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California Court of Appeal Affirms Grant of Summary Judgment Against Health Care Provider in Win for Managed Care Payors and Claims Administrators

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The California Court of Appeal, in a major win for managed care payors and claims administrators, affirmed a lower court decision granting summary judgment in favor of United Healthcare (United), finding that United did not enter into a binding agreement with an out-of-network health care provider during pre-service verification of benefits or prior authorization communications. *See Aton Center, Inc. v. United Healthcare Ins. Co*., No 2023 Cal. App. LEXIS 572, 2023 WL 4782433 (Cal. Ct. App. July 27, 2023).

This ruling will likely have a significant impact on lawsuits brought by out-of-network health care providers seeking to recover additional monies directly from payors and claims administrators based on allegations that an oral or implied contract was formed during verification of benefits and/or authorization calls, or to assert other quasi-contract or equitable grounds for recovery against a health plan or insurer.

Significantly, the court found:

- Breach of contract: The communications during verification of benefits calls did not objectively manifest mutual assent, nor was there any evidence supporting a reasonable inference that "clear and unambiguous promises or assurances of payment at rates corresponding to [the provider's] billed charges were actually made during the verification of benefits calls at issue."

- Promissory estoppel: The provider "failed to demonstrate that United made any promises to Aton during the VOB process, much less promises to reimburse as a percentage of billed charges."

- Intentional misrepresentation, negligent misrepresentation, and fraudulent concealment: The provider failed to identify any evidence demonstrating a factual dispute as to whether United intentionally misinformed or withheld information from its agents, or intended to defraud the provider or induce the provider's reliance.

- Violation of the California Unfair Competition Law (UCL): The provider could not maintain its equitable cause of action under the UCL because it had an adequate remedy at law and it had not presented evidence that United engaged in any unlawful, unfair, or fraudulent business act or practice.

Background

Plaintiff, Aton Center (Aton), is an inpatient substance abuse treatment facility. Aton was not part of United's provider network and as such, had no agreed-upon rate of reimbursement for services provided to United's members. Before admitting prospective patients for treatment, Aton employees would call United to confirm that the patients' plans provided out-of-network benefits during verification of benefits (VOB) calls. During the VOB calls, Aton would ask only whether the rate of reimbursement would be based on: (1) the usual, customary, and reasonable (UCR) rate; (2) the maximum non-network reimbursement (MNRP) rate; (3) the Medicare rate; or (4) the allowed amount. For the 29 patients whose claims were at issue in the lawsuit, the plans provided reimbursement based on UCR, MNRP (which relied on rates published by Medicare), and Medicare. The provider sought 50% of its billed charges for those plans with reimbursement rates based upon MNRP or Medicare, and 100% of its billed charges for plans based upon UCR. United allegedly paid a substantially lesser amount.

Aton asserted state law causes of action for: (1) breach of oral contract, (2) intentional misrepresentation, (3) negligent misrepresentation, (4) fraudulent concealment, (5) promissory estoppel, (6) quantum meruit, (7) violation of Business and Professions Code section 17200 (the UCL), and (8) breach of implied contract.

United demurred to all counts, and the underlying court sustained United's demurrer as to Aton's cause of action for quantum meruit based on deficiencies in its supporting allegations, but overruled the demurrer on all other grounds, including ERISA preemption. After conducting discovery, United moved for summary judgment on the remaining causes of action.

Arguments

United argued that Aton could not demonstrate the existence of mutual assent or consideration on the breach of oral and implied contract causes of action. United's director of customer service, who oversaw call agents taking inbound VOB calls from providers, testified that United representatives are not authorized to enter commitments or contracts to pay or to guarantee coverage. Rather, the agents can only give the provider preliminary information about a particular member's insurance benefits. The amount that will be paid on a particular claim is only determined after receiving the claim, and to the extent the amount paid is less than the amount billed, the provider may bill the member for any difference. United argued it had not agreed during VOB calls to reimburse 100% or 50% of the amounts Aton billed for treatment. Additionally, United argued there was neither evidence of actual, affirmative, or knowing misrepresentations by United representatives nor evidence that United intentionally concealed any facts. United also argued that Aton could not establish the unfair, unlawful, or fraudulent business practices needed to support its cause of action for violation of the UCL.

In opposition, Aton relied on testimony from numerous employees regarding Aton's understanding that UCR and MNRP reimbursement rates equated to 100 and 50%, respectively, of the billed charges. Aton's intake director testified that during VOB calls, Aton tries to verify that the patient has coverage and is eligible for services, and that he does not view the calls as a contract, but as a way to get more information. The intake director admitted Aton does not know at the VOB stage how much an insurer will pay for a particular claim, and that upon admission, patients sign an agreement acknowledging that no guarantees are made in advance regarding whether insurance will cover treatment and at what rate. The patients also sign a financial agreement that states they are responsible for Aton's daily rate, including any portion not reimbursed by the insurers. Aton's owner testified he personally believed the VOB calls to be an offer of payment from United, and that when the patients are admitted for treatment, Aton accepts the offer.

The trial court granted United's summary judgment motion and Aton appealed.

Discussion by the Court

As a threshold issue, the trial court ruled that Aton was foreclosed from relying on the terms of United's plans, because Aton contended, and the lower court accepted that it was not attempting to assert an ERISA claim or allege a breach of an ERISA plan. Aton did not challenge the trial court's ruling, and as such, the court held Aton was judicially estopped from relying on the terms of United's plans to support any of its causes of action.

Breach of Contract

Aton relied on a line of cases in which California courts determined an oral or implied contract was sufficiently pleaded based on allegations of statements made during VOB and/or authorization calls between a provider and insurer.[1] Notwithstanding the procedural basis to distinguish these cases, the court concluded the cases were factually inapposite since Aton produced no evidence showing the content of the VOB calls, let alone evidence that United's representatives made promises or offers to pay for services rendered, and further offered no evidence that both sides possessed the same understanding of the UCR and MNRP reimbursement rates.

