Case No. 8:23-cv-01198-JVS-JDE
Prime Surgical Affiliates Inc. et al v. Aetna Health California, Inc. et al

TENTATIVE Order Regarding Motion to Dismiss [42], Motion for Reconsideration [51]

Before the Court are two motions. First, Defendant Aetna Life Insurance Company ("Aetna") moves to dismiss Prime Surgical Affiliates Inc. ("Prime Surgical") and Prime Surgical Centers of Encino, Torrance, Newport Beach, and Foothill Ranch's (collectively "Prime") Third Amended Complaint. (Motion ("Mot."), Dkt. No. 42.) Prime Surgical opposed the motion, (Opp'n, Dkt. No. 48), and Aetna responded (Reply, Dkt. No. 58.)

Second, Aetna filed a motion to reconsider the Court's decision on ERISA preemption in the order regarding the motion to dismiss the Second Amended Complaint. (Motion to reconsider ("Recons. Mot."), Dkt. No. 51.) Prime opposed the motion, (Recons. Opp'n, Dkt. No. 59), and Aetna responded (Recons. Reply, Dkt. No. 60.)

For the following reasons, the Court makes the following rulings:

- **GRANTS** the motion to reconsider with **leave to amend** to add claims for ERISA within 21 days;

- **GRANTS with prejudice** Aetna's motion to dismiss.

I. BACKGROUND

The following allegations are taken from the Third Amended Complaint. (Third Am. Compl. ("SAC"), Dkt No. 40.) Prime Surgical is a management services organization that is responsible for, among other things, billing and collections on behalf of its four surgical centers. (Id. ¶ 1.) As the operational manager for the surgical centers, per a management services agreement, Prime Surgical Affiliates has a direct financial interest in the surgical centers' recovery from Aetna. (Id. ¶ 9.) Aetna is an insurance provider that insures California residents. (Id. ¶ 2.) Prime Surgical's surgical centers are "noncontracted

providers" with Aetna; therefore, any procedures performed by the surgical centers for Aetna-insured individuals require authorization from the insurer. (Id.)

Prime contacts Aetna when they needs to confirm a patient's eligibility and obtain pre-authorization for procedures. (Id. ¶¶ 3, 16, 23–27.) Aetna allegedly informed Plaintiffs that, if services were provided to the patients, Aetna would pay for the services at the rates specified in each patient's Evidence of Coverage. (Id. ¶ 29.) When Aetna approves the procedures, Prime calculates the patient's responsibility based on Aetna's estimated reimbursement amount. (Id. ¶ 26.) Aetna paid Prime at "the usual, customary, and reasonable rates" or the "UCR" rate for years. (Id. ¶¶ 4, 14.) Having provided medical services to Aetna insured for years, Prime has records of what Prime charged and Aetna paid for each year since 2016. (Id. ¶ 14.) Prime has used the data— the amounts that Aetna has previously agreed to reimburse—to determine how much each patient would be responsible for. (Id.) Prime alleges that there was a "mutual understanding" from Aetna's authorization process and its historical conduct of paying UCR rates Aetna would continue to pay those rates. (Id. ¶¶ 4, 27.) In reliance on these representations and its historical practice, the surgical centers provided medical services to Aetna members and Prime Surgical billed Aetna accordingly for approximately 343 services. (Id. ¶ 30.) Up until 2020 or 2021, Aetna reimbursed Prime "regularly, promptly, and correctly." (Id. ¶ 21.)

However, in 2020 or 2021, Aetna, without notice, allegedly ceased paying Prime its usual and customary rates. (Id. ¶ 4.) Aetna "dramatically" underpaid them for the services rendered although Prime believes that the reimbursement rates in the Evidence of Coverage have not changed. (Id. ¶¶ 31, 39.) For 170 claims, they assert that Aetna failed to compensate them at all. (Id. ¶ 32.) In total, Prime alleges it billed Aetna approximately $23 million for procedures that Aetna authorized, but Aetna has only paid a little over 3 percent of that total. (Id. ¶ 42.)

Prime brought this suit for breach of implied and oral contracts, promissory estoppel, and violation of California's Unfair Competition Law ("UCL") in California Superior Court on May 12, 2023. (Dkt. No. 1-2.) Aetna removed the case to federal district court pursuant to 28 U.S.C. § 1332 on June 30, 2023. (Dkt. No. 1.) Prime filed a First Amended Complaint on August 7, 2023. (Dkt. No. 15.) Aetna initially filed a motion to dismiss on September 11, 2023, but withdrew it after the parties stipulated to Prime filing the SAC on October 13, 2023. (See Dkt.

No. 27.) Prime filed the SAC on October 16, 2023. (Dkt. No. 28.) The Court granted Aetna's motion to dismiss SAC in part and denied in part. (Dkt. No. 39.) Prime subsequently filed the TAC on March 25, 2024, which included an additional claim of a quantum meruit. (Dkt. No. 40.) Aetna now moves to dismiss all claims against it. (Mot. at 1.)

