COURT OF APPEAL – SECOND DIST.
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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

KANA LIU, Plaintiff and Appellant, v. DIGNITY HEALTH et al., Defendants and Respondents.	B325097 Los Angeles County Super. Ct. No. 19STCV21296

APPEAL from an order of the Superior Court of Los Angeles County, Elihu M. Berle, Judge. Affirmed in part, reversed in part, and remanded with directions.

Susman Godfrey, Marc M. Seltzer, Eliza Finley, Jordan Rux, Rachel S. Black; Wolf Popper, Chet B. Waldman and Matthew Insley-Pruitt for Plaintiff and Appellant.

Buchalter, Damaris L. Medina, Robert M. Dato, Karen N. George and Andrew H. Selesnick for Defendants and Respondents VEP Healthcare, Inc. and Ridgeline Emergency Physicians Medical Group, Inc.

Polsinelli, Jonathon E. Cohn, Elizabeth J. Tucker and Lauren E. Tucker-McCubbin for Defendant and Respondent Dignity Health.

In October 2018, appellant Kana Liu visited the emergency department at Dignity Health's Northridge Hospital Medical Center (Dignity Health Northridge) with severe abdominal pain. She had received treatment from physicians at the hospital before and chose the facility because she knew it was in her health insurer's covered network. However, as Liu later learned, the physicians who worked in the hospital's emergency department did not participate in the same insurance networks as Dignity Health Northridge. Weeks after her visit, Liu received a bill from Ridgeline Emergency Physicians Medical Group, Inc. (Ridgeline)—one of several emergency physicians groups managed by VEP Healthcare, Inc. (VEP). Ridgeline had billed Liu's insurer $921.00 for the services rendered that day; Liu's insurer paid only $300.16 of the charges; and Ridgeline subsequently billed Liu for the unpaid balance of $620.84.

Liu filed this putative class action against defendants Dignity Health, VEP, and Ridgeline, asserting claims for breach of implied contract, declaratory relief, and violations of the California Unfair Competition Law (UCL; Bus. & Prof. Code, § 17200 et seq.) and California Consumers Legal Remedies Act (CLRA; Civ. Code, § 1750 et seq.). She contends she is typical of thousands of other patients who sought treatment at a Dignity Health emergency department and later received a surprise bill from a VEP physicians group for unreasonable charges that the patient's insurer refused to pay. Liu maintains her experience reflects VEP's uniform practice of automatically

billing out-of-network patients' insurers the full "chargemaster rate" and then directly billing patients for any unpaid balance, while failing to disclose the identity and out-of-network status of VEP's physicians groups.

The trial court denied Liu's motion for class certification, concluding she failed to establish the necessary community of interest. The court reasoned proving injury would require a highly individualized inquiry into how each putative class member's insurer responded to a particular bill and whether or to what extent each class member paid the remaining balance. With respect to Liu's claims stemming from defendants' alleged failure to disclose the identity and out-of-network status of VEP's physicians groups, the court also found predominantly individualized inquiries would be necessary to establish causation and, hence, defendants' liability. Liu challenges the rulings, arguing the court misconstrued both her theory of recovery and the undisputed evidence adduced in the certification proceeding. We agree with Liu on all claims except her CLRA claim based on defendants' alleged failure to disclose material information. As to that aspect of the CLRA claim, we affirm. With respect to all other claims, we reverse with directions to enter an order certifying the proposed class and subclass.

BACKGROUND

1. *Defendants Dignity Health, VEP, and Ridgeline*

Dignity Health is one of the largest health systems in the country with dozens of hospitals in California.

VEP offers administrative and nonmedical management services to professional medical groups that provide physicians and staff to hospital emergency departments. Among other things, the company maintains bookkeeping and accounting

systems for its medical group clients, including managing the clients' accounts receivables, billings, and collections.

Ridgeline is a medical group consisting of physicians who specialize in providing emergency medical services. It is one of seven VEP emergency physicians groups that serviced Dignity Health hospitals in California during the relevant period.[1]

2. *The Operative Class Action Complaint*

Liu filed this lawsuit on behalf of a class of California residents who, between June 18, 2015 and December 31, 2021, received emergency medical services from a VEP physicians group at a Dignity Health emergency department, including a subclass of residents who received services from Ridgeline at Dignity Health Northridge, and who received a bill from the physicians group despite having medical insurance that covered the relevant Dignity Health hospital. Her nine-count complaint[2] alleges defendants failed to disclose the out-of-network status of the VEP physicians groups, thus exposing class members to excessive charges, in violation of the UCL and CLRA. The pleading further alleges VEP and Ridgeline charged more than the reasonable value of the services rendered to class members in breach of the parties' implied contracts and in violation of

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[1] The terms "medical group," "physicians group," and "provider" are used interchangeably—all refer to an organized group of medical professionals who provide services to patients. For brevity, we sometimes refer to VEP and the physicians groups it manages, including Ridgeline, collectively as "VEP."

[2] The complaint asserts causes of action for violations of the UCL and CLRA against each defendant individually; breach of implied contract against VEP and Ridgeline individually; and declaratory relief.

the UCL and CLRA. In addition to compensatory damages, restitution, and disgorgement, the complaint seeks declaratory relief regarding the existence of, and the parties' rights and obligations under, the alleged implied contracts.

3. *The Motion for Class Certification*

Liu moved to certify the class and subclass. Consistent with our standard of review, we state the relevant evidence in the light most favorable to the trial court's ruling. (See *Wilens v. TD Waterhouse Group, Inc.* (2003) 120 Cal.App.4th 746, 752.)

During the class period, VEP's physicians groups staffed the emergency departments in seven Dignity Health hospitals in California. Each of the hospitals had contracted with several of the major health insurance networks. VEP's physicians groups participated in few if any of these networks. During patient intake, neither Dignity Health nor VEP's physicians groups affirmatively disclosed the emergency department staff's affiliation with VEP or the fact that VEP's physicians groups did not participate in the same insurance networks as the hospital. And, while Dignity Health allowed patients to schedule emergency department visits using an online form that listed the hospital's in-network insurance plans, it did not disclose the same plans were out-of-network for the VEP physicians group that staffed the hospital's emergency department.

When a patient visited one of these seven emergency departments, a VEP provider would administer treatment, document the services rendered in the patient's medical record, and electronically transmit the record to VEP's contracted billing company, Brault Practice Solutions (Brault). Brault then translated the services into medical billing terminology

—a process called "coding." As Brault's president explained, emergency physician services generally receive one of five Current Procedural Terminology (CPT) codes that correlate to the increasing medical complexity and intensity of the services rendered to evaluate and stabilize a patient. Apart from the five emergency CPT codes, a patient's bill may contain other CPT codes for additional services received during the visit. Every year VEP sets the price—or "chargemaster rate"—for these CPT codes for each of its physicians groups based on hospital location.

After coding a patient's record, Brault determined whether the patient's insurer was in-network or out-of-network with the VEP provider.[3] If the insurer was out-of-network, Brault billed the insurer VEP's full chargemaster rate for the relevant CPT code. In response, the insurer determined how much it deemed the claim to be worth—a sum referred to as the "Allowed Amount"—and documented this determination in an Electronic Remittance Advice (ERA) to Brault and an Explanation of Benefits (EOB) sent to the patient. From the Allowed Amount, the insurer then calculated how much of the bill it would pay

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[3] Health insurers and health care service plans in California may be governed by either the Department of Insurance or the Department of Managed Health Care. (See fn. 8, *post*.) As discussed below, because Liu's claims sound in quantum meruit, the regulatory body governing the relevant insurers or health plans makes no difference to her theory of recovery. We use the terms insurer and health plan interchangeably.

(if any) and the amount of the patient's responsibility under the insurance policy's cost-sharing provisions.[4]

If the insurer paid less than VEP's chargemaster rate, Brault issued an invoice to the patient for the unpaid balance. These invoices sometimes included amounts attributable to the patient's cost-sharing responsibility. If the patient was unable to pay the entire balance of the bill, Brault had discretion to provide a discount based on the patient's circumstances, to offer a payment plan, or to write-off the entire bill.

Brault maintains a database of "paid claims data" for each VEP physicians group it services (Paid Claims Data). The Paid Claims Data lists every billed charge by CPT code and links each charge to a specific account number tied to the specific patient. For each CPT code charge, the Paid Claims Data sets forth the amount of any payments received from the patient's insurer, the amount of any payments received from the patient, and any amount the patient still owes on the charged claim. The Paid Claims Data does not track whether any amount the patient paid is attributable to the patient's cost-sharing responsibility under the patient's insurance policy. To determine that amount, one would need to compare the Paid Claims Data to the ERA or the patient's EOB.

In her class certification motion, Liu identified two categories of claims that she maintained were amenable to class treatment: (1) the implied contract, UCL, and CLRA claims alleging VEP billed out-of-network insurers and patients at unreasonable chargemaster rates (the Rate Claims); and

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[4] For example, a patient may be required to pay a deductible, coinsurance, or a copay as a portion of the Allowed Amount.

(2) the UCL and CLRA claims alleging defendants failed to disclose the identity, out-of-network status, and billing practices of VEP's physicians groups (the Disclosure Claims). As for her declaratory relief claim, Liu characterized it as "derivative" of her damages claims and argued it would be subject to the "same common evidence."

Liu maintained the Rate Claims would turn on common legal and factual questions concerning "VEP's chargemaster rates and whether those rates exceed the reasonable value of services provided," including whether, in the absence of an express contract, VEP's physicians groups were entitled to only "the reasonable value of the services rendered" and whether VEP's "chargemaster rates exceeded the fair market or reasonable value" for each of the five emergency CPT codes at issue.[5] After resolution of these "common questions," Liu argued no more would be required than "the purely mechanical act of computing the amount of damages or restitution for each Class member by [determining] what each patient and his or her insurer paid in excess of the reasonable rate." She maintained this computation could be performed simply by referring to the Paid Claims Data, which tracked "what each patient was billed for *each* CPT code and what was paid toward *each* CPT code."

As for the Disclosure Claims, Liu argued the common issues included whether "defendants had a duty to disclose to Dignity Health's in-network patients the identity, out-of-network

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[5] Liu offered a supporting report from her expert, Dr. Zirui Song. Dr. Song opined that VEP's chargemaster rates for the five emergency CPT codes were unreasonable and that a "common methodology" using "benchmark prices" was available to "arrive at a more reasonable price" on a class-wide basis.

status, or billing practices of VEP's physicians groups"; whether this information "would have been material to a reasonable consumer"; and "whether defendants uniformly failed to disclose" this information. She emphasized the materiality of the undisclosed information would be determined by an "objective" reasonable person standard and argued a showing of materiality eliminated the need to make an individualized inquiry into each class member's reliance on the alleged nondisclosures.

4. *Opposition to Class Certification*

Defendants opposed certification, challenging Liu's theory of liability and her ability to establish each putative class member's right to recover damages on a class-wide basis.[6] While Liu had alleged she and the putative class members were injured by any charge in excess of the "reasonable value for the out-of-network emergency services" received, defendants maintained they were entitled to retain "the difference between the reasonable value and the Allowed Amount," even if "the reasonable value [was] less than the billed charges." Under their proffered framing of liability, defendants argued it was "imperative to calculate the difference between the Allowed Amount and the claim specific reasonable value," as no liability

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[6] Defendants also disputed the ascertainability of the class and subclass; the typicality of Liu's claims; the legal viability of the Disclosure Claims under case law interpreting a hospital's statutory obligations to provide emergency medical care; and the validity of Dr. Song's proposed methodology to establish the reasonable value of the services rendered for the relevant CPT codes on a class-wide basis. Because the trial court resolved these issues in favor of class treatment, defendants' arguments are not relevant to Liu's appeal.

would exist if the VEP provider retained only the Allowed Amount, including whatever portion of that amount the patient had paid as part of their cost-sharing responsibility. As there was "no database" that detailed whether a bill was "for the patient's cost-sharing amount or an amount in excess of the Allowed Amount," defendants maintained an "individualized analysis [of] each patient's Explanation of Benefit (EOB), the account ledger for the particular patient, and the bill issued to the patient" would be necessary to determine liability.

Apart from the Allowed Amount, defendants argued an individualized inquiry would be needed to determine whether a putative class member paid any portion of a bill and thus suffered an injury in fact. Because VEP's billing company had discretion to apply "[d]iscounts or write-offs" to a patient's bill upon request, defendants maintained "each patient's *entire* claim" would need to be analyzed before liability could be determined in many instances. As for those putative class members who had paid nothing because their entire bill was written off, defendants argued their inclusion in the proposed class and subclass proved Liu could not "produce evidence of classwide entitlement to damages" and this "alone defeat[ed] class certification" on the Rate Claims.

As for the Disclosure Claims, defendants argued individual inquiries were necessary to determine whether each putative class member knew or reasonably could have discovered their VEP provider was not in the same insurance network as the hospital. In support, defendants offered evidence showing several class members had received care from the same out-of-network physicians group on an earlier occasion and thus "likely *knew* that the [providers] were out-of-network with their

insurer." Defendants also suggested class members may have reviewed available information—such as their insurer's website, their benefit plan, or the conditions of admission—to learn they "may receive a separate bill from the emergency physicians." Finally, defendants argued some patients may have arrived "unconscious" or "cognitively impaired" and thus "did not rely on any representations in deciding where to receive emergency treatment."

5. *The Trial Court's Statement of Reasons for Denying Class Certification*

The trial court denied the motion, concluding Liu failed to establish the predominance and superiority requirements for class certification. The court found the proposed class and subclass were numerous and ascertainable, Liu's claims were typical, and Liu would be an adequate class representative. However, the court concluded predominant common questions were lacking, as an "individualized" inquiry would be required to determine whether each putative class member suffered an "injury in fact."[7] For that reason, the court also determined class treatment would not be the superior method for

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[7] Although the court found individualized issues predominated, it acknowledged Liu's claims would "undoubtedly involve the resolution of some common issues." Specifically, the court noted "liability" on the Disclosure Claims raised "a common question of law applicable to the entire class," even if some of defendants' cited legal authorities seemed to suggest the class would not prevail on the merits of their claims. The court also found Liu's expert had offered a valid and practical methodology for determining the reasonable value of the services rendered under the relevant emergency CPT codes on a class-wide basis.

adjudicating the claims. The court explained its reasoning in an oral statement of decision from the bench.

With respect to the Rate Claims, the court recounted defendants' argument that they "were permitted to [retain] the difference between the Allowed Amount and the reasonable value" of the services rendered, even "if the reasonable value [was] less than the billed charges." Apparently accepting the contention, the court observed "one would need to calculate the difference between the Allowed Amount and a claim-specific reasonable amount" to determine whether and to what extent putative class members were injured or defendants were unjustly enriched. Because the evidence showed "the Allowed Amount for a particular service varie[d] for each putative class member," the court found an "individualized analysis of each patient's benefit plan" would be required to determine either the amount of each putative class member's injury or whether a class member was injured at all. This individualized inquiry, the court reasoned, would necessarily entail an examination of the "extent any deductible or co-payment" might offset or eliminate a putative class member's alleged injury. Because Liu had failed to "account for any insurance or patient payments" or "which patients may have had their bill paid by a third party," the court found resolution of the liability question "would ultimately devolve into no less tha[n] thousands of individualized determinations of . . . whether [a] class member was injured and then to what extent."

As for the Disclosure Claims, the court found an individualized inquiry would be needed to determine whether a class member was "forced" to receive care from an out-of-network provider "as a result of defendants' alleged failure to disclose

the relationship between the hospital, doctors, and insurance networks." Because this "would need to be litigated individually by each class member," the court concluded identifying those class members who were in fact injured would be "an arduous, record-intensive undertaking" that did not lend itself to class treatment.

Having found Liu "did not establish predominance," the trial court reasoned "individual inquiries" would "overcome the common ones" to "such a degree that a class-action trial" would be "unmanageable." Thus, the court concluded class treatment was "not the preferable or superior method" for adjudicating the claims Liu proposed to assert on behalf of the putative class.

The trial court entered its order denying class certification. Liu filed a timely notice of appeal.

DISCUSSION

1. *Standard of Review and Governing Law*

Section 382 of the Code of Civil Procedure authorizes a class action when "the question is one of a common or general interest, of many persons, or when the parties are numerous, and it is impracticable to bring them all before the court." Our Supreme Court has "articulated clear requirements for the certification of a class" under this statute. (*Brinker Restaurant Corp. v. Superior Court* (2012) 53 Cal.4th 1004, 1021 (*Brinker*).) " 'The party advocating class treatment must demonstrate the existence of an ascertainable and sufficiently numerous class, a well-defined community of interest, and substantial benefits from certification that render proceeding as a class superior to the alternatives.' [Citation.] 'The community of interest requirement involves three factors: "(1) predominant common

questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class." ' " (*Noel v. Thrifty Payless, Inc.* (2019) 7 Cal.5th 955, 968 (*Noel*); *Linder v. Thrifty Oil Co.* (2000) 23 Cal.4th 429, 435 (*Linder*).)

Because the trial court based its superiority determination on its predominance finding, only one issue is implicated in this appeal—whether common questions predominate such that the benefits of certification make proceeding as a class superior to other available methods for adjudicating the controversy. "The 'ultimate question' the element of predominance presents is whether 'the issues which may be jointly tried, when compared with those requiring separate adjudication, are so numerous or substantial that the maintenance of a class action would be advantageous to the judicial process and to the litigants.' [Citations.] The answer hinges on 'whether the theory of recovery advanced by the proponents of certification is, as an analytical matter, likely to prove amenable to class treatment.' [Citation.] A court must examine the allegations of the complaint and supporting declarations [citation] and consider whether the legal and factual issues they present are such that their resolution in a single class proceeding would be both desirable and feasible. 'As a general rule if the defendant's liability can be determined by facts common to all members of the class, a class will be certified even if the members must individually prove their damages.' " (*Brinker, supra,* 53 Cal.4th at pp. 1021–1022.)

"Whether to grant or deny class certification is a matter within a trial court's discretion. That said, 'appellate review of orders denying class certification differs from ordinary appellate review. Under ordinary appellate review, we do not address the

trial court's reasoning and consider only whether the result was correct. [Citation.] But when denying class certification, the trial court must state its reasons, and we must review those reasons for correctness. [Citation.] We may only consider the reasons stated by the trial court and must ignore any unexpressed reason that might support the ruling. [Citations.] [¶] We will affirm an order denying class certification if any of the trial court's stated reasons was valid and sufficient to justify the order, and it is supported by substantial evidence. [Citations.] We will reverse an order denying class certification if the trial court used improper criteria or made erroneous legal assumptions, even if substantial evidence supported the order. [Citations.] A trial court's decision that rests on an error of law is an abuse of discretion.' " (*Cochran v. Schwan's Home Service, Inc.* (2014) 228 Cal.App.4th 1137, 1143 (*Cochran*), quoting *Knapp v. AT&T Wireless Services, Inc.* (2011) 195 Cal.App.4th 932, 939; accord *Linder, supra,* 23 Cal.4th at pp. 435–436; see also *Ayala v. Antelope Valley Newspapers, Inc.* (2014) 59 Cal.4th 522, 537 ["[a] certification decision is reviewed for abuse of discretion, but when the supporting reasoning reveals the court based its decision on erroneous legal assumptions about the relevant questions, that decision cannot stand"].)

2. *The Rate Claims Are Governed by Quantum Meruit Principles and Do Not Require Individualized Inquiries Regarding the Allowed Amount*

Consistent with our Supreme Court's directives, we begin with Liu's theory of recovery, as alleged in her operative complaint. (See *Brinker, supra,* 53 Cal.4th at pp. 1021–1022.) Liu's Rate Claims seek restitution and disgorgement of all amounts she and the putative class members paid to VEP or

Ridgeline in excess of the reasonable value of the emergency medical services rendered. The implied contract claims allege out-of-network patients did not enter into express contracts with VEP or Ridgeline and, thus, a contract was implied by law entitling the providers to no more than the "fair market or reasonable value of the emergency services rendered." The UCL and CLRA claims similarly allege VEP and Ridgeline were statutorily entitled to payment for no more than "the reasonable value of [the provider's] services absent an express contractual relationship specifying the rates that [would] be charged." The complaint alleges VEP and Ridgeline breached these implied contracts and violated their statutory duties to the extent these defendants billed out-of-network patients and insurers at a chargemaster rate greater than the reasonable value of the emergency medical services provided.

Liu contends the trial court misconstrued her proposed class-wide formula for determining liability on the Rate Claims. She explains her "theory of injury" is an "overcharge theory" premised on the allegation that VEP's "chargemaster rates for the five at-issue CPT codes consistently exceeded the reasonable value" of the emergency medical services rendered and billed under those codes. Because the undisputed evidence showed VEP "uniformly billed out-of-network patients using a single chargemaster rate for each CPT code," Liu argues she can establish class-wide liability simply by proving "the reasonable price for each CPT code is lower than the chargemaster rates." With liability established, Liu maintains the amount of restitution or disgorgement for each class member can also be calculated using a class-wide formula that (1) combines the amount each class member paid or is claimed to owe on a

CPT code with the amount the class member's insurer paid on the code and (2) compares this amount to the reasonable price for the CPT code. Any amounts in excess of the reasonable price, she argues, constitute unjust enrichment supporting restitution and disgorgement remedies.

Liu is correct insofar as she contends the trial court disregarded her theory of recovery in favor of defendants' alternative framing of the liability issue. As discussed, the parties' disagreement centered on the Allowed Amount —that is, the amount of the provider's billed charges that an out-of-network insurer determines it will pay, which includes the patient's cost-sharing responsibility under the relevant insurance policy. While Liu maintained VEP and its providers were liable for billing and collecting *any* amount *greater* than the reasonable value of the services rendered, defendants argued they were entitled to retain "the difference between the reasonable value and the Allowed Amount" even if "the reasonable value [was] *less* than the billed charges." (Italics added.) The trial court appears to have accepted defendants' framing, observing in its oral statement of decision that the evidence showed "the Allowed Amount for a particular service varie[d] for each putative class member" and finding an "individualized analysis of each patient's benefit plan" would be required to determine whether defendants were liable on the Rate Claims.

In accepting defendants' framing (and implicitly rejecting Liu's theory of recovery), the trial court made what amounted to a legal determination that VEP could not be held liable for collecting an Allowed Amount greater than the reasonable value of the services rendered to out-of-network patients. It was not

error, in and of itself, to reach the legal merits of the Rate Claims. While the certification question is " ' "essentially a procedural one that does not ask whether an action is legally or factually meritorious," ' " our Supreme Court has recognized that " 'issues affecting the merits of a case may be enmeshed with class action requirements.' " (*Brinker, supra,* 53 Cal.4th at p. 1023.) In those circumstances, the "rule is that a court may 'consider[ ] how various claims and defenses relate and may affect the course of the litigation' even though such 'considerations . . . may overlap the case's merits.' " (*Id.* at p. 1024.) "In particular, whether common or individual questions predominate will often depend upon resolution of issues closely tied to the merits." (*Ibid.*) "To the extent the propriety of certification depends upon disputed threshold legal or factual questions, a court may, and indeed must, resolve them." (*Id.* at p. 1025; see also *Walsh v. IKON Office Solutions, Inc.* (2007) 148 Cal.App.4th 1440, 1450 ["In examining whether common issues of law or fact predominate, the court must consider the plaintiff's legal theory of liability."].)

With that said, although the trial court appropriately reached the merits of Liu's theory of recovery, we find the court's legal conclusion was nonetheless erroneous under the quantum meruit principles that govern the Rate Claims. It is settled that when one renders beneficial services to another in the absence of an express contract stipulating price, he or she may recover the reasonable value of those services in quantum meruit. (See *Huskinson & Brown v. Wolf* (2004) 32 Cal.4th 453, 458; *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1274 (*Children's Hospital*).) "Quantum meruit refers to the well-established principle

that 'the law implies a promise to pay for services performed under circumstances disclosing that they were not gratuitously rendered.' [Citation.] To recover in quantum meruit, a party need not prove the existence of a contract [citations], but it must show the circumstances were such that 'the services were rendered under some understanding or expectation of both parties that compensation therefor was to be made.' " (*Huskinson,* at p. 458.)

"The measure of recovery in quantum meruit is the *reasonable value of the services*, provided they were of direct benefit to the [recipient]." (*Children's Hospital, supra,* 226 Cal.App.4th at p. 1274, italics added, citing *Palmer v. Gregg* (1967) 65 Cal.2d 657, 660.) "The 'reasonable value' of the services has been described as the 'going rate' for the services [citation] or the 'reasonable market value at the current market prices.' " (*Children's Hospital*, at p. 1274.) "Reasonable market value, or fair market value, is the price that ' "a willing buyer would pay to a willing seller, neither being under compulsion to buy or sell, and both having full knowledge of all pertinent facts." ' " (*Ibid.*) Quantum meruit recovery is not available for services that confer "no direct benefit" on the recipient. (*Palmer,* at pp. 660–661.)

Under common law and applicable regulations, quantum meruit principles govern reimbursement payments that health plans must make to noncontracted providers for emergency medical services rendered to out-of-network patients, like the payments at issue in this case. (See *Children's Hospital, supra,* 226 Cal.App.4th at pp. 1271–1273.) For example, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act; Health & Saf. Code, § 1340 et seq.) requires for-profit health care service plans promptly to "reimburse emergency health care

providers for both emergency medical services and authorized poststabilization emergency medical services." (*Children's Hospital,* at pp. 1270–1271.) Under this legislation and mandate, the Department of Managed Health Care (DMHC) promulgated section 1300.71 of title 28 of the California Code of Regulations (section 1300.71) to " 'define terms relating to claim settlement and reimbursement.' "[8] (*Children's Hospital,* at p. 1271.) Section 1300.71(a)(3)(B) defines the term " 'Reimbursement of a Claim' " to mean " 'the payment of the *reasonable and customary value* for the health care services rendered.' " (*Children's Hospital*, at p. 1271, quoting § 1300.71(a)(3)(B), italics added.) The regulation directs health plans to determine this value "based upon statistically credible information that is updated at least annually" and lists six factors that plans must take into consideration. (§ 1300.71(a)(3)(B).) These listed factors, however, constitute only "the minimum criteria for reimbursement of a claim, *not the exclusive criteria.*" (*Children's Hospital,* at p. 1273, italics added.) As the *Children's Hospital* court explained, in adopting section 1300.71, "the DMHC intended that reasonable value be *based on the concept of quantum meruit* and that value disputes be resolved by the courts." (*Children's Hospital,* at p. 1273, italics added.) Thus, the regulation embodies what has long been the rule under the common law of quantum meruit: "[A]lthough emergency room doctors 'are entitled to "reasonable" compensation for the services

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[8] The DMHC is charged with administering and enforcing the laws governing health care service plans. (Health & Saf. Code, § 1341.) To carry out its duties, the DMHC is authorized to promulgate regulations. (*Id.*, § 1344; *Children's Hospital, supra,* 226 Cal.App.4th at p. 1271.)

rendered, they cannot lawfully seek unreasonable payment from anyone.' " (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 508 (*Prospect Medical*); *Children's Hospital,* at pp. 1274, 1276 ["section 1300.71(a)(3)(B)'s directive to pay noncontracted providers the reasonable and customary value of their services embodies the concept of quantum meruit," and "DMHC neither intended nor had the power to dictate payment rates or change California law on quantum meruit"].)

In opposing class certification, defendants argued an individualized assessment of the "difference between the Allowed Amount and the claim specific reasonable value" would be required for every alleged overcharge because VEP could not be held liable for retaining "the difference between the reasonable value and the Allowed Amount," even if "the reasonable value is less than the billed charges." Defendants offered no legal authority to support their reframing of Liu's theory of recovery, nor did they address the quantum meruit principles undergirding her Rate Claims.[9] Instead, defendants relied exclusively upon

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[9] For the first time on appeal, defendants acknowledge section 1300.71 governs the health plan payments at issue in this case, but they argue the regulation "entitle[s]" VEP and its providers to retain the Allowed Amount because those payments "result[ed] from the minimum payment criteria [mandated] to ensure compliance with the Knox Keene standards." Additionally, because insurers " 'voluntarily' " paid the Allowed Amount in accordance with the regulation's mandated payment criteria, defendants now argue the putative class members are precluded from seeking restitution or disgorgement of payments made in excess of the reasonable value under the "voluntary-payment doctrine." As we have discussed, on review of an order

their expert's assertion that a prohibited "balance bill is the amount remaining in excess of . . . the amount the insurer determined it would pay." Because the matter of what constitutes an illicit bill is a legal question within the exclusive province of the courts, the declaration of defendants' expert was plainly inadequate to support the trial court's rejection of Liu's theory of recovery. (See *Ferreira v. Workmen's Comp. Appeals Bd.* (1974) 38 Cal.App.3d 120, 126 ["The manner in which the law should apply to particular facts is a legal question and is not subject to expert opinion."], citing *L.A. Teachers Union v. L.A. City Bd. of Ed.* (1969) 71 Cal.2d 551, 556; accord *Cooper Companies v. Transcontinental Ins. Co.* (1995) 31 Cal.App.4th 1094, 1100; *Summers v. A.L. Gilbert Co.* (1999) 69 Cal.App.4th 1155, 1179–1180.)

Liu's overcharge theory is consistent with the quantum meruit principles that govern reimbursement payments to emergency medical service providers in the absence of an express contract stipulating price. (See *Children's Hospital, supra,* 226 Cal.App.4th at pp. 1274–1276.) Under those principles, VEP and its providers have no legal entitlement to any amount in excess of the reasonable value of their services,

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denying class certification we " 'may only consider the reasons stated by the trial court and must ignore any unexpressed reason that might support the ruling.' " (*Cochran, supra,* 228 Cal.App.4th at p. 1143.) Presumably because defendants did not make these arguments in their opposition to class certification, the trial court did not discuss the Knox-Keene Act or the voluntary-payment doctrine in its statement of reasons for denying certification. Without passing judgment on the merits of defendants' arguments or the effect they may have on later proceedings, we must deem these issues forfeited for this appeal.

regardless of a patient's cost-sharing agreement with his or her insurer or what the insurer deems an Allowed Amount. (See *Prospect Medical, supra,* 45 Cal.4th at p. 508.) The trial court erred to the extent it denied certification of the Rate Claims based on individualized issues implicated by the Allowed Amount.

3. *The Disclosure Claims under the CLRA and UCL*

Liu's Disclosure Claims consist of causes of action against Dignity Health and VEP for UCL and CLRA violations stemming from these defendants' alleged "omissions of material fact" regarding VEP's relationship with Dignity Health and VEP's billing practices. On behalf of herself and the putative class and subclass, Liu seeks compensatory damages under the CLRA and restitution and equitable injunctive relief under the UCL.

The trial court denied certification of the Disclosure Claims, finding individualized inquiries would be needed to determine "which among the thousands of class members" were "forced" to receive out-of-network care "as a result of defendants' alleged failure to disclose the relationship between the hospital, doctors, and insurance networks." This finding implies the court rejected the inference of reliance that may be drawn when a defendant fails to disclose material information. (See *Vasquez v. Superior Court of San Joaquin County* (1971) 4 Cal.3d 800, 814; *Massachusetts Mutual Life Ins. Co. v. Superior Court* (2002) 97 Cal.App.4th 1282, 1292–1294 (*Mass Mutual*).) As we explain below, this was a proper basis to deny certification of the CLRA claim and substantial evidence supports the court's finding. We reach a different conclusion regarding the UCL claim. Because a claim for restitution and injunctive relief under the UCL does not

require individualized proof of deception, reliance, or injury, the trial court's finding was not a proper basis to deny certification.

a. *The CLRA requires proof of reliance to establish liability on the Disclosure Claims*

Civil Code section 1781 "exclusively" governs a class action under the CLRA. (*Mass Mutual, supra,* 97 Cal.App.4th at p. 1287.) Like Code of Civil Procedure section 382, Civil Code section 1781, subdivision (b) authorizes a class action "only when there are questions of law or fact which predominate over questions affecting individual members." (*Mass Mutual*, at p. 1287.)

Under the CLRA, a consumer may recover actual damages, punitive damages, and attorney fees. (Civ. Code, § 1780, subds. (a)(1), (4), (e).) However, relief under the CLRA is limited to those consumers who suffer "damage *as a result* of the use or employment by any person of a method, act, or practice" unlawful under the act. (Civ. Code, § 1780, subd. (a), italics added.) "[T]his limitation on relief requires that plaintiffs in a CLRA action show not only that a defendant's conduct was deceptive but that the deception *caused* them harm." (*Mass Mutual, supra,* 97 Cal.App.4th at p. 1292, italics added.)

"Causation, on a class-wide basis, may be established by *materiality*." (*In re Vioxx Class Cases* (2009) 180 Cal.App.4th 116, 129 (*Vioxx*).) " ' "A misrepresentation of fact is material if it induced the plaintiff to alter his position to his detriment. [Citation.] Stated in terms of reliance, materiality means that without the misrepresentation, the plaintiff would not have acted as he did." ' " (*Caro v. Procter & Gamble Co*. (1993) 18 Cal.App.4th 644, 668 (*Caro*); see also *Occidental Land, Inc. v. Super. Ct. of Orange Cty.* (1976) 18 Cal.3d 355, 363 ["an inference

of reliance arises if a material false representation was made to persons whose acts thereafter were consistent with reliance upon the representation"].) "If the trial court finds that material misrepresentations have been made to the entire class, an inference of reliance arises as to the class." (*Vioxx*, at p. 129, citing *Mass Mutual, supra,* 97 Cal.App.4th at p. 1292.) Thus, " ' "[p]laintiffs [may] satisfy their burden of showing causation as to each by showing materiality as to all." ' [Citation.] In contrast, however, if the issue of materiality or reliance is a matter that would vary from consumer to consumer, the issue is not subject to common proof, and the action is properly not certified as a class action." (*Vioxx,* at p. 129.)

