UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

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

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

A. Plaintiffs' ERISA Claim Is Barred By The Statute Of Repose

Plaintiffs mistakenly argue that July 5, 2007 is not the relevant date for purposes of determining when their ERISA claim accrued. According to Plaintiffs, "[the fact] 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." Pls.' Resp. Br., Dkt. #144, at 6. That assertion, however, ignores Plaintiffs' own allegations in their First Amended Complaint ("FAC"), in which Plaintiffs specifically allege that "since July 5, 2007, Plaintiffs have been overpaying for services eligible for lower MLR payment rates." Plaintiffs' FAC, Dkt. #7, at ¶ 139. It was BCBSM's alleged "fail[ure] to ensure that Plaintiffs were paying no more than MLR for MLR-eligible services" that Plaintiffs claim was a breach of fiduciary duty in violation of ERISA. *Id*. at ¶¶ 140, 146. Thus, Plaintiffs' *own allegations* demonstrate that their ERISA claim accrued on July 5, 2007; despite Plaintiffs' suggestion, no other reasonable inference can be drawn. Because Plaintiffs did not file suit until more than six years later, dismissal under Rule 12(b)(6) is appropriate. *See Bishop v. Lucent Techs., Inc*., 520 F.3d 516, 520 (6th Cir. 2008) (affirming dismissal on statute of limitations grounds because "the face of the complaint" showed that the plaintiffs' claim was time-barred).

Plaintiffs seek to extend the six-year statute of repose by asserting that their FAC contains allegations "sufficient to demonstrate that BCBSM engaged in

'fraud or concealment,'" Pls.' Resp. Br., Dkt. # 144, at 8, but that is plainly wrong. Nowhere in Plaintiffs' FAC is there any allegation of "fraud or concealment" with respect to BCBSM's alleged failure to apply MLR to Plaintiffs' medical claims. The only such allegation Plaintiffs make in their FAC relates to 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. *Hi-Lex*, however, has nothing to do with Plaintiffs' allegations concerning MLR.[1]

Finally, there is no merit to Plaintiffs' reliance on the "continuing violation doctrine." Pls.' Resp. Br., Dkt. # 144, at 9-11. Plaintiffs cite a single case in support of their position, *Novella v. Westchester County*, 661 F.3d 128 (2d Cir. 2011). But *Novella*, which did not actually apply the doctrine, observed that it is not a good "fit" in cases where "the plaintiff['s] claims are based on a single decision that results in lasting negative effects." *Id*. at 146 (citation and internal quotation marks omitted). That is consistent with this Court's decision in *McGuire v. Metro. Life Ins. Co.*, 899 F. Supp. 2d 645 (E.D. Mich. 2012), in which the Court explained that under ERISA's six-year statute of repose, "the limitations period

[1] To the extent Plaintiffs seek leave to amend their complaint *again*, it should be denied. *First*, the Sixth Circuit has held that a party may not request "leave to amend in a single sentence [in a response brief] without providing grounds or a proposed amended complaint." *Evans v. Pearson Enter., Inc.*, 434 F.3d 839, 853 (6th Cir. 2006). *Second*, the issue is not the "sufficiency of the Tribe's allegations of fraud or concealment"; it is the lack of any such allegations whatsoever.

runs from the original wrongful act and is not restarted each time a plaintiff suffers incremental, additional injury flowing from the same event." *Id*. at 662. Applying that rationale, the Court in *McGuire* held that each yearly calculation of dividends based on a change in the defendant's methodology did not "constitute a new violation." *Id*. The Sixth Circuit reached the same conclusion in *Med. Mut. of Ohio v. k. Amalia Enterprises Inc*., 548 F.3d 383 (6th Cir. 2008), holding that payment of "individual medical claims" over the course of several years based on misstatements in an insurance application did not count as "discrete wrongs"; rather, they "merely perpetuated the harm from the original wrong." *Id*. at 394.

The same analysis applies here: Plaintiffs' FAC alleges that beginning on July 5, 2007, BCBSM failed to apply MLR rates to the Tribe's medical claims, causing Plaintiffs to consistently "overpa[y] for services eligible for lower MLR payment rates." Plaintiffs' FAC, Dkt. #7, at ¶ 139. Those alleged overpayments were not "discrete wrongs," but rather "perpetuated the harm from the original [alleged] wrong." *Med. Mut. of Ohio*, 548 F.3d at 394. Plaintiffs' ERISA claim—filed well after six years had elapsed from July 5, 2007—is therefore time-barred.

B. Plaintiffs' HCFCA Claim Fails

1. Plaintiffs lack statutory standing

Plaintiffs invite this Court to gloss over the meaning and the placement of the words defining "health care insurer," as if the definition contained only:

"providing health care benefits~~ to its employees~~." That is impermissible. *Wickens v. Oakwood Healthcare Sys.*, 465 Mich. 53, 60; 631 N.W.2d 686 (2001).

