

**TENTATIVE Order Regarding Aetna’s Motion for Summary Judgment or
Partial Summary Judgment**

Defendant Aetna Life and Casualty Bermuda Ltd (“Aetna”) moved for summary judgment or, in the alternative, partial summary judgment. Am. Memo. Pts. & Auth., Dkt. No. 54 (originally filed as Dkt. No. 46). Plaintiff California Surgical Institute (“CSI”) opposed. Opp’n, Dkt. No. 58. Aetna replied. Reply, Dkt. No. 72.

On September 25, 2020, the Court requested that each side provide additional briefing regarding the applicable statute of limitations and when the statute of limitations for each element began to run. See Dkt. No. 75.

For the following reasons, the Court **GRANTS** motion in part.

The Court GRANTS Aetna’s motion for summary judgment as it relates to CSI’s claim for money had and received and promissory fraud, but DENIES its motion as it relates to CSI’s claims for promissory estoppel and account stated. Regarding the applicable statutes of limitations, the Court finds that the statute of limitations prohibits 80 underpaid and 111 unpaid claims for promissory estoppel,¹ but does not limit any of the claims for account stated.

The Court previously vacated the hearing, scheduled for September 28, 2020. Currently, there is no scheduled hearing on this matter. Should either Aetna or CSI request a hearing, they must file their request no later than 5:00 p.m. on October 14, 2020.

¹The claims that the statute of limitations prohibits for promissory estoppel are the following: Exhibit A, Attachment A, pp. A1-A16, A18, A21, A23-A24, A27-A34, A36, A38-A47, A50-A54, A56-A59, A61-A68, A70, A74, A74-A80, A82-A99, A105, and A117-A118; Attachment B, pp. B1, B3-B4, B6-B7, B10-B18, B20-B21, B23-B26, B28-B34, B37, B39-B43, B45-B46, B49-B60, B62-B63, B65, B67-B69, B71-B72, B75-B84, B86, and B92. Dkt. No. 46-2:

I. BACKGROUND

The instant dispute centers around an out-of-network surgery center, CSI, which claims that payment of its facility fees was wrongfully denied or underpaid by Aetna. FAC, Dkt. 23 ¶¶ 35, 44. Aetna is the claims and/or plan administrator of the Saudi Arabian Cultural Mission Benefit (“SACM”) plans, an insurance plan for certain students and diplomatic personnel of SACM. Id. ¶¶ 2, 9. The SACM Benefit Plans are not governed by the Employee Retirement and Income Security Act of 1974 (“ERISA”). Id. ¶¶ 9, 12, 14.

CSI alleged that “Aetna’s agents verbally promised [CSI’s] agents that Aetna would pay [CSI] “one hundred percent of [CSI’s] billing rate for the services that were to be provided to the Patients.” Statement of Undisputed Facts (“SUF”) ¶ 2, Dkt. No. 72-1. According to CSI, “said promises were verbally made to [CSI’s] agents ... prior to the commencement and/or provision of services ... for each [date of service] because [CSI] sought and obtained pre-authorization and consent from Aetna [] to render the services.” SUF ¶ 3, Dkt. No. 72-1.

On February 22, 2017, CSI filed its first lawsuit against Aetna in federal court in the Central District of California, asserting that Aetna had underpaid or failed to pay medical claims. Following discovery, “it was ascertained that the subject medical insurance plans did not fall within the auspices of ERISA.” Dkt. 9 at 2. Pursuant to the parties’ agreement, the case was voluntarily dismissed without prejudice and for tolling. Id.

On September 14, 2018, CSI brought suit in the Superior Court of the State of California, County of Orange, against Aetna for claims of (1) breach of contract; (2) breach of the duty of good faith and fair dealing; (3) fraud; (4) account stated; (5) money had and received; and (6) violation of Cal. Bus. & Prof. Code § 17200. Compl., Dkt. 8-2, Ex. 1. Aetna removed the matter on December 5, 2018 on the basis of diversity jurisdiction. Not., Dkt. 1.

On February 6, 2019, the Court granted in part Aetna’s motion to dismiss as to the claims for breach of contract, breach of the covenant of good faith and fair dealing, fraud, promissory estoppel, injunctive relief under the Unfair Competition Law (“UCL”), and punitive damages, and denied in part Aetna’s motion to dismiss with respect to the claims for account stated and money had and received. Dkt.

No. 18. On March 7, 2019, CSI filed its amended complaint. Dkt. No. 23. The Amended Complaint brought claims for breach of contract and breach of the covenant of good faith and fair dealing, quantum meruit, equitable relief under the UCL, fraud, promissory estoppel, and punitive damages. Aetna moved to dismiss, and on June 10, 2019, the Court granted in part Aetna’s motion to dismiss with prejudice as to the claims for breach of contract and breach of the covenant of good faith and fair dealing, granted in part the motion to dismiss without prejudice as to the causes of action for quantum meruit and equitable relief under the UCL, and denied in part Aetna’s motion to dismiss with respect to the claims for fraud, promissory estoppel, and punitive damages. Dkt. No. 36.

Only the claims for promissory estoppel, promissory fraud, account stated, and money had and received are subject to the instant motion for summary judgment. See Memo Pts. & Auth, Dkt. No. 54.

