UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

SAGINAW CHIPPEWA INDIAN TRIBE OF MICHIGAN, and ITS WELFARE BENEFIT PLAN,	Case No. 1:16-cv-10317-TLL-PTM
	Hon. Thomas L. Ludington

Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Defendant.

PLAINTIFFS' BRIEF IN OPPOSITION TO MOTION TO DISMISS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

I. INTRODUCTION

The remaining claims pled by the Saginaw Chippewa Indian Tribe of Michigan ("SCIT" or the "Tribe")[1] are valid and should proceed.

A. THE BREACH OF FIDUCIARY DUTY CLAIM ON BEHALF OF THE EMPLOYEE PLAN IS NOT TIME-BARRED UNDER ERISA.

The Tribe's claim on behalf of the Employee Plan for breach of fiduciary duty under ERISA is not time-barred for three independent reasons. First, the Complaint does not allege facts which establish a date certain on which BCBSM "squandered plan assets, and thereby breached its duties under ERISA to act prudently and with the best interests of the Tribe in mind when administering the plan." *Saginaw Chippewa Indian Tribe v. Blue Cross Blue Shield of Michigan*, 748 Fed. Appx. 12, 20 (6th Cir. 2018). Although the Medicare-Like Rate ("MLR") regulations went into effect on July 5, 2007, that does not prove that BCBSM acted imprudently and with a lack of care by not implementing a process for MLR pricing on July 5, 2007. The trier of fact will have to determine at what point in time BCBSM's failure to adopt processes to allow claims to be priced at MLR was imprudent and a breach of its fiduciary duty not to squander the Tribe's assets. It is premature to conclude – as a matter of law – that the Tribe's claim was not brought within six years of the date of the last action which constituted a part of the breach.

[1] Although both the Tribe and its welfare benefit plan are named as Plaintiffs in the lawsuit, for ease of reading this brief will refer to Plaintiffs in the singular as "SCIT" or "the Tribe."

Second, the Tribe has alleged "fraud or concealment" by BCBSM, which is an exception to the six year statute of repose. Specifically, BCBSM never disclosed that it was paying hospital claims for the Tribe without obtaining the Medicare-Like Rate discounts to which the Tribe was entitled. It was not until 2015 that the Tribe learned that BCBSM was squandering the Tribe's assets by paying more than Medicare-Like Rates. The Tribe's discovery of this issue was hindered by the deceptive billing practices of BCBSM and the lack of any notice or communication from BCBSM that it was paying rates in excess of MLR. The Tribe filed its lawsuit shortly after learning of this issue.

Finally, even if the Court accepts BCBSM's argument, the Tribe is entitled to sue to recover assets squandered by BCBSM during the three year period immediately prior to the filing of the original Complaint. The Tribe's ERISA claims should not be dismissed as time-barred.

B. THE TRIBE HAS STATED A CLAIM UNDER THE HEALTH CARE FALSE CLAIMS ACT.

The Tribe has legal standing to sue under the Health Care False Claims Act ("HCFCA" or the "Act"). The Tribe is a *health care insurer* – a legal entity that is self-insured and provides health care benefits to its employees. That the Tribe also provides health care benefits to some of its tribal members who are not employees does not take the Tribe out of the statutory definition of a *health care insurer*, as

there is nothing in the HCFCA that limits the coverage of the Act to claims for employees.

BCBSM presented claims to the Tribe which contained false statements about the amount owed for hospital services. As a *health care insurer*, the Tribe has a statutory right under the HCFCA to sue BCBSM for doing so, without regard to BCBSM itself being a *health care insurer* for its traditional insurance customers.

C. THE PARTIES' CONTRACT DOES NOT PRECLUDE A BREACH OF FIDUCIARY DUTY CLAIM ON BEHALF OF THE TRIBAL MEMBER PLAN.

Nothing in the parties' contract precludes the Tribe's claim on behalf of the Tribal Member Plan for breach of common law fiduciary duty. The *Calhoun County* case relied upon by BCBSM was a narrow decision in which the court held that because the parties' contract explicitly granted BCBSM the right to charge access fees, it was not a breach of fiduciary duty for BCBSM to charge those fees. Here, the parties' contract does not address MLR. There is no explicit contractual provision that exculpates BCBSM from its fiduciary duties to act prudently and with the best interests of the Tribe in mind when administering the plan.

