ("BCBSM made a decision to use Plan assets to pay hospitals based on contract rates separately negotiated between BCBSM and each hospital."). *Cf. Little River Band of Ottawa Indians, et al v. BCBSM*, 183 F. Supp. 3d 835, 837-38 (E.D. Mich. 2016) ("Under the ASC [containing identical provisions], Blue Cross would

receive, process, and pay health care claims from the Band's employees . . . and allow the Band's employees access to Blue Cross's *provider networks and their discounted rates*.") (emphasis added).

There is accordingly no dispute that the ASC contractually authorized BCBSM to administer claims by paying "standard contractual rates" negotiated by BCBSM with providers. Under Michigan law, that contractual authorization bars Plaintiffs' state-law breach of fiduciary duty claim. *Calhoun Cnty*, 297 Mich. App. at 21. Count VI of Plaintiffs' FAC must therefore be dismissed.

III. CONCLUSION

For the foregoing reasons, BCBSM respectfully requests that this Court dismiss Counts I, IV and VI of Plaintiffs' First Amended Complaint.

Respectfully submitted,

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Dated: January 29, 2019

CERTIFICATE OF SERVICE

I hereby certify that on January 29, 2019, 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/ Brandon C. Hubbard*