A. The Saudi Arabian Cultural Mission (“SACM”) Benefit Plans:

i. Coverage

As relevant to the instant dispute, Aetna was the claims and/or plan administrator of the 2012 and 2014 SACM Benefit Plans. The SACM Benefit Plan is a “rich plan” in that it was fully-funded, had no deductible, no co-insurance, and pre-certification was not required. Haley Decl. ¶¶ 8, 12, Dkt. No. 60; Vasquez Decl. ¶¶ 7, 11, Dkt. No. 61; Shifferd Decl. ¶¶ 7, 11, Dkt. No. 62; Espinosa Decl. ¶¶ 8, 12, Dkt. No. 63.

The SACM Benefit Plans provide coverage information related to various medical services for out-of-network and in-network providers. The 2012 SACM Benefit Plan contains the same language and cost-sharing/rates. Dkt. No. 65-2 at 141 (“2012 SACM Benefit Plan”).

Specifically, the Plans specify “[w]hat expenses for services and supplies are covered and what limits may apply; [w]hat expenses for services and supplies are not covered by the plan; [and] [h]ow you share the cost of your covered services and supplies.” 2010 SACM Benefit Plan, Dkt. No. 65-1 at 10. The same envisions shared costs for out-of-network providers and benefits. Id. at 12. (“The plan will pay for **covered expenses**, up to the maximums shown in the *What the*

Plan Covers or *Schedule of Benefits* section. You are responsible for any expenses incurred over the maximum limits outlined in *What the Plan Covers* or the *Schedule of Benefits* sections.”). These sections are listed later in the same document.

The Schedule of Benefits spans several pages and provides the Plan’s features and costs for in-network and out-of-network care within the United States, as well as care outside the country. Dkt. No. 65-1 at 116.

The Schedule makes several references to the rates and costs referenced being coinsurance rates. For example, on the first page of the Schedule, it notes that the “[p]lan **Coinsurance limit** excludes plan deductible, **copayments, and precertification penalties**” and that there are no limits for individual or family coinsurance. Dkt. No. 65-1 at 116. Most importantly, at the end of the first page, the Schedule provides: “***Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.***” Dkt. No. 65-1 at 116. The Schedule defines coinsurance as follows: “This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the ‘**Plan Coinsurance**’. Once applicable deductibles have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs.” Dkt. No. 65-1 at 131.

For outpatient surgery, the Schedule provides that Aetna’s share is “100% per visit/surgical procedure” for out-of-network providers. Dkt. No. 65-1 at 124.

ii. Payment Processing

As the plan sponsor, the SACM can elect which benefits would be available for out-of-network providers and what methodologies would be used to reimburse them. Am. Latham Decl. at ¶ 9 (“Latham Decl.”), Dkt. No. 56. Determining those reimbursement methodologies is necessary because as stated in the SACM Plans, “[o]ut-of-network providers have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Deductibles and coinsurance** are usually higher when you utilize **out-of-network**

providers. Except for emergency services, **Aetna** will only pay up to the **recognized** charge.”² 2010 SACM Benefit Plan at 12, Dkt. No. 65-1.

Aetna’s Coverage Card Inquiry, an internal system used by Aetna’s claims systems and accessible by its Customer Service Representatives, memorializes any features of the SACM Benefit Plans. *Id.* As memorialized in CCI, SACM was also enrolled in Aetna’s National Advantage Program (“NAP”), a component of which is the Facility Charge Review (“FCR”).³ *Id.* ¶ 15; see also Dkt. No. 54-5 at 3 (noting enrollment in “NATL ADVT PROG” and “NATIONAL ADVANTAGE HOSPITALS, OTHER FACILITIES, AND ALL PHYSICIANS WITH MODIFIED BALANCE BILL FACILITY CHARGE REVIEW AND ITEMIZED BILL REVIEW - NEW STYLE.”); Dkt. No. 46-6 at 3; Dkt. No. 46-7 at 3.

The FCR process also determines the applicable “Recognized Charge.” Am. Shuler Decl., ¶¶ 4, 6 (“Schuler Decl.”), Dkt. No. 57; Latham Decl., ¶15; ¶ 16, Dkt. No. 56. Timely processed claims are eligible for FCR. Latham Decl., ¶ 18, Dkt. No. 56. Aetna will then reimburse out-of-network providers for covered services in an amount up to the “Recognized Charge.” SUF at ¶ 10, Dkt. No. 72-1, Latham Decl., ¶ 14, Dkt. No. 56; Shuler Decl. ¶7, Dkt. No. 57. Untimely processed claims are not eligible for FCR, and are then reimbursed at 100% of the provider’s full-billed charges. Latham Decl., ¶¶ 18, 22; see also Dkt. No. 46-5 at 3 (noting line item 327-001, which references a 100% fee default); Dkt. No. 46-6 at 3; Dkt. No. 46-7 at 3.

²The 2010 SACM Benefit Plan defines a “Recognized Charge” as the following: “Only that part of a charge which is less than or equal to the **recognized charge** is a **covered** benefit.” 2010 SACM Benefit Plan at 93, Dkt. No. 65-1. It is the lowest of: “The provider’s usual charge for furnishing it; The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months. The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.” *Id.*

³The Court recognizes that CSI disputes whether SACM ‘elected’ to use NAP to determine the Recognized Charge. However, regardless of whether SACM ‘elected’ to use that process, it nonetheless *is* the process, as recognized through Aetna’s internal systems and as used by Aetna throughout its relationship with SACM and CSI, to determine billing.

