

**UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
EASTERN DIVISION
No. 4:22-CV-14-FL**

**GEORGE CANSLER, on his own behalf,
and on behalf of a class of those similarly
situated,**

Plaintiff,

v.

**UNIVERSITY HEALTH SYSTEMS OF
EASTERN CAROLINA, INC., EAST
CAROLINA HEALTH-CHOWAN,
INC., and FIRSTPOINT COLLECTION
RESOURCES, INC.,**

Defendants.

**MEMORANDUM OF LAW IN
SUPPORT OF ECU HEALTH'S
MOTION TO DISMISS**

JURY DEMAND

Pursuant to Federal Rule of Civil Procedure 12(b)(6), University Health Systems of Eastern Carolina, Inc. and East Carolina Health-Chowan, Inc. (“ECU Chowan”) (collectively, “ECU Health”) submit this Memorandum of Law in Support of their Motion to Dismiss Plaintiff George Cansler’s (“Cansler”) First Amended Class Action Complaint (“Amended Complaint”).¹

I. NATURE OF THE CASE

The material facts underlying Cansler’s claims are not only very simple, but they likely would be familiar to most Americans with commercial health insurance. During the time period at issue in this case, Cansler had private health insurance, the terms of which allowed him to obtain

¹ By filing this Motion, ECU Health does not intend to waive any of their affirmative or general defenses. ECU Health’s knowledge of third party involvement in this action is limited at this juncture. To the extent this matter progresses (which it should not), ECU Health specifically asserts that Cansler failed to join a necessary and/or an indispensable party under Federal Rule of Civil Procedure 19 -- namely, Cansler’s alleged insurer, Blue Cross Blue Shield of North Carolina (“Blue Cross”). To the extent Blue Cross is a necessary and indispensable party, Cansler’s claims against ECU Health should be dismissed under Rule 12(b)(7).

medical care from an emergency room in ECU Health's system on an "in network" basis. If Cansler obtained care from an "in network" hospital, he would be charged discounted rates compared to the standard amounts an otherwise uninsured individual would be charged for the same services. Cansler's insurer negotiated the discounted rates on Cansler's behalf using the leverage created by the insurer's large membership. When choosing his insurance policy, Cansler chose to purchase a high deductible plan, meaning he knew that if he sought medical care then he would be obligated to pay the full amount of the discounted charges up to a certain threshold.

In June 2018, Cansler began experiencing an unknown pain and sought emergency medical treatment at ECU Chowan. He signed a standard consent document wherein he agreed to pay for any of the hospital's charges that were not covered by his insurance. Cansler does not allege that he asked any questions about how much his treatment would cost. And, consistent with its obligations under the Emergency Medical Treatment and Active Labor Act ("EMTALA") to provide a medical screening without taking actions that might discourage such care, ECU Chowan did not affirmatively volunteer to Cansler the potential costs of the treatment. *See* 42 U.S.C. § 1395dd; 26 C.F.R. § 1.501(r)-4(c)(2); 42 C.F.R. § 489.24(d)(4)(iv).

After signing the consent, Cansler agreed to receive a CT scan and other ancillary services. After providing such services, ECU Chowan charged Cansler the discounted rate that Cansler's insurer had negotiated on his behalf. Notably, Cansler does *not* allege that ECU Chowan deviated from the standard charges contained in its chargemaster -- which is a list of the hospital's billable items and corresponding charges -- or that it charged him more than the discounted rate that was negotiated on his behalf by his insurer.

Even though ECU Chowan charged Cansler exactly what he agreed to pay in the consent document that he signed -- all charges not paid by his insurer -- he now claims that ECU Chowan

breached the terms of the consent because, according to Cansler, the discounted rate that was negotiated on his behalf is unreasonably high.² Cansler also claims that ECU Health's alleged failure to disclose the costs of his treatment -- again, costs his insurer negotiated on his behalf and costs he never requested -- represents a violation of the North Carolina Unfair and Deceptive Trade Practices Act ("UDTPA"). See § 75-1.1. And finally, Cansler seeks to assert his claims on behalf of every patient who visited ECU Chowan's emergency department to obtain a CT scan, signed a consent, and had to pay *any price*, whether insurer-negotiated or the hospital's standard charges.

If Cansler's purported claims were deemed viable, and commercially insured patients simply could ignore the contractual, discounted rates that were negotiated on their behalf, such a result would create a devastating slippery slope for our healthcare system. Every contract between a hospital and commercial insurer would be meaningless. And, every emergency room patient with commercial insurance would present the subject hospital with a choice between committing an unfair and deceptive act or violating EMTALA. For critical access hospitals in rural counties like ECU Chowan, which depend upon individuals with commercial insurance to survive, such a combination very well could prove fatal.

The Court need not face those systemic risks in this case because Cansler's claims do not pass muster even under the lenient standards of a motion to dismiss. Numerous well-reasoned cases from this Court, North Carolina state courts, and others make clear that Cansler has not stated any claim for relief. Indeed, Cansler's North Carolina counsel previously represented a different plaintiff with substantively identical claims that were dismissed by a North Carolina state court.

² It is telling that Cansler has not attached his insurance policy to his Amended Complaint or otherwise asserted wrongdoing by his insurer, as doing so would very likely create additional justifications for dismissal of his claims. Yet, the terms of that policy are not necessary to this Motion as Cansler's claims are doomed for multiple reasons that are unrelated to such policy.

That dismissal was affirmed by the North Carolina Court of Appeals, and the North Carolina Supreme Court denied the plaintiff's petition for discretionary review. *See Shelton v. Duke Univ. Health Sys., Inc.*, 179 N.C. App. 120, 633 S.E.2d 113 (2006); *Shelton v. Duke Univ. Health Sys., Inc.*, 643 S.E.2d 591 (N.C. 2007). Nothing about Cansler's case justifies a deviation from this uniform and well-reasoned case law, and Cansler's claims should be dismissed with prejudice.

II. STATEMENT OF ALLEGED FACTS

ECU Health operates a nonprofit hospital system comprised of nine hospitals located in Eastern North Carolina. (Am. Compl. ¶ 4, Docket Entry 48). Cansler's claims relate to his visit to the emergency room at ECU Chowan on June 6, 2018. (*Id.* at ¶ 57). ECU Chowan is a nonprofit hospital located in Edenton, North Carolina. (Am. Compl. ¶¶ 2, 5, Docket Entry 48). Like most medical facilities, ECU Chowan maintains a list of its standard charges in a document called the "chargemaster." (*Id.* at ¶ 21). However, the prices in the chargemaster are not ultimately charged to all (or even most) patients because government and commercial insurance programs negotiate rates that are discounted from the chargemaster.

As relevant to this case, commercial health insurers like Blue Cross negotiate with hospitals for the prices that the insurer's members will be charged. (Am. Compl. ¶ 15, Docket Entry 48). The resulting agreed-upon price is known as the "allowed amount." (*Id.*). The allowed amount typically is negotiated off of a hospital's chargemaster prices. (*Id.* at ¶ 22). When such an agreement is made, the hospital is then designated as an "in-network" hospital by the insurer, meaning that if members seek treatment at that hospital they will receive the benefit of the discounted allowed amount for services within the agreement with the insurer. (*Id.* at ¶ 16).