II. LEGAL STANDARD

A. Motion to Dismiss

Under Rule 12(b)(6), a defendant may move to dismiss for failure to state a claim upon which relief can be granted. A plaintiff must state "enough facts to state a claim to relief that is plausible on its face." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 570 (2007). A claim has "facial plausibility" if the plaintiff pleads facts that "allow[] the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009).

In resolving a Rule 12(b)(6) motion under Twombly, the Court must follow a two-pronged approach. First, the Court must accept all well-pleaded factual allegations as true, but "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." Iqbal, 556 U.S. at 678. Courts "'are not bound to accept as true a legal conclusion couched as a factual allegation.'" Id. (quoting Twombly, 550 U.S. at 555). "In keeping with these principles[,] a court considering a motion to dismiss can choose to begin by identifying pleadings that, because they are no more than conclusions, are not entitled to the assumption of truth." Iqbal, 556 U.S. at 679.

Second, assuming the veracity of well-pleaded factual allegations, the Court must "determine whether they plausibly give rise to an entitlement to relief." Id. at 679. This determination is context-specific, requiring the Court to draw on its experience and common sense, but there is no plausibility "where the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct." Id.

B. Motion for Reconsideration

Motions for reconsideration are governed by Federal Rule of Civil

Procedure 59(e). A motion for reconsideration "is an 'extraordinary remedy, to be used sparingly in the interests of finality and conservation of judicial resources.'" America Unites for Kids v. Lyon, No. 15-2124, 2015 WL 5822578, at *3 (C.D. Cal. Sept. 30, 2015) (citation omitted). Thus, "a motion for reconsideration should not be granted absent highly unusual circumstances," such as where a district court "is presented with newly discovered evidence, committed clear error, or if there is an intervening change in the controlling law." 389 Orange St. Partners v. Arnold, 179 F.3d 656, 665 (9th Cir. 1999). Motions for reconsideration cannot "be used to raise arguments or present evidence for the first time when they could reasonably have been raised earlier in the litigation." Carroll v. Nakutani, 342 F.3d 934, 945 (9th Cir. 2003).

"Courts in this district have interpreted Local Rule 7-18 to be coextensive with Rules 59(e) and 60(b)." Tawfilis v. Allergan, Inc., No. 15-307, 2015 WL 9982762, at *1 (C.D. Cal. Dec. 14, 2015). The grounds for reconsideration are set forth in Local Rule 7-18, which provides:

> A motion for reconsideration of the decision on any motion may be made only on the grounds of (a) a material difference in fact or law from that presented to the Court before such decision that in the exercise of reasonable diligence could not have been known to the party moving for reconsideration at the time of such decision, or (b) the emergence of new material facts or a change of law occurring after the time of such decision, or (c) a manifest showing of a failure to consider material facts presented to the Court before such decision. No motion for reconsideration shall in any manner repeat any oral or written argument made in support of or in opposition to the original motion.

L.R. 7-18.[1] The Court has discretion in determining whether to grant a motion for reconsideration. See Navajo Nation v. Confederated Tribes & Bands of the Yakima Indian Nation, 331 F.3d 1041, 1046 (9th Cir. 2003).

III. DISCUSSION

[1] See also School Dist. No. 1J, Multnomah Cnty. v. ACandS, Inc., 5 F.3d 1255, 1263 (9th Cir. 1993) (reconsideration appropriate if the movant demonstrates clear error, manifest injustice, newly discovered evidence, or an intervening change in controlling law).

Aetna seeks to dismiss five counts: breach of an implied or express contract (Counts 1 and 2); Promissory Estoppel (Count 3); Quantum Meruit (Count 5); Breach of UCL (Count 4). (See generally Mot.) Additionally, Aetna requests that the Court reconsider its previous decision to deny dismissal of Prime Surgical's state law claims on ERISA preemption grounds. (See generally Recons. Mot.)

A. Reconsideration of ERISA Preemption

The Court's previously held that the Employee Retirement Income Security Act (ERISA) does not preempt Prime's contractual, promissory estoppel, and UCL claims. (Dkt. No. 40, at 9–10.) Aetna seeks reconsideration based on a recent Ninth Circuit case, Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co., 103 F.4th 597 (9th Cir. 2024), and its concomitant district court cases, published after this Court's March 4, 2024 order regarding the motion to dismiss. (Mot., at 1.) The Court now takes up whether Bristol indicates a "change of case law" that warrants reconsideration. L.R. 7-18(b).

1. Propriety of the Motion for Reconsideration

As an initial matter, Prime contends that the motion for reconsideration is improper because Aetna asks the Court to reevaluate its order regarding Prime's SAC, which has been superseded by its TAC. (Recons. Opp'n, at 8.)