B. CSI's and Aetna's Payment Processes

i. CSI

CSI's staff was trained to complete an 'outline' prior to a patient's surgical procedure. Haley Decl., Dkt. No. 60 at ¶ 5. Part of this process included requesting from insurance providers/carriers (or in this case, Aetna), an insurance verification form, "benefits/coverage/limits information...relative to out of network providers such as CSI," pre-authorization or pre-certification if necessary, and completing any other forms required either by the physician or the provider/carrier. Id.

Moreover, in the relevant time period, CSI would not perform any surgical procedures without first (1) verifying insurance coverage by calling the insurance company pre-service; (2) obtaining benefit information including limitations on benefits for out of network outpatient surgery centers, co-insurance, deductibles, and other relevant restrictions; and (3) obtaining any appropriate pre-authorization. Haley Decl. ¶ 6; Espinosa Decl. ¶ 5; Shifferd Decl. ¶ 5; Vasquez Decl. ¶ 5. Haley, Espinosa, Shifferd, and Vasquez all attest to having followed CSI's pre-service checklist.

CSI agents also report inquiring about coverage on their calls with Aetna. Specifically, the Haley, Vasquez, Shifferd, and Espinosa Declarations all note that when they dealt "with Aetna in regard to the SACM plan" and had "personally called Aetna and inquired relative to the information CSI required for completing its pre-service process." Haley Decl., ¶ 9; Vasquez Decl., ¶ 8; Shifferd Decl., ¶ 8; Espinosa Decl., ¶ 9. Haley, Vasquez, Shifferd, and Espinosa all testify that "[i]n numerous occasions during the relevant time period at issue in this lawsuit, they were "told by Aetna operators specifically that 'this plan pays 100% of our 'billed charges' [] [sic] (and sometimes more) during the relevant period." Id.

ii. Aetna

Aetna trains its Customer Service Representatives ("Representatives") to answer calls from providers who treat Aetna members. Sandoval Decl. ¶ 8, Dkt. No. 46-8. Aetna does not directly train the Representatives, but rather uses

offshore vendors, and the vendors ultimately conduct the hiring. Sandoval Depo. at 41, Dkt. No. 67-1. Moreover, it does not hire its Representatives, instead leaving hiring to its two offshore vendors. Sandoval Depo. at 41, Dkt. No. 67-1. Aetna also trains its vendors only at the outset of its relationship with them and then will “work with their trainers as their trainers are training classes, and [] continue virtually.” Id. at 43. Prior to the years at issue (2014 to 2015), Aetna had last sent its trainers to its vendors in 2014, and its trainers had stayed there for approximately 6 months. Id. at 48.

Aetna trains its Representatives to handle provider requests, “including instruction on how to quote benefits available to Aetna’s members” and “are trained to ask a provider-caller specific questions which will enable them to understand what the caller is specifically asking for and to advise the caller as to whether the member has a benefit relating to the services the provider anticipates providing to the member.” Sandoval Decl. ¶ 4. As part of this training, Representatives are also required to read a disclaimer to the provider, advising the provider that “[a]ctual determinations are made when the claims are processed” and [a]dditional code processing details can be found on the payment estimator and code editing tools in NaviNet.” Sandoval Decl., ¶ 12.

When a provider calls in, Representatives can also provide them with benefits and coinsurance information. Sandoval Depo. at 93. Specifically, Representatives can access a “benefits tab” which provides them with “specific information about certain benefit line provisions.” Id. at 94. The information displayed is generated from Aetna’s CCI. Id. at 94. Once a Representative has identified the applicable reimbursement schedule, the Representative may provide that information to the provider. Sandoval Decl., ¶ 11. For the SACM plan, Representatives would have been trained to read “100 percent coinsurance for inpatient and outpatient services” and upon further clarification, “100 percent of the allowed amount for this expense.” Sandoval Depo. at 115.

Notably, Aetna cannot and does not provide call transcripts or logs related to any calls they had involving CSI. See Sandoval Depo. at 163, Dkt. No. 67-1.⁴

⁴According to the Sandoval’s deposition, the first time Aetna attempted to locate the records were around April-May, 2020. Sandoval Depo. at 244, Dkt. No. 67-1. They were unable to locate the recordings at that time and have not been able to produce the same in the instant

Moreover, Aetna agents could not attest to having heard recordings that related “to a provider call from [CSI].” Id. at 173. Whether the actual disclaimers were read to CSI’s agents is subject to dispute. Haley Dec. ¶¶ 5, 6, 10, 18; Espinosa Dec. ¶¶ 4, 5, 8, 10, 18; Shifferd Dec. ¶¶ 4, 5, 9, 16; Vasquez Dec. ¶¶ 4, 5, 16.

C. Past Payment Practices

CSI submitted approximately 2,000 claims over the relevant period. See Dkt. No. 65-4. 232 claims are at issue. Memo. Pts. & Auth. at 1, Dkt. No. 54. Over the same period, because certain claims were not timely processed and ineligible for FCR, Aetna reimbursed CSI at the default rate set by SACM. Latham Decl. ¶ 22. According to Hazel, Aetna would “consistently pay CSI the billed facility amount; sometimes a little less, sometimes a little more.” Hazel Decl. ¶ 16.

D. The SACM as an ERISA Plan

The 2010 and 2012 SACM Benefit Plans identify themselves as ERISA plans. Specifically, the SACM Benefit Plans contain the following language: “This is an ERISA plan, and you have certain rights under this plan.” See Latham Depo, 75:10-25; 2012 SACM Benefit Plan at 116.