Under these insurance-hospital arrangements, the hospital agrees to accept the allowed amount as payment in full for any included service provided to a member. (Am. Compl. ¶¶ 16-

17, Docket Entry 48). Once a member has received one or more covered services, the commercial health insurer is obligated to pay all or some of the agreed-upon allowed amount, and the member is obligated pay the remainder. (*Id.*) The portion of the allowed amount paid by the member is dependent upon the member’s insurance agreement with his or her insurer.

During the relevant time period, Cansler had a commercial health insurance policy with Blue Cross. (Am. Compl. ¶ 53, Docket Entry 48). ECU Chowan is “in network” for Cansler’s Blue Cross plan, meaning Cansler and Blue Cross are charged for services at an agreed-upon rate that is discounted from ECU Chowan’s chagemaster. (*Id.* at ¶¶ 54-56). Cansler’s agreement with Blue Cross is a “high deductible” plan, meaning Cansler agreed to pay the vast majority of the allowed amount charged for services until his agreed-upon deductible is met. (*Id.* at ¶ 17).

Cansler arrived at ECU Chowan’s emergency department on June 6, 2018, seeking treatment for an unknown pain. (Am. Compl. ¶ 57, Docket Entry 48). Prior to being treated, Cansler signed an Authorization and Consent for Treatment and Assignment of Benefits (the “Consent”), a redacted copy of which is attached as Exhibit A.³ In addition to documenting Cansler’s consent to medical treatment, the Consent contained the following representations regarding payment:

- “I understand that I am financially responsible to the Hospital and physicians for charges not paid by insurance.”
- “I hereby agree to pay all charges of Facility that are not covered or paid within a reasonable time by any medical insurance / coverage, whether or not I am otherwise legally obligated to pay.”

³ The Court may consider the Consent without converting this Motion to Dismiss into a motion for summary judgment because Cansler did not attach the Consent to the Amended Complaint despite it being integral. *In re FAC Realty Sec. Litig.*, 990 F. Supp. 416, 420 (E.D.N.C. 1997).

(*Id.* at ¶ 62; *see* Consent). Cansler’s Amended Complaint is devoid of any allegation that he asked about the meaning of the terms of the Consent, or that he otherwise inquired about the amount of the charges he was agreeing to pay (after any insurance). After executing the Consent, ECU Chowan provided Cansler with medical tests and treatment, including a CT scan. (*Id.* at ¶ 61).

On June 19, 2018, Cansler received an Explanation of Benefits (“EOB”), presumably from Blue Cross, which explained that Cansler had received \$662.68 in “member savings” based on Blue Cross’ agreement with ECU Chowan, and, further, that Blue Cross had paid \$1,326.11 on his behalf. (Am. Compl. ¶ 66, Docket Entry 48). The itemized bill Cansler received from ECU Chowan showed that Cansler owed \$3,119.39 for the aforementioned CT Scan, which was calculated based on the allowed amount that Blue Cross (on behalf of Cansler and its other members) had agreed to with ECU Chowan, minus the portion that Blue Cross paid on Cansler’s behalf as part of their separate insurance plan agreement. (*Id.* at ¶ 68).

Although Cansler does not contend that ECU Chowan charged him more than the discounted rate that was negotiated on his behalf by Blue Cross, Cansler disputed the bills that he received because, in his opinion, the charges were unreasonable. (Am. Compl. ¶¶ 65-67, Docket Entry 48). By October 2020, more than two years after he received treatment and after numerous discussions in which the charges were explained to him, Cansler still had not paid his bill. (*Id.* at ¶¶ 65-94). Cansler’s bill was referred to collections, resulting in more negotiations and attempts to collect the amount due. (*Id.* at ¶¶ 94-104).

Cansler initiated this lawsuit on February 18, 2022. (Am. Compl., Docket Entry 48). In his Amended Complaint, Cansler asserts that ECU Health breached the Consent and violated the UDTPA. (*Id.* at ¶¶ 134-165, 180-192). Further, Cansler seeks to represent a proposed class encompassing every patient who signed a Consent and received treatment at ECU Chowan over

the last four years. (*Id.* at ¶ 125). In addition to the allegations that do appear in Cansler's Amended Complaint, it is important to recognize what is absent from his Amended Complaint:

- **First**, while Cansler complains about the costs of his treatment and alleges that ECU Health has a policy of not disclosing prices when asked, he does **not** allege that he personally asked anyone at ECU Chowan about the cost of treatment before consenting to the services, nor does he contend that that anyone at ECU Chowan affirmatively refused to provide him with such information.
- **Second**, Cansler does **not** allege that he was charged anything other than the discounted amount that ECU Chowan agreed to charge Blue Cross' members when Blue Cross -- on Cansler and its other members' behalf -- entered into an agreement with ECU Chowan. Indeed, Cansler does not allege that ECU Chowan violated any term of its agreement with Blue Cross.
- **Third**, Cansler does **not** allege that Blue Cross -- the party that negotiated discounted rates with ECU Chowan on his behalf -- has done anything wrong. Indeed, Blue Cross' absence from this case is notable because one would expect that Cansler's insurance policy would contain certain promises in exchange for Cansler's acceptance of the discounted rates that were negotiated on his behalf.

As set forth below, each theory of relief in the Amended Complaint is foreclosed by applicable case law, and, as a result, Cansler's claims should be dismissed with prejudice.

III. LAW AND ARGUMENT

A. Cansler's Breach of Contract and Unjust Enrichment Claims Should Be Dismissed.

1. Cansler's Breach of Contract and Unjust Enrichment Claims Are Barred by the Applicable Statute of Limitations.

"A statute of limitations . . . defense may be raised by way of a motion to dismiss if it appears on the face of the complaint that such a statute bars the claim." *Hargett v. Holland*, 337 N.C. 651, 653, 447 S.E.2d 784, 786 (1994). "Once a defendant raises a statute of limitations defense, the burden of showing that the action was instituted within the prescribed period is on the plaintiff." *Horton v. Carolina Medicorp, Inc.*, 344 N.C. 133, 136, 472 S.E.2d 778, 780 (1996) (citation omitted). Under North Carolina law, both breach of contract and unjust enrichment

claims are subject to a three year statute of limitations. N.C.G.S. § 1-52(1); *see Kaleel Builders, Inc. v. Ashby*, 161 N.C. App. 34, 43, 587 S.E.2d 470, 477 (2003) (breach of contract statute of limitations is three years); *Stratton v. Royal Bank of Canada*, 211 N.C. App. 78, 85, 712 S.E.2d 221, 228 (2011) (unjust enrichment statute of limitations is three years).

