

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF
CALIFORNIA

Dameron Hospital Association v. Geico Indemnity Company;
Dameron Hospital Association v. Geico General Insurance Company

No. 2:24-cv-00934-DJC-AC; 2:24-cv-01379-DJC-AC, United States District Court for the Eastern District of
California (June 24, 2025)

OPINION

Dameron Hospital Assoc. v. Geico General Ins. Co.

PER CURIAM.

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8 UNITED STATES DISTRICT COURT

9 EASTERN DISTRICT OF CALIFORNIA

10

11 DAMERON HOSPITAL ASSOCIATION No. 2:24-cv-00934-DJC-AC

12 Plaintiff, 13 v.

14 GEICO INDEMNITY COMPANY

15 Defendant. 16 _____

17 DAMERON HOSPITAL ASSOCIATION No. 2:24-cv-01379-DJC-AC

18 Plaintiff, 19 v. ORDER

20 GEICO GENERAL INSURANCE

COMPANY

21 Defendant. 22

23 24 25 Before the Court are two related cases involving functionally identical claims, 26 2:24-
cv-00934-DJC-AC and 2:24-cv-01379-DJC-AC, concerning Plaintiff Dameron 27 Hospital and
Defendants Geico General Insurance Company and Geico Indemnity 28 1 Company (“Geico” or
“Defendant(s)”).1 Dameron alleges that Geico is responsible for 2 additional financial costs
related to Dameron’s medical treatment of five patients 3 injured in automobile accidents.
Dameron’s claims are that the patients assigned their 4 payment rights under various Geico
policies to Plaintiff as a condition of their medical 5 treatment, that Defendants’ failure to pay
violates the Unfair Competition Law, and 6 that that there is a live question as to payment order
between three patients with 7 Geico insurance and Medicaid. Most of these claims were
previously dismissed by 8 Judge John A. Mendez with leave to amend. (ECF No. 19;) Dameron
Hosp. Ass’n v. 9 Geico Gen. Ins. Co. (“Dameron”), No. 2:24-CV-00934-JAM-AC, 2024 WL
4581685 10 (E.D. Cal. Oct. 25, 2024). For the reasons discussed below, the Court finds that 11
Plaintiff’s amended pleading does not remedy some of the original complaint’s fatal 12 flaws: that

the patients' assignments of rights to Dameron were done under an impermissible contract of adhesion for four of the five patients, and that there is no viable Unfair Competition Law violation as alleged. Accordingly, the Court finds that the agreements between Dameron and four patients to assign those patients' rights are unenforceable. Also in agreement with the previous Order, the Court finds that, at this initial phase of the litigation, Plaintiff has a plausible claim that the sole uninsured patient may have validly assigned the payment rights to Plaintiff. However, the Court finds Plaintiff's UCL claims unavailing and will dismiss those claims with leave to amend. The Court further finds that Plaintiff states a claim under the federal Medicare Secondary Payer Act. Defendant's Motion to Dismiss (ECF No. 26, hereinafter "Mot.") is GRANTED in part and DENIED in part with prejudice.

FACTS AND PROCEDURAL HISTORY

Plaintiff Dameron Hospital is non-profit health services provider in Stockton, California. (ECF No. 25, First Amended Complaint, ¶ 5.) Dameron treated patients. Due to the nearly identical language between the complaints, the Court addresses them both in a single Order. All docket citations pertain to case No. 2:24-cv-00934-DJC-AC. 1 D.S., X.K., M.A., and A.G., who are Medicare Beneficiaries or have Veterans Administration healthcare, and J.M., who is a Self-Pay patient with no other applicable insurance. (Id. ¶ 6.) All unspecified hospital services and patient accounts implicated in this case arise from emergency room and ongoing medical care provided to injury victims by Dameron. (Id. ¶ 5.) As a Condition for Admission ("COA") for medical care at the hospital, Dameron required the patients to sign an Assignment of Benefits ("AOB") contract. (Id. ¶ 15.) The COAs signed by the patients include a clause specifically assigning all insurance benefits under Med-Pay (medical payment coverage; "MP") and Uninsured Motorist ("UM") policies to Dameron that might provide coverage for the treatment provided. (Id. ¶ 17; see id. ¶ 30.) Dameron alleges that the patients hold automobile, liability, or no-fault insurance policies provided by Geico. (Id. ¶¶ 2, 9.) However, Defendants apparently provided reimbursement under the insurance policies to either the patients directly or a separate third party, rather than Plaintiff, against the terms of the AOB. (Id. ¶ 24.) Plaintiff alleges three causes of action.² First, Plaintiff demands injunctive relief under California's Unfair Competition Law, Business and Professions Code section 17200 ("UCL"), stemming from Defendants' alleged breach of contract. (Id. ¶¶ 53–57.) Second, Plaintiff seeks general damages from Defendants' failure to honor the patients' AOBs. (Id. ¶¶ 58–66.) And third, Plaintiff argues that Defendants violated the Medicare Secondary Payer Act by refusing to pay Plaintiff directly for the costs associated with the care of patients covered by Medicare. (Id. ¶¶ 67–75.)