The trial court rejected an inference of class-wide materiality and reliance, expressly finding individualized inquiries would be needed to determine "which among the thousands of class members" received out-of-network care "as a result of defendants' alleged failure to disclose the relationship between the hospital, doctors, and insurance networks." Defendants maintain the record supports this finding, citing evidence that a number of patients visited the same emergency department where they had previously received out-of-network care from a VEP provider. Because this evidence proves there are circumstances when a provider's out-of-network status is not material to a patient seeking emergency medical treatment, defendants argue the trial court had a sound basis to reject the inference of class-wide reliance. Liu disputes the sufficiency of this evidence. Relying on *Mass Mutual*, she argues it is not enough that defendants "may be able to show a lack of materiality or reliance as to 'a few individual class members,' "

because this "possibility 'does not transform the common question into a multitude of individual ones.' "

Mass Mutual is materially different from our case for the simple reason that the trial court in *Mass Mutual* found the plaintiffs' CLRA claim presented predominate common questions of fact, whereas the trial court in our case did not. Thus, in affirming the trial court's order certifying the proposed CLRA class, the appellate court in *Mass Mutual* recognized that "[w]here a certification order turns on inferences to be drawn from the facts, ' "the reviewing court has no authority to substitute its decision for that of the trial court." ' " (*Mass Mutual, supra,* 97 Cal.App.4th at p. 1287.) The same principle applies when, as here, the trial court *rejects* an inference necessary to establish the requisite community of interest—we may not substitute our judgment for that of the trial court when the court's reason for denying certification is " 'sufficient to justify the order' " and " 'supported by substantial evidence.' " (*Cochran, supra,* 228 Cal.App.4th at p. 1143.)

In *Mass Mutual* there was "nothing in the record" to show the allegedly material information "was disclosed to any class member," thus the reviewing court was obliged to accept the trial court's apparent inference of reliance as to the entire class. (*Mass Mutual, supra,* 97 Cal.App.4th at p. 1295.) In contrast, here, the evidence showed some patients returned to the same emergency department, despite previously having received a bill disclosing the department was staffed by a VEP provider outside the patient's insurance network. Where the evidence shows some class members were aware of the allegedly undisclosed material information and were not influenced by it, reviewing courts have applied the prescribed standard of review and affirmed the

trial court's denial of class certification. (See, e.g., *Caro, supra,* 18 Cal.App.4th at p. 668 [affirming order denying certification of CLRA claim where "it would be a matter of individualized proof whether the claim of 'no additives' constituted a material misrepresentation to class members who . . . read the portions of the label stating 'from concentrate' "]; *Vioxx, supra,* 180 Cal.App.4th at p. 134 [affirming order denying certification of CLRA claim where, after cardiovascular risks of pharmaceutical became public, evidence showed "[s]ome patients would still take Vioxx today if it were on the market" and "some physicians would still prescribe it regardless of risks"].)

Steroid Hormone Product Cases (2010) 181 Cal.App.4th 145 (*Steroid Hormone*) is also distinguishable. Unlike the trial court's order in our case, which rests on a *factual finding* regarding causation and materiality, the trial court's order denying certification in *Steroid Hormone* rested on an erroneous *legal determination* about the type of damage a plaintiff must prove under the CLRA. As the reviewing court explained, the lower court was "led astray" when it embraced the defendant's "erroneous legal assumption" that "the showing of 'damage' required under the CLRA is governed by Civil Code section 3343, i.e., the measure of actual damages for persons defrauded in the purchase of property." (*Steroid Hormone*, at p. 156.) This assumption was "incorrect" because the " 'damage' " a plaintiff must show under the CLRA is " 'any damage,' which 'is not synonymous with "actual damages" ' and 'may encompass harms other than pecuniary damages.' " (*Ibid.*, quoting *Meyer v. Sprint Spectrum L.P.* (2009) 45 Cal.4th 634, 640.) As "the denial of class certification of the CLRA claim was based upon an erroneous

legal assumption," the *Steroid Hormone* court concluded "the ruling must be reversed." (*Steroid Hormone,* at p. 158.)

Unlike the order in *Steroid Hormone*, the trial court's ruling here does not rest on an erroneous legal assumption, and Liu does not contend otherwise. Instead, she challenges the sufficiency of the evidence to support the court's factual finding, suggesting the evidence at most shows "a lack of materiality or reliance as to 'a few individual class members.' " While it is true that defendants offered evidence of only a handful of patients who returned to the same Dignity Health hospital where they previously received out-of-network care from a VEP provider, we disagree with the contention that this undermines the trial court's factual finding. Although defendants' evidence was limited, it was consistent with a simple reality that we all understand from common experience—that is, because exigent circumstances usually attend the need for emergency medical treatment, insurance network coverage often is *not* the primary or even a significant factor influencing a patient's choice of hospital. Indeed, it was this common experience—that, "in an emergency," a patient might go to an emergency room where the doctors have "no preexisting contractual relationship" with the patient's health plan—that compelled our Supreme Court to consider and ultimately declare the practice of balance billing illegal. (*Prospect Medical, supra,* 45 Cal.4th at pp. 504–505, 507.) In view of the evidence and this practical reality, we cannot say the trial court erred in concluding individualized inquiries would be necessary to determine whether each class member received out-of-network care "as a result of" defendants' alleged non-disclosures. (Civ. Code, § 1780, subd. (a).)

b. *The UCL does not require individualized proof of deception, reliance, or injury to establish liability on the Disclosure Claims*

The trial court's ruling on the Disclosure Claims did not distinguish between the CLRA and the UCL, despite significant and, indeed, dispositive differences between the two laws. By its terms the UCL prohibits as unfair competition "any unlawful, unfair or fraudulent business act or practice." (Bus. & Prof. Code, § 17200.) Critically, and in contrast to the CLRA, "California courts have repeatedly held that relief under the UCL is available without individualized proof of deception, reliance and injury." (*Mass Mutual, supra,* 97 Cal.App.4th at p. 1288 [cataloguing cases], citing *Fletcher v. Security Pacific Nat. Bank* (1979) 23 Cal.3d 442, 452–453 (*Fletcher*).) As our Supreme Court explained in *Fletcher*, the "concern with thwarting unfair trade practices has been such that [our courts] have consistently condemned not only those alleged unfair practices which have in fact deceived the victims, but also those which are *likely to deceive* them." (*Fletcher,* at p. 451, italics added.) Although plaintiffs suing under the UCL "do not bear the traditional burden required of victims of common law fraud, by the same token relief under the UCL is limited to injunctive relief and restitution." (*Mass Mutual,* at p. 1288; see *Fletcher,* at pp. 453–454.) Unlike the CLRA, the "UCL does not provide for the recovery of damages or attorney fees." (*Mass Mutual,* at p. 1288.)

The trial court denied certification of the Disclosure Claims, finding individualized inquiries would be needed to determine whether absent class members received out-of-network care "as a result of defendants' alleged failure to disclose the

relationship between the hospital, doctors, and insurance networks." As discussed, this was a sound basis to deny certification under the CLRA, because relief under that act is limited to those consumers who suffer "damage *as a result* of" unlawful conduct. (Civ. Code, § 1780, subd. (a), italics added.) It was not, however, a sound basis to deny certification of the UCL claim. Unlike the CLRA, "relief under the UCL, including restitution, is available without proof of individual deception, reliance and injury." (*Mass Mutual, supra,* 97 Cal.App.4th at p. 1291; see *Fletcher, supra,* 23 Cal.3d at p. 451.) Thus, to obtain class-wide restitution and injunctive relief, absent class members will not need to prove defendants' alleged non-disclosures individually caused their alleged harm. It is sufficient to show defendants' conduct was "likely to deceive" patients seeking emergency care from an in-network provider. (*Mass Mutual*, at p. 1291.) That question presents a common issue and can be answered without the need for individualized proof. (See, e.g., *ibid*. [where trier of fact could find allegedly withheld information would be "important to prospective [policy] purchasers" and failure to disclose would be "misleading," certification of UCL claim was appropriate]; *Steroid Hormone, supra,* 181 Cal.App.4th at p. 158 [reversing denial of class certification where order was based on trial court's erroneous legal assumption that "plaintiffs must show class members' reliance on the alleged misrepresentations under the UCL"].)

Defendants do not address the UCL's more expansive reach. On the contrary, they argue the "same analysis" that supported the trial court's decision to deny certification under the CLRA also applies to the UCL, because, in defendants' telling, Liu necessarily predicated her Disclosure Claims

under the UCL on a violation of the CLRA. The contention is inconsistent with the allegations of Liu's complaint and contrary to established precedent. As our courts have repeatedly recognized, "the fact that [a] challenged practice or act was not previously condemned by statute or case authority presents no impediment to a finding that it is 'unfair' under the UCL." (*Paulus v. Bob Lynch Ford, Inc.* (2006) 139 Cal.App.4th 659, 682, citing *Allied Grape Growers v. Bronco Wine Co.* (1988) 203 Cal.App.3d 432, 450–451; *People v. James* (1981) 122 Cal.App.3d 25, 35–36.) Here, Liu alleged defendants' failure to disclose VEP's out-of-network status and billing procedures was an "unfair" practice. The CLRA's causation requirement does not preclude certification of the UCL claim.

Contrary to the trial court's apparent legal assumption, the UCL does not require proof that absent class members received out-of-network care "as a result of" defendants' alleged non-disclosures. The trial court abused its discretion to the extent it denied certification of the UCL claim on this basis. (See *Steroid Hormone, supra,* 181 Cal.App.4th at p. 158.)

4. *Substantial Evidence Does Not Support the Trial Court's Other Factual Findings*

Finally, we address other factual findings the trial court made in support of its predominance determination. While the court acknowledged a class may be certified even if the members must individually prove their damages (see *Brinker, supra,* 53 Cal.4th at pp. 1021–1022), it determined this rule did not apply to Liu's claims because establishing absent class members suffered "injury in fact" would require individualized inquiries to prove "the actual amount each insurer and patient paid"; how those payments were allocated to "each individual CPT

code"; and whether an absent class member had "outstanding debt."[10] Liu maintains the Paid Claims Data answers all these questions and "eliminate[s] the need to look at any other document" to determine whether a putative class member suffered injury and, if so, the extent of the harm. Thus, she argues there was no evidence to support the court's finding that these issues required individualized proof. We agree with Liu.

As discussed, VEP's contracted billing company, Brault, maintains a database that tracks all the payments that each VEP physicians group received from a patient and the patient's insurer for the relevant emergency CPT codes during the class period. Our review of the reports Brault produced from this database confirms the Paid Claims Data records (1) each patient's identity by account number; (2) the date of the visit when the VEP provider rendered services to the patient; (3) the CPT code assigned to the emergency services rendered during the visit; (4) the amount VEP billed under the CPT code; (5) the amount the patient's insurer paid under the CPT code; (6) the amount the patient paid under the CPT code; and (7) the amount the patient still owes for the services rendered

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[10] The trial court also determined an individualized inquiry would be needed to determine the difference between VEP's "out-of-network charges and what the patient would have paid to an in-network provider or facility." Assuming the trial court meant what it said, defendants acknowledge this was not a sound basis to deny certification, as Liu's theory of recovery was based on the difference between VEP's chargemaster rates and the *reasonable value* of the services received—not the in-network price class members would have paid for the services. However, defendants argue the trial court referred to "in-network" charges as a proxy for reasonable charges.

under the CPT code, if any.[11] Contrary to the trial court's findings, the Paid Claims Data plainly sets forth the amount each insurer and absent class member paid for the services VEP billed under a particular CPT code and the amount, if any, that individual absent class members still owe for those services. Where, as here, the evidence is "undisputed and only one inference may reasonably be drawn," we are "not bound by the trial court's ruling" and may decide an issue as one of law. (*Platt Pacific, Inc. v. Andelson* (1993) 6 Cal.4th 307, 319; cf. *Kendall v. Scripps Health* (2017) 16 Cal.App.5th 553, 569, 573 [where defendant's evidence showed it "would have to conduct 'an individual inquiry into hundreds of thousands of patients' records' 'to figure out what a patient has paid for his/her

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[11] The "Amount Adjusted" column in the Paid Claims Data sets forth the amount a patient still owes, if any, for the services rendered under the relevant CPT code. As Liu observes, this column appears to account for any discounts or write-offs that Brault may have granted during the collections process. Defendants contend Liu forfeited this matter by failing to raise it in the trial court, thus depriving defendants of the opportunity to "include contradictory evidence in the record explaining that the 'Amount Adjusted' column does *not* necessarily mean there was a discount or a write-off." But it was defendants who argued these discounts necessitated individualized inquiries, and it was their burden to rebut Liu's showing that the Paid Claims Data plainly recorded amounts that absent class members still owed. In any event, as Liu notes, the trial court did not base its ruling on a supposed failure to track discounts or debt forgiveness (perhaps because of what the Paid Claims Data shows), and we cannot affirm the denial of certification based on an " 'unexpressed reason.' " (*Cochran, supra,* 228 Cal.App.4th at p. 1143.)

encounter, if anything,' " the "trial court had a sufficient basis in the record to determine that class certification was not an appropriate format" for pursuing claim challenging defendant's use of chargemaster rates]; *Hale v. Sharp Healthcare* (2014) 232 Cal.App.4th 50, 63 [where "the declarations and deposition testimony of a sampling of putative class members showed some patients . . . had their bills paid or reimbursed by third parties," reviewing court was compelled to accept trial court's finding that " 'each individual [class member] will have to litigate numerous and substantial issues to determine the *right to recover* in this case' "]; see also *Noel, supra,* 7 Cal.5th at p. 986, fn. 15 [disapproving *Kendall* and *Hale* with respect to ascertainability standard].)[12]

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[12] Defendants have argued that, as in *Hale*, "individualized inquiries into whether the patients themselves or third parties paid for the patients' care" would be needed to establish liability in this case. But defendants cited no evidence to prove their premise that any third-party payments were ever made. Moreover, when asked to identify supporting evidence, defendants cited only vague references to " 'the possible ways the patient payment could have been derived' " and the fact that the Paid Claims Data does not "specify" whether patient payments were "received from the patient or from a third party on behalf of the patient." They also argue Liu cannot shift the burden to them to prove the existence of third-party payments. Plainly the absence of a record of third-party payments in the Paid Claims Data is not proof that these payments occurred. Nor is it shifting the burden of proof to require evidence of such payments from defendants when *defendants* have argued the existence of these payments impacts the predominance analysis. As Liu correctly puts it, she has "no duty to rebut any hypothetical situation [defendants] can conjure up," and defendants' " 'mere speculation' " cannot defeat certification.

Defendants concede the Paid Claims Data "seems to include" the patient and insurer payment information that the trial court found would necessitate individualized inquiries, but they argue other evidence "confirms the challenge with payment allocations." The evidence defendants cite is irrelevant, as it has no bearing on whether absent class members can establish injury in fact simply by referring to the Paid Claims Data. Defendants direct us to deposition testimony by Liu's expert, who acknowledged that "when *a patient* writes a check for a whole out-of-network surprise bill," the patient does not "think about apportioning that amount to different codes." (Italics added.) They also point to a declaration by Brault's president similarly noting that the Paid Claims Data does "not track *how the patient* allocated its payment." (First word, italics in original; other words, italics added.) As Liu correctly observes, it is irrelevant how *patients* thought their payments would be allocated because, under Liu's theory of recovery, a class member's alleged injury, and thus defendants' liability, is based on VEP's billing practices and how *VEP* allocated charges, payments, and debts to the five emergency CPT codes at issue. Defendants concede the Paid Claims Data records this information.[13]

(See, e.g., *ABM Industries Overtime Cases* (2017) 19 Cal.App.5th 277, 307 [defendant's "speculation that some potential class members identified in the data may ultimately not be entitled to relief" is an inappropriate basis to deny certification]; accord *Nicodemus v. Saint Francis Memorial Hospital* (2016) 3 Cal.App.5th 1200, 1216 (*Nicodemus*).)

[13] Defendants' reliance on their expert's assertion that the Paid Claims Data does " 'not provide enough information to

The record shows that once a factfinder determines the reasonable value for each of the five emergency CPT codes at issue (a determination the trial court found could be made on a class-wide basis), the Paid Claims Data supplies the necessary payment information to determine each absent class member's injury, if any, and the amount of harm purportedly suffered. As Liu posits, this calculation can be performed simply by comparing the reasonable value of the services to the combined amount the class member and his or her insurer paid for those services —all of which is set forth in the Paid Claims Data. Under Liu's theory of recovery, any amount paid or still owed in excess of the reasonable value constitutes injury for both her Rate and Disclosure Claims.[14] The trial court erred to the extent it found

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distinguish among the possible ways the patient payment could have been derived' " is similarly unhelpful. Even if we assume Brault's process for determining how to allocate patient payments to a particular CPT code is relevant—a dubious proposition for the reasons discussed above—there is no evidence to suggest this process is not uniform or that it varies from patient to patient.

[14] The trial court assumed, but did not decide, that the existence of debt constitutes injury or damages. We agree with the courts that have addressed this issue and held medical debt constitutes injury in fact. (See *Sarun v. Dignity Health* (2014) 232 Cal.App.4th 1159, 1167 ["the existence of an enforceable obligation, without more, ordinarily constitutes actual injury or injury in fact"]; *Hale v. Sharp Healthcare* (2010) 183 Cal.App.4th 1373, 1383–1384 [obligation to pay for medical services constitutes injury in fact because the patient faces "at least an *imminent* invasion or injury to a legally protected interest"]; see also *Adams v. Paul* (1995) 11 Cal.4th 583, 591, fn. 5 ["actual injury . . . may well precede quantifiable financial costs"].)

individualized questions regarding patient and insurer payments predominated over common questions regarding defendants' alleged overcharges and non-disclosures. (See, e.g., *Nicodemus, supra,* 3 Cal.App.5th at p. 1219 [trial court erred by denying certification of claim alleging uniform practice of overcharging for photocopying medical records, notwithstanding "fact that each class member ultimately may be required to establish his or her records request was submitted before or in contemplation of litigation" to establish statutory liability].)

5. *Individualized Issues Do Not Render the Class Unmanageable*

The trial court predicated its superiority finding on its conclusion that individualized issues predominated. Having found Liu "did not establish predominance," the trial court reasoned "individual inquiries" would "overcome the common ones" to "such a degree that a class-action trial" would be "unmanageable" and "not the preferable or superior method" for adjudicating Liu's claims. As we have concluded the trial court's predominance findings regarding the Rate Claims and the UCL Disclosure Claim were not sound, the court's order affords no basis to refuse certification of these claims for lack of manageability or superiority. (See, e.g., *Wilson v. The La Jolla Group* (2021) 61 Cal.App.5th 897, 920 [where "trial court abused its discretion by determining that common questions did not predominate" on wage statement claim, court's order provided no "grounds to refuse certification of the wage statement claim on the basis of manageability or superiority"].)

6. *The Record Provides No Grounds to Deny Certification of the Declaratory Relief Claim*

Liu's declaratory relief claim seeks a judicial declaration regarding the existence of, and the parties' rights and obligations under, the alleged implied contracts. Because the claim raises the common legal issue of whether VEP's providers are entitled to only the reasonable value of the emergency services rendered, and the trial court did not address the declaratory relief claim in its statement of reasons for denying class certification, Liu maintains the court erred and certification is mandated. Defendants contend it is sufficient that their opposition argued the declaratory relief claim presented the same individualized issues as the Rate Claims, because the basis for the court's ruling can be discerned from the record. We need not resolve the dispute. As we have concluded the court failed to state a sound basis for denying certification of the Rate Claims, it makes no difference whether the trial court intended to base its ruling on its predominance findings. On this record, there were no grounds to deny certification of the declaratory relief claim.

DISPOSITION

The part of the order denying class certification of Liu's CLRA claim based on defendants' alleged failure to disclose material information is affirmed. The order is reversed in all other respects and the trial court is directed to enter a new order certifying the proposed class and subclass as to the remaining claims. Plaintiff Kana Liu is entitled to costs.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

EGERTON, J.

We concur:

EDMON, P. J.

BERSHON, J.*

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* Judge of the Los Angeles County Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.