Further, Aetna’s Representatives informed CSI employees of the same. Haley Decl. ¶¶ 11, 12 (“Consistently, when I dealt with Aetna’s CSR’s, I was told that the SACM plan was an ‘ERISA Plan’”); Vasquez Decl. ¶ 10; Espinosa Decl. ¶ 11; Shifferd Decl. ¶ 10. Moreover, because the plans were ERISA plans, Haley, Vasquez, Espinosa, and Shifferd, “[a]fter inquiry, [] discovered that there were certain protections and procedures that Aetna had to abide by, including fair process and providing us with detailed information relative to the plan, the benefits, the appeal process, the reconsideration process, and factual explanation of the reasons for denial and low-pay.” Id. They also “relied upon Aetna’s representation” and as a result “actually brought claims against Aetna which were litigated for months based on the belief that the SACM plan was an ERISA plan.” Id.

litigation. Id. Aetna’s retention policy for those recordings during the relevant time frame was 18 to 24 months. Id. at 37.

Despite such language, the deposition testimony, and the Declarations of these four CSI employees, the plans are not subject to ERISA. Dkt. No. 9 at 2.

II. LEGAL STANDARD

Summary judgment is appropriate where the record, read in the light most favorable to the nonmovant, indicates “that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a); see also Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986). Summary adjudication, or partial summary judgment “upon all or any part of [a] claim,” is appropriate where there is no genuine dispute as to any material fact regarding that portion of the claim. Fed. R. Civ. P. 56(a); see also Lies v. Farrell Lines, Inc., 641 F.2d 765, 769 n.3 (9th Cir. 1981) (“Rule 56 authorizes a summary adjudication that will often fall short of a final determination, even of a single claim . . .”) (internal quotation marks omitted).

Material facts are those necessary to the proof or defense of a claim, and are determined by referring to substantive law. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). In deciding a motion for summary judgment, “[t]he evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor.” Anderson, 477 U.S. at 255.⁵

The moving party has the initial burden of establishing the absence of a material fact for trial. Anderson, 477 U.S. at 256. “If a party fails to properly support an assertion of fact or fails to properly address another party’s assertion of fact . . ., the court may . . . consider the fact undisputed.” Fed. R. Civ. P. 56(e)(2). Furthermore, “Rule 56[(a)] mandates the entry of summary judgment . . . against a party who fails to make a showing sufficient to establish the existence of an element essential to that party’s case, and on which that party will bear the burden of proof at trial.” Celotex Corp., 477 U.S. at 322. Therefore, if the nonmovant does not make a sufficient showing to establish the elements of its claims, the Court must grant the motion.

⁵“In determining any motion for summary judgment or partial summary judgment, the Court may assume that the material facts as claimed and adequately supported by the moving party are admitted to exist without controversy except to the extent that such material facts are (a) included in the ‘Statement of Genuine Disputes’ and (b) controverted by declaration or other written evidence filed in opposition to the motion.” L.R. 56-3.

III. DISCUSSION

Aetna argues that each of CSI's four causes of action – for promissory estoppel, promissory fraud, account stated, and money had and received – is predicated on an alleged verbal promise or agreement by Aetna to pay CSI 100% of its billing rate for the medical services at issue, despite that Aetna never made such a promise or agreement. Am. Memo. Pts. & Auth. at 1, Dkt. No. 54. In opposition, CSI argues that triable issues of fact exist as to whether Aetna did make such a verbal promise or agreement, owing to calls between CSI and Aetna's agents in which CSI claims that Aetna's agents made such promises. See generally Opp'n, Dkt. No. 58. Further, CSI contends that Aetna has not submitted admissible evidence negating these triable issues of fact. Id. at 2.

A. Evidentiary Objections

As a preliminary matter, both Aetna and CSI submit numerous objections to the admission of certain pieces of evidence. Evidence presented at summary judgment must be admissible and have a proper foundation to be considered. Fed. R. Civ. P. 56; Canada v. Blain's Helicopters, Inc., 831 F.2d 920, 925 (9th Cir. 1987). On a motion for summary judgment, a party may object that the material used to “dispute a fact cannot be presented in a form that would be admissible in evidence.” Fed. R. Civ. P. 56(c)(2). A court must rule on material evidentiary objections. Norse v. City of Santa Cruz, 629 F.3d 966, 973 (9th Cir. 2010).

A declaration “used to support or oppose [summary judgment] must be made on personal knowledge, set out the facts that would be admissible in evidence, and show that the ... declarant is competent to testify on the matters stated.” Fed. R. Civ. P. 56(c)(4); see also L.R. 7-7 (“Declarations shall contain only factual, evidentiary matter”). “Although the source of the evidence may have some bearing on its credibility and on the weight it may be given by a trier of fact, the district court may not disregard a piece of evidence at the summary judgment stage solely based on its self-serving nature.” Nigro v. Sears, Roebuck & Co., 784 F.3d 495, 497 (9th Cir. 2015).⁶

⁶The Court recognizes Aetna's contention that many of the statements contained in the Declarations submitted in CSI's opposition could be construed as self-serving and vague.