II. LAW AND ARGUMENT

A. THE BREACH OF FIDUCIARY DUTY CLAIM ON BEHALF OF THE EMPLOYEE PLAN IS NOT TIME-BARRED UNDER ERISA.

1. Legal Standard

The Tribe agrees that the statute of repose for a breach of fiduciary duty claim under ERISA is "six years after … the date of the last action which constituted a part of the breach…." 29 U.S.C. § 1113(1).

Because determining "the date of the last action which constituted a part of the breach" is typically a question of fact, "more often than not, a statute of limitations issue cannot be decided on a motion to dismiss or from the face of a plaintiff's complaint. … Rather, given the factual issues often involved in such a determination, summary judgment is a more appropriate vehicle." *Abbruzzino v. Hutchinson*, No. 08-11534, 2009 WL 1015558, at *2 (E.D. Mich. Apr. 15, 2009)(citation omitted)(holding that motion to dismiss based upon statute of limitations will be denied if any issues of fact are involved).

Section 1113 also includes "an exception for a case involving fraud or concealment, extending the filing period to a date no later than six years after the time of discovery of the violation." *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, 751 F.3d 740, 747 (6th Cir. 2014); 29 U.S.C. § 1113(2). "[T]he six-year statute of limitations should be applied to cases in which a fiduciary: (1) breached its duty by making a knowing misrepresentation or

omission of a material fact to induce [a plaintiff] to act to his detriment; or (2) engaged in acts to hinder the discovery of a breach of fiduciary duty." *Caputo v. Pfizer*, 267 F.3d 181, 190 (2d Cir. 2001); *McGuire v. Metro. Life Ins. Co.*, 899 F. Supp. 645, 659 (E.D. Mich. 2012)(quoting *Caputo*).

Under section 1113 of ERISA, "a fiduciary who violates the trust placed in him by the plan will not easily find protection from a time bar." *Useden v Acker*, 734 F. Supp. 978, 979-980 (S.D. Fla. 1989); *Stockwell v. Hamilton*, 163 F. Supp. 3d 484, 488 (E.D. Mich. 2016) ("Courts have found that Congress evidently did not desire that those who violate ERISA fiduciary trust could easily find refuge in a time bar." (quotations and alterations omitted)).[2]

2. <u>The Complaint Does Not Identify A Date Certain On Which BCBSM Acted Imprudently And Inconsistent With The Best Interests Of The Tribe.</u>

The six year statute of repose runs from "the date of the last action which constituted a part of the breach." 29 U.S.C. § 1113(1). The date of the last action by BCBSM which constituted a part of the breach is not the date the MLR regulations went into effect. As the Sixth Circuit made clear on appeal, the Tribe's

[2] "[C]ourts must always bear in mind the ultimate consideration whether allowance or disallowance of particular relief would best effectuate the underlying purposes of ERISA—enforcement of strict fiduciary standards of care in the administration of all aspects of [] plans and promotion of the best interests of participants and beneficiaries." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 158 (1985) (Brennan, J., concurring).

claim is not that ERISA places a duty on BCBSM to price eligible claims at MLR. Rather, ERISA places a duty on BCBSM to "act prudently and with the best interests of the Tribe in mind when administering the plan." *SCIT*, 748 Fed. Appx. at 20-21 (noting that the fiduciary duties of BCBSM under ERISA include the duty to use due care to preserve plan assets).

That the MLR regulations went into effect on July 5, 2007, does not prove that as of July 5, 2007, BCBSM acted imprudently or failed to use due care on the Tribe's behalf. For example, the trier of fact may conclude that BCBSM needed time to understand the new regulations and develop policies and procedures, including computer algorithms, to allow BCBSM to price claims for the Tribe using MLR methodology. Indeed, the Complaint does not allege that BCBSM even knew about the MLR regulations on July 5, 2007.

