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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SIXTH APPELLATE DISTRICT

MARIA LEON et al., Plaintiffs and Appellants, v. WATSONVILLE HOSPITAL CORPORATION, Defendant and Respondent.	H037288 (Santa Cruz County Super. Ct. No. CV166066)

Plaintiffs Maria Leon and Rafael Leon brought an action against defendant Watsonville Hospital Corporation for the hospital's failure to advise them, when they were admitted to the emergency room, that the emergency room physicians did not accept plaintiffs' health care plan and for the hospital's failure to take other action to prevent the emergency room physicians from "balance billing" or charging excessive fees for services rendered. Plaintiffs, who brought the action on behalf of themselves and other similarly situated persons, sued the hospital for breach of contract, breach of the implied covenant of good faith and fair dealing, unfair business practices, violation of the Consumers Legal Remedies Act (Civ. Code, § 1750 et seq.; CLRA), and declaratory and injunctive relief.

"Balance billing" occurs when a patient's health care plan pays the medical provider a "reasonable rate" that is less than the amount billed and the provider bills the

patient for the difference. (See *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 502, 503 (*Prospect*).) In *Prospect*, after "[i]nterpreting the applicable statutory scheme as a whole," the California Supreme Court held that balance billing by an emergency room provider is prohibited by statute. (*Id*. at p. 502.) The court concluded that: (1) "billing disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the [patient's health maintenance organization (HMO)], which is obligated to make that payment"; (2) a "patient who is a member of an HMO may not be injected into the dispute"; and (3) "[e]mergency room doctors may not bill the patient for the disputed amount." (*Id.* at p. 502; see *id*. at p. 507.) In this case, plaintiffs were "balance billed" by emergency room providers and paid the disputed amounts before the Supreme Court decided *Prospect.* Unlike *Prospect*, which considered the respective responsibilities of emergency medical providers, patients, and health care plans, this case involves the potential liability of the hospital for balance billing or excessive billing by emergency room physicians.

Plaintiffs appeal from the judgment entered after the trial court sustained demurrers without leave to amend to all but their declaratory relief cause of action and granted summary judgment on their declaratory relief cause of action. We find no error in either ruling and will affirm the judgment.

FACTS[1]

In 2006 and 2007, plaintiffs, who are husband and wife, went to the emergency room of Watsonville Community Hospital[2] (together with defendant Watsonville

[1] The facts are based primarily on evidence plaintiffs presented in opposition to the hospital's motion for summary judgment.

[2] Watsonville Community Hospital was not a party to plaintiffs' action and is not a party to this appeal.

Hospital Corporation, the two entities are collectively referred to here as Hospital), where they received treatment from physicians employed by Emergency Medical Group of Watsonville (Medical Group).

Plaintiffs went to Hospital because it was close to their home and was a participating provider in their health plan, the Blue Cross Blue Shield Federal Employee Program (Health Plan). Unbeknownst to plaintiffs, Medical Group was not a participating provider in Health Plan; instead, Medical Group was an "non-preferred," "non-participating" provider. (Capitalization omitted.)

On December 16, 2006, Rafael[3] went to Hospital's emergency room and received medical care. Medical Group charged $502 for the services. Health Plan determined that the allowable amount for the services provided by a non-participating provider was $175.47 and made a payment of $157.93 (the allowable amount of $175.47 minus Rafael's coinsurance or co-pay of $17.54). In an explanation of benefits letter, Health Plan stated, "Benefits for this service are included in the payment for the primary service. Additional benefits are not available. Because the provider is not a preferred or participating network provider, you are responsible for this charge. [¶] . . . We provide benefits for covered services by non-participating providers based on the non-participating provider allowance. . . . You are responsible for these charges. [¶] Your responsibility to the provider[] is $502.00. We paid $157.93. The provider can collect $502.00 from you for these services." (Capitalization omitted.) According to plaintiffs, Health Plan's non-participating provider allowance is "at least 100% of the usual,

[3] We will refer to plaintiffs Rafael Leon and Maria Leon individually by their first names to avoid confusion or collectively as plaintiffs.

customary and reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained."[4]

On December 18, 2006, Rafael went to Hospital's emergency room, where he was treated by Dr. Kaplan. Medical Group charged $318 for Dr. Kaplan's services. Health Plan determined that the non-participating provider allowance for Dr. Kaplan's services was $112.30 and made a payment of $101.07 (the allowable amount of $112.30 less Rafael's coinsurance or co-pay of $11.23). Similar to the previous claim, Health Plan's explanation of benefits letter stated, "We provide benefits for covered services by non-participating providers based on the non-participating provider allowance. . . . You are responsible for these charges. [¶] Your responsibility to the provider[] is $318.00. We paid $101.07. The provider can collect $318.00 from you for these services." (Capitalization omitted.)

On September 8, 2007, Maria went to Hospital's emergency room and was treated by Dr. Clum. Medical Group charged $318 for Dr. Clum's services. Health Plan determined that the non-participating provider allowance for Dr. Clum's services was $112.30 and made a payment of $101.07 (the allowable amount minus Maria's coinsurance or co-pay of $11.23). The explanation of benefits letter for this visit contained the same statements as the letter for Rafael's second visit.

Plantiffs paid Medical Group in full. Apparently, plaintiffs were also billed by Hospital for Hospital services related to each of these emergency room visits. But there is no dispute regarding amounts billed by Hospital. The dispute here centers on whether

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[4] The Health Plan documents plaintiffs cite provide that the non-participating provider allowance "is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the . . . Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways."

Hospital had a duty to either warn plaintiffs that the physicians in its emergency room do not participate in plaintiffs' health plan or to insure that only participating providers staff the emergency room. Although the class allegations are not limited in time, plaintiffs were treated in 2006 and 2007, before *Prospect, supra*, 45 Cal.4th 497, was decided in 2009, but while that case was pending in the California Supreme Court.

Each time they were admitted to Hospital's emergency room, plaintiffs signed "Conditions of Admission and Consent to Medical Treatment" (COA) forms, which provided in relevant part: "I hereby voluntarily consent for treatment/admission to the Facility. I permit the Facility and its employees, physicians and others involved in my care to treat me in ways they judge to be beneficial to me. . . . I consent to examinations, . . . nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s). [¶] I agree and understand that all physicians, dentists, oral surgeons and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for the acts or omissions of the aforementioned. **Some services may be performed by independent contractors who are not employed by the Facility**. . . . [¶] . . . [¶] . . . I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility." (Bold in original.)

As we shall explain, plaintiffs' opposition to Hospital's motion for summary judgment relied on paragraph 6.5 of the contract between Hospital and Medical Group (the Medical Group contract),[5] which provided: "Contractor [Medical Group] shall

[5] The Medical Group contract was in effect from January 1, 2005, until December 31, 2008. Hospital and Medical Group subsequently agreed to extend the contract for one year.
(continued)

participate in all third-party payment or managed care programs in which Hospital participates, render services to those patients covered by such programs, and accept payment amounts provided for under these programs as payment in full for services of [Medical Group]. If requested by Hospital, [Medical Group] agrees to discount his/her charges proportionately to any discounts given by Hospital of its charges to a third-party payor or any patient participation plan, provided such discounts are within the normal ranges provided by similar contractors in central California." Plaintiffs argue that other provisions of the Medical Group contract are "indicia" that Hospital exercised "significant control" over Medical Group.

PROCEDURAL HISTORY

Original Complaint and Hospital's Demurrer

In December 2009, plaintiffs filed a class action complaint "on behalf of themselves and others similarly situated" against Hospital and Doe defendants alleging causes of action for declaratory and injunctive relief, breach of contract, breach of the

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Plaintiffs submitted excerpts from the Medical Group contract as exhibit E to their counsel's declaration in opposition to the motion for summary judgment. The parties subsequently stipulated that the original exhibit E be removed from the trial court's file and destroyed because it contained "confidential, proprietary business information that should have been redacted prior to filing." They also stipulated that a revised exhibit E, which contained a redacted copy of the contract excerpts, be filed in its place. The trial court granted the parties' request and ordered that the unredacted version of exhibit E be removed from the court's file, destroyed, and replaced by the redacted version of exhibit E. However, plaintiffs' appendix on appeal contains a copy of the original, unredacted exhibit E. Hospital has made a motion to strike the unredacted exhibit E from plaintiffs' appendix "because it does not exist in the trial court's file," and has asked us to refer instead to the redacted version of exhibit E, which is in Hospital's appendix. We grant that request and order that pages 245 through 258 be removed from plaintiff's appendix and destroyed by the clerk of this court. (See Cal. Rules of Court, rule 8.124(g) ["Filing an appendix constitutes a representation that the appendix consists of accurate copies of documents in the superior court file"].) We note also that Hospital's reply papers contained additional excerpts from the Medical Group contract.

implied covenant of good faith and fair dealing, unfair business practices under the unfair competition law (UCL) (Bus. & Prof. Code, § 17200 et seq.), and violation of the CLRA. The complaint alleged that although Hospital accepted health insurance as full compensation for its services, the health care providers that worked in its emergency room (Providers) did not, which resulted in patients being "billed for the full, list or chargemaster rates[6] demanded by such Providers" and " 'balance billing.' " Plaintiffs complained that the rates charged by Providers were not reasonable, were not revealed by Hospital, and were not consented to by plaintiffs. Plaintiffs alleged that Hospital failed (1) to maintain agreements with Providers that assured that Providers would accept the same insurance plans as Hospital, or (2) to disclose at the time of admission that some of its Providers did not accept plaintiffs' insurance or "which . . . Providers do or do not accept which insurer's insurance." The complaint alleged that by doing so, Hospital breached its contractual duties to its patients and engaged in unfair business practices.

In March 2010, Hospital demurred to the original complaint. Hospital argued that since California law prohibits the corporate practice of medicine, a private hospital may not employ physicians, except in limited situations, none of which apply here, and that

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6 Since July 2004, the Payers' Bill of Rights (Health & Saf. Code, § 1339.50 et seq.) has required hospitals to submit a "charge description master" to the Office of Statewide Health Planning and Development (OSHPD) each year, which OSHPD publishes on its "Hospital Chargemaster" website. (Health & Saf. Code, §§ 1339.55, subd. (a), 1339.51, subd. (b); <http://www.oshpd.ca.gov/chargemaster/FAQ.pdf> [as of Dec. 5, 2012].) A "[c]harge description master" is "a uniform schedule of charges represented by the hospital as its gross billed charge for a given service or item, regardless of payer type." (Health & Saf. Code, § 1339.51, subd. (b)(1).) A hospital "shall make a written or electronic copy of its charge description master available, either by posting an electronic copy of [it] on the hospital's Internet Web site, or by making one written or electronic copy available at the hospital location" and "shall post a clear and conspicuous notice in its emergency department, if any, in its admissions office, and in its billing office that informs patients that the hospital's charge description master is available" at those locations. (*Id*., § 1339.51, subds. (a)(1), (c).)