For example, Plaintiffs focus on the HCFCA's definition of "claim" and "health care benefit," erroneously suggesting that neither contain the "to its employees" restriction. Pls.' Resp. Br., Dkt. #144, at 13-14. But that argument contains an analytical gap: the "to its employees" restriction is embedded within "claim" and "health care benefit" through each word's definitional use of "health care insurer"—a statutorily-defined word that *does* contain the "to its employees" restriction. Mich. Comp. Laws §§ 752.1002(a), (d), and (f). Plaintiffs' focus is thus misplaced.

Of critical (and dispositive) import, the *sole reason* Plaintiffs can even attempt to bring their HCFCA claim is because, under the Sixth Circuit's decision in this case, the HCFCA claim does not touch upon the Tribe's separate and distinct Employee Plan (*i.e.,* the claim is not pre-empted by ERISA). Plaintiffs seek to bring the HCFCA claim only with regard to the Tribe's *Member Plan*, which, by definition, has nothing to do with employees.

Plaintiffs cannot have it both ways, by attempting to argue that: (1) the HCFCA claim is not preempted by ERISA because they are *not* providing health care benefits to employees; but (2) they can state an HCFCA claim because they *are* providing health care benefits to employees. Dismissal of Plaintiffs' HCFCA

claim is proper. Otherwise, the "to its employees" restriction is rendered nugatory.

2. BCBSM did not "present" or "cause to be presented" any claims

It is undisputed that BCBSM – not Plaintiffs – processed and paid claims. BCBSM's Br. Sup. Mtn. To Dis., Dkt. #142, at 12-14. *See also id*. at Exhibit 1, ASC, Art. II (A) ("The responsibilities of BCBSM . . . are limited to providing administrative services for the processing and payment of claims."). It is also undisputed that Plaintiffs *reimbursed* BCBSM for BCBSM's payment of those claims. Plaintiffs' FAC, Dkt. #7, at ¶ 167. That indisputable backdrop makes clear that BCBSM did not "present" (or "cause to be presented") any claims to Plaintiffs within the meaning of Mich. Comp. Laws § 752.1009.

Nevertheless, relying on a "monthly claims listing" required by the ASC, Plaintiffs try to convince this Court that BCBSM actually did "present" claims to Plaintiffs. That position is erroneous.

Critically, the "monthly claims listing" process occurs *after* BCBSM has already processed and paid the subject claims—a fact acknowledged by Plaintiffs. Pls'. Resp. Br., Dkt. # 144, at 16 ("the Tribe pre-authorized BCBSM to pay claims prior to . . . the monthly claims listings"). That is to say, the function of the "monthly claims listing" is not an "attempt to cause [Plaintiffs] ***to make*** the payment of a health care benefit," which is statutorily required before liability can trigger. Mich. Comp. Laws § 752.1002(a) (emphasis added). Instead, the

"monthly claims listing" is an after-the-fact means of reporting to Plaintiffs the claims presented to, and thereafter processed and paid by, BCBSM. Plaintiffs then had 60 days to utilize the "monthly claims listing" to dispute a payment ***already made*** by BCBSM—not dispute whether "***to make*** the payment of a health care benefit" in the first place. *Id.* (emphasis added). If a dispute arose, BCBSM could, for example, "seek recovery of an amount from a third party" (*e.g.*, a hospital) and later "credit the recovered or corrected amount." ASC, Art. II (D).

No matter Plaintiffs' ostensible angle, the "monthly claims listing" does not constitute an "attempt to cause [Plaintiffs] ***to make*** the payment of a health care benefit"—a requirement for Plaintiffs' claim to survive. Mich. Comp. Laws § 752.1002(a) (emphasis added). Plaintiffs' HCFCA claim thus fails.

C. Plaintiffs' Common-Law Fiduciary Duty Claim Fails

Plaintiffs attempt to distance themselves from the *Calhoun County* decision by pointing out that the ASC "is silent as to the issue of Medicare-Like Rates," and improperly suggest that, "[a]bsent express contractual language [about MLR], BCBSM should not be exculpated. . . ." Pls.' Resp. Br., Dkt. #144, at 20. Plaintiffs' position is once again wrong.

As an initial matter, it is no surprise that the ASC does not contain any "express contractual language" explicitly addressing MLR—the parties executed the ASC in 2002, long before Congress enacted laws relative to MLR (in 2007).

In any event, *Calhoun County* does not require the existence of "express contractual language" actually discussing MLR. Instead, to warrant dismissal, BCBSM needs only to be entitled—contractually—to do that which it did. The following *Calhoun County* passage is dispositive:

> However, because this alleged breach of [fiduciary] duty *resulted from [BCBSM]'s charging a fee that it was contractually entitled to charge*, that allegation should also have been dismissed on defendant's motion for summary disposition.

Calhoun County v. BCBSM, 297 Mich. App. 1, 21, 824 N.W.2d 202 (2012) (emphasis added).

It is undisputed that Plaintiffs' alleged breach of fiduciary duty results from BCBSM doing that which the ASC "contractually entitled" BCBSM to do—pay "standard contractual rates" when processing claims, as negotiated by BCBSM with providers. Plaintiffs' common-law fiduciary duty claim must be dismissed.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 5, 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*