Evidence in the related lawsuit pending against BCBSM by the Grand Traverse Band of Ottawa and Chippewa Indians ("GTB") suggests that BCBSM made some efforts over the years – or at least paid lip service to making some efforts over the years – to develop a process for pricing hospital claims using MLR methodology. For example:

- September 2007: BCBSM spoke with GTB about the "new rule entitling tribal health group discounts equal to Medicare" and had a "preliminary discussion of how BCBSM will accommodate the new law."

- December 2007: BCBSM updated GTB "on BCBSM progress in evaluating the legal and business aspects of the law"
- March 2009: BCBSM, GTB, and Munson Medical Center ("Munson") entered into a contract to give GTB contractual pricing "close to" MLR at Munson as a compromise to accommodate the MLR regulations.
- October 2010: Another third-party administrator approached GTB touting their ability to price eligible claims using MLR methodology.
- August 2011: BCBSM updated GTB on the possible implementation of a new system to price claims under which "if the [new] system could be designed to give GTB members Medicare Like Rates then we would be able to get Medicare Like Rates immediately when BCBS processed the claims…."
- March 2013: GTB switches its third-party administrator from BCBSM to Forest County Potawatomi Insurance Department, "a TPA specializing in providing MLRs…."
- May 2013: BCBSM internal email raises concern about loss of business from other tribes due to the "Medicare Like Rate situation." "I think once you update them on the progress BCBSM is trying to make regarding MLR, they'll be happy."

GTB documents, **Ex. A**.

Ultimately, the trier of fact will determine at what point in time BCBSM's failure to implement MLR pricing for the Tribe rose to the level of being imprudent and a breach of BCBSM's duty to take reasonable steps to ensure it was not squandering plan assets. The evidence relevant to determining when BCBSM breached its duty of care – none of which appears in the Complaint – demonstrates why BCBSM's motion is premature under Rule 12 and is properly decided on summary judgment or at trial, after discovery has been completed.

3. BCBSM Concealed That It Was Acting Imprudently And Inconsistent With The Best Interests Of The Tribe.

Section 1113(2) extends the time period for a plaintiff to file a claim for breach of fiduciary duty in cases of "fraud or concealment." Here, the Complaint alleges that (1) BCBSM was aware of the MLR regulations; (2) BCBSM presented claims to the Tribe that were eligible for MLR discounts with pricing at BCBSM's standard contractual rates; and (3) the Tribe did not learn that BCBSM was squandering Plan assets by paying claims above MLR until 2015. Am. Compl. ¶¶ 136, 139-140, 148-149. Indeed, the Complaint also alleges that BCBSM's failure to inform the Tribe that BCBSM was using Plan assets to pay amounts in excess of MLR was, in and of itself, a breach of fiduciary duty. Am. Compl. ¶ 146(f).

These allegations are more than sufficient to demonstrate that BCBSM engaged in "fraud or concealment" regarding its breach of fiduciary duty. BCBSM's failure to use due care to implement a process to price eligible claims at the lower of MLR or BCBSM's standard contractual price was clearly a "material fact," as the Tribe overpaid claims by millions of dollars as a result. There was no reason for the Tribe to know that it had a legal claim against BCBSM for squandering plan assets until the Tribe learned in 2015 that it had been overpaying

on hospital claims for tribal members. It would be unjust to bar the Tribe's ERISA claim under these circumstances.[3]

4. Plaintiffs Are Entitled To Recover On Any Health Care Claims For Which BCBSM Squandered Plan Assets From January 29, 2013 To The Present.

