UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

TIMOTHY GENDREAU, individually, and on behalf of himself and all others similarly situated, Plaintiff, v. CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA et al., Defendants.	Case No.: 15-cv-02455-CAB-AGS **ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** [Doc. No. 43]

This matter is before the Court on the motion for summary judgment filed by Defendants California Physicians' Service, d/b/a Blue Shield of California and Blue Shield of California Life and Health Insurance Company (together "Blue Shield").[1] The motion has been fully briefed, and the Court has deemed the motion suitable for determination without a hearing. After a thorough review of the issues and for the reasons discussed below, the motion is granted.

I. Background[2]

Plaintiff Timothy Gendreau has been a Blue Shield insured member since 2005.

[1] Neither the complaint nor the parties in the briefs makes any separate arguments with respect to either defendant, so the Court treats them as if they are one defendant in connection with this motion.

[2] The parties have each made various objections to the opposing parties' evidence. [Doc. Nos. 60-7, 65, 66.] Because none of these objections concern any evidence the exclusion of which would result in a different outcome of the instant motion, both parties objections are denied as moot.

[Doc. No. 60-2 at 1.][3] Plaintiff obtains his insurance through a group health service contract between Blue Shield and his company, The Gendreau Group. [Doc. No. 60-6 at 51.] While Plaintiff has been covered under different plans, each plan contains substantively similar plan terms specifying the plan's "Calendar Year Maximum Out-of-Pocket Responsibility." [Doc. No. 48-3 at 311.] The Plan's[4] Certificate of Insurance provides a summary of the benefits, exclusions, and general provisions of the Plan. [Doc. No. 48-3 at 286.]

A. Plan Language

> The Plan states under Calendar Year Maximum Out-of-Pocket Responsibility:
>
> 1. INDIVIDUAL COVERAGE
>
> The per Insured maximum out-of-pocket responsibility required each Calendar Year for covered Services* rendered by Preferred Providers, MHSA Participating Providers and Other Providers is shown in the Summary of Benefits.
> The per Insured maximum out-of-pocket responsibility required each Calendar Year for covered Services* rendered by Non-Preferred Providers and MHSA Non-Participating Providers is shown in the Summary of Benefits. Once the maximum out-of-pocket responsibility has been met, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year.

[Doc. No. 60-6 at 49.] The term "Allowable Amount" is defined under the Plan's definitions section. The amount varies depending on whether a particular service involves a participating or non-participating provider, emergency or non-emergency services, and if services were received in or out of state. [Doc. No. 48-3 at 347.] The Plan also states:

> If the Insured or Physician requests a Brand Name Drug when a Generic Drug equivalent is available, the Insured is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the Insured must pay is not applied

[3] Pinpoint page citations to documents in the record are to the ECF page number at the top of the page.
[4] For the purpose of this order, because none of the differences between the various plans that covered Gendreau are relevant to his claims, the Court generally uses "Plan" in reference to the health care plan that covered Gendreau at any given time.

> to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

[*Id.* at 323.]

With regard to payment of benefits, the Plan states, "Claims will be paid promptly upon receipt of proper written proof and determination that Benefits are payable." [*Id.* at 342.] The Plan also includes a section on Blue Shield's grievance process for "receiving, resolving and tracking Insureds' grievances with Blue Shield Life." [*Id.* at 343-45.] Members should first contact the customer service department to request an initial review and if not resolved may then request a grievance. [*Id.*] After submitting the grievance, members also have the option to make a request to the Department of Insurance to have the matter submitted to an independent agency for external review in accordance with California law. [*Id.*]

B. Plaintiff's Complaints and Grievances with Blue Shield

Plaintiff began contacting Blue Shield several times a year dating back to as early as April 12, 2011, with complaints that he had met or overpaid his deductible or out-of-pocket maximum. [*Id.* at 8.] On that date, Plaintiff asked to speak to a supervisor who discussed with Plaintiff how much of his deductible had been satisfied for the year, reviewed his out-of-pocket maximum, and explained how claims are processed. [*Id.* at 12.] About a month later, Plaintiff contacted Blue Shield again to correct claims that over applied on his deductible and Blue Shield complied. [Doc. No. 60-6 at 2.] The administrative record provides several instances of Plaintiff contacting Blue Shield with similar complaints each year through 2016. [*See* Doc. Nos. 48-3, 60-6.]