The statute of limitations begins to run for both breach of contract and unjust enrichment claims at the time “the cause of action has accrued.” *See* N.C.G.S. § 1-15(a). A claim for breach of contract accrues either on the date of the defendant’s breach, or if the breach remains unknown to the plaintiff for some period of time, on the date when the plaintiff first becomes aware of or should have become aware of such breach. *Kaleel Builders, Inc.*, 587 S.E.2d at 477; *see Penley v. Penley*, 314 N.C. 1, 20, 332 S.E.2d 51, 62 (1985). A claim for unjust enrichment accrues when the alleged wrong is completed, regardless of the plaintiff’s notice. *Cody Creek Park, Inc. v. Cap. One Servs., LLC*, 2017 WL 3172411, at *2 (M.D.N.C. July 25, 2017); *Stratton*, 712 S.E.2d at 227.

In this case, Cansler’s breach of contract and unjust enrichment claims are time barred. Cansler’s breach of contract claim is premised on the allegation that ECU Chowan breached the Consent by charging a price that exceeds the reasonable price term Cansler claims should be implied into the contract. As such, the accrual date for the three-year limitations period is most likely **June 19, 2018**, when Blue Cross officially notified Cansler of the total amount charged by ECU Chowan and remaining balance for Cansler’s medical procedure. (Am. Compl. ¶¶ 65-67, Docket Entry 48). The latest possible date ECU Chowan’s alleged breach could have accrued is **June 22, 2018**, when ECU Chowan first requested payment of the remaining balance of the bill from Cansler directly. (*Id.* at ¶ 70). Both of these events and, thus, the accrual of Cansler’s breach of contract claim, occurred more than three years before Cansler filed the present action on

February 18, 2022.⁴ As such, Cansler’s breach of contract claim is barred by the three-year statute of limitations contained in N.C.G.S. § 1-52(1) and should be dismissed.

Unlike his breach of contract claim, Cansler’s unjust enrichment claim accrued when ECU Chowan’s committed the alleged wrong, regardless of when Cansler became aware of the alleged wrong. *See Cody Creek Park, Inc.*, 2017 WL 3172411, at *2; *see also Stratton*, 712 S.E.2d at 227. The alleged wrong underlying Cansler’s unjust enrichment claims relates to the allegation that ECU Chowan “caused” Cansler to confer “monetary payments . . . in excess of the monetary amounts [Cansler] owed toward the reasonable value of the CT scan.” (Am. Compl. ¶ 191, Docket Entry 48). Cansler alleges that he submitted an initial \$100.00 payment to ECU Chowan for the medical treatment at issue on **June 6, 2018**, and then three additional \$50.00 payments between **August 2018** and **October 2018**.⁵ (*See id.* at ¶¶ 60, 73). Of course, all four payments were made more than three years before Cansler initiated this action on February 18, 2022.⁶ As a result, Cansler’s unjust enrichment claim is barred by the three-year statute of limitations contained in N.C.G.S. § 1-52(1) and should be dismissed. *See Stratton*, 712 S.E.2d at 228.

2. Even Without the Statute of Limitations Issue, Cansler Has Failed to State a Claim for Breach of Contract.

⁴ The February 18, 2022, date gives Cansler the benefit of the doubt that his breach of contract and unjust enrichment claims sufficiently relate back to the claims that originally were asserted in Cansler’s Class Action Complaint. *See* FED. R. CIV. P. 15(c). Even with the benefit of the earlier filing date, Cansler’s claim still are barred by the applicable three-year statute of limitations.

⁵ The Amended Complaint references another payment by Cansler, but Cansler admits that payment was for an entirely “different medical event” and is, thus, irrelevant to the accrual of Cansler’s unjust enrichment claim. (*See* Amended Compl. ¶¶ 76, 191, Docket Entry 48).

⁶ As with the breach of contract claim, ECU Chowan has given Cansler the benefit of the doubt that his unjust enrichment claim relates back to the original claims contained in Cansler’s February 18, 2022, Class Action Complaint. *See* FED. R. CIV. P. 15(c). Even assuming this earliest possible filing date, Cansler’s unjust enrichment claim for 2018 payments is still time barred.

In North Carolina, the “elements of a claim for breach of contract are (1) existence of a valid contract and (2) breach of the terms of that contract.” *Shriners Hospitals for Children v. Shaver*, 2021 WL 641433, at *6 (E.D.N.C. Feb. 18, 2021) (quoting *Crosby v. City of Gastonia*, 635 F.3d 634, 645 (4th Cir. 2011)). In the Amended Complaint, Cansler contends that ECU Chowan breached the Consent because it charged Cansler a price that exceeded the “reasonable price,” which Cansler contends must be implied into the Consent because the Consent allegedly lacks a sufficiently definite price term. (See Am. Compl. ¶¶ 182-187, Docket Entry 48).

Contrary to Cansler’s unsupported legal conclusions, applicable case law is clear that, under the circumstances that existed at the time the Consent was executed, Cansler’s agreement to “pay all charges of [ECU Chowan] that are not covered or paid . . . by any medical insurance” is free from ambiguity. (See Exhibit A). Indeed, the North Carolina Court of Appeals already has reached this conclusion in the virtually identical case of *Shelton v. Duke University Health System, Inc.*, 633 S.E.2d 113. As such, there is no breach of contract here.

In *Shelton*, the plaintiff -- who was represented by the same North Carolina counsel who represent Cansler in this case -- sought treatment from the defendant’s hospital. *Id.* at 114. Prior to receiving treatment, the plaintiff signed a general consent form that did not contain a specific price term, but instead obligated her to pay the hospital’s regular rates. *Id.* According to the plaintiff, the hospital never provided her with any information on the hospital’s rates -- including no information about the amount of such rates -- prior to execution of the consent. *Id.* The plaintiff did allege, however, that the hospital’s rates were kept in a document called the “charge master.” *Id.* at 123. She did not claim that she attempted to get access to the charge master at any point. *Id.*

After the plaintiff was discharged, she received medical bills totaling \$7,891.00, an amount she claimed was unreasonable. *Id.* at 114-15. The plaintiff did not contend, however, that this

amount was inconsistent with the rates contained in the aforementioned charge master. *Id.* at 125. The *Shelton* plaintiff filed a putative class action asserting claims for, *inter alia*, breach of contract. *Id.* at 115. Just like Cansler’s claim, the breach of contract claim asserted that the consent failed to contain a definite price term and, thus, that a reasonable price should be inferred. *Id.* at 122-23.

The trial court in *Shelton* dismissed the breach of contract claim on a motion to dismiss, and the plaintiff appealed. On appeal, the North Carolina Court of Appeals affirmed the trial court’s dismissal of the breach of contract claim, holding that “the contested language [in the consent] is free from ambiguity” *Id.* at 124. The court’s opinion in this regard was supported by its conclusion that the “rates of services contained in the ‘charge master’ were necessarily implied in the contract signed by the plaintiff.” *Id.* at 125. This was based on the “doctrine of implication of unexpressed terms,” which the court described as follows:

Intention or meaning in a contract may be manifested or conveyed either expressly or impliedly, and it is fundamental that that which is plainly or necessarily implied in the language of a contract is as much part of it as that which is expressed. If it can be plainly seen from all the provisions of the instrument taken together that the obligation in question was within the contemplation of the parties when making their contract or is necessary to carry their intention into effect, the law will imply the obligation and enforce it.