When an amended complaint is filed, the original complaint "cease[s] to exist." Ramirez v. Cnty. of San Bernardino, 806 F.3d 1002, 1008 (9th Cir. 2015). Prime's TAC supersedes its SAC, which is the operative complaint. Generally, a motion to reconsider the TAC would be moot as granting the motion would result in two operative complaints. However, the Court is faced with a "highly unusual circumstance[]," where there is an "intervening change in the controlling law." See Arnold, 179 F.3d at 665. Prime filed their TAC on March 25, 2024 but the Bristol decision was filed on May 31, 2024. Both the Federal and Local Rules account for such exceptional circumstances where there is a change in the law. Denying the motion to dismiss would belie the purpose of a motion for reconsideration. Thus, Aetna appropriately moved for reconsideration.

Prime argues that it would be"unfair, procedurally improper, and prejudicial to Prime" for the Court to apply the Bristol case to the TAC, which came weeks

before the Ninth Circuit case. (Id.) However, the Court is unpersuaded. First, acknowledging that the Bristol case may impact this instant case and in the interest of just and speedy determination, both parties stipulated to address the motion for reconsideration and the motion to dismiss contemporaneously. (Joint Stipulation, Dkt. No. 59; Order on Joint Stipulation, Dkt. No. 60.) Second, with the motion for reconsideration, Prime is given an opportunity to oppose and apply the Bristol case to the TAC. Lastly, though the Court finds that the gravamen of the TAC is not materially different from its SAC with respect to ERISA preemption, any prejudice may be cured by granting Prime another opportunity to amend their complaint. With the remedy in mind, the Court proceeds to address the merits of the motion for reconsideration.

2. ERISA Preemption Standard

ERISA provides for the comprehensive federal regulation of employee benefit plans. Metropolitan Life Ins. Co. v. Parker, 436 F.3d 1109, 1111 (9th Cir. 2006). To that end, ERISA includes two preemption provisions that defeat certain state law claims: "express preemption" under 29 U.S.C. § 1144(a) and "conflict preemption" based on 29 U.S.C. § 1132(a). Depot, Inc. v. Caring for Montanans, Inc., 915 F.3d 643, 665 (9th Cir. 2019) (citing Paulsen v. CNF Inc., 559 F.3d 1061, 1081, 1083 (9th Cir. 2009)).

ERISA's express preemption provision provides that ERISA "shall supersede any and all State laws insofar as they may . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a); Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 319 (2016). To provide some "workable standards" for determining the scope of § 1144(a), the Supreme Court has identified "two categories" of state-law claims that "relate to" an ERISA plan—claims that have a "reference to" an ERISA plan, and claims that have "an impermissible 'connection with'" an ERISA plan. Caring for Montanans, 915 F.3d at 665 (quoting Gobeille, 577 U.S. at 319–20). These two categories operate separately. Id. (citing Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 324–25 (1997). A state law claim makes "reference to" an ERISA plan if (1) the claim acts "immediately and exclusively" on an ERISA plan or (2) "the existence of ERISA plans is essential to the law's operation." Golden Gate Rest. Ass'n v. City & Cnty. of S.F., 546 F.3d 639, 657 (9th Cir. 2008) (quoting Dillingham, 519 U.S. at 325).

Aetna argues that Prime's claims necessarily rely on Aetna's promise to pay in accordance with the terms of ERISA plans and therefore require an interpretation of those ERISA plans. (Mot., at 18). The Court previously denied the dismiss the SAC based on ERISA preemption (Order, Dkt. No. 39, at 8):

> "[M]erely mentioning the plan terms that formed their expectation for payment is not enough to amount for the claims to relate to an ERISA plan. See In re Out of Network Substance Use Disorder Claims against UnitedHealthcare, No. SACV 19-2075, 2020 WL 5913855, at *5 (C.D. Cal. July 29, 2020). Instead, Prime's causes of action are premised on Aetna's independent obligation to pay for the services Prime provided and arise from promises Aetna allegedly made. (SAC ¶¶ 17–19); see The Meadows v. Employers Health Ins., 47 F.3d 1006, 1008–09 (9th Cir. 1995)." In its motion for reconsideration, Aetna contends that The Meadows is no longer the applicable case law.

(Id.)

3. Bristol Case and Application

Bristol involved Sure Haven, an out-of-network provider for Cigna-administered health plans, that made "verification calls" to Cigna for confirmation that it would provide coverage before providing care to patients. 103 F.4th at 600. In 2014, Cigna began to suspect that Sure Haven was engaging in "fee-forgiving," a practice of failing to charge patients for cost-sharing and then passing those costs to Cigna. Id. After an investigation into Sure Haven's fee-forgiveness practice, Cigna began denying Sure Haven's claims. Id. Bristol SL Holdings, Inc., the successor-in-interest to Sure Haven filed a claim against Cigna for breach of oral contract, breach of implied contract, and promissory estoppel. Id. at 601. The district court held that ERISA preempts Bristol's state law claims and Bristol appealed. Id. at 602.