In 2012, Plaintiff received medical services through Scripps Clinic Medical Group ("Scripps"), a Blue Shield participating provider. [Doc. No. 48-3 at 26.] However, due to a mistake by Scripps in using an incorrect provider code, Blue Shield erroneously processed Plaintiff's claims as if Scripps was a non-participating provider. [*Id.*] After Blue Shield was made aware of the error, it reprocessed the claims from these services and determined it made several incorrect payments to Plaintiff which were intended to be sent

to Scripps. [*Id.* at 75.] Blue Shield sent Plaintiff several letters requesting reimbursement of the incorrect payments that were sent to Plaintiff in error. [*Id.* at 134-146.] Plaintiff contacted Blue Shield to appeal their reimbursement requests stating that he did not owe Blue Shield any money and that he believed Blue Shield sent him these checks as overpayment because he had already met his deductible and out-of-pocket maximum. [*Id.* at 75.]

On January 4, 2013, Blue Shield sent a letter initially denying Plaintiff's appeal after determining that the reimbursement efforts were valid and stating that Blue Shield was unable to confirm Plaintiff's contention that he was advised the checks were issued to him as overpayment of his deductible or out-of-pocket maximum. [*Id.* at 148.] However, Blue Shield ultimately discontinued all reimbursement efforts as a one-time exception to take Plaintiff out of the middle of billing issues. [*Id.* at 114-120.]

In April 2013, Plaintiff contacted Blue Shield stating he had already met his out-of-pocket maximum for the year and he was appealing any further out-of-pocket costs. [*Id.* at 110.] Blue Shield's records indicate there were some accumulation issues with the out-of-pocket maximum showing as met while pharmacy services were not reflecting as such, resulting in Plaintiff continuing to contribute out-of-pocket. [Doc. No. 60-6 at 7-10.] After review from a grievance coordinator, Blue Shield denied Plaintiff's appeal advising him that when he requests a brand name drug when a generic drug is available, he is responsible for paying the difference between the contracted rate for the brand name drug and its generic drug equivalent as well as the applicable generic drug copayment. [Doc. No. 48-3 at 153.] Further, Blue Shield confirmed that while Plaintiff had met his calendar year deductible, the difference in cost is not applied to the calendar year deductible and is not included in the calendar year maximum out-of-pocket responsibility calculation. [*Id.*] In June 2013, Plaintiff filed a grievance that he should not have to pay the difference in cost between the brand name drug and the available generic equivalent due to allergies to the generic equivalent. [*Id.* at 216.] Blue Shield denied the request informing Plaintiff that his policy does not include a provision to approve a lower out-of-pocket option regardless of

the circumstances and Blue Shield must follow a consistent administration of the benefit coverage as outlined in the policy materials. [*Id.*]

In March 2015, Plaintiff contacted Blue Shield claiming once again that he had met his out-of-pocket maximum for the year. [*Id.* at 241.] Plaintiff claimed he had a pre-paid debit card with $4,500 which he had exhausted exclusively for covered medical expenses. [*Id.*] Blue Shield responded to Plaintiff's grievance that although his out-of-pocket maximum was not showing as met, Plaintiff was charged the full amount for two of his prescriptions that should have been authorized to waive the member co-pay difference because a prior authorization was not processed in time. [*Id.* at 243.] Blue Shield agreed to send Plaintiff a check to cover this overpayment, but advised it would not be counted towards Plaintiff's out-of-pocket maximum. [*Id.*] Blue Shield also agreed to have the pharmacy department audit Plaintiff's claims and reimburse him for any claims that were due refunds where Plaintiff overpaid towards his deductible. [*Id.*]

With regard to Plaintiff's grievances of Blue Shield's accumulation issues with his deductible and out-of-pocket maximum, in an email dated March 18, 2015, one Blue Shield employee stated, "This is a known issue affecting all HSA plans in Facets and they are working to resolve the issue." [Doc. No. 60-6 at 18.] In 2013, an employee in the appeals and grievance department stated in an email, "Member had more than paid their copay max and Blue Shield had dropped the ball in multiple ways." [*Id.* at 43.] The employee also mentioned that Plaintiff was advised this could possibly be caused by Plaintiff obtaining brand name drugs with generics available, but also stated, "This is near impossible to track by the way." [*Id.*] In 2015, Blue Shield admitted someone had advised Plaintiff that he met his out-of-pocket maximum and therefore Blue Shield agreed to reprocess all of Plaintiff's pharmacy claims to refund the coinsurances he was charged. [*Id.* at 26.]