Id. at 124 (quoting *Lane v. Scarborough*, 284 N.C. 407, 409-11, 200 S.E.2d 622, 624-25 (1973)).

Applying the doctrine of implication to the facts before it, the *Shelton* court reasoned that the particular circumstances surrounding the execution of the consent indicated a mutual intent to imply the rates contained in the charge master into the terms of the consent:

Inherent in providing medical care and treatment is the element of the unforeseen. It is common, almost expected, that a course of treatment embarked upon will, through unforeseen circumstances, be amended, altered, enhanced, or terminated altogether, and a completely new course of treatment begun. In light of this, it would be impossible for a hospital to fully and accurately estimate all of the treatments and costs for every patient before treatment has begun. It would be cumbersome, and against patients’ interests, to require hospitals to seek new authorization from a patient whenever some medical circumstance requires a new

course of treatment. For this reason, it is entirely reasonable and predictable that patients would agree to pay the hospital's regular rates for whatever services might be necessary in treating their particular ailments or afflictions. None of this is to suggest that patients have no right to question hospitals concerning any particular treatment and the costs therefore, or that patients cannot refuse treatment for reasons of cost.

Id. at 124-25. Based on this reasoning, the court concluded that the rates contained in the charge master were necessarily implied in the consent. *Id.* at 125. Because the defendant hospital in *Shelton* had charged rates that were in line with its charge master, the Court of Appeals affirmed the conclusion that there was no breach. *See id.* at 124-25. The North Carolina Supreme Court denied the *Shelton* plaintiff's petition for discretionary review. *See Shelton*, 643 S.E.2d 591.

Consistent with *Shelton*, “[n]o North Carolina case holds that, absent disclosures about specific charges or the amount of those charges, the contractual obligation created by the Consent Form is not enforceable.” *Gleason v. The Charlotte-Mecklenburg Hosp. Auth.*, 2021 WL 2561505, at *8 (N.C. Super. May 25, 2021) (*affirmed by Gleason v. Charlotte-Mecklenburg Hosp. Auth.*, 2022-NCCOA-420, 873 S.E.2d 70 (N.C. App. June 21, 2022)). In *Gleason*, the plaintiff sought to invalidate the terms of a consent he signed upon presenting to an emergency room where the consent did not list specific price terms, but instead referred merely to the hospital's regular rates. *Gleason.*, 2022 WL 2204433, at *1-2. As in *Shelton*, the court entered judgment in the defendant's favor on the breach of contract claim, finding that the charge master was implied into the terms of the consent and that the allegedly undisclosed facility fee with which plaintiff took issue was listed in such charge master. *Id.* at *4-5. Also as in *Shelton*, the *Gleason* court found it notable that the plaintiff did not ask about pricing when executing the consent. *Id.* at *5.

The reasoning in *Shelton* and its progeny is consistent with other opinions on this issue. In *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255 (3d Cir. 2008), the Third Circuit held that the term “all charges” in a consent that was executed by a plaintiff seeking treatment at the defendant's hospital

was *not* an open price term. While the court noted that the term “‘all charges’ is certainly less precise” than a typical contract for goods or services, the use of such a term is “the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him.” *Id.* at 264. Given this reasoning, as well as the reality that there is an entire scheme of discounting that takes place with patients’ insurers after treatment, the court held that “‘all charges’ unambiguously can only refer to [defendant’s] uniform charges set forth in its Chargemaster.” *Id.*

Here, just like in the aforementioned cases, ECU Chowan maintains a chargemaster that lists its billable items and corresponding charges. (Am. Compl. ¶ 21, Docket Entry 48). Cansler’s insurance company -- Blue Cross -- has negotiated discounted rates with ECU Chowan off of the chargemaster on Cansler’s behalf. (*Id.* at ¶¶ 55-56). Also as in those cases, Cansler presented at ECU Chowan’s emergency department and executed the Consent prior to his receiving treatment, meaning the contract was executed before anyone knew what condition Cansler had or what treatment would be necessary for his condition. (*Id.* at 62). In the Consent, Cansler agreed to pay “all charges of [ECU Chowan] that are not covered or paid . . . by any medical insurance,” and that he was “financially responsible to [ECU Chowan] for charges not paid by insurance.” (*Id.*, see Exhibit A). Cansler does not allege that he asked for ECU’s chargemaster, or inquired about the hospital’s charges prior to signing the Consent or accepting treatment. And, Cansler does not claim that ECU Chowan charged him anything other than the rates discounted from its chargemaster that were negotiated for him by Blue Cross. (*Id.* at ¶¶ 78, 106).

Under these facts, the Court should follow the reasoning in *Shelton*, *Gleason*, and *DiCarlo*, and hold (1) that ECU Chowan’s chargemaster and its agreement to charge Cansler discounted rates are necessarily implied into the terms of the Consent to define the term “all charges,” and (2)

that ECU Chowan did not breach the Consent because it charged Cansler according to those rates.⁷ Such a ruling would be consistent with the circumstances surrounding the execution of the Consent, including the uncertainty of medical care generally and the existence of Cansler's insurance policy that was guaranteed to affect the prices he would ultimately be paying. To hold otherwise would be to conclude that contractual arrangements between hospitals and private insurers are completely meaningless if the patient does not like the price that already was negotiated for them. For these reasons, Cansler's breach of contract claim should be dismissed.

3. Even Without the Statute of Limitations Issue, Cansler Has Failed to State a Claim for Unjust Enrichment.

Unjust enrichment “is neither in tort nor contract but is described as a claim in quasi contract or a contract implied in law.” *Booe v. Shadrick*, 322 N.C. 567, 570, 369 S.E.2d 554, 556 (1988). In order to state a claim for unjust enrichment, a plaintiff must allege the following elements: “(1) a measurable benefit was conferred on the defendant, (2) the defendant consciously accepted that benefit, and (3) the benefit was not conferred officiously or gratuitously.” *See United States v. Jurik*, 943 F. Supp. 2d 602, 612 (E.D.N.C. 2013) (quoting *Primerica Life Ins. Co. v. James Massengill & Sons Constr. Co.*, 211 N.C.App. 252, 259–60, 712 S.E.2d 670, 677 (2011)). “[T]he measure of damages for unjust enrichment is the reasonable value of the goods and services to the defendant.” *Booe*, 369 S.E.2d at 556. Cansler cannot recover under a theory of unjust