The Court only considered admissible evidence in resolving Aetna’s motion for summary judgement. When this Order cites evidence to which Aetna or CSI have objected, the objection is impliedly overruled. Additionally, the Court declines to rule on objections to evidence upon which it did not rely.

i. CSI’s Evidentiary Objections to the Latham Declaration

CSI raises a number of evidentiary objections related to exhibits attached to the Latham Declaration. See e.g. Dkt. No. 69 at 6-10. Specifically, CSI argues that such exhibits, specifically, the copies of the CCI for the SACM Benefit Plan, constitute hearsay. Id. Aetna replies that the CCI copies constitute business records. For a record to be admissible as a business record, it must be “(1) made by a regularly conducted business activity, (2) kept in the “regular course” of that business, (3) “the regular practice of that business to make the memorandum,” (4) and made by a person with knowledge or from information transmitted by a person with knowledge.” Clark v. City of Los Angeles, 650 F.2d 1033, 1036–37 (9th Cir. 1981) (citing FRE 803(6)). The Court finds the CCI records to be admissible as business records.

The Court also recognizes that CSI claims that a number of statements in the Latham Declaration, specifically about what decisions SACM made in determining cost-sharing protocols, constitute hearsay. See generally Dkt. No. 69. The Court views whether SACM elected these provisions as immaterial, given its ruling that the CCI records constitute business records and its reliance on the CCI records , not SACM’s actions in the production of those records.

ii. CSI’s Evidentiary Objections to the Shuler Declaration

CSI also raises a number of evidentiary objections against the Shuler Declaration. The Court recognizes that CSI claims that a number of statements in the Shuler Declaration, specifically about what decisions SACM made in determining cost-sharing protocols, constitute hearsay. See generally Dkt. No. 71. The Court views whether SACM elected these provisions as immaterial, given its

However, the Court nonetheless finds these Declarations to be based in fact and cannot disregard them at the summary judgment stage merely because they may be self-serving. S.E.C. v. Phan, 500 F.3d 895, 909 (9th Cir.2007).

ruling that the CCI records constitute business records and its reliance on the CCI records, not SACM's actions in the production of those records.

iii. Aetna's Evidentiary Objections

First, the Court upholds Aetna's objection that Haley's statements "there was a verifiable *pattern and practice* for many months between Aetna and CSI whereby CSI presented bills to Aetna and said bills were paid in full by Aetna without any issue. Haley Decl. ¶ 9. This statement is improper opinion testimony by a lay witness and lack foundation. Fed. R. Evid. 602, 701. The Court also upholds Aetna's objection to the same statement in the Vasquez Declaration, ¶ 9, Shifferd Declaration, ¶ 9, and Espinosa Declaration, ¶ 9, all of which makes the same claim and are subject to the same objection. The Court can look to the evidence itself to determine whether there was a pattern and practice of paying CSI.

Second, the Court overrules Aetna's objection regarding the following statement: "In dealing with Aetna in regard to the SACM plan, I have personally called Aetna operators and inquired relative to the information CSI required for completing its pre-service process. On numerous occasions during the relevant time period at issue int his lawsuit, I was told by Aetna operators specifically that 'this plan pays 100% of our 'billed charges' [] [sic] (and sometimes more) during the relevant period." Haley Decl. ¶ 10. The Court also overrules Aetna's objection to the same statement in the Vasquez Declaration, ¶ 8, Shifferd Declaration, ¶ 8, and Espinosa Declaration, ¶ 9, all of which makes the same claim and are subject to the same objection.

Aetna objects to these statements on a number of grounds, specifically, that they are hearsay, irrelevant, and lack foundation. Dkt. No. 72-2 at 2-3. Aetna also argues that the Explanation of Benefits is the best evidence, pursuant to Federal Rule of Evidence Rules 1001-1004. The Court rejects Aetna's claim that this statement constitutes hearsay. However, "[a]n out-of-court statement is not hearsay [] if it is "offered against an opposing party and ... was made by the party[.]" Fed. R. Evid. 801(d)(2) (defining "an opposing party's statement" as a category of non-hearsay); see also United States v. Pang, 362 F.3d 1187, 1193 (9th Cir. 2004). The Court also finds that these statements are relevant to whether Aetna or its agents did actually promise CSI payment for 100% of billed charges.

B. Whether Summary Judgment is Appropriate on CSI's Claims

i. Promissory Estoppel

The doctrine of promissory estoppel provides that, “[a] promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise.”

Kajima/Ray Wilson v. Los Angeles County Metro. Transp. Auth., 23 Cal. 4th 305, 310 (2000).

To allege promissory estoppel under California law, the plaintiff must allege: (1) defendant made a clear and unambiguous promise; (2) the plaintiff relied on that promise; (3) the reliance was reasonable and foreseeable; (4) plaintiff was damaged as a result. Aceves v. U.S. Bank, N.A., 192 Cal. App. 4th 218, 225 (Cal. Ct. App. 2011). The promise will be clear and unambiguous when the “court can determine the scope of the duty, and the limits of performance must be sufficiently defined to provide a rational basis for the assessment of damages.” Glen Holly Entm’t Inc. v. Tektronix, Inc., 343 F.3d 1000, 1017 as amended by 352 F.3d 367 (9th Cir. 1992).

In its motion for summary judgment, Aetna claims that “the undisputed material facts establish that: (1) Aetna’s Representatives would not have promised to pay Plaintiff to pay its full-billed charges; (2) Plaintiff could not have reasonably relied on such a promise, as during every verification of benefits call, the provider is read a disclaimer to indicate that the information obtained during the call is not a guarantee of payment; and (3) the SACM Plan does not reimburse out-of-network providers for their services at 100% of their billing rates.” Memo. Pts. & Auth. at 16, Dkt. No. 54. Specifically, Aetna claims that its Representatives would not have had the authority to agree to reimburse at 100% of billed charges and that it is impossible for those Representatives to know before a procedure is done what reimbursement policies will apply and what the final cost-sharing will be. Id. at 17. Regardless of what the SACM Benefit Plan stated, it does not counter what CSI’s employees had been told.