On July 20, 2015, Plaintiff filed his initial complaint in San Diego County Superior Court, Blue Shield then removed it to this Court. Plaintiff has continued his grievances with Blue Shield while this suit has been pending. First, he requested that his 2015 accumulations towards his out-of-pocket maximum be carried over to 2016, which Blue

Shield denied. [Doc. No. 48-3 at 247.] Plaintiff also filed a complaint with the California Department of Managed Healthcare that he overpaid his 2016 calendar year deductible and out-of-pocket maximum. [*Id.* at 268.] Blue Shield responded agreeing a refund was warranted, but once again advised Plaintiff the difference in cost of a brand name drug and generic equivalent does not accrue towards yearly amount calculations. [*Id.* at 268-269.]

II. Legal Standards on Motions for Summary Judgment

A party is entitled to summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). To avoid summary judgment, disputes must be both (1) material, meaning concerning facts that are relevant and necessary and that might affect the outcome of the action under governing law, and (2) genuine, meaning the evidence must be such that a reasonable jury could return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *Cline v. Indus. Maint. Eng'g & Contracting Co.*, 200 F.3d 1223, 1229 (9th Cir. 2000) (citing *Anderson*, 477 U.S. at 248).

The initial burden of establishing the absence of a genuine issue of material fact falls on the moving party. *See Celotex Corp.*, 477 U.S. at 322-23. If the moving party can demonstrate that its opponent has not made a sufficient showing on an essential element of his case, the burden shifts to the opposing party to set forth facts showing that a genuine issue of disputed fact remains. *Id.* at 324. When ruling on a summary judgment motion, the court must view all inferences drawn from the underlying facts in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). However, "[t]he district court need not examine the entire file for evidence establishing a genuine issue of fact, where the evidence is not set forth in the opposing papers with adequate references so that it could conveniently be found." *Carmen v. S.F. Unified Sch. Dist.*, 237 F.3d 1026, 1031 (9th Cir. 2001).

III. Discussion

In the Second Amended Complaint, Plaintiff brings a single claim for breach of fiduciary duty under ERISA 29 U.S.C. § 1132(a)(3). [Doc. No. 38.] Section 1132(a)(3) provides that a civil action may be brought "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3).

Blue Shield moves for summary judgment on grounds that: (1) the matter is time barred subject to 29 U.S.C. § 1113(2); (2) the mere calculation of benefits does not constitute a fiduciary act; and (3) in the alternative, Blue Shield is entitled to summary adjudication of Plaintiff's claims to the extent they involve the years 2014-2016 because no breach of fiduciary duty occurred. [Doc. No. 43.]

A. Statute of Limitations

ERISA's statute of limitations provides:

> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the *earlier* of--
>
> (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
>
> **(2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;**
>
> except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1113 (emphasis added). To determine whether Plaintiff's ERISA claim is barred under 29 U.S.C. § 1113(2), two questions must be answered: (1) when did the alleged "breach or violation" occur; and (2) when did the plaintiff have "actual knowledge"

of the breach or violation? *See Ziegler v. Conn. Gen. Life Ins. Co.*, 916 F.2d 548, 550 (9th Cir. 1990).

1. Occurrence of Breach or Violation

To determine when the alleged "breach or violation" occurred, "we must first isolate and define the underlying violation upon which . . . [plaintiff's] claim is founded." *Id.* at 550-51 (citing *Meagher v. Int'l Ass'n of Machinists and Aerospace Workers Pension Plan*, 856 F.2d 1418, 1422 (9th Cir.1988), cert. denied, 490 U.S. 1039 (1989)). Here, Plaintiff alleges that Blue Shield breached its fiduciary duties because: (1) Blue Shield represents and markets its employee health benefit Plans as having specific deductibles and out-of-pocket maximum amounts; (2) monies understood to accrue toward these amounts were erroneously calculated, accumulated, and applied; (3) Blue Shield fails to accurately calculate and track the advertised deductibles and out-of-pocket maximums resulting in financial losses; (4) Blue Shield did not and does not disclose that it does not accurately calculate and track these amounts; and (5) Blue Shield's misrepresentations and refusal to provide the benefits of the stated deductibles and out-of-pocket maximums under the Plans is in violation of the Plans. [Doc. No. 38.]