⁷ The Court should consider *Shelton* and *Gleason* -- and especially the North Carolina's Supreme Court's denial of discretionary review in *Shelton* -- to be extremely persuasive authority as to how the North Carolina Supreme Court would rule on this issue. When interpreting North Carolina law, a federal court is “obliged to apply the jurisprudence of North Carolina's highest court, the Supreme Court of North Carolina.” *NAPCO, Inc. v. Landmark Tech. A, LLC*, 555 F. Supp. 3d 189, 202 (M.D.N.C. 2021). Absent an instructive ruling from the North Carolina Supreme Court, a federal court must predict how the Supreme Court would rule. *Rogers v. Keffer, Inc.*, 243 F. Supp. 3d 650, 657 (E.D.N.C. 2017). It must do so by “follow[ing] the decision of an intermediate state appellate court unless there is persuasive data that the highest court would decide differently.” *Id.* at 658 (quoting *Town of Nags Head v. Toloczko*, 728 F.3d 391, 397-98 (4th Cir. 2013)).

enrichment for two reasons: (1) there is an express contract between the Parties; and (2) ECU Chowan has not been unjustly enriched by Cansler.

a. *Cansler Cannot State an Unjust Enrichment Claim Because the Parties Entered into an Express Contract.*

The existence of an express contract precludes recovery for unjust enrichment. *Reaves v. Seterus, Inc.*, 2015 WL 2401666, at *4 (E.D.N.C. May 20, 2015) (“[T]he existence of an express contract precludes recovery for unjust enrichment and in quantum meruit.”); see *Vetco Concrete Co. v. Troy Lumber Co.*, 256 N.C. 709, 713, 124 S.E.2d 905, 908 (1962). In other words, “[i]f there is a contract between the parties the contract governs the claim and the law will not imply a contract.” *Reaves*, 2015 WL 2401666, at *4 (quoting *Booe*, 369 S.E.2d at 556).

Here, Cansler cannot state a claim for unjust enrichment because there is an enforceable contract between the Parties -- the Consent. (See Exhibit A; Am. Compl. at ¶ 62, Docket Entry 48). Cansler does not dispute the existence of the Consent. Indeed, he actually asserts a breach of contract based on the Terms of the Consent. (See Am. Compl. ¶¶ 62, 181-87, Docket Entry 48). Instead, Cansler asserts the legal conclusion that the Consent is unenforceable because, according to him, it lacks a price term. (See *id.* at ¶¶ 45,189). However, as addressed in more detail above, Cansler’s contentions in this regard are wrong. The Consent’s price term is unambiguous and, as a result, the Consent is enforceable as a matter of law. (See *supra* at Section IV(A)(2)). Because the existence of an enforceable contract precludes recovery for unjust enrichment, Cansler’s unjust enrichment claim should be dismissed as a matter of law. See *Reaves*, 2015 WL 2401666, at *4.

b. *Cansler Cannot State an Unjust Enrichment Claim Because ECU Chowan Has Not Been Unjustly Enriched By Cansler’s Voluntary Payments.*

Unjust enrichment applies where the plaintiff is seeking compensation for the reasonable value of services that the plaintiff provided to the defendant. See *W.F. Magann Corp. v. Diamond*

Mfg. Co., 775 F.2d 1202, 1208 (4th Cir. 1985). It does **not** apply to situations where the plaintiff seeks to recoup voluntary payments for services that the defendant provided to the plaintiff. *See Brown v. Loancare, LLC*, 2020 WL 7389407, at *6 (W.D.N.C. Dec. 16, 2020) (“Plaintiff’s Complaint makes clear she received the benefit of the services for which she paid—that is, timely payment of her mortgage -- which contradicts any allegation that Defendant’s retention of the fees is somehow ‘unjust.’”); *Krebs v. Charlotte Sch. of Law, LLC*, 2017 WL 3880667, at *6 (W.D.N.C. Sept. 5 2017) (“Payment of tuition and fees cannot be unjust if the students received the benefit for which they paid.”). In other words, “[w]here a person has officiously conferred a benefit upon another, the other is enriched but is not considered to be unjustly enriched. The recipient of a benefit voluntarily bestowed without solicitation or inducement is not liable for their value.” *Wright v. Wright*, 305 N.C. 345, 350, 289 S.E.2d 347, 351 (1982) (quoting *Rhyne v. Sheppard*, 224 N.C. 734, 737, 32 S.E.2d 316, 318 (1944)); *see Cross v. Formativ Health Mgmt., Inc.*, 439 F. Supp. 3d 616, 630 (E.D.N.C. 2020), *appeal dismissed*, 2020 WL 5203204 (4th Cir. July 22, 2020) (“Under North Carolina law, it is a ‘well established rule of law that the voluntary payment of money by a person who has full knowledge of all the facts cannot be recovered.’”).

Here, ECU Chowan provided a service to Cansler, meaning Cansler indisputably “received the benefit for which [he] paid.” *See Krebs*, 2017 WL 3880667 at *6. Cansler also submitted the payments he did make to ECU Chowan voluntarily. Cansler made his first payment with full knowledge that the Consent’s price term did not contain an exact dollar amount and that he would be responsible for any charge not covered by his insurance policy, and he submitted three additional payments with full knowledge of the amount ECU Chowan claimed it was owed. (Am. Compl. ¶¶ 60-66, 70-73, Docket Entry 48). Cansler cannot recoup his payments to ECU Chowan because such payments are not “unjust” as a matter of law. *See Krebs*, 2017 WL 3880667 at *6.

Further, even if Cansler were to argue that the \$250.00 in payments he remitted for medical services he admittedly received were somehow involuntary, such would still not be “unjust” because the amount he paid is *less* than the value that *Cansler* alleges is reasonable for such services. (*See* Am. Compl. ¶ 117, Docket Entry 48). Put another way, Cansler cannot argue it is unjust for him to pay ECU Chowan \$250.00 for services that even Cansler alleges are worth \$679.00. (*See id.*). And, applicable case law makes clear that Cansler does not have standing to rely upon the \$456 Blue Cross paid ECU Chowan on Cansler’s behalf. *See Fed. Deposit Ins. Corp. v. Brit.-Am. Corp.*, 755 F. Supp. 1314, 1324 (E.D.N.C. 1991) (dismissing unjust enrichment claim where a third party, and not the plaintiff, conferred the alleged benefit on defendant). For all of these reasons, Cansler’s unjust enrichment claim should be dismissed.

B. Cansler Has Not Adequately Alleged the Elements of His UDTPA Claim.

To establish a UDTPA claim, a plaintiff must prove that (1) the defendant’s act was in or affecting commerce, (2) the defendant committed an unfair or deceptive act or practice, and (3) the defendant’s act was the proximate cause of the plaintiff’s injury. *Bumpers v. Cmty. Bank of N. Virginia*, 367 N.C. 81, 88, 747 S.E.2d 220, 226 (2013). Cansler has failed to adequately plead *any* of these required elements because the specific wrongdoing at issue -- ECU Health’s alleged failure to disclose (without inquiry) the amount Cansler might be charged -- is (1) exempted from the scope of the UDTPA, (2) does not constitute an unfair and deceptive practice under the statute, and (3) did not proximately cause Cansler’s alleged damages.

1. ECU Health’s Alleged Acts Fall Within the Learned Profession Exemption and, Thus, Are Not “In or Affecting Commerce.”

“Before a practice can be declared unfair and deceptive, it must first be determined that the practice or conduct which is complained of takes place within the context of [the UDTPA’s] language pertaining to trade or commerce.” *Oberlin Cap., L.P. v. Slavin*, 147 N.C. App. 52, 62,

554 S.E.2d 840, 848 (2001) (quoting *Johnson v. Insurance Co.*, 300 N.C. 247, 261, 266 S.E.2d 610, 620 (1980)).⁸ “[W]hether an act is ‘in or affecting commerce’ is a question of law for the Court to decide.” *Kingsdown, Inc. v. Hinshaw*, 2016 WL 661823, at *21 (N.C. Super. Feb. 17, 2016) (quoting *Hardy v. Toler*, 288 N.C. 303, 210, 218 S.E.2d 342, 346-47 (1975)).

The UDTPA’s plain language excludes “professional services rendered by a member of a learned profession” from its definition. N.C.G.S. § 75-1.1(b). The relevant language provides:

- (a) Unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are declared unlawful.
- (b) For purposes of this section, “commerce” includes all business activities, however denominated, but does not include professional services rendered by a member of a learned profession.

N.C.G.S. § 75-1.1(a-b). See *Burgess v. Busby*, 142 N.C. App. 393, 407, 544 S.E.2d 4, 11-12 (2001) (“[A] matter affecting the professional services rendered by members of a learned profession and therefore falls within the exception in N.C.G.S. § 75-1.1(b).”); *Alamance Fam. Prac., P.A. v. Lindley*, 2018 WL 3871627, at *8 (N.C. Super. Aug. 14, 2018) (“It is well-settled by our Courts that a matter affecting the professional services rendered by members of a learned profession . . . falls within the exception.”) (quoting *Wheless v. Maria Parham Med. Ctr., Inc.*, 237 N.C. App. 584, 589, 768 S.E.2d 119, 123 (2014)).

Courts utilize a two-prong inquiry to determine whether particular conduct comes within the learned profession exemption. See *Sykes v. Health Network Sols., Inc.*, 372 N.C. 326, 334, 828 S.E.2d 467, 472 (2019). **First**, the entity against whom the UDTPA claim is alleged must be a “member of a learned profession.” *Id.* **Second**, the conduct at issue must sufficiently affect a

⁸ *Johnson* was overruled on other grounds by *Myers & Chapman, Inc. v. Thomas G. Evans, Inc.*, 323 N.C. 559, 374 S.E.2d 385 (1988).

“professional service.” *Id.* As set forth below, both prongs of the inquiry clearly establish that ECU Health’s alleged misconduct falls squarely within the learned profession exemption.

a. *ECU Health Is a Member of a Learned Profession.*

Medical professionals universally are considered “members of a learned profession.” *See Gaunt v. Pittaway*, 139 N.C. App. 778, 784, 534 S.E.2d 660, 664 (2000) (“[M]edical professionals are expressly excluded from the scope of [N.C.G.S.] § 75-1.1(a.)”); *Cohn v. Wilkes Gen. Hosp.*, 767 F. Supp. 111, 114 (W.D.N.C.), *aff’d sub nom. R. Ernest Cohn, D.C., D.A.B.C.O. v. Bond*, 953 F.2d 154 (4th Cir. 1991). Relevant here, the “exception for medical professionals has been broadly interpreted by [the North Carolina Court of Appeals] and includes hospitals under the definition of ‘medical professionals.’” *Shelton*, 633 S.E.2d at 117 (internal citations omitted).

There is no question that ECU Health is a member of a learned profession in this case. The Amended Complaint collectively identifies ECU Health as hospitals providing medical care to patients, and alleges that Cansler went to ECU Chowan seeking medical treatment that he then was provided. (*See* Am. Compl. ¶¶ 3-5, 57, 61, Docket Entry 48). A hospital that provides medical care to patients definitively falls within the definition of a “member of a learned profession.” *Shelton*, 633 S.E.2d at 117. As such, the first prong to the relevant inquiry is satisfied.

b. *ECU Health’s Alleged Conduct Affects a Professional Service.*

If the defendant is a member of a learned profession, courts next consider whether the conduct at issue affects a “professional service.” *Sykes*, 828 S.E.2d at 472. It is well-established that the learned profession exemption applies to “a broad range of conduct,” and that it “is not limited to the actual delivery of professional services but extends to decision-making that affects the delivery of those services.” *Se. Anesthesiology Consultants, PLLC v. Rose*, 2019 WL 5090364,

at *9 (N.C. Super. Oct. 10, 2019); *Sykes v. Health Network Sols., Inc.*, 2017 WL 3601347, at *19 (N.C. Super. Aug. 18, 2017), *aff'd*, 372 N.C. 326, 828 S.E.2d 467 (2019).

“[T]here is no requirement that a member of a learned profession . . . be actively engaged in the practice of medicine” for the exemption to apply. *See Anesthesiology Consultants, PLLC*, 2019 WL 5090364, at *9. Rather, North Carolina courts have ruled that numerous types of conduct falling outside of the specific delivery of medical care still come within the learned profession exemption. *See e.g., id.* (applying exemption to non-medical conduct during contract negotiations and execution and operation of medical practices); *Sykes*, 828 S.E.2d at 473-74 (applying exemption to price fixing procedures that would reduce medical services); *Phillips v. A Triangle Women’s Health Clinic, Inc.*, 155 N.C. App. 372, 378-79, 573 S.E.2d 600, 604-05 (2002), *aff’d in part, review dismissed in part*, 357 N.C. 576, 597 S.E.2d 669 (2003) (applying exemption to alleged misrepresentations during patient communications); *Cameron v. New Hanover Memorial Hospital, Inc.*, 58 N.C. App. 414, 445, 293 S.E.2d 901, 920 (1982) (applying exemption to denial of hospital staff privileges); *Alamance*, 2018 WL 3871627, at *9 (applying exemption to use of patient data for solicitation and referral activities).

The alleged misconduct in Cansler’s Amended Complaint -- having Cansler execute the Consent and allegedly failing to affirmatively disclose its pricing -- clearly affects a professional service and, thus, comes within the learned profession exemption. Indeed, the North Carolina Court of Appeals already reached this conclusion in the aforementioned *Shelton* case. (*See supra* at Section IV(A)(2)). In *Shelton*, just as Cansler does here, the plaintiff claimed that a hospital did not provide her information regarding the hospital’s allegedly unreasonable rates prior to her execution of a consent. *Id* at 122. The plaintiff also specifically alleged that the defendant

hospital's actions did not qualify for the professional services exemption in N.C.G.S. § 75-1.1(b). (See *Shelton v. Duke University Health System, Inc.* Complaint at ¶¶ 54-57, attached as Exhibit B).

The North Carolina Court of Appeals affirmed dismissal of the UDTPA claim, holding:

“Our Court has made clear that unfair and deceptive acts committed by medical professionals are not included within the prohibition of N.C.G.S. § 75–1.1(a).” This exception for medical professionals has been broadly interpreted by this Court, and includes hospitals under the definition of “medical professionals.” We hold that the facts of this case do not justify a departure from this precedent. This argument is without merit.