Hospital staffs its emergency room by contracting with Medical Group, an independent group of physicians. The demurrer asserted that Hospital and Medical Group were distinct legal entities that contracted separately with health plans and billed independently of one another. Hospital argued that plaintiffs failed to state a cause of action for declaratory and injunctive relief because they failed to plead facts showing an actual controversy between the parties and merely asked the court to create new law. Hospital argued that no contract, statute, or regulation imposed duties on Hospital to insure that Medical Group accepted plaintiffs' insurance or warn that it did not; that there was no dispute between the parties about these matters; and that it was unnecessary to impose additional duties on hospitals since patients are protected from balance billing by Health and Safety Code section 1379 and *Prospect*. Hospital argued that although the contract cause of action alleged that plaintiffs and the class had "entered into written contractual relationship[s]" with Hospital, it failed set forth the terms of the contracts, identify the contracts by name, or attach copies of the contracts. Hospital asserted that the cause of action for breach of the implied covenant of good faith and fair dealing was no different from the contract claim, since the allegations were the same. Hospital argued that plaintiffs failed to allege unfair business practices with sufficient particularity and that the complaint failed to identify the conduct that gave rise to the claim. Hospital asserted that the complaint was devoid of facts showing that Hospital made any representations to plaintiffs regarding Medical Group or included any unconscionable provisions in a contract that violated the CLRA.

Hospital also filed written notice that in May 2009, plaintiffs filed a related action against Medical Group entitled *Leon v. Emergency Medical Group of Watsonville* (Super. Ct. Santa Cruz County, No. CV163961).

Plaintiffs opposed the demurrer, arguing that the allegations of the complaint were sufficient as to each cause of action.

The trial court overruled the demurrer to the declaratory and injunctive relief cause of action and sustained the demurrers with leave to amend as to the remaining causes of action.

First Amended Complaint and Hospital's Demurrer

Plaintiffs filed a first amended complaint, which contained the same five causes of action as the original complaint. The first amended complaint (1) identified the contracts at issue as the COA forms that plaintiffs and other class members signed upon being admitted to the emergency room and (2) contained more detailed allegations regarding plaintiffs' dates of admission, the amounts billed by Medical Group, the amounts Health Plan determined were allowable rates, and the amounts paid. Plaintiffs also apparently attached copies of "pertinent portions" of the COA forms to their first amended complaint as exhibit A.[7] The unfair business practices cause of action set forth the specific statutes and case law that plaintiffs alleged Hospital had violated[8] and asserted violations under all three prongs of the UCL (namely, unfair, unlawful, and fraudulent

[7] Plaintiffs' appendix does not contain a copy of exhibit A to their first amended complaint. Presumably, that exhibit contained the same COA forms that are attached as exhibit A to their third amended complaint, which is in the appendix. The papers in support of and in opposition to the demurrer to the first amended complaint, which refer to exhibit A and discuss the language of the COA forms, support that conclusion.

[8] Plaintiffs asserted the following bases for the unfair business practices claim: (1) misrepresentations under Civil Code sections 1572, 1573, 1709, 1710, and 1770, subdivision (a)(14), alleging that Hospital led them to believe that only regular rates would be charged; (2) violations of Health and Safety Code section 1317 and the holdings in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211 and *Prospect*; (3) negligent failure to control the conduct of independent contractors, citing Civil Code section 1714, subdivision (a); (4) that the contract with Hospital was unconscionable (Civ. Code, §§ 1670.5, 1770, subd. (a)(19)); (5) breach of contract; (6) breach of the implied covenant of good faith and fair dealing; and (7) violations of "Section 5 of the Federal Trade Commission Act."

acts). The allegations of plaintiffs' CLRA cause of action were substantially the same as those in the original complaint.

Hospital responded with another demurrer, arguing that there was no factual or legal basis for holding Hospital liable for a dispute between plaintiffs, Health Plan, and Medical Group over amounts plaintiffs were charged by Medical Group. Hospital asserted that plaintiffs had not identified any legal authority or contract that required Hospital (1) to ensure that Medical Group charged reasonable rates, (2) to require Medical Group to contract with plaintiffs' health plan, or (3) to advise plaintiffs that Medical Group did not accept their health plan. Hospital argued that the COA did not contain any provision regarding Medical Group's services or rates, that the COA expressly stated that some services may be performed by independent contractors who are not employed by Hospital, and that plaintiffs had not identified any provisions of the COA that Hospital allegedly breached. Hospital renewed its argument that the cause of action for breach of the implied covenant of good faith and fair dealing was no different from the breach of contract claim and argued that plaintiffs had failed to plead any facts showing that Hospital had engaged in bad faith conduct. In addition, Hospital attacked the UCL, CLRA, and declaratory relief causes of action. Hospital also filed a motion to strike the class action allegations of the first amended complaint, arguing that they were overly broad.

Plaintiffs opposed the demurrer, arguing that Hospital's liability was based on the "express, if ambiguous terms of the COA" and Hospital's duties under "premises liability law." Plaintiffs argued that the COA promised that charges from the "Facility" would be at regular rates and that the term "Facility" includes Providers. They asserted that Hospital had an obligation to control people who worked in its facility to insure that they complied with the law.

At the hearing on the demurrer, Hospital asserted that if hospitals "are going to be required to make . . . additional disclosures to patients regarding the contractual

relationship between the physicians and [insurance companies] or if they're going to be required to police the contracts between physicians and insurance companies, those changes should come through the [L]egislature and not the courts."

The court overruled the demurrer to the first cause of action for declaratory relief, sustained the demurrers to the remaining causes of action without leave to amend, and granted the motion to strike the class action allegations with leave to amend.

Second Amended Complaint and Hospital's Response

Plaintiff filed a second amended complaint that contained a single cause of action for declaratory relief. The class allegations remained essentially the same. Hospital responded with another motion to strike, arguing that plaintiffs failed to amend the class action allegations and that those allegations should be stricken because they were still overly broad. The court granted the motion to strike with leave to amend as to the class allegations.

Motion for Summary Judgment and Third Amended Complaint

On February 2, 2011, two days before the hearing on the motion to strike, Hospital filed a motion for summary judgment, challenging the declaratory relief action.

On March 3, 2011, plaintiffs filed a third amended class action complaint for declaratory and injunctive relief. Hospital answered the third amended complaint in April 2011, before the hearing on the motion for summary judgment.

Hospital's motion for summary judgment argued that this lawsuit was an unreasonable attempt to hold Hospital liable for a dispute between plaintiffs, Health Plan, and Medical Group and to expand the holding in *Prospect*. Hospital contended that it did not and could not employ Providers, that Medical Group was an independent contractor, and that Hospital and Medical Group were distinct legal entities that contracted separately with patients' health plans. Hospital argued that it did not have a duty to ensure that Medical Group charged reasonable rates, to require Medical Group to contract with plaintiffs' health plans, or to advise plaintiffs that Medical Group did not accept

their health plan. Hospital asserted that the trial court had already determined that these duties, which plaintiffs sought to impose on Hospital, did not exist when it dismissed the other causes of action. Hospital argued that declaratory relief was not necessary or proper since plaintiffs did not need to be told that Medical Group did not accept Health Plan and plaintiffs were already protected from balance billing by Health and Safety Code section 1379 and *Prospect*.

In opposition, plaintiffs argued that there was a material factual dispute regarding Hospital's duties to protect patients from or warn them about Medical Group's billing practices. Plaintiffs contended that Hospital's duties were based on: (1) the COA, (2) common law premises liability theories, and (3) obligations created by Hospital's written contract with Medical Group. Plaintiffs argued that the Medical Group contract imposed a duty on Hospital to control Medical Group's billing practices, that Hospital breached that duty, and that plaintiffs were third party beneficiaries of that contract. Plaintiffs argued that Hospital had a common law duty to control the activities on its premises, including Medical Group's billing practices, and that its duty was analogous to that of a property owner's duty to supervise a concessionaire. Repeating arguments they had made in support of their breach of contract and breach of the implied covenant of good faith and fair dealing causes of action, plaintiffs argued that the COA imposed a duty on Hospital to protect or warn patients of Medical Group's billing practices. They also argued that the COA failed to conform to the California Hospital Association's model conditions of admission form. Plaintiffs asserted that declaratory relief was appropriate because this case did not involve only past wrongs and the fact that the law controls Providers' conduct does not preclude imposing liability on Hospital. Plaintiffs requested leave to amend, arguing that the Medical Group contract, which had recently been produced in discovery, changed the case and that, in light of that contract, the other causes of action were improperly dismissed.

In reply, Hospital argued that the Medical Group contract required Medical Group not to balance bill, but did not create any duties on the part of Hospital; that the model conditions of admissions form did not create any duties; and that plaintiffs had not met their burden of showing they were entitled to amend.

The court granted the motion for summary judgment. The court ruled that the COA did not contain any limitation on "what the physicians can charge," that Hospital did not have a "duty, based upon this contract, to ensure physicians will only charge reasonable rates," and that Hospital did not have an "express contractual duty to advise patients regarding the rates physicians charge." Rejecting plaintiffs' premises liability theory, the court stated that it was not aware of any case holding property owners "responsible for the unfair business practices of a third party on their premises." Although the court agreed that plaintiffs were third party beneficiaries of the Medical Group contract, it was not persuaded that that contract created any duty on the part of Hospital to enforce contract terms for the benefit of plaintiffs. The court therefore declared that Hospital "owed no duty to the Plaintiffs to either prevent physicians from overcharging or to warn the Plaintiffs that physicians may or did indeed overcharge."

Plaintiffs appeal, challenging the rulings on both the demurrer to the first amended complaint and the summary judgment motion.

DISCUSSION

Plaintiffs have organized their brief and their arguments around two questions of duty: (1) whether Hospital had a duty to insure that "only regular rates [are] charged" under the COA, the Medical Group contract, or the implied covenant of good faith and fair dealing; and (2) whether Hospital had a duty to prevent or warn of Medical Group's billing practices under common law premises liability principles, the UCL, or the CLRA. Hospital, on the other hand, addresses the questions presented by discussing each cause of action separately. Since plaintiffs attack the propriety of the trial court's rulings on both the demurrer to the first amended complaint and the motion for summary judgment,

we adopt the latter approach and will organize our discussion by cause of action rather than by claim of duty.

I. *Demurrer to First Amended Complaint*

A. Standard of Review

"A general demurrer searches the complaint for all defects going to the existence of a cause of action and places at issue the legal merits of the action on assumed facts." (*Carman v. Alvord* (1982) 31 Cal.3d 318, 324.)

"On appeal from a judgment of dismissal after a demurrer is sustained without leave to amend, the reviewing court assumes the truth of all facts properly pleaded by the plaintiff. [Citation.] 'We also accept as true all facts that may be implied or reasonably inferred from those expressly alleged. [Citation.]' . . . But we do not assume the truth of ' " 'contentions, deductions or conclusions of fact or law.' " ' [Citation.]" (*Trinity Park, L.P. v. City of Sunnyvale* (2011) 193 Cal.App.4th 1014, 1026 (*Trinity Park*).)

"We also consider matters that may be judicially noticed. [Citations.] Among other things, the Evidence Code provides that judicial notice may be taken of '[f]acts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy.' [Citation.] We may therefore take judicial notice of an agreement where 'there is and can be no factual dispute concerning the contents of the agreements. [Citation.]' [Citation.] However, we keep in mind the general rule that '[w]hen judicial notice is taken of a document . . . the truthfulness and proper interpretation of the document are disputable. [Citation.]' [Citation.]" (*Trinity Park, supra,* 193 Cal.App.4th at pp. 1026-1027.)