The court held: "when an insurer merely provides information about a prospective patient's healthcare plan in response to a provider's inquiries, this does not, on its own, amount to a promise to pay… But when the insurer goes further and tells the provider it ***will pay*** the provider for a particular patient's treatment, the insurer ***may*** be found to have extended an offer or promise because such words reasonably signal an intent to transact." (Internal citations omitted; emphasis added). However, the court clarified it was not suggesting a contract is created whenever an insurer's representative uses the words "will pay" during a VOB call, but that in any event Aton failed to establish those facts existed in this case.

The court concluded the VOB calls, which Aton's owner described as "[Aton] calling and asking for the benefit [and] [t]he benefit being quoted[,]" were "devoid of communications objectively manifesting an intent to contract."

Aton pointed to testimony that its owner "understood" the parties were entering into oral or implied agreements during VOB calls, but the court found this "unilateral, subjective impression of their effect falls short of establishing mutual assent."

With respect to Aton's argument that United should have understood that UCR and MNRP meant 100 and 50% of billed charges based on what United "historically paid," the court held this only established Aton's "unilateral expectation that United's future reimbursements would reflect its historical payment rates; it does not establish that the parties mutually agreed during VOB calls that United's payment of the subject claims would comport with its payment of prior claims."

The court also explained it "would not regard [authorization of treatment] as evidence of payment agreements independent of the terms of United's plans," as United's authorization letters were devoid of information about the cost of anticipated treatment and instead cautioned that "payment for services described in this letter is subject to, among other things, benefit plan limitations." The court concluded that "this evidence tends to negate, rather than establish, that any rate agreement was formed during the authorization process, much less an

agreement that was independent of existing plan terms."

The court further found Aton failed to cite evidence of any acts by United that caused Aton to believe VOB representatives possessed authority to contract, and therefore there was no material dispute as to the United VOB representatives' lack of authority to contract on behalf of United.

The court rejected Aton's assertion that the trial court failed to consider previous payments between the parties, historical knowledge, and the parties' history, as Aton "provide[d] no evidence that United agreed to pay the subject claims the same as it had paid previous claims." Citing *Pacific Bay*, the court noted that evidence of prior payments to the provider at disparate rates does not establish an implied contract to pay future claims at a particular rate.

Promissory Estoppel

The trial court granted summary adjudication of Aton's promissory estoppel cause of action on the ground that Aton "failed to demonstrate that United made any promises to Aton during the VOB process, much less promises to reimburse as a percentage of billed charges."

While Aton argued on appeal that United gave reimbursement methods supported by specific percentages and authorized specific treatment, the court concluded that Aton had not offered any evidence "supporting a reasonable inference that clear and unambiguous promises or assurances of payment at rates corresponding to Aton's billed charges were actually made during the VOB calls at issue or the authorization process." Notably, the court found that references on the provider's VOB form to a specific "percent reimbursed" reflected only a percentage of the reimbursement rate and did not reflect a percentage of the providers' total billed charges.

Intentional Misrepresentation, Negligent Misrepresentation, and Fraudulent Concealment

The trial court granted summary adjudication of all three fraud-based causes of action, finding Aton lacked evidence to support each cause of action. On appeal, the court rejected Aton's challenges to these rulings, as Aton again failed to identify any evidence demonstrating a factual dispute as to whether United intentionally misinformed or withheld information from its agents or intended to defraud Aton or induce Aton's reliance.

Violation of the UCL

The trial court found that Aton could not maintain its equitable cause of action under the UCL because it had an adequate remedy at law through other causes of action for which it sought monetary damages. Additionally, Aton had not presented evidence that United engaged in any unlawful, unfair, or fraudulent business act or practice. On appeal, the court concluded that Aton failed to establish that the trial court erred in granting summary adjudication for violation of the UCL.

Conclusion:

Following the *Pacific Bay Recovery v. Cal. Phys. Servs.* decision in 2017, California state and federal courts have addressed at length the requirements for pleading oral and/or implied contract causes of action where out-of-

network providers seek to recover directly against health plans and insurers based on alleged pre-service VOB and authorization communications. However, few cases have directly addressed the type of evidence required for such lawsuits to survive summary judgment. This decision provides needed guidance in that regard, and likely will have a measurable impact on pending and future litigation in the area.

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[1] In *Pacific Bay Recovery, Inc. v. California Physicians' Services, Inc.,* 12 Cal. App. 5th 200, 215 (2017), an out-of-network provider alleged it called the insurer to verify benefits and obtain prior authorization and was advised that it "would be paid" and "was led to believe that it would be paid a portion or percentage of its total billed charges, which charges correlated with usual, reasonable and customary charges." *Id.* at 216. The court held these allegations "lack[ed] the specific facts required … to determine there was any meeting of the minds between the parties," because "it does not appear the parties reached any sort of agreement as to the rate [the insurer] would pay [the provider.]" *Id.* Subsequently, a handful of unpublished federal decisions concluded that an oral or implied contract cause of action based on pre-service VOB or authorization communications, *could* be sustained at the pleading stage where the complaint alleged facts beyond the mere verification of benefits and showing an express promise to pay a specific rate for services at issue. *See, e.g., Summit Estate, Inc. v. Cigna Healthcare of California, Inc.* 2017 WL 4517111, at *3 (N.D. Cal. Oct. 10, 2017); *Aton Center, Inc. v. Blue Cross and Blue Shield of Illinois*, 2021 WL 615051 (S.D. Cal. Feb. 16, 2021).

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