Finally, even if BCBSM's argument regarding the statute of repose is accepted by this Court, it does not merit dismissal of the Tribe's ERISA claim. Rather, the time period for which SCIT could recover for BCBSM's breaches of fiduciary duty would be limited to health care claims during the three year period immediately preceding the filing of the original Complaint.[4]

BCBSM administered thousands of separate health care claims on behalf of the Tribe. Each time BCBSM processed a health care claim for a Plan participant, BCBSM had to make a determination of how much (if anything) would be paid from the Tribe's assets for that claim. BCBSM breached its fiduciary duty in administering a particular health care claim only when, as a result of its lack of due

[3] Should the Court find that Plaintiffs allegations of fraud or concealment are not pled with sufficient particularity, Plaintiffs should be granted leave to amend their complaint, as this is the first time BCBSM has challenged the sufficiency of the Tribe's allegations of fraud or concealment. *Sparks v. Homecoming Financial, LLC*, No. 090-12092, 2009 WL 3602083 at *4 (E.D. Mich. Oct. 27, 2009)(holding that plaintiff could amend their complaint with additional detail of fraudulent misrepresentations in response to a Rule 9(b) challenge); *Coffey v. Fomex*, 2 F.3d 157, 162 (6th Cir. 1993)("[I]n meeting the Rule 9(b) particularity requirement, federal courts must be liberal in allowing parties to amend their complaints") (quotation omitted).

[4] The original Complaint was filed on January 29, 2016. Compl., Doc. #1.

care, BCBSM squandered plan assets by causing the Plan to pay more than it should have paid for that particular health care claim.[5] BCBSM's failure to implement a process to consider MLR in its claims administration process is not, standing alone, a breach of fiduciary duty.

As such, a Plaintiff can recover for each individual occurrence within the statutory period preceding the commencement of the action, even though there may be other breaches of fiduciary duty that would have been actionable except that they fall outside of the statutory period. At least one court of appeals has acknowledged that under ERISA, where there are separate violations of the same character that are repeated over time, the plaintiff may recover for those violations that occurred within the statutory time frame under the "continuing violation doctrine." *Novella v. Westchester County*, 661 F.3d 128, 146 (2d Cir. 2011). (noting that the continuing violation doctrine should apply "where separate violations of the same type, or character, are repeated over time"). There is not a "single event" that triggers each of the Tribe's claims.

The violation of ERISA in this case is the squandering of plan assets by overpaying on certain individual health care claims. The nature of the violations of

[5] For example, if BCBSM negotiated a contractual reimbursement rate with Ascension St. Mary's Hospital of $100 for an x-ray, but the Medicare-Like Rate for an x-ray is $120, BCBSM would not violate its fiduciary duties to the Plan by causing the Plan to pay St. Mary's the $100 contractual reimbursement rate for the x-ray.

ERISA by BCBSM are such that, even if BCBSM's statute of limitations argument is accepted, it does not act as an absolute bar to Plaintiffs' breach of fiduciary lawsuit, but would only bar recovery for health care claims that were paid prior to January 29, 2013.

B. THE TRIBE HAS STATED A CLAIM UNDER THE HEALTH CARE FALSE CLAIMS ACT.

1. Legal Standard

The Health Care False Claims Act ("HCFCA" or the "Act") provides as follows:

> A person who receives a health care benefit or payment from a health care corporation or health care insurer which the person knows that he or she is not entitled to receive or be paid; or a person who knowingly presents or causes to be presented a claim which contains a false statement, shall be liable to the health care corporation or health care insurer for the full amount of the benefit or payment made.
>
> Mich. Comp. Laws § 752.1009.
>
> As explained by the Michigan Supreme Court:
>
> Application of the plain meaning of these words reveals the Legislature's intent that MCL 752.1009 make one who presented a claim that he or she knew they were not entitled to receive, or who presented a claim that contained a false statement, legally responsible to health care corporations or health care insurers for the full amount of the overpayment of the benefit or payment.

State of Michigan ex rel. Gurganus v. CVS Caremark Corp., Nos. 299997, 299998, 299999, 2013 WL 238552, at * 8 (Mich. Jan. 22, 2013)(holding that the HCFCA creates a private cause of action for violations of the Act).

2. SCIT Is A Health Care Insurer With Standing To Sue Under The HCFCA.

a. The Plain Language Of The HCFCA Grants The Tribe Standing To Sue.

BCBSM's primary argument in support of its motion to dismiss the Tribe's HCFCA claim is that the Tribe is not a *health care corporation* or *health care insurer* and therefore does not have standing to sue under the HCFCA. The HCFCA defines a *health care insurer* as follows:

> 'Health care insurer' means any insurance company authorized to provide health insurance in this state or any legal entity which is self-insured and providing health care benefits to its employees.