CSI has demonstrated that a triable issue of material fact remains as to

whether Aetna made a “clear and unambiguous promise” that it would pay CSI 100% of its billing rate. In its Complaint, CSI alleged that “[beginning in 2012 and continuing through 2015, authorized agents of Aetna . . . verbally promised authorized agents of Plaintiff that payment for services provided, as reflected on Attachment ‘A’ and Attachment ‘B,’ would be provided under the August 2010 Benefit Plan, and/or, the May 2012 Benefit Plan.” FAC, ¶ 128. In support of those claims, it now attaches to its Opposition to Aetna’s motion for summary judgment the Declarations of four CSI employees, all of whom testify to have called Aetna and been told by its Representatives that it would reimburse 100% of billed charges. Haley Decl., ¶ 9; Vasquez Decl., ¶ 8; Shifferd Decl., ¶ 8; Espinosa Decl., ¶ 9. The Court cannot simply ignore these statement on the grounds proffered by Aetna. There is a triable issue was as to whether and what statements were made.

Accordingly, the Court DENIES summary judgment in favor of Aetna on this claim.

ii. Promissory Fraud

“The elements of promissory fraud (i.e., of fraud or deceit based on a promise made without any intention of performing it) are: (1) a promise made regarding a material fact without any intention of performing it; (2) the existence of the intent not to perform at the time the promise was made; (3) intent to deceive or induce the promisee to enter into a transaction; (4) reasonable reliance by the promisee; (5) nonperformance by the party making the promise; and (6) resulting damage to the promise[e].” Behnke v. State Farm Gen. Ins. Co., 196 Cal. App. 4th 1443, 1453 (2011) (citing Muraoka v. Budget Rent–A–Car, 160 Cal. App. 3d 107, 119 (1984)).

Not only must a party have made a promise and failed to perform, but also, an intent not to perform must have existed at the time the promise has made. Lazar v. Superior Court, 12 Cal. 4th 631, 638, 909 P.2d 981, 985 (1996) (“A promise to do something necessarily implies the intention to perform; hence, where a promise is made without such intention, there is an implied misrepresentation of fact that may be actionable fraud.”); Riverisland Cold Storage, Inc. v. Fresno-Madera Prod. Credit Assn., 55 Cal. 4th 1169, 1183, 291 P.3d 316, 325 (2013) (“[W]e stress that the intent element of promissory fraud

entails more than proof of an unkept promise or mere failure of performance." "[S]omething more than nonperformance is required to prove the defendant's intent not to perform his promise ... if plaintiff produces no further evidence of fraudulent intent than proof of nonperformance of an oral promise, he will never reach a jury." Magpali v. Farmers Group, Inc., 48 Cal.App.4th 471, 481 (1996). This is because a "declaration of intention, although in the nature of a promise, made in good faith, without intention to deceive, and in the honest expectation that it will be fulfilled, even though it is not carried out, does not constitute a fraud." Edmunds v. Valley Circle Estates, 16 Cal.App.4th 1290 (1993).

In its complaint, CSI alleges that authorized agents of Aetna informed CSI employees that "prior to commencement of any service rendered, that the procedures described on Attachment "A" and Attachment "B" would be subject to coverage under the benefits afforded by the August 2010 Benefit Plan, and/or, the May 2012 Benefit Plan, and that payment would be made by Aetna life to [CSI] at one hundred percent of [CSI's] billing rate." FAC ¶ 126. It also claims that Aetna agents told CSI employees that the plans were subject to the "legal tenets of ERISA and only ERISA." Id.

CSI alleges that Aetna made two promises, one regarding whether the services would be covered by Aetna, and another related to whether the plan was subject to ERISA.

Aetna's argument regarding CSI's claims concerning the billing rate mirror its promissory estoppel argument, specifically, that it would be impossible for its Representatives to promise CSI that it would pay 100% of CSI's billing rates. It also argues in response to CSI's ERISA-based claims that there is no evidence that its representatives told CSI "prior to the provision of medical services, that the SACM Plan was subject to ERISA," that "the SACM plan is not governed by ERISA," and that even if it was, such a representation is not material to induce reliance. Memo. Pts. & Auth. at 19-20, Dkt. No. 54.

However, as discussed above, by way of the Haley, Vasquez, Espinosa, and Shifferd Declarations, CSI at least demonstrated that a triable issue of material fact remains as to whether Aetna made a promise to pay CSI 100% of billed charges. Therefore, CSI has at least demonstrated that a triable issue of material fact remains as to whether Aetna promised that the SACM Benefit Plans were subject

to ERISA, and whether such promises were material in inducing CSI's provision of services.

The Court notes that neither party briefed whether Aetna had the requisite intent to make out a claim for promissory fraud (though CSI claims that the lack of financial incentives for Aetna to pay for the services at issue demonstrates intent, Opp'n at 21-22, "Aetna actually had no intent to perform because it would negatively affect Aetna financially."). The mere promise and failure to follow through with that promise is insufficient alone to establish a claim of promissory fraud. Neither does the possible claim of Aetna's financial benefit establish intent. Therefore, CSI has failed to allege that a triable issue of fact exists as to Aetna's intent at the time the promise was made.