" 'We also consider the complaint's exhibits. [Citations.] Under the doctrine of truthful pleading, the courts "will not close their eyes to situations where a complaint contains allegations of fact inconsistent with attached documents, or allegations contrary to facts which are judicially noticed." [Citation.] "False allegations of fact, inconsistent with annexed documentary exhibits [citation] or contrary to facts judicially noticed

[citation], may be disregarded . . . .” [Citations.]’ [Citation.]” (*Trinity Park, supra*, 193 Cal.App.4th at p. 1027, fn. omitted.)

After reviewing the allegations of the complaint, the exhibits to the complaint, and matters properly subject to judicial notice, we exercise our independent judgment on the question of whether the complaint states a cause of action as a matter of law. (See *Moore v. Regents of University of California* (1990) 51 Cal.3d 120, 125.) In exercising our independent judgment, “ ‘we give the complaint a reasonable interpretation, reading it as a whole and its parts in their context.’ [Citations.]” (*Melton v. Boustred* (2010) 183 Cal.App.4th 521, 528.) “On appeal, ‘the plaintiff bears the burden of demonstrating that the trial court erred’ in sustaining the demurrer. [Citation.]” (*Ibid.*)

B. Leave to amend

Where, as here, the trial court sustained a demurrer without leave to amend, we review the court’s determination that no amendment could cure the defect in the complaint for abuse of discretion. (*Schifando v. City of Los Angeles* (2003) 31 Cal.4th 1074, 1081.) “If we see a reasonable possibility that the plaintiff could cure the defect by amendment, then we conclude that the trial court abused its discretion in denying leave to amend. If we determine otherwise, then we conclude it did not. [Citation.] The plaintiff has the burden of proving that an amendment would cure the defect. [Citation.]” (*Campbell v. Regents of University of California* (2005) 35 Cal.4th 311, 320.)

C. Breach of Contract

1. *Allegations of the Complaint*

The breach of contract cause of action in plaintiffs’ first amended complaint is based on the COA forms, copies of which were apparently attached to the first amended complaint. Plaintiff alleged that although the COA forms “expressly stated that charges incurred at the facility are to be at a regular rate,” Providers billed “at a rate that was much more than the regular, usual, customary or reasonable rate.” They alleged that “even absent the ‘regular rate’ language of the COA,” the agreement between plaintiffs

and Hospital implied a regular rate because Hospital accepted plaintiffs' health plans but did not inform them that Providers did not accept their health plans or expressly agree on a price, which meant that a "reasonable" price term would be implied. They alleged that Hospital breached the contract (1) by allowing Providers to charge "other than regular rates," (2) by having Providers in its facility who did not accept plaintiffs' health plans, or (3) by not informing plaintiffs that Providers did not accept their health plans, which resulted in balance billing and economic damages.

2. *Controlling Principles of Contract Interpretation*

The basic goal of contract interpretation is to give effect to the parties' mutual intent "as it existed at the time of contracting, so far as the same is ascertainable and lawful." (Civ. Code, § 1636; accord, *Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, 1264.) When a contract is reduced to writing, the parties' intention is determined from the writing alone, if possible. (Civ. Code, § 1639.) The language of the contract governs its interpretation, "if the language is clear and explicit, and does not involve an absurdity." (*Id*., § 1638.) "California recognizes the objective theory of contracts [citation], under which '[i]t is the objective intent, as evidenced by the words of the contract, rather than the subjective intent of one of the parties, that controls interpretation' [citation]. The parties' undisclosed intent or understanding is irrelevant to contract interpretation. [Citations.]" (*Founding Members of the Newport Beach Country Club v. Newport Beach Country Club, Inc*. (2003) 109 Cal.App.4th 944, 956.)

"The words of a contract are to be understood in their ordinary and popular sense. . . ." (Civ. Code, § 1644.) The court may explain a contract "by reference to the circumstances under which it was made, and the matter to which it relates." (Code Civ. Proc., § 1647; see also *Lloyd's Underwriters v. Craig & Rush, Inc*. (1994) 26 Cal.App.4th 1194, 1197-1198 ["We interpret the intent and scope of the agreement by focusing on the usual and ordinary meaning of the language used and the circumstances under which the agreement was made"].) A contract is to be interpreted as a whole, "so

as to give effect to every part, if reasonably practicable, each clause helping to interpret the other." (Civ. Code, § 1641.) Where there are several provisions to the contract, "such a construction is, if possible, to be adopted as will give effect to all." (Code Civ. Proc., § 1858.)

The construction of a contract calls for different standards of review, depending upon whether the trial court admits extrinsic evidence on the contract interpretation question. When no extrinsic evidence is introduced, as was the case here, the appellate court independently construes the contract. (*Parsons v. Bristol Development Co*. (1965) 62 Cal.2d 861, 865, 866.)

3. *Analysis*

The pertinent provisions of the COA provide: "1) **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES**: [¶] I hereby voluntarily consent for treatment/admission to the Facility. I permit the Facility and its employees, physicians and others involved in my care to treat me in ways they judge to be beneficial to me. . . . I consent to examinations, . . . nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s). [¶] I agree and understand that all physicians, dentists, oral surgeons and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for the acts or omissions of the aforementioned. **Some services may be performed by independent contractors who are not employed by the Facility**. . . . [¶] . . . [¶] 4) **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY**: [¶] I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits. . . . [¶] I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility." (Bold in original.)

Renewing arguments they made below, plaintiffs argue that the term "Facility" "is not specifically defined, despite being capitalized." Plaintiffs argue that the word "Facility" "encompasses under its roof employees, physicians and others involved in care at the Facility"; that it "appears to encompass all services provided at the facility"; and that "it seems fair to include all those who provide services at the facility to be included in the terms of the [fourth] paragraph—regular rates and terms apply." Plaintiffs assert that "the most reasonable interpretation is that facility refers not just to [Hospital] itself, but to the providers working within it" and that "the COA imposes a duty on [Hospital] to assure regular rates, the ones usually, customarily or reasonably charged are the rates to be paid for all services provided at the facility."

In ruling on the demurrer, the trial court concluded that the term "Facility" meant the hospital. The court also rejected plaintiffs' contention that the COA contained a promise that Medical Group would bill at regular rates. The court held that the COA "specifically says that the 'facility based physicians' are independent contractors and it does not appear to constrain their billings in any way. It does not require the hospital to (1) ensure what those rates are, or (2) advise patients as to supposedly reasonable rates."

We agree with the trial court's interpretation of the contract. A "facility" is "something (as a hospital, machinery, plumbing) that is built, constructed, installed or established to perform some particular function or to serve or facilitate some particular end." (Webster's 3d New Internat. Dict. (1993) pp. 812-813.) The licensing provisions in the Health and Safety Code define " '[g]eneral acute care hospital' " in pertinent part as "a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff" (Health & Saf. Code, § 1250, subd. (a)) and " 'health facility' " in part as "any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of

human illness" (*id*., § 1250). The COA's use of the term "Facility" to refer to the hospital is consistent with these statutes.[9]

Although not a model of clarity, when read as a whole, the COA distinguishes services provided by Hospital and its personnel from services provided by facility-based physicians (physicians who have privileges to treat patients at Hospital but are not employed by Hospital) and others who treat patients at the hospital.[10] In paragraph 1 of the COA, in which the patient consents to treatment, the patient authorizes treatment by the "Facility and its employees, physicians and others involved in my care." It is not clear whether the reference to "physicians" in this sentence means physicians employed by Hospital, facility-based physicians, or both. But in any event, this sentence does not relate to billing or the liability of Hospital for the acts of others. And although the language of this first sentence seems to be broad, the provisions that follow are more specific and narrow its scope. In paragraph 1, the patient also consents to treatment rendered by "my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel." This language distinguishes physicians from other Facility personnel and advises the patient that persons other than those employed by Hospital may be involved in his or her care. Paragraph 1 also provides that the patient "agree[s] and understand[s] that *all* physicians, dentists, oral surgeons and podiatrists

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[9] The Health and Safety Code contains two separate statutory schemes that govern "Hospital Fair Pricing Policies" (Health & Saf. Code, §§ 127400-127446) and "Emergency Physician Fair Pricing Policies" (*id*., §§ 127450-127462). For the purpose of these statutes, with two exceptions that do not apply here, " '[h]ospital' " includes "a facility that is required to be licensed under subdivision (a) of Section 1250" of the Health and Safety Code. (*Id*., § 127450, subd. (f); accord, *id*., § 127400, subd. (d).)

[10] By comparison, the California Hospital Association's model conditions of admission form in the record, which was promulgated after the treatment at issue in this case, is clearer on this point. It provides: "All physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist and others, are not employees or agents of the hospital."

involved in [his or her] care in any way are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for the acts or omissions of the aforementioned." (Italics added.) This sentence distinguishes the acts of physicians from the acts of the Facility; and Hospital disavows liability for the acts of "all physicians." Paragraph 1 next advises in bold letters: "**Some services may be performed by independent contractors who are not employed by the Facility**." In addition, the assignment of insurance benefits in paragraph 4 of the COA distinguishes between "the Facility" and "any facility-based physician." If "Facility" included Medical Group, there would be no need for an assignment of benefits to "any facility-based physician." Based on the plain language of these provisions, read as a whole, we reject plaintiffs' contention that the term "Facility" includes facility-based physicians like Medical Group who treat patients on Hospital's premises.

We also reject plaintiffs' contention that the COA contains a promise that persons who treat patients at Hospital, including Medical Group, will only charge "regular rates."[11] The COA provides in paragraph 4: "I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility." By this language, the patient promises to pay Hospital according to its regular rates and

[11] Plaintiffs argue that "regular rates" are the ones "usually, customarily or reasonably charged" and that the phrase "certainly means a rate much less than the chargemaster rate," which Hospital reports annually to the OSHPD. But by statutory definition, the chargemaster rate is the "gross billed charge for a given service or item, regardless of payer type." (Health & Saf. Code, § 1339.51, subd. (b)(1).) It is not clear whether the phrase "regular rates" in the COA includes allowable rates under plaintiffs' health plan, which are presumably discounted rates negotiated between health plans and their participating providers. According to plaintiffs, Health Plan's allowable rate was approximately one-third of the "chargemaster rate" that Medical Group charged. Since we conclude that the "regular rates" language in the COA only applies to amounts billed by Hospital and plaintiffs do not challenge the amounts billed by Hospital, we need not interpret the phrase "regular rates."

terms. We may infer from this language a promise by Hospital to bill the patient according to its regular rates and terms. But, since the term "Facility" means Hospital and does not include independent physicians and providers who treat patients at Hospital, and since paragraph 4 mentions only "the account of the Facility," and not Medical Group's account, or the account of any facility-based physician or any other physician, we conclude that the COA does not contain a promise that Medical Group will only charge regular rates.

Furthermore, there is nothing in the language of the COA that requires Hospital to ensure that Medical Group accepts the same health plans as Hospital, to determine which health plans Medical Group contracts with, or to advise patients that Medical Group may not accept the same health plans as Hospital. To the contrary, upon signing the COA, the patient acknowledges "that all physicians . . . involved in my care in any way are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for acts or omissions of the aforementioned" and that some persons involved in the patient's care may be independent contractors.