The evidence demonstrates that the alleged improper calculation and accrual of his deductible and out-of-pocket maximum amounts occurred at least as early as April 2011, when Plaintiff first complained to Blue Shield about this issue. [Docs. No. 48-3 at 8, 12; 60-6 at 2.] On April 12, 2011, Plaintiff complained and asked to speak with a Blue Shield supervisor to discuss his deductible amount and the processing of his claims. [Doc. No. 48-3 at 12.] The record also indicates Plaintiff complained to Blue Shield at least once more in 2011 with the same issues. Accordingly, the underlying breach or violation upon which Plaintiff's claim is founded in this case first occurred as early as April 2011.

2. Actual Knowledge

The "inquiry into plaintiffs' actual knowledge is entirely factual, requiring examination of the record." *Ziegler*, 916 F.2d at 552. In *Ziegler*, the court noted that although the plaintiff may not have been able to accurately quantify its injury that does not

mean that plaintiff lacked actual knowledge. *Id.* Here, Plaintiff complained about overpaying his deductible and out-of-pocket amounts on more than one occasion in April 2011. [Doc. No. 48-3 at 8-12.] Thus, he had actual knowledge of the alleged violations as of April 2011.

3. The Continuing Violation Theory Does Not Apply

Plaintiff does not dispute that he had actual knowledge of Blue Shield's alleged breach of its fiduciary duty as of April 2011. Instead, he argues that his complaint is not time barred because of the "continuing violation" theory discussed in *L.I. Head Start Child Dev. Servs., Inc. v. Econ. Opportunity Comm'n of Nasau County*, 558 F. Supp. 2d 378 (E.D.N.Y. 2008). Under the continuing violation theory, "a new cause of action accrues for each violation where separate violations of the same type, or character, are repeated over time." *L.I. Head Start*, 558 F. Supp. 2d at 400. The Ninth Circuit, however, "has expressly rejected the continuing violation theory in an ERISA benefit case arising under § 1113(a)(2)." *Pisciotta v. Teledyne Indus., Inc.*, 91 F.3d 1326, 1332 (9th Cir. 1996). Thus, "a series of discrete but related breaches," does not reset the § 1113(2) limitations period with each related breach. *Phillips v. Alaska Hotel and Rest. Emp. Pension Fund*, 944 F.2d 509, 520–21 (9th Cir. 1991). "When a plaintiff has actual knowledge of a breach, § 1113(2) operates to keep [him] from sitting on [his] rights and allowing the series of related breaches to continue." *Tibble v Edison Int'l*, 843 F.3d 1187, 1196 (9th Cir. 2016). Accordingly, the continuing violation theory does not save Plaintiff's complaint from being time-barred.

Because it is undisputed that Plaintiff had actual knowledge of the alleged ERISA breach or violation at least as early as April 2011, Plaintiff filed his complaint outside of the statutory limitations period. Blue Shield is entitled to summary judgment on this ground alone.

B. Merits

Even if the complaint is not time barred, Blue Shield is entitled to summary judgment on the merits. "In every case charging breach of fiduciary duty . . . the threshold question

is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). To prevail on a claim for equitable relief under ERISA § 502(a)(3), a plaintiff must show that the defendant is an ERISA fiduciary acting in its fiduciary capacity and that the defendant violated an ERISA-imposed fiduciary obligation. *Mathews v. Chevron Corp.*, 362 F.3d 1172, 1178 (9th Cir. 2004); *see also Burstein v. Ret. Account Plan For Emps. of Allegheny Health Educ. & Research Found.*, 334 F.3d 365, 384 (3d Cir. 2003) ("[A] plaintiff must establish . . . defendant's status as an ERISA fiduciary *acting as a fiduciary*.") (emphasis added; quotations and citation omitted). Therefore, to succeed on this claim Plaintiff must establish: (1) Blue Shield's fiduciary status and (2) that Blue Shield was performing a fiduciary function. Blue Shield does not appear to contest that it is an ERISA fiduciary. Rather, Blue Shield primarily argues that the acts about which Plaintiff complains were not fiduciary acts.