Accordingly, even though triable issue of fact exists as to the promise, the Court GRANTS summary judgment in favor of Aetna on this claim because CSI has failed to demonstrate that a triable issue of fact exists as to whether Aetna had the intent not to perform at the time it made the aforementioned promises, and mere nonperformance is insufficient.

iii. Account Stated

"An account stated is a document—a writing—which exhibits the state of account between parties and the balance owing from one to the other, and when assented to, either expressly or impliedly, it becomes a new contract." Gardner v. Watson, 170 Cal. 570, 574 (1915). "An account stated constitutes a new contract, which supersedes the original contract." Jones v. Wilton, 10 Cal. 2d 493, 498 (1938). "The essential elements of an account stated are: (1) previous transactions between the parties establishing the relationship of debtor and creditor; (2) an agreement between the parties, express or implied, on the amount due from the debtor to the creditor; (3) a promise by the debtor, express or implied, to pay the amount due." Zinn v. Fred R. Bright Co., 271 Cal. App. 2d 597, 600 (Ct. App. 1969).

CSI alleges that "authorized agents" of Aetna informed CSI agents before medical services were rendered that procedures identified on Attachment "A" and Attachment "B" of the Complaint would be covered by the plans and that Aetna would pay CSI directly. FAC, ¶ 136. Despite repeated requests from CSI, Aetna

refused to pay these claims and refused to provide information about the claims process. Id. ¶¶ 126, 147.

In its motion, Aetna argues that CSI cannot sustain a claim for account stated because “the agreement upon which [CSI] bases [sic] its claim for account stated is Aetna’s alleged agreement to pay [CSI] an amount equal to 100% of its billing rate for the services provided to the Patients” and “there is no evidence that there was an agreement, either express or implied, on a balance due to [CSI].” Memo. of Pts. & Auth at 21, Dkt. No. 54.

However, as discussed above, CSI has demonstrated a triable issue of fact regarding the promise element of an account stated cause of action. Even though the terms of the SACM Benefit Plan are undisputed, CSI argues that Aetna has not negated its evidence. Opp’n at 3, Dkt. No. 58. Specifically, it argues that “[CSI] has submitted the declaration of its General Manager and former employees who attest under penalty of perjury that they were specifically told by Aetna’s agents that the SACM Plans pay at “100% of billed charges.” Id. Because of these Declarations, CSI can demonstrate that a triable issue of fact exists as to the possibility of an express or implied agreement to pay 100% of CSI’s billed charges.

Accordingly, the Court DENIES summary judgment on this claim.

iv. Money Had and Received

“A cause of action is stated for money had and received if the defendant is indebted to the plaintiff in a certain sum for money had and received by the defendant for the use of the plaintiff.” Schultz v. Harney, 27 Cal. App. 4th 1611, 1623 (1994) (internal quotations omitted). This cause of action is “based upon an implied promise which the law creates to money which the defendant in equity and good conscience should not retain.” Rotea v. Izuel, 14 Cal.2d 605, 611 (1939) (internal citations omitted). “The elements are as follows: (1) defendant received money; (2) the money defendant received was for plaintiff’s use; and (3) defendant is indebted to plaintiff.” Lincoln Nat’l Life Ins. Co. v. McClendon, 230 F. Supp. 3d 1180, 1190 (C.D. Cal. 2017)

CSI alleged that Aetna became indebted to it for the amounts listed in

Attachment “A” and Attachment “B” in its First Amendment Complaint, specifically, the full-billed charges for the claims that “reflect the reasonable value for the services performed by Plaintiff.” FAC ¶¶ 140-141.

In its motion for summary judgment, Aetna this claim is based on Aetna’s agreement to pay it 100% of its billed charges. Moreover, because the SACM Benefit Plans are fully insured, i.e., “because SACM pays Aetna premiums in exchange for full funding of benefits covered under the terms of the Plan,” Aetna contends that “any money received by Aetna from the Cultural Mission is limited to insurance premiums and not intended for or belonging to Plaintiff.” Memo. Pts. & Auth. at 27, Dkt. No. 54. In its opposition, CSI argues that because no pre-certification was required, “it followed that procedures and corresponding amounts billed were automatically approved under the SACM plans.” Opp’n at 22, Dkt. No. 58. However, CSI fails to demonstrate that the money Aetna received from SACM, specifically to provide coverage for SACM students and personnel, was for CSI’s use.

Accordingly, the Court GRANTS summary judgment on CSI’s claim for Money Had and Received.

C. Whether CSI’s claims are time-barred

On September 25, 2020, the Court ordered both CSI and Aetna to submit supplemental briefing regarding the applicable statute of limitations for each of CSI’s claims. Dkt. No. 75. Both Parties timely submitted their briefing materials.

Both CSI and Aetna agree that the following statute of limitations apply:

- Promissory Estoppel: Two years. See Cal. Code Civ. Pro. § 339.
- Promissory Fraud: Three years. See Cal Code Civ. Pro. § 338(d)
- Money had and received: Two years. See Cal. Code Civ. Pro. § 339.
- Account stated: Four years. See Shubin v. Midland Credit Mgmt., Inc., No. CV 07-8033 AHM (EX), 2008 WL 5042849, at *4 (C.D. Cal. Nov. 24, 2008).