The Ninth Circuit affirmed the district court's ruling, finding that Bristol's state law claims are both a "reference to" and an "impermissible connection with" the ERISA plans that Cigna administers. Id. at 603. First, Bristol's claims have a reference to the ERISA plan and are "in the garb of state law." Id. (cleaned up.) There was no dispute that the patients were covered by the plans and that the essential purpose of calling Cigna was to determine whether reimbursement was available under the ERISA plans. Id. Moreover, Bristol acknowledged that the

"plan payment rate may potentially apply" and supersede the representations made during the verifications call. Id. To that end, the substance of the ERISA plans was necessary to calculate damages. Id.

The Ninth Circuit also found that Bristol's claims have an impermissible connection with an ERISA plan. Id. at 604. First, the claims "unduly intrude on a central matter of plan administration" as reimbursement is ultimately contingent on information and events that occur after the initial verification phone call. Id. For example, Cigna-administered plans prohibit reimbursement without the required contribution from plan participants, who may contribute after services are rendered. Id. at 605. The Court found that binding plan administrators through pre-treatment calls would strip them of their ability to enforce plan terms that cannot be applied prior to treatment. Id.

Second, the Bristol court found the claims have an impermissible connection to an ERISA plan because they interfere with the nationally uniform plan administration. 103 F.4th at 605. The court reasoned that binding insurers to their representations on verification and authorization calls regardless of plan rules on billing practices would interfere with the goal of ERISA to "induc[e] employers to offer benefits by assuring a predictable set of liabilities." Id. (citing Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379, (2002).)

Finally, Bristol did not overrule The Meadows but clarified that the facts were distinguishable such that the provider could bring state law breach of contract and estoppel claims against the insurer. Id. at 605-606. Contrary to the Bristol case, patients' coverage had lapsed and they were not beneficiaries under any plan at the time of the alleged violations. Thus, the Ninth Circuit held that ERISA preemption did not apply when the state claims do not arise from any ERISA plan (Id. at 605.) Clearly, Bristol appears to be more applicable to the case before this Court.

Aetna contends that this case echoes the same facts of Bristol and its reasoning should apply in full force. (Recons. Mot., at 5–17.) First, Aetna Prime's claims are a "reference to" the ERISA plans that Aetna administers. (Id. at 10.) As in Bristol where the patients were covered by the ERISA Plans that Cigna administered (103 F.4th at 600), here, a "vast majority" of these individuals

appear to be covered by the ERISA plans (Recons. Mot. at 3.).[2] Similar to Sure Haven who would place verification calls to Cigna to confirm that a patient was eligible for coverage (Bristol, 103 F.4th at 600), Prime called Aetna to determine whether each patient was eligible"under the health plan coverage," and to "obtain authorization from Aetna to perform the service" (TAC ¶ 23). Prime substantially relied on the substance of the ERISA plan in the TAC by referencing and seeking reimbursement at the rate specified in each Evidence of Coverage, which is essentially an ERISA claim for recovery of plan benefit. (Recons. Mot., at 11.)

Prime counters that there is no "reference to" an ERISA plan because the Court can determine the payment terms by referring to the verification calls and not the ERISA plan's payment terms. (Recons. Opp'n, at 12.) They argue that the claims involve promises and obligations formed "outside of the health plan's terms." (Id. at 12–13.) However, the Court cannot ignore that the context of those phone calls was to determine whether each patient was eligible under the health plan coverage. Prime attempts to evade the evident context by alleging that they seek to enforce reimbursement of the *representations* that were made. Yet, these representations are based on ERISA plan terms and its benefits. Though relevant to the second prong of the preemption analysis, it would also be remiss not mention that under Prime's theory, the plan benefits would be determined by phone calls rather than the plan terms, which would be "at odds with the way ERISA plans operate." Bristol, 103 F.4th at 604.

Next, Prime argues there is no "connection with" any ERISA plan because the claims are not between traditional ERISA entities. (Recons. Opp'n, at 13.) Prime claims that the Bristol opinion failed to consider the long-standing tradition that ERISA does not preempt claims by a third-party who sues an ERISA plan not as an assignee of a purported ERISA beneficiary. (Id. at 13.) For this reason, the non-contracted providers in these district-court cases appealed the dismissal orders to the Ninth Circuit and Prime urges this Court not to follow Bristol. (Id.)

This Court notes the contrary position that the Ninth Circuit did not consider: that out-of-network providers are not subject to the relationships governed by ERISA. (Opp'n, at 13–14.) ERISA preemption as to third-party

[2]Of the 103 claims identified by Plaintiffs in their Exhibit A, at least 87 concern care provided to participants in commercial employer-sponsored health plans.

claims is "troublesome" because it would subject a non-contracted provider to the terms of a health plan and force the provider to accept arbitrary underpayments with no recourse to recoup the reasonable value of its services. (Id. at 15.) The costs are ultimately passed to patients by providers, who would either require up-front payments from patients or deny care or raise fees to protect themselves against the risk of noncoverage. (Id.) (citing Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 239 (3d Cir. 2020).)