Mich. Comp. Laws § 752.1002(f).

The Tribe obviously meets the statutory definition of a *health care insurer*. It is not disputed that (1) SCIT is a "legal entity which is self-insured" and that (2) the Tribe provides "health care benefits to its employees." *See, e.g.*, Am. Compl. ¶¶ 12-13.

Under the plain and unambiguous language of the HCFCA, the Tribe is a *health care insurer*. This Court is obligated to apply the plain language of the HCFCA as written. *See, e.g.*, *Ally Financial Inc. v. State Treasurer*, 502 Mich. 484, 493, 918 N.W.2d 662, 667 (2018)("When interpreting unambiguous statutory language, the statute must be enforced as written. No further judicial construction is required or permitted.").

b. The HCFCA Does Not Require That The False Claims Involve Benefits Provided To Employees.

Under ERISA, the purpose of the statute is regulation of employee benefits (thus the title "Employee Retirement Income Security Act"). As such, the Sixth Circuit, in analyzing whether the Tribe's claims were governed by ERISA, held that the Court was required to determine if the Tribe provided the benefits at issue "as part of the employment relationship" in determining whether the Tribe's claims arose under ERISA. *SCIT*, at 19.

In contrast, the purpose of the HCFCA is regulation of health insurance. Specifically, the Legislature's goal was to protect private entities who pay for health care claims from being ripped off for the health care services they pay for:

> The Legislature's purpose in enacting the HCFCA was to extend to private health care corporations and insurers the same protections against fraud that it afforded the Department of Social Services (now the Family Independence Agency) in the [Medicare False Claims Act].
>
> *Gurganus*, 2013 WL 238552, at * 8.

Notably, the HCFCA does not state that the "claim which contains a false statement" must be a claim for health care services provided to an employee. Mich. Comp. Laws § 752.1009. Rather, a *claim* is "any attempt to cause a health care corporation or health care insurer to make the payment of a health care benefit." Mich. Comp. Laws § 752.1002(a) (emphasis added). As alleged in the Complaint, BCBSM presented SCIT – a *health care insurer* – with a *claim* for

payment of a health care benefit on numerous occasions. *See, e.g.,* Am. Compl. ¶¶ 1-2, 20, 136, 139, 146, 168, 170.

Similarly, the definition in the HCFCA of what constitutes a *health care benefit* also does not state that the health care benefit must have been provided to an employee. Rather, the *health care benefit* must have been provided under a contract or insurance policy:

> 'Health care benefit' means the right under a contract or a certificate or policy of insurance to have a payment made by a health care corporation or health care insurer for a specified health care service.

Mich. Comp. Laws § 752.1002(d).

There is no dispute that the payment of the health care benefits at issue occurred under a contract – namely, the Administrative Services Contract between SCIT and BCBSM. *See* Am. Compl. ¶¶ 18-19.

Ultimately, nothing in the text of the HCFCA provides any justification for this Court to ignore the plain language of the Act. SCIT is a *health care insurer*. BCBSM presented SCIT with one or more *claims* for payment of *health care benefits* that the Tribe has alleged contained false statements. The Tribe has stated a claim for relief under the plain language of the HCFCA.

3. <u>BCBSM Presented Claims For Payment By The Tribe</u>.

The HCFCA creates civil liability for two different categories of people: (1) " a person who receives a health care benefit or payment from a … health care

insurer which the person knows that he … is not entitled to receive or be paid" and (2) "a person who knowingly presents or causes to be presented a claim which contains a false statement. " Mich. Comp. Laws § 752.1009. [6]

The HCFCA does not define what it means to "present" a claim to a health care insurer. However, in the context of the HCFCA – which is intended to financially protect health care insurers from being defrauded – it is reasonable to interpret this language to encompass any action that induces a health care insurer to pay a claim, where the person knows the claim is "wholly or partially untrue or deceptive."