Shelton, 633 S.E.2d at 117 (internal citations omitted) (citing *Burgess*, 544 S.E. 2d at 11; *Cameron*, 293 S.E.2d at 921; *Gaunt*, 534 S.E.2d at 664; *Phillips*, 573 S.E.2d at 604-05; *Abram*, 398 S.E.2d at 334). The North Carolina Supreme Court then denied the *Shelton* plaintiff's petition for discretionary review. See *Shelton*, 643 S.E.2d 591.

The holding in *Shelton* is on all fours with the facts of this case. Cansler's claims are driven entirely by ECU Health's alleged failure to disclose (without inquiry) the cost of medical services, which then were billed to the patient and alleged to be unreasonably high. *Shelton*'s reasoning demonstrates that such billing activities come squarely within the learned profession exemption. *Shelton*, 633 S.E.2d at 117. Indeed, Cansler's North Carolina counsel are the same counsel who represented the plaintiff in *Shelton*, so they knew that filing this case in North Carolina state court would have resulted in an immediate dismissal based on the binding precedent in *Shelton*. Cansler's attempts to switch forums should not yield a new result, and the Court should follow *Shelton* and find that Cansler's UDTPA claims are foreclosed by the learned profession exemption.

2. ECU Health Did Not Commit an Unfair or Deceptive Act Because Cansler's UDTPA Claim Is Premised Upon Contractual Enforceability and Fails to Constitute Fraudulent Concealment.

The UDTPA declares “unfair or deceptive acts or practices affecting commerce” to be unlawful. N.C.G.S. § 75-1.1. While “unfair” and “deceptive” are not defined in the statute, courts

have found that the statute “is broader and covers more than traditional common law proscriptions on tortious conduct, though fraud and deceit tend to be included within its ambit.” *Bumpers*, 747 S.E.2d at 226 (citing *Marshall v. Miller*, 302 N.C. 539, 543, 276 S.E.2d 397, 400 (1981)). “The statute does not, however, prohibit all wrongful conduct stemming from commercial transactions.” *Id.* “The determination of whether an act is unfair or deceptive is a question of law for the court.” *Dalton v. Camp*, 353 N.C. 647, 656, 548 S.E.2d 704, 711 (2001).

Relevant to this case, “North Carolina courts repeatedly have held that a ‘mere breach of contract, even if intentional, is not sufficiently unfair or deceptive to sustain an action under [the UDTPA].’” *Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.2d 331, 347 (4th Cir. 1998); see *Forest2Market, Inc. v. Arcogent, Inc.*, 2016 WL 56279, at *6 (N.C. Super. Jan. 5, 2016) (“As a general rule, however, where, as here, the parties’ contract required the defendant to only bill for services rendered, a plaintiff’s allegations of overbilling will usually amount to, at most, an intentional breach of contract.”). “[C]ourts ‘differentiate between contract and deceptive trade practice claims, and relegate claims regarding the existence of an agreement, the terms contained in the agreement, and the interpretation of an agreement to the arena of contract law.’” *Elrod v. WakeMed*, 2021 WL 4312557, *14 (E.D.N.C. Sep. 22, 2021) (citing *Broussard*, 155 F.3d at 347).

Thus, if a case involves questions related to the existence, terms, or interpretation of a contract, “‘a plaintiff must show substantial aggravating circumstances attending the breach’ to establish a UDTPA claim.” *PCS Phosphate Co., Inc. v. Norfolk Southern Corp.*, 559 F.3d 212, 224 (4th Cir. 2009) (internal citations omitted); see *Di Sciullo v. Griggs & Co. Homes, Inc.*, 2015 WL 6393813, at *12 (E.D.N.C. Oct. 22, 2015) (“ [A]n assertion that defendants abused their position by overcharging plaintiffs still is insufficient evidence of an unfair or deceptive trade practice”). “Circumstances that are sufficiently egregious or aggravating to permit a UDTP[A]

claim based on conduct that occurred during the course of contractual performance involve ‘clear deception,’ such as forgery, destruction of documents, or concealment of the breach combined with other acts to deter plaintiff from investigating the conduct.” *Alamance*, 2018 WL 3871627, at *9. North Carolina courts have found that allegations of deceptive, excessive billing practices alone do not state a UDTPA claim. *See e.g., Crescent Foods, Inc. v. Evason Pharmacies, Inc.*, 2016 WL 5817469, at *10 (N.C. Super. Oct. 5, 2016) (defendant’s failure to share rebates and improper calculation of contract payments did not establish aggravating factors); *Forest2Market, Inc.*, 2016 WL 56279 at *6 (holding plaintiff’s allegations of intentional overbilling and concealment of same were insufficient to establish a UDTPA claim).

a. *Cansler’s UDTPA Claims Relate to Contract Issues and Do Not State Separate Claims for Unfair or Deceptive Trade Practices.*

Because Cansler’s UDTPA claims center on “the existence of an agreement, the terms contained in an agreement, and the interpretation of an agreement,” the claims should be decided in “the arena of contract law” rather than under the UDTPA. *Elrod*, 2021 WL 4312557, at *14 (citing *Broussard*, 155 F.3d at 247). In particular, Cansler contends that when he presented to the emergency department at ECU Chowan, he signed the Consent, which set forth his promise to pay and otherwise be “financially responsible to the Hospital and physicians for charges not paid by insurance.” (Am. Compl. ¶ 62, Docket Entry 48). And, while Cansler asserts the legal conclusion that the Consent is unenforceable because it does not contain specific price terms⁹, numerous cases have held that substantively identical hospital consent forms, including those without specific price

⁹ While the Court is obligated to accept well-pled facts as true on a motion to dismiss, it “does not consider ‘legal conclusions . . . bare assertions devoid of further factual enhancement[,] . . . unreasonable conclusions, or arguments.’” *Elrod*, 2021 WL 4312557, at *4 (quoting *Nemet Chevrolet, Ltd.*, 591 F.3d at 255).

terms, are valid and enforceable on their face. *See Shelton*, 633 S.E.2d at 122-25 (holding general consent was enforceable and unambiguous even without specific price term); *Gleason*, 2021 WL 2561505, at *8-9 (N.C. Super. May 25, 2021) (same); *see also Elrod*, 2021 WL 4312557, at *5 (holding that general consent signed at emergency room was valid and enforceable on its face). Based on this reasoning, the allegations in Cansler’s Amended Complaint make clear that the Consent that Cansler signed is a valid contract, on its face.

Regardless, Cansler’s entire UDTPA claim is premised upon the alleged unenforceability of the terms of the Consent, which means such claims relate to “the existence of an agreement [and] the terms contained in an agreement.” *Elrod*, 2021 WL 4312557, at *14 (citing *Broussard*, 155 F.3d at 247). Cansler is asking the Court to interpret or imply a “reasonable” price term into the Consent, as opposed to the rate that Cansler’s insurance company negotiated on his behalf as a percentage of ECU Chowan’s chargemaster rate. (*See Am. Compl.* ¶¶ 55-56, 63, Docket Entry 48). As such, “the rights and remedies of the parties lie in contract law and not in unfair and deceptive trade practices.” *Elrod*, 2021 WL 4312557, at *14 (citing *Broussard*, 155 F.3d at 247).