The Court must now assess the applicable statute of limitations for each claim.

i. Promissory Estoppel

For Promissory Estoppel claims, the statute of limitations begins to run on the date for which the service was rendered. Corato v. Corato's Estate, 201 Cal. 155, 159, 255 P. 825 (1927). The Complaint was filed on February 22, 2017, meaning that under this rule, any services rendered prior to February 22, 2015, would be time-barred. This would mean 80 underpaid and 111 unpaid claims would be non-recoverable. See Dkt. No. 46-2: Exhibit A, Attachment A, pp. A1-A16, A18, A21, A23-A24, A27-A34, A36, A38-A47, A50-A54, A56-A59, A61-A68, A70, A74, A74-A80, A82-A99, A105, and A117-A118; Attachment B, pp. B1, B3-B4, B6-B7, B10-B18, B20-B21, B23-B26, B28-B34, B37, B39-B43, B45-B46, B49-B60, B62-B63, B65, B67-B69, B71-B72, B75-B84, B86, and B92.

Aetna argues that February 22, 2015, should be the relevant date for the instant inquiry. Dkt. No. 77 at 2. CSI claims that the relevant date from which the statute of limitations began to run was June 20, 2018, which it claims to be “the date Aetna confirmed via sworn declaration to the Court that ERISA did not apply and Plaintiff discovered the extent of Aetna’s unclean hands). Dkt. No. 76 at 3.

Equitable estoppel may also apply to the statute of limitations context where a party’s actions or omissions reasonably induced the opposing party’s actions. Lantzy v. Centex Homes, 31 Cal. 4th 363, 385 (2003). “The requisite act or omission must involve a misrepresentation or nondisclosure of a material fact bearing on the necessity of bringing a timely suit.” Doe v. Marten, 49 Cal. App. 5th 1022, 1028 (2020), reh'g denied (June 23, 2020), review denied (Aug. 19, 2020). Equitable estoppel may apply even where a defendant did not intend to mislead or did not engage in fraud or bad faith, provided that the defendant was in such a position that he or she ought to have known. Lantzy, 31 Cal. 4th at 384; Krolikowski v. San Diego City Employees’ Retirement System, 24 Cal.App.5th 537, 566 (2018).

CSI provides a detailed chronology of events, involving materials from a related case within the District (“CSI I” – Case No. 8:17-cv-00310-AG-PLA) that it argues indicate it “wasted 17+ months pursuing ERISA claims and exhausting administrative remedies) because of Aetna’s conduct. Dkt. No. 76 at 4. This

includes a Joint Rule 26 Report, in which Aetna asserted that ERISA controlled the action and Judge Guilford spent numerous pages discussing the procedure for ERISA-based claims and discovery, as well as other joint reports in which Aetna noted it would confirm with Judge Guilford whether the plan at issue was an ERISA or non-ERISA controlled plan. *Id.* at 5. Aetna maintains that there is no admissible evidence that Aetna represent during the claim process that the SACM Plan was an ERISA plan, and that there is no admissible evidence that CSI justifiably relied on those representations. Dkt. No. 77 at 4-5.

The Court finds that the claims for services rendered prior to February 22, 2015 are time-barred. There is nothing in the record to suggest that Aetna's conduct at the time CSI filed its suit, i.e., February 22, 2017, caused any delay. CSI does not demonstrate that Aetna's actions caused CSI to delay filing the suit.

ii. *Promissory Fraud*⁷

As stated above, the applicable statute of limitations is three years. Aetna does not contend that CSI's claim for promissory fraud is time-barred. Dkt. No. 76 at 2-3. However, the Court adopts the reasoning above in discussing whether equitable tolling is appropriate. Therefore, the Court finds that the applicable period from which the statute of limitations began to run was February 22, 2014.

iii. *Money Had and Received*

As stated above, the applicable statute of limitations is two years. The Court adopts its reasoning in the above section discussing promissory estoppel. The Court finds that the claims for services rendered prior to February 22, 2015 are time-barred.

iv. *Account Stated*

As stated above, the applicable statute of limitations is four years. Moreover, this begins to run as of the date of the last item in the account. Shubin

⁷The Court recognizes that it granted summary judgment in favor of Aetna on CSI's claims for promissory fraud and money had and received. It discusses the applicable statutes of limitation for the sake of clarity.

2008 WL 5042849, at *4. The last transaction date was December 30, 2015. Because CSI filed its Complaint against Aetna on February 22, 2017 and the applicable statute of limitations is four years, the statute of limitations does not preclude this claim.

IV. CONCLUSION

For the foregoing reasons, the Court **GRANTS** the motion in part.

The Court **GRANTS** Aetna's motion for summary judgment as it relates to CSI's claim for money had and received and promissory fraud, but **DENIES** its motion as it relates to CSI's claims for promissory estoppel and account stated. Regarding the applicable statutes of limitations, the Court finds that the statute of limitations prohibits 80 underpaid and 111 unpaid claims for promissory estoppel,⁸ but does not limit any of the claims for account stated.

IT IS SO ORDERED.

⁸The claims that the statute of limitations prohibits for promissory estoppel are the following: Exhibit A, Attachment A, pp. A1-A16, A18, A21, A23-A24, A27-A34, A36, A38-A47, A50-A54, A56-A59, A61-A68, A70, A74, A74-A80, A82-A99, A105, and A117-A118; Attachment B, pp. B1, B3-B4, B6-B7, B10-B18, B20-B21, B23-B26, B28-B34, B37, B39-B43, B45-B46, B49-B60, B62-B63, B65, B67-B69, B71-B72, B75-B84, B86, and B92. Dkt. No. 46-2: