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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION TWO

TENET 1500 SAN PABLO, INC., Plaintiff and Appellant, v. HOTEL EMPLOYEES AND RESTAURANT EMPLOYEES INTERNATIONAL UNION WELFARE FUND, Defendant and Respondent.	B237523 (Los Angeles County Super. Ct. No. BC438672)

APPEAL from a judgment of the Superior Court of Los Angeles County. Ronald M. Sohigian, Judge. Affirmed.

Helton Law Group, Carrie McLain and Jack A. Janov for Plaintiff and Appellant.

Seyfarth Shaw, F. Scott Page, James M. Harris and Daniel Hargis for Defendant and Respondent.

* * * * * *

Tenet 1500 San Pablo, Inc. (the Hospital)[1] sued Hotel Employees and Restaurant Employees International Union Welfare Fund (the Fund)[2] for payment for services provided to a patient. Summary judgment was awarded in favor of the Fund and the Hospital appeals. We find no disputed issue of material fact and affirm.

FACTUAL AND PROCEDURAL BACKGROUND

The Fund is a multiemployer benefit plan under the Labor Management Relations Act (29 U.S.C. § 186(c)(5)) and is administered in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.) (ERISA). The Fund is an "employee welfare benefit plan" as defined in ERISA, and provides health and welfare benefits to eligible employees and their dependents of contributing employers.

The patient at issue here was a beneficiary of the Fund through his spouse. On June 16, 2008, he was transferred from a hospital in Las Vegas by air ambulance to the Hospital with an open abdominal wound and fistulas. On admission, he assigned his benefits rights from the Fund to the Hospital. He remained at the Hospital for three months from June 16 through September 16, 2008, when he was transferred back to the hospital in Las Vegas at the Fund's request.

For the first two months of the patient's hospitalization, the Hospital believed the patient was covered only by his own insurance through TriWest Healthcare Alliance, a nonparty to this case. On August 27, 2008, the patient's spouse informed the Hospital he was also covered by the Fund. On that day, the Hospital contacted the Fund's third-party administrator, American Benefit Plan Administrators, Inc. (ABPA), to verify that the patient was covered by the Fund. ABPA was responsible for verifying eligibility and coverage of benefits for Fund participants and beneficiaries. ABPA verified the patient's

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[1] The Hospital was formerly known as USC University Hospital, Inc., which owned and operated USC University Hospital, where services were rendered.

[2] The Fund is now known as UNITE HERE Health and is also informally known as the Culinary Health Fund.

eligibility for benefits and provided automated and live disclaimers that its verification was not a guarantee of payment. It is undisputed that the Fund did not verify the patient's eligibility.

The Hospital also contacted Encompass Health Management Systems for authorization of treatment on the same day. Encompass is a third-party entity that provides utilization review services for the Fund. Utilization review involves the determination of medical necessity for specific treatment. A determination of medical necessity is not a guarantee of payment or an authorization for payment. Encompass also provided disclaimers that its authorization for treatment was not a guarantee of payment.

After the patient was discharged from the Hospital, the Hospital sent the Fund a bill for $1,742,687.57 for services rendered to the patient. The Fund asked consultant Jack London for assistance in negotiating the bill. London's company, London Medical Management, Inc., had a "Consulting Agreement" with the Fund to provide patient advocacy services and negotiate rates for services provided. The Consulting Agreement expressly states: "The parties are not, and shall not be construed to be, in a relationship of employer and employee, principal and agent, partnership, or joint venture."

On October 10, 2008, London and the Hospital executed a document entitled "Letter of Agreement" (LOA), which stated that the Fund would pay the Hospital the reduced amount of $1,002,800 for the patient's treatment within seven to 10 business days. The LOA does not indicate that London signed on behalf of the Fund, and the evidence shows that no one from the Fund signed the LOA or knew of its existence or contents until after it had been signed by London. Upon learning of the LOA, the Fund disclaimed any purported obligation under the LOA, and informed the Hospital that London had no authority to bind the Fund. The Fund denied payment for lack of preauthorization and the Hospital submitted a formal appeal to the Fund. The Fund reviewed the matter and paid the Hospital $15,000, the maximum allowable benefit under the plan for a noncontracting provider. The Hospital promptly cashed the check.

In May 2010, the Hospital sued the Fund alleging six causes of action. The Fund removed the case to federal court on the ground of ERISA preemption. In October 2010, the federal court granted the Hospital's motion for remand.

In December 2010, the Hospital filed an amended complaint against the Fund alleging eight causes of action for (1) breach of implied contract, (2) negligent misrepresentation, (3) quantum meruit, (4) accounts stated, (5) breach of the implied covenant of good faith and fair dealing, (6) breach of written contract, (7) negligent misrepresentation, and (8) breach of the implied covenant of good faith and fair dealing. The first five claims (the "predischarge" claims) are based on the verification of coverage and authorization of treatment, and assert that the Fund owes the full amount of $1,742,687.57, despite the patient's other insurer having already paid approximately $460,000. The final three claims (the "postdischarge" claims) are based on the LOA and assert that the Fund owes $1,002,800 under the LOA.

The Fund moved for summary judgment on two grounds—ERISA preemption and the Hospital's failure to establish a disputed issue of material fact as to each of its causes of action. The Hospital opposed the motion. Summary judgment was granted and this appeal followed.

DISCUSSION

I. Standard of Review.

We review a grant of summary judgment de novo, considering "'all of the evidence set forth in the [supporting and opposition] papers, except that to which objections have been made and sustained by the court, and all [uncontradicted] inferences reasonably deducible from the evidence.'" (*Artiglio v. Corning Inc.* (1998) 18 Cal.4th 604, 612.) "In independently reviewing a motion for summary judgment, we apply the same three-step analysis used by the superior court. We identify the issues framed by the pleadings, determine whether the moving party has negated the opponent's claims, and determine whether the opposition has demonstrated the existence of a triable, material factual issue." (*Silva v. Lucky Stores, Inc.* (1998) 65 Cal.App.4th 256, 261.) If there is

no triable issue of material fact, "we affirm the summary judgment if it is correct on any legal ground applicable to this case, whether that ground was the legal theory adopted by the trial court or not, and whether it was raised by defendant in the trial court or first addressed on appeal." (*Jordan v. Allstate Ins. Co.* (2007) 148 Cal.App.4th 1062, 1071.)

The general rule is that summary judgment is appropriate where "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).) A defendant "moving for summary judgment bears an initial burden of production to make a prima facie showing of the nonexistence of any triable issue of material fact." (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 850.) The moving defendant may meet this burden either by showing that one or more elements of a cause of action cannot be established or by showing that there is a complete defense thereto. (Code Civ. Proc., § 437c, subd. (o)(2); *Aguilar v. Atlantic Richfield Co., supra,* at p. 850.) "'[A]ll that the defendant need do is to show that the plaintiff cannot establish at least one element of the cause of action . . . [;] the defendant need not himself conclusively negate any such element . . . .' [Citation.]" (*Mills v. U.S. Bank* (2008) 166 Cal.App.4th 871, 894.) Once the moving party's burden is met, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of material fact. (*Silva v. Lucky Stores, Inc., supra,* 65 Cal.App.4th at p. 261.) The plaintiff must produce "'*substantial*'" responsive evidence sufficient to establish a triable issue of fact. (*Leek v. Cooper* (2011) 194 Cal.App.4th 399, 417.) "[R]esponsive evidence that gives rise to no more than mere speculation cannot be regarded as substantial, and is insufficient to establish a triable issue of material fact." (*Sangster v. Paetkau* (1998) 68 Cal.App.4th 151, 163.) """When opposition to a motion for summary judgment is based on inferences, those inferences must be reasonably deducible from the evidence, and not such as are derived from speculation, conjecture, imagination, or guesswork."' [Citation.]" (*Mills v. U.S. Bank, supra,* at p. 894.)

II. ERISA Preemption.

In its motion for summary judgment, the Fund argued that all of the Hospital's claims were preempted by ERISA because they "relate to" an employee benefit plan under title 29 United States Code section 1144(a). The Hospital argued that there was no preemption under the different standard of "complete" preemption in title 29 United States Code section 1132(a). While the federal court remanded the case finding there was no complete preemption, the trial court here determined that the five predischarge claims were preempted because they relate to an employee benefit plan governed by ERISA.[3] The Fund asserts that the trial court's ruling intended to encompass the three postdischarge claims as well, because the court noted that its preemption ruling "incorporates the point that there is no separate contract in our case." But we need not decide whether the Hospital's claims are preempted by ERISA because even if not preempted, the Hospital has not met its burden of creating a triable issue of material fact as to any of its causes of action.

III. Predischarge Causes of Action.

Initially, we address whether the Hospital has abandoned certain of its causes of action or has forfeited challenges to the judgment on those claims. As noted, the Fund's amended complaint alleged five predischarge claims based on actions that took place while the patient was still hospitalized—namely, the verification of coverage and the authorization of treatment for medical necessity. In opposing summary judgment, the Hospital repeatedly took the position that the only dispute at issue involved the Fund's alleged breach of the LOA, which is the basis for the postdischarge claims. The Fund argued in its reply brief that the Hospital had therefore abandoned the five predischarge

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[3] A federal court's jurisdictional ruling on "'complete preemption' has no preclusive effect on the state court's consideration of the substantive preemption defense." (*Whitman v. Raley's Inc.* (9th Cir. 1989) 886 F.2d 1177, 1181; *Soley v. First Nat'l. Bank of Commerce* (5th Cir. 1991) 923 F.2d 406, 409; *AT&T Communications, Inc. v. Superior Court* (1994) 21 Cal.App.4th 1673, 1680–1681.)

claims. While the trial court found this to be a plausible interpretation of the opposition, it did not base its ruling exclusively on the finding of abandonment.

We practice differently on appeal. "[A]n appellant's failure to discuss a theory of liability on appeal constitutes abandonment of that theory." (*Los Angeles Equestrian Center, Inc. v. City of Los Angeles* (1993) 17 Cal.App.4th 432, 444; *Walker v. Sonora Regional Medical Center* (2012) 202 Cal.App.4th 948, 957, fn. 6.) "Although our review of a summary judgment is de novo, it is limited to issues which have been adequately raised and supported in [the appellant's] brief. [Citations.] Issues not raised in an appellant's brief are deemed waived or abandoned. [Citation.]" (*Reyes v. Kosha* (1998) 65 Cal.App.4th 451, 466, fn. 6.) Our de novo review "does not obligate us to cull the record for the benefit of the appellant in order to attempt to uncover the requisite triable issues. As with an appeal from any judgment, it is the appellant's responsibility to affirmatively demonstrate error and, therefore, to point out the triable issues the appellant claims are present by citation to the record and any supporting authority. In other words, review is limited to issues which have been adequately raised and briefed." (*Lewis v. County of Sacramento* (2001) 93 Cal.App.4th 107, 116.)

Because the Hospital does not present any argument addressing the trial court's summary judgment with respect to the third cause of action for quantum meruit, fourth cause of action for accounts stated, and fifth and eighth causes of action for breach of the implied covenant of good faith and fair dealing, we do not address the merits of these causes of action and deem any challenge to the ruling with respect to these claims as forfeited.

A. Breach of Implied Contract

The Hospital alleged that the Fund entered into an implied contract to pay the charges billed by the Hospital for the care and treatment of the patient because the Hospital received verification of coverage and authorization for treatment.

"An implied contract is one, the existence and terms of which are manifested by conduct." (Civ. Code, § 1621.) "It is essential to the existence of a contract that there

should be: [¶] 1. Parties capable of contracting; [¶] 2. Their consent; [¶] 3. A lawful object; and, [¶] 4. A sufficient cause or consideration." (Civ. Code, § 1550.) The heart of an implied contract is an intent to promise. (*Zenith Ins. Co. v. O'Connor* (2007) 148 Cal.App.4th 998, 1010.) "If there is no evidence establishing a manifestation of assent to the 'same thing' by both parties, then there is no mutual consent to contract and no contract formation." (*Weddington Productions, Inc. v. Flick* (1998) 60 Cal.App.4th 793, 811 [citing Civ. Code, §§ 1550, 1565 & 1580].)[4]

It is undisputed that coverage was verified by ABPA and authorization was given by Encompass. The Fund presented uncontroverted evidence that neither of these third parties was authorized to enter into contracts on behalf of the Fund. The declaration of the Fund's director of healthcare delivery established that at no time did either ABPA or Encompass have any authority or ability to enter into contracts or make any binding promises on behalf of the Fund. ABPA's customer service manager also confirmed that ABPA had no authority to enter into contracts on behalf of the Fund. These declarations also explained that the disclaimers provided by ABPA and Encompass that verifications and authorizations are not guarantees of payment are standard practice and custom in the healthcare industry, and that healthcare providers understand that such verifications and authorizations do not guarantee payment of medical claims.

The Fund also submitted the deposition testimony of the Hospital's person most knowledgeable (PMK), who repeatedly testified that verification of coverage and authorization of services was not a guarantee of payment of claims, that it was standard practice in the healthcare industry that insurance companies and employee welfare benefit plans deny payment after giving authorization, and that the Fund never told the Hospital that it would pay for the patient's treatment.

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[4] Civil Code section 1565 provides: "The consent of the parties to a contract must be: [¶] 1. Free; [¶] 2. Mutual; and, [¶] 3. Communicated by each to the other."

Civil Code section 1580 provides that "Consent is not mutual, unless the parties all agree upon the same thing in the same sense."

In opposing summary judgment, the Hospital agreed in its separate statement that "neither the Fund nor Encompass made any guarantee or agreement that any payment would be made to [the Hospital] for the treatment it provided" (fact No. 26). The Hospital purported to dispute fact No. 22 that "neither the Fund nor ABPA made any guarantee or agreement that any payment would be made to [the Hospital] for the treatment it provided," despite its own deposition testimony. But the Hospital relied entirely on the undisputed facts that coverage was verified by ABPA and authorization was provided by Encompass. It therefore failed to meet its burden of providing "substantial" responsive evidence necessary to create a triable issue of material fact on the existence of an implied contract to pay. (*Guz v. Bechtel National, Inc*. (2000) 24 Cal.4th 317, 337 ["where the undisputed facts negate the existence or the breach of the [implied] contract claimed, summary judgment is proper"].)

B. Negligent Misrepresentation

The Fund alleged that the verification and authorization it received amounted to a promise to pay, that the promise was false when made, and that the Hospital reasonably relied upon the promise to its detriment.

The elements of a claim for negligent misrepresentation are "(1) the misrepresentation of a past or existing material fact, (2) without reasonable grounds for believing it to be true, (3) with intent to induce another's reliance on the fact misrepresented, (4) justifiable reliance on the misrepresentation, and (5) resulting damages." (*Apollo Capital Fund LLC v. Roth Capital Partners, LLC* (2007) 158 Cal.App.4th 226, 243; *Continental Airlines, Inc. v. McDonnell Douglas Corp*. (1989) 216 Cal.App.3d 388, 402.) The Fund argues that the Hospital's negligent misrepresentation cause of action fails as a matter of law because the promise to pay involves future conduct rather than a past or existing material fact. (See *Tenet Healthsystem Desert, Inc. v. Fortis Ins. Co.* (C.D.Cal. 2007) 520 F.Supp.2d 1184, 1195 [finding that under California law representation concerning future conduct cannot form the basis of a negligent misrepresentation claim].)

The Hospital did not refute this argument either below or in its opening appellate brief. In its reply brief, the Hospital cites *Cedars Sinai Med. Ctr. v. Mid-West Nat'l Life Ins. Co.* (C.D.Cal. 2000) 118 F.Supp.2d 1002, in which the court found that the insurer's verification of coverage concerned a "present or existing fact." (*Id.* at p. 1011.) We do not consider authority provided for the first time in a reply brief. (*Medill v. Westport Ins. Corp.* (2006) 143 Cal.App.4th 819, 836, fn. 3.) But even if we did, it is undisputed that *the Fund* did not provide verification or authorization to the Hospital.

Moreover, the Hospital cannot establish the necessary element of justifiable reliance. The Hospital began treating the patient more than two months before it learned that he might be covered by the Fund. The Hospital's PMK testified that the Hospital would have treated the patient even if the Hospital had not received verification or authorization, regardless of whether the Hospital thought it was going to receive any payment for the treatment.