LEGAL STANDARD

A. Federal Rule of Procedure 12(b)(1) A party may move to dismiss a complaint for "lack of subject matter jurisdiction" under Federal Rule of Civil Procedure 12(b)(1). Challenges to a plaintiff's Article III standing are properly raised under a 12(b)(1) motion as standing is

required for a 27 2 The Court discusses these out of order below, as an analysis of the AOBs is necessary before moving 28 to the UCL claim. 1 federal court to exercise jurisdiction. *Chandler v. State Farm Mut. Auto. Ins. Co.*, 598 2 F.3d 1115, 1122 (9th Cir. 2010); see, e.g., *Nat'l Fed'n of the Blind of Cal. v. Uber 3 Techs., Inc.*, 103 F. Supp. 3d 1073, 1078 (N.D. Cal. 2015). Taking the allegations in the 4 complaint as true, “the court must determine whether a lack of federal jurisdiction 5 appears from the face of the complaint itself.” *Nat'l Fed'n of the Blind*, 103 F. Supp. 3d 6 at 1078. The “party invoking the federal court's jurisdiction has the burden of proving 7 the actual existence of subject matter jurisdiction.” *Thompson v. McCombe*, 99 F.3d 8 352, 353 (9th Cir.1996); *Chandler*, 598 F.3d at 1122. 9 B. Federal Rule of Procedure 12(b)(6) 10 A party may move to dismiss for “failure to state a claim upon which relief can 11 be granted.” Fed. R. Civ. P. 12(b)(6). The motion may be granted only if the complaint 12 lacks a “cognizable legal theory or sufficient facts to support a cognizable legal 13 theory.” *Mendondo v. Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1104 (9th Cir. 2008). 14 While the Court assumes all factual allegations are true and construes “them in the 15 light most favorable to the nonmoving party,” *Parks Sch. of Bus., Inc. v. Symington*, 51 16 F.3d 1480, 1484 (9th Cir. 1995), if the complaint's allegations do not “plausibly give 17 rise to an entitlement to relief” the motion must be granted, *Ashcroft v. Iqbal* (“*Iqbal*”), 18 556 U.S. 662, 679 (2009). 19 A complaint need contain only a “short and plain statement of the claim 20 showing that the pleader is entitled to relief,” Fed. R. Civ. P. 8(a)(2), not “detailed 21 factual allegations,” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). However, 22 this rule demands more than unadorned accusations; “sufficient factual matter” must 23 make the claim at least plausible. *Iqbal*, 556 U.S. at 678. In the same vein, conclusory 24 or formulaic recitations of elements do not alone suffice. *Id.* “A claim has facial 25 plausibility when the plaintiff pleads factual content that allows the court to draw the 26 reasonable inference that the defendant is liable for the misconduct alleged.” *Id.* This 27 evaluation of plausibility is a context-specific task drawing on “judicial experience and 28 common sense.” *Id.* at 679.

1 DISCUSSION

2 Plaintiff has plausibly alleged facts that would confer federal court standing. 3 However, on the merits, Plaintiff is unable to show that the AOBs were valid for four of 4 the five patients, nor does Plaintiff advance a viable UCL claim. However, Plaintiff 5 properly invokes the federal Medicare Secondary Payer Act, and its claim under that 6 statute may proceed. 7 A. Plaintiff Has Article III Standing 8 A plaintiff bears the burden of establishing an actual “case or controversy” 9 within the meaning of Article III. *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016). At 10 the pleading stage, this means a plaintiff must allege facts that if proved, would confer 11 standing upon them. *Warren v. Fox Fam. Worldwide, Inc.*, 328 F.3d 1136, 1140 (9th 12 Cir. 2003).

13 Plaintiff has met this burden. The FAC alleges that the injured patients received 14 medical care as a “covered benefit under [defendants’] policy of insurance.” 15 (FAC ¶ 9.) While the FAC is somewhat scarce on details, Plaintiff need not allege with 16 specificity the intricacies of the

agreement between Defendants and the injured 17 patients or how those agreements pertain to the injuries sustained by the patients. At 18 the pleading stage, the Court is required to take Plaintiff's allegations as true. Nat'l 19 Fed'n of the Blind, 103 F. Supp. 3d at 1078. Therefore, the Court must accept 20 Plaintiff's assertion that the injuries are covered under Defendants' insurance policies, 21 which is sufficient to establish a case or controversy under Article III. See Warren, 328 22 F.3d at 1140. 23 To defeat Plaintiff's claim, Defendants rely on out-of-circuit cases that dictate 24 that the mere allegation that an insured party's injury is covered by a defendant's 25 insurance policy is insufficient to establish standing. See, e.g., MAO-MSO Recovery II, 26 LLC v. State Farm Mut. Auto. Ins. Co., No. 1:17-CV-1537, 2019 WL 6311987 (C.D. Ill.

27 Nov. 25, 2019); MSP Recovery Claims, Series LLC v. AIG Prop. Cas. Co., 2021 WL 28 1164091 (S.D.N.Y. Mar. 26, 2021); MSP Recovery Claims, Series LLC v. Merchants Mut. 1 Ins. Co., 2022 WL 2439410 (W.D.N.Y. Mar. 28, 2022). But these cases are not binding 2 on the Court and do not provide an adequate basis for denying Plaintiff standing at 3 this early stage in the litigation. Defendants further argue that the "factual allegations 4 do not support a connection between the accident and the medical service provided 5 to the patient." (See Mot. at 13.) Not so. Plaintiff, albeit briefly, sufficiently connects 6 the care it provided to the injured parties and Defendants' insurance policies. (See 7 FAC ¶ 9 ("DEFENDANT insured (or insures) the patients who DAMERON treated for 8 injuries, and for whom DAMERON'S hospital services were a covered benefit under 9 the DEFENDANT'S policy of insurance.")) 10 Accordingly, the Court finds that Plaintiff has sufficiently linked its services 11 provided to Defendants' insurance policies. 12 B. The AOBs Signed by D.S., X.K., M.A., and A.G. Are Contracts of Adhesion 13 and Are Unenforceable 14 A contract of adhesion is a contract "that is offered to consumers of goods and 15 services on essentially a 'take it or leave it' basis without affording the consumer a 16 realistic opportunity to bargain and under such conditions that the consumer cannot 17 obtain the desired product or services except by acquiescing in the form contract." 18 Dameron Hosp. Assn. v. AAA N. Cal., Nev. & Utah Ins. Exch. ("AAA"), 77 Cal. App. 5th 19 971 (2022), quoting Wheeler v. St. Joseph Hospital, 63 Cal. App. 3d 345, 356 (1976). 20 "The distinctive feature of a contract of adhesion is that the weaker party has no 21 realistic choice as to its term." Wheeler, 63 Cal. App. 3d at 356. "A hospital's standard 22 printed 'CONDITIONS OF ADMISSION' form possesses all the characteristics of a 23 contract of adhesion." Id. at 357. That is, "the would-be patient is in no position to 24 reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to 25 find another hospital. The admission room of a hospital contains no bargaining table 26 where, as in a private business transaction, the parties can debate the terms of their 27 contract." Tunkl v. Regents of Univ. of Cal., 60 Cal. 2d 92, 102 (1963). Contracts of 28 adhesion may be unenforceable under California law if the weaker contracting party's 1 reasonable expectations of the services provided by the stronger contracting party 2 are frustrated by the contract. See Wheeler, 63 Cal. App. 3d at 356–57. 3 In AAA, a case with strikingly similar facts to the one at hand, the California 4 Court of Appeal considered the same COA before this

Court and held that it was a 5 contract of adhesion. 77 Cal. App. 5th at 992–93. In the previous Order dismissing 6 this case in part, Judge Mendez noted that “AAA squarely holds that Dameron 7 Hospital’s COAs are adhesion contracts and are unenforceable if patients do not 8 reasonably expect such assignment of benefits to occur.” Dameron, 2024 WL 9 4581685, at *2. This Court agrees: “Dameron’s COAs possess all the characteristics of 10 a contract of adhesion because [t]he would-be patient is in no position to reject the 11 proffered agreement, to bargain with the hospital, or in lieu of agreement to find 12 another hospital.” *Id.*, internal quotations omitted. 13 Finding that Plaintiff’s COAs are contracts of adhesion, the Court then turns to 14 whether these contracts impermissibly frustrate the patients’ reasonable expectations 15 of Dameron’s services. See Wheeler, 63 Cal. App. 3d at 356–57. The Court again 16 agrees with the previous Order and AAA’s conclusion that “any policy holder with 17 medical insurance would not reasonably expect to assign their MP and/or UM Benefits 18 because persons with these benefits ‘expect benefits to be paid directly to them to 19 compensate them for their bodily injuries.’” See Dameron, 2024 WL 4581685, at *3, 20 quoting AAA, 77 Cal. App. 5th at 993-94; see also Dameron Hosp. Ass’n v. Progressive 21 Cas. Ins. Co., --- Cal. Rptr. 3d ---, No. C099467, 2025 WL 1502017 (Cal. Ct. App. May 22 27, 2025) (reaffirming that conclusion). That is to say, when a person obtains an 23 insurance policy that reimburses for harm suffered, it is reasonable for them to assume 24 that reimbursement will go to them, rather than to a different party. 25 Plaintiff has not meaningfully responded to the concerns raised by Judge 26 Mendez in dismissing the initial complaint. Plaintiff’s sole response seems to be the 27 brief addition of the argument that, even if the AOBs are contracts of adhesion, an 28 insured would not have their reasonable expectation frustrated by the COA’s 1 assignment of payment to Plaintiff. (See FAC ¶¶ 21, 22.) But this argument was 2 already expressly rejected by Judge Mendez, Dameron, 2024 WL 4581685, at *3, and 3 in any event is flatly inconsistent with the reasoning of the California Courts of Appeal 4 that have considered this same AOB. Plaintiff has alleged no new facts that would 5 otherwise recast the COA as being a permissible contract of adhesion. Instead, 6 Plaintiff merely expresses its disagreement with the Order’s conclusion. Plaintiff does 7 not get a second chance at its failing argument simply because the case has been 8 reassigned to a new judge — it must allege new facts to undergird its arguments if it 9 hopes to be successful on a previously dismissed complaint. 10 Because these four contracts are unenforceable, Plaintiff’s related breach of 11 contract claims fail. 12 C. Plaintiff’s Claim Regarding J.M. May Be Viable 13 Patient J.M., as an otherwise uninsured patient, is dissimilar to the other four 14 patients who had medical insurance besides their Geico policies. (See FAC ¶ 20.) 15 AAA contemplated that a patient with an insurance cap on a specific policy could 16 reasonably believe that any additional costs would need to come from an alternate 17 funding source or insurance policy. 77 Cal. App. 5th at 995. For the reasons 18 discussed below, J.M. may be similar to the patient considered in AAA, and this claim 19 may be viable, at least at the early stages of this litigation. 20 MP benefits are intended to cover costs associated with medical treatment, 21 rather than damages for bodily injuries suffered. See AAA,