However, the policy rationale supplied in Bristol similarly applies in this case— a claim should not "intrude on a central matter of plan administration" nor interfere with a "nationally uniform plan administration." 103 F.4th at 604. No facts differentiate this case from that of Bristol for this Court to find otherwise. As the Ninth Circuit is binding on this Court, the Court must necessarily follow the applicable case on point.

Accordingly, the Court **grants** the motion to reconsider on ERISA preemptions grounds and considers the motion to dismiss in this context. Claims for breach of implied or oral contract, promissory estoppel, UCL, and quantum meruit are dismissed as to ERISA patients as they are premised on the existence of an ERISA plan. The Court **grants Prime leave to amend** to add claims for ERISA benefits under 29 U.S.C. § 1132(a)(1)(B).

B. Motion to Dismiss

Next, the Court determines whether Prime may continue to assert claims for breach of implied or oral contract, promissory estoppel, and UCL as to non-ERISA patients, and the quantum meruit claim.

1. Breach of Implied and Oral Contracts

Aetna asserts that Prime failed to adequately plead mutual assent and consideration; thus, Prime's claims for breach of implied and oral contracts fail. (Id. at 5.)

a. Breach of Implied Contract

Prime fails to state "enough facts to state a claim" for breach of an implied contract that is "plausible on its face." See Twombly, 550 U.S. at 570. A contract may be either express or implied. Cal. Civil Code § 1619. "A cause of action for breach of implied contract has the same elements as does a cause of action for breach of contract, except that the promise is not expressed in words but is implied from the promisor's conduct."[3] Yari v. Producers Guild of Am., Inc., 161 Cal. App. 4th 172, 182 (2008). "A contract implied in fact 'consists of obligations arising from a mutual agreement and intent to promise where the agreement and promise have not been expressed in words.'" San Mateo Union High Sch. Dist. v. Cnty. of San Mateo, 213 Cal. App. 4th 418, 439 (2013) (citation omitted). Thus, like an express contract, an implied contract is "founded upon an ascertained agreement or, in other words, are consensual in nature, the substantial difference being in the mode of proof by which they are established." Allied Anesthesia Med. Grp., Inc. v. Inland Empire Health Plan, 80 Cal. App. 5th 794, 808 (2022) (citations omitted). However, "the assumption, intention or expectation of either party alone, not made known to the other, can give rise to no inference of an implied contract." Gateway Rehab and Wellness Ctr., Inc. v. Aetna Health of Cal., Inc., No. SACV 13–0087, 2013 WL 1518240, at *3 (C.D. Cal. Apr. 10, 2013) (quoting Travelers Fire Ins. Co. v. Brock & Co., 47 Cal. App. 2d 387, 392 (1941)).

Prime alleges that Aetna should be found in breach of an implied contract because it engaged in a pattern of routinely authorizing Prime to provide medical services to its subscribers and indicating it would pay at the rate specified in the patients' Evidences of Coverage, but then reimbursed them at a much lower rate. (TAC ¶¶ 48–52.) They further allege that it was their understanding that Aetna, due to its past payments for certain procedures, would continue to pay at those historic rates. (Id. ¶¶ 49–50.) This routine, according to Prime's allegations, was in line with industry practice and created an implied contract. (Id. ¶¶ 48–49.)

Aetna argues that Prime fails to adequately allege mutual assent because courts, when applying California law, have found verification of benefits and authorization of services to be insufficient to plead an implied contract claim.

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[3]In California, "the elements of a cause of action for breach of contract are (1) the existence of the contract, (2) plaintiff's performance or excuse for nonperformance, (3) defendant's breach, and (4) the resulting damages to the plaintiff." Oasis West Realty, LLC v. Goldman, 51 Cal. 4th 811, 821 (2011).

(Mot. at 5.) Additionally, it contends its previous payment history with Prime is irrelevant for determining mutual assent because a course of dealing can only supplement an agreement, it cannot form one, and the parties here never reached an agreement. (Id. at 6–7.) Even if the Court considers these past payments, Aetna asserts that Prime admit in the TAC that the parties never agreed to a specific price for their services. (Id. at 7.) Moreover, it claims that it is implausible to infer that a change in reimbursement rate, a common occurrence for health care plans, makes Aetna liable. (Id. at 8.) Lastly, Aetna argues that Prime did not allege the specific reimbursement rates in any patient's Evidence of Coverage, making it unclear whether the rates it paid to Prime actually breached a provision of the various health plans. (Id. at 10.)