Here, there is no question that the Tribe has alleged that BCBSM induced the Tribe to pay claims that were "wholly or partially untrue or deceptive." BCBSM did so by reporting to the Tribe that the amount due for certain hospital services to Tribal members was more than what was actually due to the hospital under the MLR regulations.

BCBSM argues that it did not "present" claims to the Tribe for payment because BCBSM was pre-authorized to pay the claims on behalf of the Tribe under

[6] A "false statement" means that the claim includes information that is "wholly or partly untrue or deceptive." Mich. Comp. Laws § 752.1002(c). BCBSM's motion to dismiss does not challenge the Tribe's allegation that the claims that were priced in excess of MLR were "wholly or partly untrue or deceptive."

the parties' contract. However, BCBSM's argument leaves out a critical component of the payment process.

BCBSM was contractually required to provide the Tribe a "monthly claims listing" which included a list of "Facility [*i.e.*, Hospital] claims listings showing charges by claim and in total." ASC, Art. IV (B)(4)(1), **Ex. B**. SCIT then had 60 days after receipt of the claims listing to review the claims listing and notify BCBSM in writing if the Tribe objected to or otherwise disputed BCBSM's payment of any of the claims on the claims listing. *Id.* at Art. II (D).

Under this process, the Tribe had the opportunity to review each claim, as "presented" to the Tribe by BCBSM in the monthly claims listing, and determine whether to object or dispute the payment of any claim for any reason. If BCBSM had informed the Tribe that a claim presented in the monthly claims listing did not include the MLR discounts to which the Tribe was eligible, the Tribe would have had the ability to dispute the payment of that claim through the dispute resolution process.[7]

That the Tribe pre-authorized BCBSM to pay claims prior to the presentment of the claims in the monthly claims listings (subject to the Tribe's right

[7] The Tribe would also have had the ability to either terminate the ASC or renegotiate the ASC in some way, perhaps by eliminating the pre-authorization for payment to ensure that claims were priced using MLR discounts before being paid for from the Tribe's assets.

to dispute improperly paid claims), does not take these claims outside of the statutory language of the HCFCA. A "claim" is defined as "any attempt to cause a health care corporation or health care insurer to make the payment of a health care benefit." Mich. Comp. Laws § 752.1002(a)(emphasis added). BCBSM clearly attempted to have the Tribe pay health care benefits – and was successful in doing so. Certainly, BCBSM cannot demonstrate as a matter of law that it did not "knowingly present or cause to be presented a claim which contains a false statement."

4. The Court Should Not Nullify The HCFCA, Which Does Not Produce An "Absurd Result" When Applied To BCBSM In This Case.

BCBSM's final argument on the HCFCA count is that because it is a *health care corporation* under the HCFCA, "holding BCBSM liable under the HCFCA would be an absurd result." There is no question that BCBSM is both a *health care corporation* and a *health care insurer* under the HCFCA. Mich. Comp. Laws § 752.1002(e)-(f).

However, there is nothing in the HCFCA that immunizes either a *health care corporation* or a *health care insurer* from liability if they receive a health care payment from a health care insurer that they know they are not entitled to receive, or if they knowingly present a claim which contains a false statement. The HCFCA extends such liability to any "person" – without exception. Mich. Comp.

Laws § 752.1009. The HCFCA defines a "person" as "an individual, corporation, partnership, association, or any other legal entity" and does not exclude *health care corporations* or *health care insurers* from potential liability for violations of the Act. Mich. Comp. Laws § 752.1002(i).

BCBSM is a "person" under the HCFCA. BCBSM provides third party administration services to self-insured *health care insurers*, such as SCIT. If BCBSM "knowingly presents or causes to be presented a claim which contains a false statement" as part of its third party administration services, it is civilly liable under the plain language of the HCFCA.