Plaintiff and Blue Shield appear to disagree on Plaintiff's underlying claim for breach of a fiduciary duty. Blue Shield argues it is simply a calculation of benefits, while Plaintiff contends that the calculation of benefits is a symptom of the greater issue. Ultimately, Plaintiff argues Blue Shield breached its fiduciary duty to disclose material information because Blue Shield fails to inform consumers of all relevant facts pertaining to the out-of-pocket maximum. Blue Shield maintains that Plaintiff's theory of liability in his opposition differs from what he alleged in the complaint. Blue Shield believes Plaintiff's initial theory of liability in his operative complaint was that Blue Shield failed to properly calculate and accumulate his deductible and out-of-pocket maximum amounts. Although Blue Shield's argument has merit, neither theory of liability survives summary judgment.

According to the Ninth Circuit, "[a] fiduciary's mishandling of an individual benefit claim does not violate any of the fiduciary duties defined in ERISA." *Amalgamated*

Clothing & Textile Workers Union, AFL-CIO v. Murdock, 861 F.2d 1406, 1414 (9th Cir. 1988), (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985)). To find a breach of fiduciary duty based on a denial of individual benefits, a plaintiff could show that the denial is part of a "larger systematic breach of fiduciary obligations." *Russell*, 423 U.S. at 147. ERISA requires a "fiduciary" to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries." ERISA § 404(a), 29 U.S.C. § 1104(a).

A "fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even when a beneficiary has not specifically asked for the information." *Barker v. Am. Mobil Power Corp.*, 64 F.3d 1397, 1403 (9th Cir. 1995). A violation of ERISA's disclosure requirement, which arises under the general fiduciary duties imposed by ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), requires evidence of an intentionally misleading statement. *See Varity Corp. v. Howe*, 516 U.S. 489, 505 (1996).

Here, Plaintiff has failed to allege anything larger in scope than the mishandling of his own personal benefits, which Blue Shield provides evidence to show it continuously made efforts to correct. Although the record indicates several instances of Plaintiff's complaints to Blue Shield regarding the accrual of his deductible and out-of-pocket maximum, it appears Blue Shield remedied any errors. Blue Shield even acknowledged this was an issue with Plaintiff's account and the record indicates Blue Shield would reprocess his claims and provide refunds if warranted. There is no evidence supporting Plaintiff's allegation that Blue Shield's failure to properly calculate and accrue his deductible and out-of-pocket maximum amounts are a symptom of Blue Shield's systematic failure to discharge its duties in the interest of the participants and beneficiaries of the Plan.

Nor is there any evidence supporting Plaintiff's allegation that Blue Shield fails to disclose all material aspects of the out-of-pocket maximum Plan term. Plaintiff asserts that Blue Shield fails to disclose "the amount you will be out of pocket assuming you advocate tirelessly for yourself," or that Blue Shield "does not disclose that it forces loans from its members." [Doc. No 60 at 16-17.] However, Blue Shield's Plan documents define the

deductible and out-of-pocket maximum terms, including the "allowable amount." [Doc. No. 48-3 at 347.] The Plan informs members of situations in which they will be responsible for amounts that fall outside of the allowable amount if services are out of network. [*See id.*] Additionally, it informs of similar situations where members seek brand name drugs with a generic equivalent available and that the difference in payment is not applied to the deductible or out-of-pocket maximum. [*See id.* at 323.] The Plan further informs members on the processing of claims and Blue Shield's grievance process should any complications arise. [*Id.* at 342-45.] Members are also notified of the option to have the matter submitted to the Department of Insurance to have an independent agency provide an external review. [*Id.*]

Blue Shield's Plan documents provide its members with information relating to Plaintiff's initial complaints and how to remedy member's grievances. There is no evidence suggesting Blue Shield has failed to "convey complete and accurate information." *Barker*, 64 F.3d at 1403. Nor is there any evidence to support Blue Shield made any intentionally misleading statements. *See Varity Corp.*, 516 U.S. at 505.

Accordingly, even if the complaint is not time-barred, summary judgment is warranted.

IV. Conclusion

For the foregoing reasons, Blue Shield's motion for summary judgment [Doc. No. 43] is **GRANTED**. In addition, Plaintiff's motion to certify a class [Doc. No. 70] is **DENIED AS MOOT**. Judgment shall be entered for Defendants and the Clerk of the Court shall **CLOSE** the case.

It is **SO ORDERED**.

Dated: July 14, 2017

Hon. Cathy Ann Bencivengo
United States District Judge