IV. Postdischarge Causes of Action.

Breach of Written Contract

The Hospital based its sixth cause of action for breach of written contract on the LOA. It is undisputed that the Fund is not a signatory to the LOA. Jack London's signature on the LOA appears above the designation of "PatientPAL Advocate." The Hospital's claim depends on whether London was an agent of the Fund with authority to bind the Fund.

The Fund presented uncontroverted evidence that London was not its agent. London himself testified at his deposition that he was not an agent of the Fund: "[COUNSEL] Q. You're agreeing with the Fund that you didn't stand in the shoes of principal and agent with the Fund, right? [LONDON] A. Correct. [COUNSEL] Q. You were not its agent, right? [LONDON] A. Correct." London also testified as follows: "[COUNSEL] Q. As consultant to the Fund, you agree with me that you, in that role, don't have the authority to commit the Fund to pay millions of dollars however you deem fit, correct? [LONDON] A. Correct. [COUNSEL] Q. And there's no writing that you

can identify, is there, that gives you any authority, general authority like that, correct? [LONDON] A. Correct." The Consulting Agreement between the Fund and London's company corroborates this testimony, stating that the "parties are not, and shall not be construed to be, in a relationship of . . . principal and agent."

But even if London were considered the Fund's agent as the Hospital asserts, the distinction between an agent's authority to negotiate for the principal and an agent's authority to bind the principal is well recognized. (See, e.g., *Toth v. Metropolitan Life Ins. Co.* (1932) 123 Cal.App. 185, 192 ["A mere soliciting agent or other intermediary operating between the insured and the insurer has authority only to initiate contracts, but not to consummate them, and cannot bind his principal by anything he may say or do during the preliminary negotiations"]; *Ernst v. Searle* (1933) 218 Cal. 233, 239–240 [agent with authority to negotiate a property exchange had no authority to convey the property]; *Mason v. Mazel* (1947) 82 Cal.App.2d 769, 773 ["An intention to give such an agent additional authority, such as to bind the owner to convey the property, must be clearly and definitely stated"]; *Angus v. London* (1949) 92 Cal.App.2d 282, 285 ["Agency to negotiate a sale or purchase of real property does not authorize the agent to bind his principal by contract"]; Rest.3d Agency, § 1.01, com. c ["Agents who lack authority to bind their principals to contracts nevertheless often have authority to negotiate or to transmit or receive information on their behalf"].)

The Fund submitted the declaration of its president, who executed the consulting agreement on behalf of the Fund, that London was not authorized to enter into or consummate any agreement on behalf of the Fund. Rather, London and his company's roles "with respect to negotiation services involving healthcare providers, were to explore what deals might be possible with the provider, or solicit an offer from the healthcare provider, that he could bring back to the Fund for its consideration." The Fund's president explained that only the Fund had authority to approve a proposed deal or to accept an offer from a healthcare provider. The authority to sign documents on the Fund's behalf is regulated by the Fund's written Trust Agreement and is strictly limited to the trustees and certain designated Fund officers and executives.

The Hospital's PMK also admitted that the Hospital had no evidence that London had authority to bind the Fund and that the Hospital's contemporaneous records of discussions with London showed only that he had authority to negotiate payment. The Hospital's records also showed that after the Fund became aware that London had signed the LOA, the Fund informed the Hospital that London did not have authority to authorize payment.

In opposition, the Hospital bore the burden of creating a triable issue of fact as to the existence and scope of an agency. (*Inglewood Teachers Assn. v. Public Employment Relations Bd.* (1991) 227 Cal.App.3d 767, 780.) """"The law indulges in no presumption that an agency exists but instead presumes that a person is acting for himself and not as agent for another."""" (*Ibid*.) "[P]ersons dealing with an assumed agent are bound at their peril to ascertain the extent of the agent's authority." (*Lindsay-Field v. Friendly* (1995) 36 Cal.App.4th 1728, 1734.)