In response, Prime argues that it adequately plead mutual assent, which does not require Prime to plead specific names and dates of calls between the parties. (Opp'n. at 13.) Primes distinguishes the case from Pac. Bay Recovery, Inc. v. Cal. Physicians' Servs., Inc., 12 Cal. App. 5th 200, 216 (2017), Namdy Consulting, Inc. v. UnitedHealthcare Ins. Co., CV 18-01283, 2018 WL 6507890, at *4 (C.D. Cal. Dec. 7, 2018), Aton Ctr., Inc. v. United Healthcare Ins. Co., 93 Cal. App. 5th 1214, 1241–42 (2023). (Id.) Rather, as in Aton Ctr., Inc. v. Blue Cross and Blue Shield of N. C., No. 3:20-cv-00492, 2020 WL 4464480, at *4 (S.D. Cal. Aug. 3, 2020), Prime argues that they have plead more than verification of benefits and authorization of services to show mutual assent— by relying on the parties' past conduct. (Opp'n, at 14.)

Prime's efforts to amend the complaint and focus on past conduct are unavailing. Prime argues that Pac Bay is inapplicable because in that case, the insurer only paid for 6 of 31 days of treatment at an out-of-network facility, and this partial payment, without more, did not indicate a meeting of the minds to pay the full charge. (Opp'n, at 14.) However, this argument parallels Prime's argument that Aetna did not reimburse Prime for some of the services rendered. Furthermore, the thrust of the complaint in Pac Bay was that prior authorizations and practice led Pac Bay to believe it would be paid, as is the case here. 12 Cal. App. 5th at 205. However, the Court held that this was insufficient to find mutual assent. Id. at 216. Similarly, in Namdy, the Court dismissed the implied contract claim because allegations that the insurer defendant "authorized the treatment when called and made payments towards treatment" are insufficient to establish mutual assent to pay usual and customary rates. 2018 WL 6507890, at *4.

Accordingly, the Court finds that Prime did not adequately plead a breach of implied contract claim because the allegations do not support a "reasonable inference" that there was mutual assent. See Iqbal, 556 U.S. at 678.

2. Breach of Oral Contract

Prime fails to state "enough facts to state a claim" for breach of an oral contract that is "plausible on its face." See Twombly, 550 U.S. at 570. "The elements of a breach of oral contract claim are the same as those for a breach of written contract: a contract; its performance or excuse for nonperformance; breach; and damages." Stockton Mortg., Inc. v. Tope, 233 Cal. App. 4th 437, 453 (2014). "An oral contract may be pleaded generally as to its effect, because it is rarely possible to allege the exact words." Khoury v. Maly's of Cal., Inc., 14 Cal. App. 4th 612, 616 (1993) (citing 4 Witkin, Cal. P. (3d ed. 1985) Pleading, § 471, p. 509)). To do so, "plaintiff must 'allege the substance of its relevant terms." Heritage Pac. Fin., LLC v. Monroy, 215 Cal. App. 4th 972, 993 (2013) (citation omitted).

They allege that they were "[f]ollowing industry practice" by contacting Aetna by telephone to confirm patient eligibility and authorization for treatment. (TAC ¶ 58.) These authorizations by Aetna, according to Prime, formed an oral contract between the parties because it "gave rise to a promise to pay" for the services performed by Prime. (Id.) They further allege that Aetna, based on its "historical practices" and "through its conduct . . . intended to and would pay at the prior rates agreed upon by the parties." (Id.) The payment term between the parties allegedly could be "inferred from Aetna's historical conduct, prior payments, and ongoing verifications and authorizations." (Id. ¶ 59.) The inferred term was that Aetna would pay Prime the "UCR rate for its services." (Id.) Thus, because Prime performed the medical procedures as authorized by Aetna, but Aetna did not compensate them at the implied payment term, Aetna is in breach of the oral contract. (Id. ¶ 63.) The Court disagrees and finds Prime's TAC suffers from the same failings as their SAC. (See Order at 17.)

Specifically, the alleged communications between the parties "lack the specific facts required for [the Court] to determine there was any meeting of the minds between [Prime and Aetna]." Pac. Bay, 12 Cal. App. 5th at 216. In other words, the TAC fails to allege facts to infer mutual consent in which "the parties

all agree[d] upon the same thing in the same sense." Cal. Civ. Code § 1580. Although Prime alleges the payment terms between themselves and Aetna could be "inferred" by previous payments, (SAC ¶ 59), this is not enough for the Court to "reasonably" infer that Aetna promised to pay those same rates again, see Iqbal, 556 U.S. at 678. Indeed, Prime does not allege that Aetna ever promised to continue paying at its previous reimbursement rate. See Pac. Bay, 12 Cal. App. 5th at 216 (holding that Prime must allege that "the parties reached . . . [an] agreement as to the rate [the defendant] would pay."). As discussed in the Court's previous Order, such allegations are a far cry from cases where other courts have found Prime adequately pleaded the substance of an oral contract's relevant terms.