In addition, by its own terms the COA applies to both "Inpatient/Outpatient" admissions. To interpret the COA as plaintiffs suggest would require Hospital to monitor and oversee the billing practices of not only the emergency room physicians, but of surgeons who admit their patients to Hospital for surgical procedures, obstetricians who deliver babies at Hospital, and all other independent "physicians, dentists, oral surgeons and podiatrists" who have hospital privileges and treat patients at Hospital. Nothing in the COA imposes such a duty on Hospital. Plaintiffs do not cite any statutory or other legal authority that imposes such a duty.

Given our construction of the COA, we conclude as a matter of law that plaintiffs cannot state a cause of action for breach of contract based on their allegations that Hospital breached the COA (1) by allowing Providers to charge "other than regular rates," (2) by having Providers in its facility who did not accept plaintiffs' health plans,

or (3) by not informing plaintiffs that Providers did not accept their health plans. We therefore hold that the trial court did not err when it sustained the demurrer to the breach of contract cause of action without leave to amend.

D. Breach of the Implied Covenant of Good Faith and Fair Dealing

Plaintiffs contend the trial court erred when it sustained the demurrer to their claim for breach of the implied covenant of good faith and fair dealing (hereafter breach of the implied covenant claim) without leave to amend. Hospital argues that the court did not err because (1) plaintiffs' breach of the implied covenant claim "was identical to [their] breach of contract claim, was based entirely on the same allegations, and was therefore superfluous"; (2) plaintiffs cannot show that Hospital did anything to frustrate the promises in or the purpose of the COA; and (3) it would be absurd to find that Hospital had a duty to tell patients that Medical Group might do what it promised not to do (balance bill) in the Medical Group contract.

" 'Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.' (Rest.2d Contracts, § 205.)" (*Foley v. Interactive Data Corp.* (1988) 47 Cal.3d 654, 683 (*Foley*).) "The covenant of good faith and fair dealing, implied by law in every contract, exists merely to prevent one contracting party from unfairly frustrating the other party's right to receive the benefits of the agreement actually made. [Citation.] The covenant thus cannot ' "be endowed with an existence independent of its contractual underpinnings." ' [Citations.] It cannot impose substantive duties or limits on the contracting parties beyond those incorporated in the specific terms of their agreement." (*Guz v. Bechtel National, Inc*. (2000) 24 Cal.4th 317, 349-350, italics omitted (*Guz*).)

"[D]efining what is required by this covenant has not always proven an easy task." (*Carma Developers (Cal.), Inc. v. Marathon Development California, Inc*. (1992) 2 Cal.4th 342, 372 (*Carma*).) "It is universally recognized the scope of conduct prohibited by the covenant of good faith is circumscribed by the purposes and express terms of the

contract. [Citations.] As explained in *Foley*, under traditional contract principles, the implied covenant of good faith is read into contracts 'in order to protect the express covenants or promises of the contract, not to protect some general public policy interest not directly tied to the contract's purpose.' [Citation.]" (*Id.* at p. 373.) "Notwithstanding the difficulty in devising a rule of all-encompassing generality, a few principles have emerged in the decisions. To begin with, breach of a specific provision of the contract is not a necessary prerequisite. [Citation.] . . . Nor is it necessary that the party's conduct be dishonest. Dishonesty presupposes subjective immorality; the covenant of good faith can be breached for objectively unreasonable conduct, regardless of the actor's motive." (*Ibid*.)

We begin by addressing Hospital's contention that the breach of the implied covenant claim was superfluous. In *Guz*, which involved the alleged breach of an at-will employment contract, the court explained, "A breach of the contract may also constitute a breach of the implied covenant of good faith and fair dealing. But insofar as the employer's acts are directly actionable as a breach of an implied-in-fact contract term, a claim that merely realleges that breach as a violation of the covenant is superfluous." (*Guz, supra,* 24 Cal.4th at p. 352.) "To the extent [the] implied covenant cause of action seeks to impose limits on [the employer's] termination rights beyond those to which the parties actually agreed, the claim is invalid. To the extent the implied covenant claim seeks simply to invoke terms to which the parties did agree, it is superfluous." (*Ibid.*, italics omitted.)

Plaintiffs' breach of contract cause of action alleged that Hospital breached the COA (1) because Providers "billed at a rate that was much more than the regular, usual, customary or reasonable rate," (2) by allowing Providers who did not accept plaintiffs' health plans to work in the Hospital, and (3) when Hospital failed to inform plaintiffs that Providers did not accept their health plan. The breach of the implied covenant claim in plaintiffs' first amended complaint incorporated the allegations of their declaratory

relief and breach of contract causes of action by reference and alleged that Hospital's "acts, as alleged above, constitute a breach of [the] duty of good faith and fair dealing, since only a regular or reasonable rate could be charged in order to fulfill the contracts made. [¶] . . . Such unfair and bad faith conduct by defendant[] proximately caused economic injury and other damages . . . ." Thus, the breach of the implied covenant claim did not allege any conduct separate and apart from the alleged breach of the implied promise that Hospital would only charge a regular rate. In this case, as in *Guz*, the implied covenant claim seeks simply to invoke contract terms the parties had agreed to and is therefore superfluous.

Citing *Acree v. General Motors Acceptance Corp*. (2001) 92 Cal.App.4th 385 (*Acree*), plaintiffs argue that when a contract gives one party a discretionary power affecting the rights of the other party, the implied covenant imposes "a duty to exercise that discretion in good faith and in accordance with fair dealing." As stated in *Carma*, "The covenant of good faith finds particular application in situations where one party is invested with a discretionary power affecting the rights of another. Such power must be exercised in good faith." (*Carma*, *supra*, 2 Cal.4th at p. 372.) "The essence of the good faith covenant is objectively reasonable conduct. Under California law, an open term in a contract must be filled in by the party having discretion within the standard of good faith and fair dealing." (*Lazar v. Hertz Corp*. (1983) 143 Cal.App.3d 128, 141 (*Lazar*).)

Acree was a class action suit by automobile buyers against General Motors Acceptance Corporation (GMAC), the company that financed their purchases. (*Acree*, *supra*, 92 Cal.App.4th at pp. 389, 390.) The standard sales agreement required buyers/borrowers to insure the vehicles and provided that if they did not or the coverage lapsed, GMAC may purchase collateral protection insurance (CPI) in its place. (*Id*. at pp. 390, 395.) After a borrower purchased or reinstated coverage, GMAC used an accelerated method, rather than a "pro rata-by-time" or "actuarial" method that was more advantageous to the borrower, to calculate the amount of any premium refund. (*Id.* at

p. 395; see *id*. at p. 391.) Since the standard sales agreement left the terms of the CPI policy, including the method for computing premium refunds, to GMAC's reasonable discretion, the court concluded that "the issue of whether GMAC breached the standard sales agreement involves whether GMAC breached the implied covenant of good faith and fair dealing." (*Id.* at p. 393, italics omitted.) The court explained, "[a] borrower can legitimately expect that an appropriate amount of the premiums will be refunded if the insurance is ended before its term. And although GMAC can unilaterally decide the premium refund method, that decision, pursuant to the implied covenant, must be a reasonable one; legitimate expectations naturally flow from this recognition." (*Id.* at p. 395, fn. omitted.) In *Acree*, there was evidence that the actuarial method is commonly used to compute premium refunds, that GMAC used that method for some of its CPI policies, and that GMAC had filed a notice with the Michigan Insurance Bureau and sent notices to customers stating that it used the actuarial method. (*Ibid*.) In light of this evidence, the court held that although the agreement was silent on the premium refund method, a borrower could reasonably expect that an actuarial method would be used, and affirmed the judgment finding a breach of the implied covenant. (*Id.* at pp. 390, 395-396.)

Plaintiffs argue that "similar to *Acree*, the COA was at best silent about the fact that providers [who] balance billed, or did not accept insurance were working within its hospital, but actually was either explicit or at best ambiguous in informing patients that only regular rates would be charged at the facility." But plaintiffs do not articulate the specific discretionary power affecting the rights of the other party that they assert as the basis for their breach of the implied covenant claim. For example, in *Acree*, the sales agreement left the terms of the CPI policy, including the method for computing premium refunds, to GMAC's reasonable discretion. (*Acree*, *supra*, 92 Cal.App.4th at p. 393.) In *Perdue v. Crocker National Bank* (1985) 38 Cal.3d 913, the court held that a checking account signature card, which permitted a bank to set insufficient funds charges at its

discretion, was a contract subject to the bank's duty of good faith and fair dealing in setting such charges. (*Id*. at pp. 923-924.) In *Lazar*, the court concluded that the term in a rental car agreement that permitted the rental car company to unilaterally determine the price charged to refill the gas tanks on returned rental cars was subject to the standard of good faith and fair dealing. (*Lazar*, *supra,* 143 Cal.App.3d at p. 141; see also *Cal. Lettuce Growers v. Union Sugar Co.* (1955) 45 Cal.2d 474, 484 [agreement that was silent as to price provided for verification of an average net selling price by an independent firm of public accountants *chosen by* the buyer].)

Similarly, Hospital's implied promise to bill patients according to its "regular rates and terms" is an open price term that gave Hospital discretion in setting the rates charged for its services, and is therefore subject to its duty of good faith and fair dealing. However, since we hold that "Facility" means Hospital and does not include Medical Group or other providers, and plaintiffs do not complain about Hospital's billing rates or terms, we conclude that plaintiffs' reliance on *Acree* is misplaced.

Citing *Carma*, Hospital argues that plaintiffs may not use the implied covenant to vary the terms of an unambiguous agreement or override an express term of the contract. As we have noted, the implied covenant "cannot impose substantive duties or limits on the contracting parties beyond those incorporated in the specific terms of their agreement." (*Guz*, *supra*, 24 Cal.4th at pp. 349-350.) Since we conclude that the COA is not ambiguous, does not contain a promise that Medical Group will only charge regular rates, and does not require Hospital to ensure that Medical Group accepts the same health plans as Hospital, determine which health plans Medical Group contracts with, or advise patients that Medical Group may not accept the same health plans as Hospital, we agree that the implied covenant cannot be used to impose such duties.

For these reasons, we conclude that the trial court did not err when it sustained the demurrer to the breach of the implied covenant claim without leave to amend.

E. Violation of the UCL (Bus. & Prof. Code, § 17200 et seq.)

Plaintiffs contend that the trial court erred when it sustained Hospital's demurrer to their cause of action alleging unfair business practices under the UCL without leave to amend.

1. *General Principles Regarding the UCL*

The UCL "does not proscribe specific activities, but broadly prohibits 'any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising.' ([Bus. & Prof. Code,] § 17200.) The UCL 'governs "anti-competitive business practices" as well as injuries to consumers, and has as a major purpose "the preservation of fair business competition." [Citations.]' . . . ' "Because . . . section 17200 is written in the disjunctive, it establishes three varieties of unfair competition—acts or practices which are unlawful, or unfair, or fraudulent. 'In other words, a practice is prohibited as "unfair" or "deceptive" even if not "unlawful" and vice versa.' " ' [Citation.]" (*Puentes v. Wells Fargo Home Mortgage, Inc*. (2008) 160 Cal.App.4th 638, 643-644.)