In attempting to create a triable issue as to agency in the separate statement, the Hospital relied on the following evidence: The verification of benefits, the LOA, the consulting agreement, e-mails produced by the Fund, London's deposition testimony, and the declaration of the Hospital's director of managed care who negotiated the LOA. But none of this evidence creates a triable issue. Indeed, in one of the e-mails presented by the Hospital from London to the Fund, dated after the LOA was signed, London asked the Fund, "Let me know how you will respond to [the Hospital]." In another e-mail the Fund informed the Hospital that London "does not have the authority to commit the funds of the Fund."

The Hospital's reliance on London's testimony is also unavailing. The Hospital cites to London's testimony that "We would secure—and negotiate, it's not on the first signature by all means. It's the art of negotiating, so back and forth until an agreed upon reimbursement has been achieved. Once that has occurred, we then seek a signed agreement that says they will agree to this discount, and we will secure it based on our relationship with our client." But this testimony is consistent with the testimony of the Fund's president that London's role in negotiating with healthcare providers was to

explore what deals might be possible or solicit an offer that could be brought back to the Fund for its consideration. Just prior to this testimony, London also testified as follows: "[COUNSEL] Q. Do you have signature authority for the Fund to disburse its resources however you decide to disburse them? [LONDON] A. . . . I don't pay claims. [COUNSEL] Q. Right. [LONDON] A. I negotiate claims. We are requested to secure a signed letter of agreement so that our negotiated fees are nondisputable. So our role is to negotiate a claim. [COUNSEL] Q. When you say 'our negotiated fees,' I'm not sure what you're—who is 'our' in there? [LONDON] A. London Medical Management . . . is the negotiator, and we are negotiating with a given facility provider, [a] hospital."

The declaration of the Hospital's employee who negotiated the LOA states, "Jack London represented that he was authorized to enter into the Letter of Agreement on behalf of [the Fund]." The trial court found this statement lacked foundation and was inadmissible against the Fund, noting that statements of an alleged agent regarding the nature and scope of his authority are not admissible against the principal. (See *Hilyar v. Union Ice Co.* (1955) 45 Cal.2d 30, 42 ["'It is axiomatic that agency cannot be established by the declarations of the agent not under oath or in the presence of the principal'"]; *Warfield v. Summerville Senior Living, Inc.* (2007) 158 Cal.App.4th 443, 448 ["'an agency cannot be created by the conduct of the agent alone; rather, *conduct by the principal* is essential to create the agency'"], citing *Flores v. Evergreen at San Diego, LLC* (2007) 148 Cal.App.4th 581, 587–588.)

Having failed to establish that London was an actual agent with authority to bind the Fund, the Hospital argues there is a triable issue of fact as to whether London had ostensible authority. Ostensible authority focuses on the state of mind of the affected third parties. "Ostensible authority is such as a principal, intentionally or by want of ordinary care, causes or allows a third person to believe the agent to possess." (Civ. Code, § 2317.) "Ostensible authority is not established by the statements and representations of the agent; rather, it is created only by the acts or declarations of the principal." (*House v. State* (1981) 119 Cal.App.3d 861, 875.) "Ostensible authority must

be based on the acts or declarations of the principal and not solely upon the agent's conduct." (*Taylor v. Roseville Toyota, Inc.* (2006) 138 Cal.App.4th 994, 1005.)

What London may have told the Hospital regarding his authority is irrelevant. Without some action by the Fund, there can be no ostensible agency. Here, the Hospital agreed in its separate statement that "[d]uring the time relevant to this suit, the Fund never represented to [the Hospital] or anyone else that London was authorized to enter into the LOA or any other contract on behalf of the Fund." The Hospital therefore failed to create a triable issue of material fact as to ostensible agency.

Finally, the Hospital has failed to create a triable issue on the theory of ratification, raised for the first time on appeal. Ratification requires the principal's unequivocal assent to the unauthorized act. (*Gates v. Bank of America* (1953) 120 Cal.App.2d 571, 576; Civ. Code, § 2307.) It is undisputed that the Fund disclaimed the LOA after learning of its existence.

DISPOSITION

The summary judgment is affirmed. The Fund is entitled to recover its costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS.

_____, J.

DOI TODD

We concur:

_____, P. J.

BOREN

_____, J.

CHAVEZ