Instead, Prime pleads that "Aetna historically promised to reimburse" them "at consistent rates" and list numerous examples of rates that Aetna has paid in the past. (SAC ¶¶ 15, 59 ("The payment term, inferred from Aetna's historical conduct, prior payments, and ongoing verifications and authorizations . . . was that Aetna would pay [Plaintiff's] UCR rates for its services, as it had for years.") (emphasis added)); see also Aton Ctr., Inc. v. United Healthcare Ins. Co., 93 Cal. App. 5th 1214, 1238 (2023) (finding that health center plaintiff's belief that defendant insurer would continue paying the same rate for services that it previously paid only established "unilateral expectation" of future reimbursements, not mutual assent). Prime cites Maglica v. Maglica, 66 Cal. App. 4th 442, 455 (1998) in support of the proposition that a contract can be implied from the parties' past dealings. However, the Maglica opinion explains, in no less than a paragraph, that the conduct of the married couple may establish an implied contract. Id. The case does not hold that past dealings create a mutual assent to an implied contract. Moreover, Prime's reliance on Arcade Cnty. Water Dist. v. Arcade Fire Dist., 6 Cal. App. 3d 232, 233 (Ct. App. 1970) is inapposite as there was some agreement entered by the parties in that case. Prior course of dealing may create a subjective expectation that Prime would be compensated at the same rate, but Prime cannot allege there was any manifestation indicating that the rate would continue indefinitely.

Given that mutual assent is an essential element of a contract and is not adequately pled here, the Court declines to address the arguments regarding consideration. Thus, the Court finds that Prime's breach of oral contract claim fails to state a claim upon which relief can be granted. See Fed. R. Civ. 12(b)(6)

As Prime was given four opportunities to plead this claim, the Court **grants** the motion to dismiss as to the breach of contract claims **with prejudice**.

B. Promissory Estoppel

Prime does not state a claim for promissory estoppel upon which relief can be granted. See Fed. R. Civ. P. 12(b)(6). Under the doctrine of promissory estoppel, 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 Cnty. Metro. Transp. Auth., 23 Cal. 4th 305, 310 (2000). The elements of promissory estoppel are: (1) a clear and unambiguous promise; (2) reliance by the party to whom the promise is made; (3) the reliance is both reasonable and foreseeable; and (4) the party asserting estoppel is injured by his reliance. Broome v. Regents of Univ. of Cal., 80 Cal. App. 5th 375, 389 (2022) (citation omitted).

Aetna argues that Prime "fail[s]o allege any specific promise" that satisfies the requirements for a promissory estoppel claim. (Mot. at 11.) Specifically, it contends that none of the alleged conversations between itself and Prime constituted a "clear and unambiguous" promise. (Id.) In response, Prime argues that the standard requires that the promise is less stringent. (Opp'n, at 18.) Garcia v. World Savings, FSB, 183 Cal. App. 4th 1031, 1045 (2010). Indeed, a promise must be "definite enough for a court to determine the scope of the duty" and provide a "rational basis for the assessment of damages." Garcia v. World Sav., FSB, 183 Cal. App. 4th 1031, 1045 (2010). However, "if extrinsic evidence is needed to interpret a promise, then obviously the promise is not clear and unambiguous." Id. (citation omitted).

Prime contends that it meets the less stringent standard with its examples of the historically agreed reimbursement rates, the parties' history of dealing, payment-discrepancy examples, and an explanation that Aetna's billing rates are plan-specific, pegged to a UCR or Medicare-rate percentage. (TAC ¶¶ 66–69; Opp'n, at 18–19). But by its own logic then, Prime appears to rely on the "extrinsic evidence" of prior payments and industry standard to prove their claim. See Garcia, 183 Cal. App. 4th at 1045. Therefore, Aetna did not make a "clear and unambiguous promise" that it would pay the same amount in the future.

Accordingly, the Court **grants** the motion to dismiss the promissory estoppel **with prejudice**.

C. Quantum Meruit

Prime's quantum meruit claim does not "allow[] the court to draw the reasonable inference that the [Aetna] is liable for the misconduct alleged." See Iqbal, 556 U.S. at 678. Quantum meruit permits the recovery of the reasonable value of services rendered. Pac. Bay, 12 Cal. App. 5th at 214 (citing Palmer v. Gregg, 65 Cal. 2d 657, 660 (1967)). To recover in quantum meruit, the "plaintiff must establish *both* that he or she was acting pursuant to either an *express* or *implied* request for such services from the defendant *and* that the services rendered were *intended to and did benefit* the defendant." Id. (quoting Day v. Alta Bates Med. Ctr., 98 Cal. App. 4th 243, 248 (2002)). "[F]urther, the defendant must have 'retained [the] benefit with full appreciation of the facts.'" Id. at 214–15 (second alteration in original) (quoting Day, 98 Cal. App. 4th at 248).