" '[A]n action based on Business and Professions Code section 17200 to redress an unlawful business practice "borrows" violations of other laws and treats these violations, when committed pursuant to business activity, as unlawful practices independently actionable under section 17200 et seq. and subject to the distinct remedies provided thereunder.' " (*Farmers Ins. Exchange v. Superior Court* (1992) 2 Cal.4th 377, 383.) Virtually any law or regulation – state or federal, common law or statutory – may serve as a predicate for a UCL claim under the unlawful prong. (*People v. E.W.A.P., Inc*. (1980) 106 Cal.App.3d 315, 318-319; *Californians for Population Stabilization v. Hewlett-Packard Co.* (1997) 58 Cal.App.4th 273, 287 [listing types of state laws that have been enforced under the unlawful prong of Business and Professions Code section 17200], overruled on another ground in *Cortez v. Purolator Air Filtration Products Co*. (2000) 23 Cal.4th 163, 175-178; Stern, Bus. & Prof. C. § 17200 Practice

(The Rutter Group 2013) ¶¶ 3:56-3:111, pp. 3-13 to 3-29 (Stern).) But if the complaint fails to state a violation of the underlying " 'borrowed' " law, the UCL claim based on that law also fails. (Stern, *supra*, ¶ 5:141, p. 5-50.4, citing *Whiteside v. Tenet Healthcare Corp*. (2002) 101 Cal.App.4th 693, 706 (*Whiteside*) [patient's UCL claim failed to the same extent as his breach of contract claim, since there was nothing in hospital's agreement with patient that was likely to mislead a consumer], *Van Ness v. Blue Cross of California* (2001) 87 Cal.App.4th 364, 376-377 [dismissal of contract claim results in dismissal of dependent UCL claim], and other cases.)

" '[A] practice may be deemed unfair even if not specifically proscribed by some other law.' " (*Korea Supply Co. v. Lockheed Martin Corp*. (2003) 29 Cal.4th 1134, 1143.) As the court explained in *Boschma v. Home Loan Center, Inc*. (2011) 198 Cal.App.4th 230 (*Boschma*), "According to some appellate courts, a business practice is 'unfair' under the UCL if (1) the consumer injury is substantial; (2) the injury is not outweighed by any countervailing benefits to consumers or competition; and (3) the injury could not reasonably have been avoided by consumers themselves. (*Camacho v. Automobile Club of Southern California* (2006) 142 Cal.App.4th 1394, 1403–1405.) Other courts require 'that the public policy which is a predicate to a consumer unfair competition action under the "unfair" prong of the UCL . . . be tethered to specific constitutional, statutory, or regulatory provisions.' (*Bardin v. DaimlerChrysler Corp*. (2006) 136 Cal.App.4th 1255, 1260–1261.) Still others assess whether the practice 'is immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers . . . [weighing] the utility of the defendant's conduct against the gravity of the harm to the alleged victim.' (*Id*. at p. 1260.) And some courts, in reviewing a pleading, apply all three tests. (*Drum v. San Fernando Valley Bar Assn*. (2010) 182 Cal.App.4th 247, 256–257.)" (*Boschma*, at p. 252.)

" '[A] fraudulent business practice is one that is likely to deceive members of the public.' " (*Boschma*, *supra*, 198 Cal.App.4th at p. 252, quoting *Morgan v. AT&T*

Wireless Services, Inc. (2009) 177 Cal.App.4th 1235, 1255.) " 'A claim based upon the fraudulent business practice prong of the UCL is "distinct from common law fraud. 'A [common law] fraudulent deception must be actually false, known to be false by the perpetrator and reasonably relied upon by a victim who incurs damages. None of these elements are required to state a claim for . . . relief' under the UCL. [Citations.] This distinction reflects the UCL's focus on the defendant's conduct, rather than the plaintiff's damages, in service of the statute's larger purpose of protecting the general public against unscrupulous business practices." ' [Citation.] A fraudulent business practice ' " 'may be accurate on some level, but will nonetheless tend to mislead or deceive. . . . A perfectly true statement couched in such a manner that it is likely to mislead or deceive the consumer, such as by failure to disclose other relevant information, is actionable under' " the UCL.' [Citation.]" (*Boschma,* at pp. 252-253.)

2. *Allegations of the First Amended Complaint and Contentions on Appeal*

The UCL claim in plaintiffs' *original* complaint contained broad allegations that Hospital and Doe defendants had "unfairly, unlawfully, and fraudulently" led them to believe "that they would be covered for medical treatment at their facilities." In granting leave to amend, the court told plaintiffs' counsel that it would help focus the litigation if he alleged "with precision" what he wanted to "accomplish" or "what the basis of [the] claim is."

Plaintiffs' first amended complaint asserted the following bases for their UCL claim under the unlawful prong: (1) misrepresentations under Civil Code sections 1572, 1573, 1709, 1710, and 1770, subdivision (a)(14), alleging that Hospital led them to believe that only regular rates would be charged; (2) violations of Health and Safety Code section 1317 and the holdings in *Bell v. Blue Cross of California* and *Prospect*; (3) negligent failure to control the conduct of independent contractors, citing Civil Code section 1714, subdivision (a) and *Sprecher v. Adamson Companies* (1981) 30 Cal.3d 358

(*Sprecher*); (4) that the contract with Hospital was unconscionable, citing Civil Code sections 1670.5 and 1770, subdivision (a)(19)); (5) breach of contract; and (6) breach of the implied covenant of good faith and fair dealing. They relied on these same bases for their claim under the unfair prong, adding violations of "fundamental rules of honesty" and "Section 5 of the Federal Trade Commission Act," and asserted claims under the fraudulent prong of the UCL. As we shall explain, on appeal, plaintiffs assert some, but not all, of these theories as the bases for their UCL claim.

Plaintiffs' arguments on appeal related to the UCL cause of action are difficult to follow, since they have organized their brief according to broad claims of duty and do not present their arguments regarding their UCL claim under a single, separate argument heading.[12] Plaintiffs appear to rely on the unlawful and fraudulent prongs of the UCL; their brief does not contain any argument about the unfairness prong. On appeal, plaintiffs' unlawful business practices claim is based on common law theories of negligence, premises liability, the theory of "ostensible agency" in *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332 (*Elam*), contractual duties based on the Medical Group contract (which was not pleaded in the first amended complaint), and fraud (Civ. Code, § 1710).

Since plaintiffs' brief fails to discuss the other bases enumerated in their UCL claim in the first amended complaint, we conclude that they have waived or abandoned any claim of error related to those theories. (*Reyes v. Kosha* (1998) 65 Cal.App.4th 451, 466, fn. 6 [even when our review is de novo, the scope of review is limited to issues that

[12] Plaintiffs' argument headings that discuss the UCL claim state: "[Hospital] had a duty to prevent or warn of potential harm at its premises and made material misrepresentations or omissions for the purposes of declaratory relief, the [UCL] and the [CLRA]" and "[Hospital] had a duty to disclose in the COA or elsewhere key terms in a clear and unambiguous manner to avoid making misrepresentations or omissions under common law theories for the purposes of the [UCL] and/or [CLRA]."

have been adequately raised and supported in the appellant's brief, and issues not raised in the brief are deemed waived or abandoned].) And since we conclude that plaintiffs' breach of contract and breach of the implied covenant of good faith and fair dealing claims based on the COA are without merit, their UCL claims based on those theories fail. (See *Whiteside, supra,* 101 Cal.App.4th at p. 706.)

3. *Analysis: Unlawful Business Practices*

Plaintiffs contend that Hospital's business practices were unlawful under the UCL because they breached a common law duty to control activities on their premises. Plaintiffs cite Civil Code section 1714, which provides in relevant part: "(a) Everyone is responsible, not only for the result of his or her willful acts, but also for an injury occasioned to another by his or her want of ordinary care or skill in the management of his or her property or person, except so far as the latter has, willfully or by want of ordinary care, brought the injury upon himself or herself." (*Id*., subd. (a).) Plaintiffs argue that Hospital was negligent when it failed to assure that Medical Group abided by the Medical Group contract.

Plaintiffs cite *Sprecher, supra,* 30 Cal.3d 358, where the California Supreme Court abrogated the "old common law rule which immunized a possessor of land from liability for injury caused by a natural condition of his land to persons or property not on the land." (*Id.* at p. 360.) The court rejected the common law distinction between artificial and natural conditions and held that a possessor's exposure to liability is to be determined by reference to ordinary principles of negligence. (*Id.* at pp. 364-371.) The court held that the basic policy of the state is that everyone is responsible for any injury caused to another by his or her want of ordinary care or skill in the management of his or her property, and that the question is whether the possessor of land has acted as a reasonable person under all of the circumstances. (*Id.* at pp. 371-372.)

Plaintiffs analogize this case to *McCordic v. Crawford* (1943) 23 Cal.2d 1 (*McCordic*), a personal injury case involving the duty of an amusement park operator to

supervise a concessionaire who operated a ride on the Venice Pier. In *McCordic*, the court applied the rule " 'that a proprietor, or one who operates a place of amusement, owes a legal duty to exercise due care to protect from injury individuals who come upon his premises by his express or implied invitation. He must see that such premises are in a reasonably safe condition. It constitutes a breach of this duty for him to fail to exercise reasonably careful supervision of the appliances or methods of operating concessions under his management. The proprietor or operator of such a place of amusement is liable to an invited member of the public for injuries received as the result of negligence on the part of an independent contractor or concessionaire when it is shown that the failure to exercise such supervision proximately results in injuries to a patron. The duty of exercising care, and the responsibility for the negligence of independent concessionaires, are extended by law to the owner, the occupier or those in possession of the premises on which the amusement is being operated.' " (*Id.* at pp. 6-7.)

We agree with the trial court that plaintiffs cannot rely on a premises liability theory as the basis for their unlawful business practices claim. As the authority plaintiffs cite illustrates, the essence of premises liability is the liability of the owner or possessor of property for conditions or activities on the property. (See also 6 Witkin, Summary of Cal. Law (10th ed. 2005) Torts, § 1082, pp. 405-406.) Plaintiffs have not cited any authority that supports the proposition that a property owner may be held liable for unfair business practices of third parties or independent contractors who work on the premises. In addition, although the first amended complaint alleges that "emergency room professionals" employed by Medical Group provided health care services at Hospital, it acknowledges that Medical Group is a separate legal entity and alleges that Medical Group's bills were prepared by Marina Medical Billing Services. There is no allegation that Medical Group's billing practices had anything to do with the condition of the Hospital's premises or even occurred on the premises.

Citing *Elam*, plaintiffs argue that "there is a lengthy body of authority imposing [a] duty on hospitals even when fault lies against wholly independent physicians working within a hospital under the theory of ostensible agency" and that Hospital had an affirmative duty to control Medical Group's conduct. Although Plaintiffs' argument refers to the theory of ostensible authority, *Elam* actually considered the doctrine of corporate hospital liability. (*Elam*, *supra*, 132 Cal.App.3d at pp. 337-338.)