77 Cal. App. 5th at 994. 22 Dameron seeks to collect on its costs from J.M.'s MP benefits: it does not seek to 23 recoup any costs from J.M.'s UM benefits. (See FAC ¶ 20;) see also Dameron, 2024 WL 4581685, at *3. Because J.M. does not otherwise have an insurance policy — 25 medical or otherwise — that would cover their medical expenses, and because 26 Dameron fairly points out that it is solely seeking payment under J.M.'s MP benefits 27 which are designed to reimburse medical payments, it is plausible that when signing 28 the AOB, J.M. reasonably expected to assign any insurance coverage payments 1 related to medical expenses to Dameron. See Dameron, 2024 WL 4581685, at * 3; 2 AAA, 77 Cal. App. 5th at 994 (“[I]t is possible a trier of fact might conclude it was 3 within [a patient’s] reasonable expectations that Dameron would seek to collect direct 4 payments . . . out of [a patient’s] MP benefits.”). However, the Court acknowledges 5 AAA’s observation that “the fact that the MP coverage is imbedded in an automobile 6 insurance policy suggests that perhaps, a patient would not expect a hospital to 7 collect payments from MP benefits directly from his MP provider,” and that “there 8 remains a factual question as to whether . . . it was within the reasonable expectations” 9 of the patient for them to assign their MP rights. Id. 10 On this point, Geico argues that under California law, it needs to have 11 consented to any assignment of benefits under its policies for that assignment to be 12 valid. (See Mot. at 19–21.) In agreement with Judge Mendez’s prior Order, the Court 13 finds that Geico need not have consented to the assignment of its policy to Dameron. 14 Defendants cite no relevant case law that shows J.M. needed Geico’s assent to 15 effectuate the AOB. Defendants rely on Buckeye Refin. Co. v. Kelly, 163 Cal. 8 (1912) 16 and Stein v. Cobb, 38 Cal. App. 2d 8 (1940), but these cases discuss consent in 17 distinguishable contexts. Buckeye Refining Co. discusses partial assignments of 18 benefits for property bonds, and regardless recognizes that there are instances where 19 “partial assignment . . . [is] not entirely ineffectual, even though it be without the 20 assent of the debtor.” 163 Cal. at 13. And Stein, a case already distinguished by 21 Judge Mendez, focuses on assignment of publishing rights, rather than medical 22 insurance policies. 38 Cal. App. 2d at 10. The Court adopts Judge Mendez’s prior 23 conclusion that, at this juncture, Geico has not established as a matter of law that it 24 must consent to the assignment of its policies. See Dameron, 2024 WL 4581685, at 25 *4. 26 Accordingly, Plaintiff’s claim regarding J.M.’s treatment is distinct from the 27 other patients and may be viable. 28 //// 1 D. Plaintiff Fails to State a Claim Under the UCL For All Patients 2 The UCL protects California’s consumers by prohibiting any “unlawful, unfair or 3 fraudulent business act or practice.” Cal. Bus. & Prof. Code § 17200. As relevant here, 4 when assessing UCL claims, the Court considered whether a defendant’s actions are 5 unlawful or unfair. 6 1. Unlawful Prong 7 Under the unlawful prong of the UCL, a plaintiff must allege more than a 8 common law violation of breach of contract. Shroyer v. New Cingular Wireless Servs. 9 Inc., 622 F.3d 1035, 1044 (9th Cir. 2010.) 10 For all five patients, Plaintiff does not allege more than a common law violation 11 of breach of contract. (See FAC ¶ 31.) Plaintiff’s claims again rely on the rejected 12 argument that the AOBs are valid assignments, rather than unenforceable contracts of 13 adhesion. (See ECF No. 28, hereinafter

“Opp’n,” at 21–22.) But as already discussed, 14 Plaintiff’s argument here is unavailing. And while J.M.’s AOB may be valid due to their 15 reasonable expectation that they could assign Geico’s insurance coverage payments 16 to Plaintiff, Plaintiff’s allegations do not rise above a common law violation of breach of 17 contract. Common law violations for breach of contract do not offend the UCL, and 18 therefore, Plaintiff’s claims under this prong are not viable. See Shroyer, 622 F.3d at 19 1044. While Plaintiff later alleges there are unlawful violations of the Medicare 20 Secondary Payer Act that would invoke the UCL, those allegations come in Plaintiff’s 21 Opposition, rather than Complaint, and are therefore not properly presented. (See 22 Opp’n at 22;) see also *McMichael v. Napa Cnty.*, 709 F.2d 1268, 1273 n.4 (9th Cir.1983) (a court need not consider claims that were not raised in the complaint). 24 2. Unfair Prong 25 While there is no exact definition of unfairness under the UCL, California courts 26 have generally proscribed “unfair” or “deceptive” acts, even if those acts are not 27 “unlawful.” See *Cal-Tech. Comm., Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 180 28 (1999). 1 In its FAC, Plaintiff merely realleges the same arguments previously rejected by 2 this Court as to its UCL claims. Specifically, Plaintiff argues that Dameron’s 3 assignments do not exceed the reasonable expectations of the patients because the 4 patients intended that their benefits provided to Geico would cover their medical 5 expenses related to their accidents. (See FAC ¶ 14; see also Opp’n at 21.) As 6 previously discussed by Judge Mendez, and as discussed earlier in this Order, the 7 Court finds that the AOBs signed by four of the five patients are unenforceable 8 contracts of adhesion, and therefore, no breach of contract occurred from those 9 agreements. See *Dameron*, 2024, WL 4581685 at *4–5. And while J.M.’s agreement 10 has not been deemed an unenforceable contract of adhesion and therefore may be 11 valid, Plaintiff does not identify any unfair or deceptive acts that would invoke the UCL. 12 For example, Plaintiff relies on the already-rejected claim that Defendants’ actions 13 offend a “long-standing public policy” which favors hospital patients’ assignments of 14 benefits. (FAC ¶ 32.) Plaintiff provides no citation for this assertion. Instead, it merely 15 references the hospital’s “unfunded mandate to treat all accident victims.” (*Id.* ¶ 33, 16 emphasis removed.) But nothing is preventing Plaintiff from being paid; here, for four 17 of the five patients, Plaintiff is instead seeking to reap higher payments than what it 18 would normally charge the patients on their own. Plaintiff’s gambit to receive higher 19 payments for the same care provided does not properly invoke any public policy 20 goals. 21 E. Defendant States a Claim Under the Medicare Secondary Payer Act 22 Under the Medicare Secondary Payer Act (“Act”), primary insurance plans — 23 including automobile, liability, or no-fault insurance policy plans — must be paid out 24 before Medicare insurance payments. 42 U.S.C. § 1395Y(b)(2)(A)(ii). Further, 25 Medicare insurance payments are restricted when “payment has been made or can 26 reasonable expected to be made . . . under an automobile or liability insurance policy 27 or plan (including a self-insured plan) or under no fault insurance.” *Id.* Under the Act, 28 a Plaintiff must plead: (1) the defendant’s status as a primary plan; (2) the defendant’s 1 failure to provide for primary payment or appropriate reimbursement; and (3) the 2

damages amount. MSP Recovery Claims, Series LLC v. Metro. Gen. Ins. Co., 40 F. 4th 3 1295, 1302 (11th Cir. 2022). 4 Here, the Court departs slightly with Judge Mendez’s prior Order, which found 5 that Plaintiffs failed to state a claim under the Act because they could not allege that 6 Defendants’ insurance policies were contemplated as primary payers under the Act. 7 See Dameron, 2024 WL 4581685, at *5. Plaintiff alleges that patients M.A., A.G., and 8 X.K. are Medicare beneficiaries and therefore their Geico automobile insurance would 9 need to provide payment as it is the primary payment plan. (FAC ¶¶ 67–75.) As noted 10 in the preceding paragraph, the Act specifically identifies the kinds of policies offered 11 by Geico (i.e., automobile, liability, or no-fault insurance policy plans) as being primary 12 payment sources before Medicare. See 42 U.S.C. § 1395Y(b)(2)(A)(ii). Plaintiff has 13 also pled that Defendants have not paid Plaintiff for the medical services and the 14 specific damages amount. (FAC ¶ 6.) Plaintiff satisfies its pleading requirements 15 under the Act. See MSP Recovery Claims, Series LLC, 40 F. 4th at 1302. 16 Relying again on out-of-circuit case law, Defendants argue that Plaintiffs have 17 not sufficiently alleged that Defendants’ policies should be considered as primary 18 payment sources. But the text of the statute is clear: these kinds of policies are 19 explicitly acknowledged as primary payment sources, and Plaintiff has sufficiently 20 identified those policies in its FAC. Defendants can point to no controlling case law 21 that would otherwise bar Plaintiffs’ claim. 22 Plaintiff therefore has a viable claim under the Act. Patients M.A., A.G., and X.K. 23 are covered both by Medicare and Defendants’ insurance policies, which Plaintiff 24 alleges cover the medical care provided. (See FAC ¶ 9.) And, Plaintiff alleges that it 25 has not been paid out the amount it claims that it is owed under those policies. 26 Accordingly, Plaintiff may invoke the Act’s private cause of action. 27