Aetna contends that Prime's quantum meruit claim fails because they did not "expressly or impliedly request services." (Mot. at 12.) It argues that Prime initiated the request by either submitting an electronic form or calling Aetna. (Id.) The crux of the request, Aetna argues, was the patients and their doctors, who asked Prime to perform a service. (Id.) Prime then requested authorization from Aetna. (Id.) At no point, it contends, did Aetna, as the insurer, make a request of any party. (Id.) In addition, it asserts that Prime only obtained authorization from Aetna for some of the services provided and the TAC fails to differentiate the claims that were authorized and those that were not. (Id.) Aetna also contends that Prime implausibly alleges that Aetna benefited from its services to patients. (Id. at 13.) Moreover, it argues that even in California, where the benefit does not necessarily need to directly benefit the defendant in a quantum meruit claim, Prime fails to properly plead that this exception applies. (Id. at 14.)

Prime counters that a course of conduct can establish an implied request for services. (Opp'n, at 21–22); California Spine & Neurosurgery Inst. v. Oxford Health Ins. Inc., 2019 WL 6171040, at *5 (N.D. Cal. Nov. 20, 2019); Long Beach Mem'l Med. Ctr. v. Blue Cross Blue Shield of S.C., No. CV 17-8181-GW, 2018 WL 5099703, at *4 (C.D. Cal. June 7, 2018) (refusing to conclude as a matter of law that authorization for treatments could not show insurer requested services).

Though calls for verification may not, as a matter of law, constitute an express request, the TAC fails to plead on its face that Primes' calls with Aetna do. Prime's claim that Aetna explicitly requested services hinges on the "multiple verification calls and inquiries with Prime, [and Aetna's] written authorizations for the Patients' procedures." (TAC ¶ 89.) The record simply does not reveal that Aetna took steps to expressly request this service. See ABC Servs. Grp., Inc. v. Aetna Health & Life Ins. Co., 2022 WL 187849, at *2 (9th Cir. Jan. 20, 2022) (affirming the district court's dismissal of ABC's claim on the basis that verification called did not establish explicit requests for service). Furthermore, it would be illogical to find that the authorizations and verification calls do not constitute mutual assent on Aetna's part, but that they constitute requests for services.

Accordingly, the Court **dismisses** the quantum meruit claim with **prejudice**.

D. Unfair Competition

California's Unfair Competition Law prohibits "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising." Cal. Bus & Prof. Code § 17200. The "unlawful" prong of the UCL treats violations of other federal, state, regulatory, or court-made law as unlawful business practices independently actionable under state law. Nat'l Rural Telecomms. Co-op v. DIRECTV, Inc., 319 F. Supp. 2d 1059, 1074 (C.D. Cal. 2003) (citation omitted). An unfair business practice under the UCL is "one that either offends an established public policy or is immoral, unethical, oppressive, unscrupulous, or substantially injurious to consumers." McDonald v. Coldwell Banker, 543 F.3d 498, 506 (9th Cir. 2008).

Prime's UCL claim falls short for numerous reasons[4]. Aetna contends that though UCL authorizes only equitable remedies where no remedy at law exists, Prime failed to allege that there is no adequate remedy at law. (Mot., at 15.) Prime only responds that "contract damages will be insufficient if Aetna changed an internal reimbursement or payment metric." (Opp'n, at 29.) This is clearly not sufficient. Aetna also argues that Prime cannot show that its conduct was "unlawful" under the UCL." (Mot., at 15.) Prime counters that Aetna breached

[4]The Court notes that most arguments are addressed in the tentative but not in its entirety.

the covenant of good faith and fair dealing by failing to settle claims, which is unlawful conduct under the UCL. (Opp'n at 26.) But this claim relies on an adequately pled oral and implied contract, which confers an obligation of good faith. Prime further responds that it has adequately plead misrepresentation, an unlawful conduct under the UCL, with particularly under Rule 9. (Id. at 27.) However, the allegations in the TAC only demonstrate such misrepresentations as to patients K.H. and J.P. (TAC ¶ 82.) The Court can not ascertain whether Aetna acted in the same manner with other claims. Lastly, Prime also cites Sections 790.03(a), 790.03(h), and 10112.82 of the California Insurance Code, alleging that Aetna has an obligation to ensure pricing transparency and fairness to patients. (Id. ¶ 83.) But Section 790.03(a) is part of the Unfair Insurance Practices Act, which does not allow for a private cause of action. See Zhang v. Superior Ct., 57 Cal. 4th 364, 284 (2013). As to Section 790.03(h), Prime fails to plead in the TAC that they are the claimants, which would generally refer to patients, not its agents. Furthermore Prime does not provide an explanation of whether Section 10112.82 either applies to out-of-network providers or how it applies to this case. Consequently, the Court **GRANTS** Aetna's motion to dismiss Prime's UCL claim **with prejudice** as Prime had four prior opportunities to amend.

IV. CONCLUSION

For the following reasons, the Court makes the following rulings:

- **GRANTS** the motion to reconsider with **leave to amend** to add claims for ERISA within 21 days;

- **GRANTS with prejudice** Aetna's motion to dismiss.

IT IS SO ORDERED.