Elam was a medical malpractice action against a podiatrist, two physicians, and the hospital that had granted the podiatrist surgical privileges. The plaintiff alleged the podiatrist negligently performed surgery at the hospital. It was undisputed that the podiatrist was an independent contractor and not the hospital's employee or agent. (*Elam*, *supra*, 132 Cal.App.3d at pp. 335-336.) The court observed that although case precedent had established that a hospital may be held liable for a doctor's malpractice when the physician is actually employed by the hospital or is ostensibly the agent of the hospital, there were no appellate decisions addressing the application of the doctrine of corporate hospital liability for the negligent conduct of independent physicians and surgeons who use the hospital's facilities. (*Id.* at pp. 337-338.) The court noted that the hospital had a "peer review mechanism designed to continually monitor, evaluate and improve the quality of medical care furnished patients at [the hospital]." (*Id.* at p. 336.) The court observed that the doctrine of corporate hospital liability "has been utilized and expanded by the courts of several jurisdictions to collectively impose upon a hospital a direct and independent responsibility to its patients of insuring the competency of its medical staff and the quality of medical care provided through the prudent selection, review and continuing evaluation of the physicians granted staff privileges" and held that "a hospital is accountable for negligently screening the competency of its medical staff to insure the adequacy of medical care rendered to patients at its facility." (*Id.* at p. 346.)

Although *Elam* held that a hospital "owes generally a duty to insure the competency of its medical staff and to evaluate the quality of medical treatment rendered

on its premises" (*Elam, supra,* 132 Cal.App.3d at p. 347), nothing in that case suggests that a hospital's duty extends to monitoring and evaluating an independent physician's business or billing practices, including amounts charged for professional services. As Hospital notes, at least one case has declined to extend *Elam* as plaintiffs suggest. (See *Fisher v. San Pedro Peninsula Hospital* (1989) 214 Cal.App.3d 590, 616 [court declined to extend corporate hospital liability for negligent acts to a suit by one doctor for retaliation by another staff physician].) Since we conclude that the rule stated in *Elam* does not apply in this case, plaintiffs cannot state a claim for unlawful business practices based on *Elam*.

Plaintiffs argue that Hospital was "negligent in its failure to assure the providers were abiding by the mandate" in paragraph 6.5 of the Medical Group contract. However, plaintiffs did not plead this theory in their first amended complaint and it was not before the court at the hearing on the demurrer. It, therefore, is not cognizable on appeal. (*Richmond v. Dart Industries, Inc.* (1987) 196 Cal.App.3d 869, 874.)

As we shall explain in our discussion of Hospital's summary judgment motion, plaintiffs cannot state a claim for breach of a third party beneficiary contract against Hospital based on its contract with Medical Group. Thus, any unlawful business practices claim under the UCL based on that contract also fails.

4. *Analysis: Alleged Unlawful Business Practices Based on Fraud and Alleged Fraudulent Business Practices*

Plaintiffs seem to lump their unlawful business practices claim based on fraud and their fraudulent business practices claim together. They cite the following authority in support of those claims in their opening brief: "A duty may also arise where one makes a representation, or accompanies representations with omissions. Civil Code section 1710. This includes the suppression of a fact by one bound to disclose it, or who gives information facts which are likely to mislead for want of communication of other facts (Civil Code section 1710(3), CACI 1901, Concealment, see also *Brownlee v. Vang*

(1965) 235 Cal.App.2d 465, 477 [duty to disclose arises from when suppression or concealment materially qualifying stated terms] and negligent misrepresentation (Civil Code section 1710(2), CACI 1903, Deceit, see also *Newhall Land v. Superior Court* (1993) 19 Cal.App.4th 334, 349 [negligent failure to disclose known material facts]).” This is the only authority they cite regarding their UCL claim based on fraud. None of the authority plaintiffs cite involves the UCL or fraudulent business practices under the UCL. *Brownlee v. Vang* was a common law fraud case and the issue on appeal was whether there was sufficient evidence to support the trial court’s finding that the plaintiff relied on the defendant’s misrepresentations. (*Brownlee v. Vang*, *supra*, 235 Cal.App.2d at pp. 470, 478.) The cited passage from *Newhall Land & Farming Co. v. Superior Court* (1993) 19 Cal.App.4th 334 discusses predecessor landowner liability and the duty of a seller of real property to disclose to a buyer “ ‘ “any hidden defects which he knows or should know may present an unreasonable risk of harm to persons on the premises, and which he may anticipate that the [buyer] will not discover.” ’ ” (*Id*. at p. 349.)

A fundamental rule of appellate review is that an appealed judgment or order is presumed correct. (*Denham v. Superior Court* (1970) 2 Cal.3d 557, 564 (*Denham*).) To overcome the presumption of correctness, the appellant must provide reasoned argument with citations to legal authority on each point raised. (*Niko v. Foreman* (2006) 144 Cal.App.4th 344, 368.) When the appellant asserts a point, but fails to support it with reasoned argument and citation to authority, the appellate court may treat the point as waived and pass it without consideration. (*People v. Stanley* (1995) 10 Cal.4th 764, 793 (*Stanley*); *Associated Builders & Contractors, Inc. v. San Francisco Airports Com.* (1999) 21 Cal.4th 352, 366, fn. 2 [point not properly raised where the appellant “fails to provide any analysis or argument in support of the assertion”].) “We are not bound to develop appellants’ arguments for them. [Citation.] The absence of cogent legal argument or citation to authority allows this court to treat the contentions as waived.” (*In re Marriage of Falcone & Fyke* (2008) 164 Cal.App.4th 814, 830.) Plaintiffs’ bare

citation of a few statutes about fraud and two cases that have no application here, combined with their failure to discuss legal authority involving fraud under the UCL, is insufficient to meet their burden on appeal of providing this court with reasoned argument and citation to authority on each point raised. We therefore conclude that these claims have been waived.

Even if we were to consider these claims on the merits, given our construction of the COA, we would conclude there is nothing expressly deceptive about the language used therein. As we have stated, the "account of the Facility" refers only to Hospital's bill. Moreover, the COA advises patients that certain services may be provided by independent contractors and that physicians are responsible for their own acts and omissions. In addition, Hospital's alleged failure to advise plaintiffs that Medical Group was not a preferred provider under their health plan cannot be viewed as deceptive. Nothing required Hospital to make such a disclosure and the Medical Group contract required Medical Group to accept the same health plans as Hospital.

F. CLRA Claim

"The CLRA makes unlawful, in Civil Code section 1770, subdivision (a) . . . , various 'unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in a transaction intended to result or which results in the sale or lease of goods or services to any consumer.' " (*Meyer v. Sprint Spectrum L.P.* (2009) 45 Cal.4th 634, 639 (*Meyer*).) In their opening brief, plaintiffs rely on subdivision (a)(14) of Civil Code section 1770, which proscribes "[r]epresenting that a transaction confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law."[13]

[13] In their first amended complaint, plaintiffs also alleged that the fees charged by Medical Group were unconscionable in violation of subdivision (a)(19) of Civil Code section 1770, which proscribes "[i]nserting an unconscionable provision in the contract." (continued)

"The self-declared purposes of the act are 'to protect consumers against unfair and deceptive business practices and to provide efficient and economical procedures to secure such protection.' (Civ. Code, § 1760 . . . .)" (*Hogya v. Superior Court* (1977) 75 Cal.App.3d 122, 135 (*Hogya*).) The CLRA supplements remedies available under other statutory and case law, and actions brought under the CLRA are governed exclusively by its own provisions. (*Hogya, supra*, at p. 135; see also Civ. Code, § 1752.) Any consumer who suffers any damage as a result of the use or employment by any person of a method, act, or practice declared to be unlawful by Civil Code section 1770 may bring an action against that person to recover actual damages, injunctive relief, restitution of property, punitive damages, and any other relief the court deems proper. (Civ. Code, § 1780, subd. (a).) The provisions of the act are to be liberally construed. (*Id*., § 1760.)

Plaintiffs' first amended complaint alleged Hospital "violated numerous provisions of the CLRA by engaging in and continuing to engage in deceptive practices, unlawful methods of competition, and/or unfair acts to the detriment of Plaintiffs and the class . . . in violation of [Civil Code section 1170, subdivision] (a)(14) . . . . The Leons[]

Plaintiffs do not address the alleged violation of subdivision (a)(19) in their opening brief. However, their reply brief contains approximately two pages of argument regarding the alleged unconscionability of the COA under subdivision (a)(19). Plaintiffs also fault Hospital for ignoring their unconscionability claim in its brief on appeal. As we have stated, an appealed judgment or order is presumed correct. (*Denham*, *supra*, 2 Cal.3d at p. 564.) To overcome that presumption, the appellant must provide reasoned argument with citations to authority. If the appellant fails to do so, the appellate court may treat the point as waived and pass it without consideration. (*Stanley*, *supra*, 10 Cal.4th at p. 793.) In addition, issues not properly addressed in the opening brief and raised for the first time in the reply are waived and will not be considered. (*Julian v. Hartford Underwriters Ins. Co*. (2005) 35 Cal.4th 747, 761, fn. 4; *Tilton v. Reclamation Dist. No. 800* (2006) 142 Cal.App.4th 848, 864, fn. 12.) Since plaintiffs did not brief the alleged violation of subdivision (a)(19) until their reply, we hold that the issue has been waived as to this court. Moreover, Hospital cannot be faulted for disregarding a claim that plaintiffs did not properly raise in their opening brief.

actually or presumptively relied on representations as to price in paying the full, irregular and unreasonable price set forth above."[14]

As we have noted, subdivision (a)(14) of Civil Code section 1770 prohibits "[r]epresenting that a transaction confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law." Other than the allegation that Hospital made representations regarding price, the first amended complaint merely recites the language of Civil Code section 1770. Plaintiffs did not plead that Hospital made any representations to them other than those contained in the COA. Given our construction of the COA (our conclusion that the sentence "I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility" refers only to Hospital's bill) plaintiffs are unable to show that Hospital represented that the transaction involved "obligations which it does not . . . involve, or which are prohibited by law." (Civ. Code, § 1770, subd. (a)(14).) We therefore hold that the trial court did not err when it sustained the demurrer to the CLRA cause of action without leave to amend.

II. *Summary Judgment on the Declaratory Relief Cause of Action*

A. Standard of Review

Summary judgment provides "courts with a mechanism to cut through the parties' pleadings in order to determine whether, despite their allegations, trial is in fact necessary to resolve their dispute." (*Aguilar v. Atlantic Richfield Co*. (2001) 25 Cal.4th 826, 843 (*Aguilar*).) A motion for summary judgment "shall be granted if all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." (Code Civ. Proc., § 437c, subd. (c).) "The

[14] In light of our conclusion that plaintiffs have waived any claims under Civil Code section 1770, subdivision (a)(19), we have omitted the allegations related to that claim.

pleadings determine the issues to be addressed by a summary judgment motion [citation], and the declarations filed in connection with such motion 'must be directed to the issues raised by the pleadings.' [Citation.]" (*Knapp v. Doherty* (2004) 123 Cal.App.4th 76, 84 (*Knapp*).)

The moving party "bears the burden of persuasion that there is no triable issue of material fact and that he is entitled to judgment as a matter of law." (*Aguilar, supra*, 25 Cal.4th at p. 850, fn. omitted; accord, Code Civ. Proc., § 437(c), subd. (c).) A defendant moving for summary judgment, like Hospital, meets this burden by presenting evidence demonstrating that one or more elements of the plaintiff's cause of action cannot be established or that there is a complete defense to the action. (Code Civ. Proc., § 437c, subd. (p)(2); *Aguilar, supra*, at pp. 849-850, 853-854 [discussing former subdivision (*o*), now subdivision (p), of Code of Civil Procedure section 437c].) Once the defendant makes this showing, the burden shifts to the plaintiff to show that a triable issue of material fact exists with regard to that cause of action or defense. (Code Civ. Proc., § 437c, subd. (p)(2); see *Aguilar, supra,* at p. 850.) Material facts are those that relate to the issues in the case as framed by the pleadings. (*Juge v. County of Sacramento* (1993) 12 Cal.App.4th 59, 67.) In ruling on the motion, the court must consider the evidence and inferences reasonably drawn from the evidence in the light most favorable to the party opposing the motion. (*Aguilar, supra,* at p. 843.)