C. THE PARTIES' CONTRACT DOES NOT PRECLUDE A BREACH OF FIDUCIARY DUTY CLAIM ON BEHALF OF THE TRIBAL MEMBER PLAN.

1. Legal Standard

A fiduciary is bound to act for the benefit of the principal regarding matters within the scope of the relationship. *Prentis Family Found. v. Barbara Ann Karmanos Cancer Inst.*, 266 Mich. App. 39, 43, 698 N.W.2d 900, 906 (2005). This includes a duty to preserve the assets of the principal. *Matter of Trust of Rosati*, 177 Mich. App. 1, 5, 441 N.W.2d 30, 32 (1989) ("A trustee is by law charged with the duty of preserving the trust property"). *See also In re Estate of Karmey*, 468 Mich. 68, 74, 658 N.W.2d 796, 799 n.2 (2003) ("Fiduciary

relationships—such as trustee beneficiary, guardian-ward, agent-principal, and attorney-client—require the highest duty of care").

2. The Contract Does Not Address The Medicare-Like Rate Regulations.

BCBSM's argument on this issue relies exclusively upon the Michigan Court of Appeals' decision in *Calhoun County v. BCBSM*, 297 Mich. App. 1, 824 N.W.2d 202 (2012). However, the facts in *Calhoun County* are readily distinguishable from the Tribe's claims in this case.

In *Calhoun County*, the plaintiff brought both a breach of contract and breach of fiduciary duty claim against BCBSM, alleging that it was both a breach of contract and a breach of fiduciary duty for BCBSM to charge an access fee to the county. The Michigan Court of Appeals began its analysis by examining the parties' contract, concluding that:

- "The language of the ASC expressly provided for the collection of additional fees…."
- "The agreed-upon terms of the ASC allowed for the collection of the access fee, the means for collection, and the process through which it could be determined."
- [T]he parties unequivocally agreed to the payment of the access fee, what it covered, and how it would be paid."

Calhoun County, 297 Mich. App. at 15-17, 824 N.W.2d at 210-211.

Under this set of facts – where the court found that the contract expressly contemplated the charging of access fees – the court held that "plaintiff cannot

maintain its breach-of-fiduciary-duty claim" under Michigan common law. *Id.* at 20-21, 824 N.W.2d at 213.

Here, the contract is silent as to the issue of Medicare-Like Rates. Nowhere in the contract does it discuss the applicability of the Medicare-Like Rate regulations or whether BCBSM would (or would not) include MLR discounts available to the Tribe when processing claims for the Tribe. Unlike in *Calhoun County*, the Tribe did not "unequivocally agree" that BCBSM could ignore the Medicare-Like Rate regulations applicable to the Tribe.

That the contract generally stated that BCBSM would follow its "standard operating procedures" in pricing claims does not inform the Tribe (or the Court) as to whether the contract includes or does not include MLR pricing. One cannot tell from the contract whether BCBSM's "standard operating procedures" include discounts the Tribe is entitled to by operation of law. This is a far different circumstance than in *Calhoun County*, where the court held that the access fee charged by BCBSM was "unequivocally agreed to" by the parties. Absent express contractual language, BCBSM should not be exculpated from its fiduciary duties to act prudently and with the best interests of the plan in mind when administering the plan.

III. CONCLUSION

For the foregoing reasons, this Court should deny BCBSM's Motion to Dismiss.

Respectfully submitted,

VARNUM LLP
Attorneys for Plaintiffs

Date: February 19, 2019

By: s/*Bryan R. Walters*

Perrin Rynders (P38221)
Bryan R. Walters (P58050)
Aaron M. Phelps (P64790)
Business Address & Telephone:
Bridgewater Place, PO Box 352
Grand Rapids, MI 49501-0352
Phone: (616) 336-6000
Fax: (616) 336-7000
prynders@varnumlaw.com
brwalters@varnumlaw.com
amphelps@varnumlaw.com

CERTIFICATE OF SERVICE

I hereby certify that on February 19, 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.

Respectfully submitted

VARNUM LLP
Attorneys for Plaintiffs

Date: February 19, 2019

By: s/*Bryan R. Walters*

Perrin Rynders (P38221)
Bryan R. Walters (P58050)
Aaron M. Phelps (P64790)
Business Address & Telephone:
Bridgewater Place, PO Box 352
Grand Rapids, MI 49501-0352
Phone: (616) 336-6000
Fax: (616) 336-7000
prynders@varnumlaw.com
brwalters@varnumlaw.com
amphelps@varnumlaw.com

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