1 F. Leave to Amend is Granted in Part

2 A court granting a motion to dismiss a claim must decide whether to grant 3 leave to amend. Leave to amend should be “freely given” where there is no “undue 4 delay, bad faith or dilatory motive on the part of the movant, . . . undue prejudice to 5 the opposing party by virtue of allowance of the amendment, [or] futility of [the] 6 amendment” *Foman v. Davis*, 371 U.S. 178, 182 (1962); *Eminence Cap., LLC v. 7 Aspeon, Inc.*, 316 F.3d 1048, 1052 (9th Cir. 2003) (listing the *Foman* factors as those to 8 be considered when deciding whether to grant leave to amend). But, dismissal 9 without leave to amend may be proper if it is clear that the complaint could not be 10 saved by any amendment. *Intri-Plex Techs., Inc. v. Crest Grp., Inc.*, 499 F.3d 1048, 11 1056 (9th Cir. 2007); *Ascon Props., Inc. v. Mobil Oil Co.*, 866 F.2d 1149, 1160 (9th Cir. 12 1989) (“Leave need not be granted where the amendment of the complaint . . . 13 constitutes an exercise in futility”). 14 Here, Plaintiff seeks leave to amend to file a second amended complaint to cure 15 any deficiencies in its pleadings. (Opp’n. at 24.) The Court will grant Plaintiff’s request 16 for leave to amend solely as to the UCL claims. At present, Plaintiff only pleads 17 common law contract violations pertaining to the AOBs, which do not qualify as UCL 18 violations. While the Court has determined that claims pertaining to the AOBs are 19 nonviable, the Court recognizes that there is a viable Medicare Secondary Payer Act 20 claim, and

thus, the Court will give Plaintiff the option of realleging its UCL claims in 21 light of that conclusion. 22 However, the Court will deny leave to amend for Plaintiff's AOB claims 23 pertaining to D.S., X.K., M.A., and A.G. Those claims have now been unsuccessfully 24 litigated twice, and the Court deems them unsalvageable by amendment. See Intri- 25 Plex Techs, Inc., 499 F.3d at 1056. 26 //// 27 //// 28 ////

1 CONCLUSION

2 Defendants' Motions to Dismiss in cases 2:24-cv-00934-DJC-AC and 2:24-cv- 3 | 01379-DJC-AC (ECF No. 26 for both cases) are GRANTED with prejudice as to 4 | Plaintiff's claims regarding D.S., X.K., M.A., and A.G.'s Assignment of Benefits. 5 || Additionally, the Motions are GRANTED without prejudice as to Plaintiffs' claims under 6 || the UCL. Defendants' Motions to Dismiss are DENIED as to J.M.'s Assignment of 7 | Benefits and Plaintiff's Medicare Secondary Payer Act claim pertaining to patients 8 | M.A.,A.G., and X.K. Plaintiff may refile aSecond Amended Complaint within 21 days 9 | realleging claims under the UCL if it so chooses. 10 14 IT IS SO ORDERED. 12 | Dated: _June 23, 2025 "Darel A CDbnetto Hon. Daniel alabretta

13 UNITED STATES DISTRICT JUDGE

14 15 16 17 18 | bJcs - Dameron24cv00934, 01379.MTD 19 20 21 22 23 24 25 26 27 28 14