We review an order granting summary judgment de novo, considering all the evidence set forth in the moving and opposition papers, except that to which objections have been made and sustained. (*Aguilar, supra*, 25 Cal.4th at p. 860; *Guz, supra*, 24 Cal.4th at p. 334.) In undertaking our independent review, we apply the same three-step analysis as the trial court. First, we identify the issues framed by the pleadings. Next, we determine whether the moving party has established facts justifying judgment in its favor. Finally, if the moving party has carried its initial burden, we decide whether the opposing party has demonstrated the existence of a triable issue of material fact. (*Varni Bros.*

Corp. v. Wine World, Inc. (1995) 35 Cal.App.4th 880, 886-887 (*Varni*); see also *Burroughs v. Precision Airmotive Corp*. (2000) 78 Cal.App.4th 681, 688.) "We need not defer to the trial court and are not bound by the reasons for the summary judgment ruling; we review the ruling of the trial court, not its rationale." (*Knapp*, *supra*, 123 Cal.App.4th at p. 85.)

B. Background

Hospital moved for summary judgment on plaintiffs' only remaining cause of action, the claim for declaratory relief, which alleged that there was an actual controversy between Hospital and plaintiffs concerning their respective rights and duties. Hospital's motion for summary judgment focused on the question of duty and argued that it did not have a duty to ensure that Medical Group charged reasonable rates, to require Medical Group to contract with plaintiffs' health plans, or to advise plaintiffs that Medical Group did not accept their health plans. Hospital asserted that the trial court had already determined such duties did not exist when it dismissed the other causes of action. Hospital also argued that declaratory relief was not necessary or proper since plaintiffs did not need to be told that Medical Group did not accept Health Plan and plaintiffs were already protected from balance billing by Health and Safety Code section 1379 and *Prospect*.

In opposition, plaintiffs argued there were three bases for Hospital's alleged duties: (1) the COA, (2) the common law duty to use due care to manage one's property, and (3) the Medical Group contract.[15] Plaintiffs rely on these same three sources of duty

[15] The declaratory relief claims in plaintiffs' second and third amended complaints were based on the COA and did not request a declaration of rights based on the Medical Group contract. However, plaintiffs relied on the Medical Group contract as a basis for their opposition to the motion for summary judgment. By responding on the merits to plaintiffs' claims based on the Medical Group contract, Hospital has waived any objection that plaintiffs failed to plead the Medical Group contract as a basis for its (continued)

in their brief on appeal. As for the Medical Group contract, plaintiffs argued that the Medical Group contract imposed a duty on Hospital to control Medical Group's billing practices, that Hospital breached that duty, and that plaintiffs were third party beneficiaries of that contract. The court found that plaintiffs "can indeed be considered third party beneficiaries" of that contract, but was not persuaded that the contract created a duty on the part of the promisee (Hospital) to enforce the terms of the contract for the benefit of the third party beneficiaries (plaintiffs) and stated that it was not aware of any authority for that proposition. After considering the parties' arguments regarding duty, the court granted summary judgment and "declare[d] that [Hospital] owed no duty to the Plaintiffs to either prevent physicians from overcharging or to warn the Plaintiffs that physicians may or did indeed overcharge."

C. Nature of Declaratory Relief

Code of Civil Procedure section 1060 provides in relevant part: "Any person interested . . . under a contract, or who desires a declaration of his or her rights or duties with respect to another, . . . may, in cases of actual controversy relating to the legal rights and duties of the respective parties, bring an original action . . . in the superior court for a declaration of his or her rights and duties in the premises, including a determination of any question of construction or validity arising under the . . . contract. He or she may ask for a declaration of rights or duties, either alone or with other relief; and the court may make a binding declaration of these rights or duties, whether or not further relief is or could be claimed at the time. . . ." An action for declaratory relief should show (1) a proper subject for relief within the scope of Code of Civil Procedure section 1060; and (2) an actual controversy involving justiciable questions relating to a party's rights or obligations. (*City of Tiburon v. Northwestern Pac. R.R. Co.* (1970) 4 Cal.App.3d 160,

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declaratory relief claim. (*Neverkovec v. Fredericks* (1999) 74 Cal.App.4th 337, 346, fn. 5.)

170.) Code of Civil Procedure section 1060 expressly provides for the declaration of rights under a contract.

" ' "The purpose of a declaratory judgment is to 'serve some practical end in quieting or stabilizing an uncertain or disputed jural relation.' " [Citation.] "Another purpose is to liquidate doubts with respect to uncertainties or controversies which might otherwise result in subsequent litigation [citation]." [Citation.]' [Citation.] ' "One test of the right to institute proceedings for declaratory judgment is the necessity of present adjudication as a guide for plaintiff's future conduct in order to preserve his legal rights." ' [Citation.]" (*Meyer, supra,* 45 Cal.4th at p. 647.)

D. Duty Under the COA and Common Law Premises Liability Theories

In our analysis of plaintiffs' contract cause of action based on the COA and their UCL claim based on a premises liability theory, we have rejected plaintiffs' first two claims of duty as a matter of law and concluded that Hospital did not have a duty to ensure Medical Group charged reasonable rates, to require Medical Group to contract with plaintiffs' health plans, or to advise plaintiffs that Medical Group did not accept their health plans.

Before we address the question of duty under the Medical Group contract, we shall discuss one more point regarding the COA. In their opposition to the motion for summary judgment and on appeal, plaintiffs point to differences between the language of Hospital's COA form and the model conditions of admission form promulgated by the California Hospital Association in March 2008. Plaintiffs cite no authority for the proposition that a model agreement promulgated by a trade association can impose any duty on members who use a different form. In addition, the model form was promulgated after plaintiffs were treated by Hospital. Given our construction of the COA, we shall not address plaintiffs' arguments regarding the model conditions of admission form further.

For these reasons, we conclude that the trial court correctly found that Hospital had no duty under the COA or a premises liability theory to ensure Medical Group only

charged a reasonable rate or to advise patients regarding Medical Group's rates, and we shall not address those points further. We turn next to plaintiffs' claim that Hospital had a duty to enforce the Medical Group contract for plaintiffs' benefit.

E. Hospital's Duty to Plaintiffs as Third Party Beneficiaries of Its Contract with Medical Group

Plaintiffs contend that they are third party beneficiaries of the Medical Group contract and that under that contract, Hospital had a duty to ensure that Medical Group charged only reasonable rates. Plaintiffs rely primarily on paragraph 6.5 of the contract, which provides: "Contractor [Medical Group] shall participate in all third-party payment or managed care programs in which Hospital participates, render services to those patients covered by such programs, and accept payment amounts provided for under these programs as payment in full for services of [Medical Group]. If requested by Hospital, [Medical Group] agrees to discount his/her charges proportionately to any discounts given by Hospital of its charges to a third-party payor or any patient participation plan, provided such discounts are within the normal ranges provided by similar contractors in central California." Plaintiffs cite contract provisions that require Medical Group to consider Hospital's recommendations when establishing Medical Group's schedule of charges and to comply with Hospital's polices regarding courtesy, bad debt, and charity; plaintiffs argue that the contract contains other indicia of control.

A person who is not a party to a contract may nevertheless enforce it if the contract was made expressly for his or her benefit. (Civ. Code, § 1559.)[16] "For a third party to qualify as a beneficiary of a contract, the contracting parties must have intended to benefit that third party and their intent must be evident in the terms of the contract."

[16] Civil Code section 1559 provides: "A contract, made expressly for the benefit of a third person, may be enforced by him at any time before the parties thereto rescind it."

(*Amaral v. Cintas Corp. No. 2* (2008) 163 Cal.App.4th 1157, 1193 (*Amaral*).) " '[A] putative third party's rights under a contract are predicated upon the contracting parties' intent to benefit' it. [Citation.] Ascertaining this intent is a question of ordinary contract interpretation. [Citation.] Thus, '[t]he circumstance that a literal contract interpretation would result in a benefit to the third party is not enough to entitle that party to demand enforcement.' [Citation.]" (*Hess v. Ford Motor Co.* (2002) 27 Cal.4th 516, 524.)

" ' " ' "A third party should not be permitted to enforce covenants made not for his benefit, but rather for others. He is not a contracting party; his right to performance is predicated on the contracting parties' intent to benefit him." ' [Citations.] . . . [¶] The fact that . . . the contract, if carried out to its terms, would inure to the third party's benefit is insufficient to entitle him or her to demand enforcement. [Citation.] Whether a third party is an intended beneficiary or merely an incidental beneficiary to the contract involves construction of the parties' intent, gleaned from reading the contract as a whole in light of the circumstances under which it was entered. [Citation.]" ' [Citation.]" (*Landale-Cameron Court, Inc. v. Ahonen* (2007) 155 Cal.App.4th 1401, 1410-1411 (*Landale-Cameron*).)

The Restatement Second of Contracts distinguishes between *intended* third party beneficiaries and *incidental* third party beneficiaries. (Rest.2d Contracts, § 302; see also 1 Witkin, Summary of Cal. Law, *supra*, Contracts, §§ 687-689, pp. 773-776.) The critical right of the third party beneficiary is the right to sue the promisor to enforce the contract. (9 Corbin on Contracts (rev. ed. 2007) § 44.6, p. 65.) An intended beneficiary may sue to enforce the contract; an incidental beneficiary may not. (See e.g., *Amaral, supra,* 163 Cal.App.4th at pp. 1193-1194 [intended beneficiary]; *Landale-Cameron, supra,* 155 Cal.App.4th at p. 1411 [incidental beneficiary]; see also 1 Witkin, Summary of Cal. Law, *supra,* §§ 687-689, pp. 773-776.)

"[A] third party beneficiary contract must either satisfy an obligation of the promisee to pay money to the beneficiary, or the circumstances indicate the promisee

intends to give the beneficiary the benefit of the promised performance." (*Medical Staff of Doctors Medical Center in Modesto v. Kamil* (2005) 132 Cal.App.4th 679, 685.) Plaintiffs contend they are third party beneficiaries of Medical Group's promises to "participate in all third-party payment or managed care programs" that Hospital participates in and to "accept payment amounts provided for under these programs as payment in full for services of [Medical Group]." These promises do not "satisfy an obligation of the promisee" (Hospital) "to pay money to the beneficiar[ies]" (plaintiffs). (*Ibid.*) But this language may be interpreted as indicating that Hospital intended to give the beneficiaries (patients like plaintiffs) the benefit of the promised performance. Medical Group's promises to participate in the same health plans as Hospital and accept payment from those plans as payment in full benefit Hospital's patients by avoiding the situation that occurred here where Hospital is a participating provider but Medical Group is not, resulting in higher medical costs for the patient.

Neither side challenges the trial court's finding that plaintiffs were third party beneficiaries of the Medical Group contract. But although the trial court concluded that plaintiffs were third party beneficiaries of the Medical Group contract, its order did not state whether they were intended or incidental beneficiaries. The dispute here centers on the question of whether Hospital (the promisee) had a duty to enforce Medical Group's (the promisor's) promises for the benefit of plaintiffs (the third party beneficiaries). We shall therefore, assume without deciding, that plaintiffs were intended third party beneficiaries of the Medical Group contract.

Citing 1 Witkin, Summary of California Law, *supra*, Contracts, section 694, plaintiffs argue that as third party beneficiaries of the Medical Group contract, they had the right to sue either Hospital or Medical Group or both to enforce that contract. At that section, the treatise states: "A[n] . . . 'intended beneficiary' . . . can sue either the promisor or the promisee, or may join them and obtain judgment against both, for the

promisee is indebted to the beneficiary on the old obligation and the promisor on the new promise." (*Id.* at p. 781.)

Hospital relies on the following from Williston on Contracts: "As provided in the Restatement (Second) of Contracts, 'Where an intended beneficiary has an enforceable claim against the promisee, he can obtain a judgment or judgments against either the promisee or the promisor [or both] based on their respective duties against him. Satisfaction in whole or in part of either of these duties, or of a judgment thereon, satisfies to that extent the other duty or judgment, subject to the promisee's right of subrogation.' This rule is qualified by the requirement that a beneficiary may bring an action against the promisee only where the beneficiary had a previous enforceable claim against the promisee and the promisor essentially assumed the promisee's obligation. In other situations, that is, in the typical donee beneficiary setting, a beneficiary may maintain an action only against the promisor who breached its agreement to the promisee, not a promisee who has otherwise fulfilled its obligations under the contract." (13 Williston on Contracts (4th ed.) § 37:54, fns. omitted, quoting Rest.2d Contracts, § 310, subd. (1).) The rule that plaintiffs cite applies to the situation where the beneficiary has a previous enforceable claim against the promisee (Hospital) and the promisor (Medical Group) has assumed the promisee's obligation; in Witkin's words, when "the promisee is indebted to the beneficiary on [an] old obligation." (1 Witkin, Summary of Cal. Law, *supra*, Contracts, § 694, p. 781.) But in this case, Medical Group has not assumed any prior obligation or debt that Hospital owed to plaintiffs. Thus, this appears to be a situation where the third party beneficiary can only enforce the promise against the promisor (Medical Group).

Citing three cases from other jurisdictions, including a California federal district court case,[17] Hospital argues, "Plaintiffs cannot maintain a third party beneficiary action against the Hospital (the promisee) because Plaintiffs do not have a previously enforceable claim against Hospital." We find the reasoning and analysis in the federal district court case, *Doe v. Wal-Mart Stores, Inc*. (C.D.Cal. Mar. 30, 2007, No. CV 05-7307 AG (MANx)) 2007 U.S. Dist. LEXIS 98102 (*Doe*), persuasive. *Doe* involved the alleged failure by Wal-Mart to adequately monitor its suppliers' factories in foreign countries to insure that the suppliers treated their employees fairly, in accordance with labor standards that had been incorporated into the contracts between Wal-Mart and the suppliers. (*Id*. at pp. *1-*5.) The plaintiffs, employees of the suppliers, claimed they were intended third party beneficiaries of Wal-Mart's promise to enforce the suppliers' compliance with the labor standards. The court cited the Restatement Second of Contracts, section 304, which provides: "A promise in a contract creates a duty in the *promisor* to any intended beneficiary to perform the promise, and the intended beneficiary may enforce the duty." (Italics added; see *Doe*, at p. *9.) The court explained: "[T]he third-party beneficiary can enforce such a contract against the party that made the promise (the promisor) and cannot enforce the contract against the party that bargained for the promise (the promisee). 'The only category of cases mentioned in the Restatement where the beneficiary may maintain an action against the promisee is where the beneficiary had a previous enforceable claim against the promisee and the promisor essentially assumed the promisee's obligation.' [Citation.]" (*Doe*, at p. *9.) The court concluded that although the plaintiffs had alleged sufficient facts showing Wal-

[17] The other two cases cited by Hospital are *District of Columbia v. Campbell* (D.C. 1990) 580 A.2d 1295, 1302-1303 (presumed intended beneficiary may maintain third party beneficiary claim against breaching promisor only and not promisee who failed to enforce the promise) and *Sullivan v. United States* (Fed.Cir. 2010) 625 F.3d 1378, 1380-1381.

Mart's intent to benefit foreign factory workers by incorporating the labor standards into the supply contracts, it was the suppliers who had made the promise to comply with the standards, and therefore the plaintiffs' breach of contract claims would lie against the suppliers (the promisors) and not Wal-Mart (the promisee). (*Id.* at pp. *9-*10.)

The plaintiffs in *Doe* also argued that Wal-Mart made separate promises in the supplier contracts to monitor and enforce the suppliers' compliance with the labor standards and that the plaintiffs were third party beneficiaries of those promises. The court concluded that contract language giving Wal-Mart the right to inspect and stating Wal-Mart's intent to inspect was insufficient to support a promise to inspect and monitor the factories. The court stated, "[I]t more than strains logic to think that the suppliers would have been motivated to bargain for a counter-promise from [Wal-Mart] to enforce the suppliers' contractual promise to comply." (*Doe*, *supra*, 2007 U.S. Dist. LEXIS 98102 at p. *11.) The court held that the plaintiffs' failure to allege a contractual promise enforceable by the suppliers against Wal-Mart prevented the plaintiffs from alleging a proper breach of contract claim as third party beneficiaries, and granted Wal-Mart's motion to dismiss with leave to amend. (*Id.* at pp. *12-*13.)

Plaintiffs rely on Medical Group's promises in the Medical Group contract to "participate in all third-party payment or managed care programs" that Hospital participates in and to "accept payment amounts provided for under these programs as payment in full for services of [Medical Group]." As in *Doe*, these promises may create a duty in Medical Group that plaintiffs may enforce against Medical Group. But these promises by Medical Group cannot be construed as a prior enforceable claim against Hospital that Medical Group assumed, which would entitle plaintiffs to also enforce the contract against Hospital. In addition, plaintiffs do not point to any language in the Medical Group contract that could be construed as a separate promise by Hospital to monitor or enforce Medical Group's compliance with the requirements of paragraph 6.5. Finally, it makes no sense to impose a duty on Hospital to warn that Medical Group

might balance bill when Medical Group has effectively promised not to do so in the Medical Group contract.

For these reasons, we agree with the trial court that Hospital did not have a duty to enforce the Medical Group contract for plaintiffs and conclude the court did not err when it declared that Hospital owed no such duty to plaintiffs.

F. Propriety of Granting Summary Judgment

Having completed our analysis of duty under the contract and tort theories that plaintiffs advance, we turn to the question whether Hospital met its initial burden of establishing facts justifying judgment in its favor. (*Varni, supra,* 35 Cal.App.4th at pp. 886-887.) In support of its motion, Hospital presented evidence that it contracts with Medical Group to staff Hospital's emergency room, that Medical Group's physicians are not Hospital's employees, that Hospital does not enter into contracts with health plans on behalf of Medical Group, that plaintiffs signed COA forms when they were treated in the emergency room, that plaintiffs were treated by Medical Group physicians, and that plaintiffs were billed by Medical Group for those services. Hospital relied on the COA forms that were attached as exhibits to plaintiffs' second amended complaint and plaintiffs' allegations that although Hospital contracted with Health Plan, Medical Group did not. It appears from this evidentiary showing that Hospital met its initial burden as the moving party of presenting prima facie evidence that negated plaintiffs' claims of duty under the theories advanced in their declaratory relief action. The burden therefore shifted to plaintiffs to present facts sufficient to create a triable issue of material fact regarding their duty claims. (Code Civ. Proc., § 437c, subd. (p)(2).)

Plaintiffs' response to the motion did not meet their burden of showing the existence of a triable issue of material fact relating to their claims of duty. In their separate statement of facts in opposition to the motion, plaintiffs objected to and repeated their legal arguments regarding Hospital's facts, but they did not set forth any facts or evidence that created a triable issue regarding the material facts in Hospital's separate

statement. They did not suggest that there were any disputed material facts that were not included in Hospital's papers. (Code Civ. Proc., § 437c, subd. (b)(3).) Plaintiffs submitted evidence in opposition to the motion, including declarations from themselves, the COA forms they signed, the explanation of benefits forms from Health Plan for their emergency rooms visits, documents describing Health Plan benefits, excerpts from the Medical Group contract, and Hospital's discovery responses. Some of that evidence supported Hospital's material facts; none of it created a triable issue. Moreover, the issues on appeal turn on the legal question of duty under the COA, the Medical Group contract, and the premises liability theory advanced by plaintiffs. Plaintiffs do not argue that there was a triable issue of fact that would preclude summary judgment.

For all these reasons, we conclude the court properly granted summary judgment on the declaratory relief cause of action.

G. Leave to Amend

Plaintiffs argue that the trial court erred when it denied their request for leave to amend. In their opposition to the motion for summary judgment, plaintiffs asked for leave to amend based on Hospital's alleged "contractual obligation" under the Medical Group contract. Plaintiffs acknowledged that they had not pleaded the Medical Group contract as a basis of liability and argued that the Medical Group contract "changes the entire circumstances of this case" and "provides bases for several causes of action against [Hospital]."

Since the pleadings determine the scope of relevant issues on a summary judgment motion, if a party wishes the court to consider previously unpleaded issues in connection with such a motion, the party may request leave to amend. (*Bostrom v. County of San Bernardino* (1995) 35 Cal.App.4th 1654, 1663 (*Bostrom*).) "Given the long-standing California court policy of exercising liberality in permitting amendments to pleadings at any stage of the proceedings [citation] and of disregarding errors or defects in pleadings unless substantial rights are affected [citation], . . . a party should be permitted to

introduce [an affirmative defense] in a summary judgment procedure so long as the opposing party has adequate notice and opportunity to respond." (*Cruey v. Gannett Co.* (1998) 64 Cal.App.4th 356, 367 (*Cruey*).) In *Cruey*, the court allowed the defendant to rely on an unpleaded defense in its motion for summary judgment since the plaintiff had responded by arguing the inapplicability of the defense and did not show that he was prejudiced by the process. (*Ibid.*)

Plaintiffs relied on the unpleaded Medical Group contract in their opposition to Hospital's motion for summary judgment and asked the court for leave to amend so the court could "consider previously unpleaded issues in connection with" the motion, citing *Bostrom*, *Cruey*, and other cases that considered amendment at the summary judgment stage. Hospital responded to plaintiffs' arguments regarding the Medical Group contract on the merits and, although it argued against leave to amend, it did not claim it was prejudiced by plaintiffs' assertion of this unpleaded theory. Although the court did not make an express ruling on plaintiff's request for leave to amend, we infer that the court granted that request, since it made specific findings regarding the Medical Group contract in its order on the motion.

On appeal, plaintiffs mischaracterize the trial court's order and argue that the court erred when it *denied* their request for leave to amend. Since the court actually granted their request for leave to amend, we perceive no error.

DISPOSITION

The judgment is affirmed.

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BAMATTRE-MANOUKIAN, J.

WE CONCUR:

_____
ELIA, ACTING P.J.

_____
MÁRQUEZ, J.