Further, Cansler has not alleged any “sufficiently egregious or aggravating” factors that would “permit a UTDP[A] claim based on conduct that occurred during the course of contractual performance” such as “forgery, destruction of documents, or concealment of the breach combined with other acts to deter plaintiff from investigating the conduct.” *Alamance*, 2018 WL 3871627, at *9. To the contrary, Cansler merely contends that ECU Health attempted to collect on the debt that they were owed when Cansler refused to pay, which “is nothing more than two [parties] fighting over the enforceability of an agreement,” and does not constitute a sufficiently egregious or aggravating factor. *PSC Phosphate Co.*, 559 F.3d at 224-25.

At bottom, Cansler's claims are substantively identical to the numerous consent-based breach of contract claims that have been dismissed by this Court and others in North Carolina. *See Shelton*, 633 S.E.2d at 122-25; *Gleason*, 2021 WL 2561505, at *8-9; *see also Elrod*, 2021 WL 4312557, at *14. Those cases make clear that claims related the enforceability or interpretation of contractual rights do not create separate claims for unfair or deceptive trade practices. *See Broussard*, 155 F.3d at 347. Because Cansler's claims all relate to the existence, interpretation, or performance of the Consent, "the rights and remedies of the parties lie in contract law and not in unfair and deceptive trade practices." *Elrod*, 2021 WL 4312557, at *14 (citing *Broussard*, 155 F.3d at 347). Cansler's UDTPA claims against ECU Health should be dismissed.

b. *To the Extent Cansler's UDTPA Claims Are Premised on a Theory of Fraudulent Concealment, the Amended Complaint Does Not Adequately Plead Such a Claim.*

Even if the Court were to conclude that Cansler's UDTPA claims do not sound in breach of contract, and instead sound in fraudulent concealment based on an alleged failure to disclose the cost of treatment, Cansler still has not adequately pled a UDTPA claim because he has not adequately pled that ECU Health owed him a duty to disclose such costs. "[A] fraud-based UDTPA claim is subject to the Rule 9(b) heightened pleading standard," and the plaintiff must plead each of the standard elements of a fraud claim. *Withers v. BMW of North Am., LLC*, 2021 WL 4204332, at *5 (W.D.N.C. Sep. 15, 2021). "If fraud is based on failure to disclose a material fact, there must have been a duty to speak or the party accused of fraud must have taken steps to actively conceal facts." *Id.* (citing *Setzer v. Old Rep. Life Ins. Co.*, 257 N.C. 396, 398, 126 S.E.2d 135, 137 (1962)). A duty to speak exists where "(1) there is a fiduciary relationship between the parties; (2) 'a party has taken affirmative steps to conceal material facts from the other'; or (3) 'one party has knowledge of a latent defect in the subject matter of the negotiations about which

the other party is both ignorant and unable to discover through reasonable diligence.” *Id.* (quoting *Jacobson v. Walsh*, 2014 WL 266354, at *6 (N.C. Super. Jan. 22, 2014)). Mere silence does not constitute fraud unless it “relate[s] to a material matter known by the defendants which they had a legal duty to communicate to plaintiff . . .” *Breeden v. Richmond Community College*, 171 F.R.D. 189, 196 (M.D.N.C. Feb. 14, 1997) (citing *Setzer*, 126 S.E.2d at 137).

Cansler’s claims are premised on the allegation that ECU Health failed to disclose his treatment costs prior to providing such treatment. This allegation is not sufficient to plead fraudulent concealment because Cansler has not adequately pled that ECU Health owed him a duty to make the disclosure. This Court recently rejected the existence of a fiduciary duty in a similar context in *Elrod v. WakeMed*, 2021 WL 4312557, at *13-14. In *Elrod*, the plaintiffs alleged that the defendant hospital breached its fiduciary duty to the plaintiffs when it had them sign a general consent form in the emergency room. *Id.* at *2, *13. While the Court recognized that a general fiduciary duty exists between a physician and patient, it held that the fiduciary duty did *not* extend to the execution of the general consent because it “comprises a valid means of payment collection for plaintiffs’ treatment.” *Id.* at *13. Because the forms were “akin to a form for insurance information or for payment for medication treatment, defendant . . . did not breach a fiduciary duty by including [the assignment of benefits] within the general consent and failing to draw further attention to it or explain its terms to plaintiffs.” *Id.* at *14. The Court held that the plaintiffs’ breach of fiduciary duty and constructive fraud claims failed as a matter of law. *Id.* at *14, n.16.

In *Gleason v. The Charlotte-Mecklenberg Hosp. Authority*, the plaintiff claimed that the defendant hospital breached its fiduciary duty by failing to disclose certain charges. 2021 WL 2561505, at *9-11. The plaintiff signed a consent agreeing to pay for the services and failed to ask any questions about the cost prior to treatment. *Id.* at *8-9. In finding that the defendant owed no

fiduciary duty to disclose its prices, the Superior Court of North Carolina reasoned: “[Plaintiff] cites no case holding that [defendant] had a fiduciary duty to him in the context of billing (as compared to in connection with the furnishing of medical care), and courts in other states have rejected such a claim.” *Id.* at *11 (citing *Morrell v. Wellstar Health Sys., Inc.*, 280 Ga. App. 1, 7, 633 S.E.2d 68, 74 (2006); *DiCarlo*, 530 F.3d at 268-69; *Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707, 723-24 (E.D. Mich. 2005)). Thus, the court found the defendant had no fiduciary duty to disclose pricing and dismissed the claims as a matter of law. *Id.*¹⁰

Here, any purported UDTPA claim based on fraudulent concealment must fail because ECU Health did not owe Cansler any fiduciary duty to disclose the costs of the services described in the Consent. Just as in *Elrod* and *Gleason*, Cansler presented to the hospital for medical treatment and signed a Consent as part of that process. Also as in *Gleason*, Cansler does not contend that he asked for any information about the costs of ECU Health’s services before signing. Under the above, the Consent was “akin to a form for insurance information or for payment for medication treatment, [so ECU Health] . . . did not breach a fiduciary duty by including [the agreement to pay the hospital’s charges] within the general consent and failing to draw further attention to it or explain its terms to plaintiffs.” *Elrod*, 2021 WL 4312557, at *14. Such is especially true where Cansler does not allege that he asked for more information.¹¹

¹⁰ The North Carolina Court of Appeals recently affirmed the *Gleason* court’s opinion. See *Gleason*, 2022 WL 2204433.

¹¹ Nor has Cansler alleged that a duty existed because ECU Health has “taken affirmative steps to conceal material facts from [Cansler]” or that ECU Health has “knowledge of a latent defect in the subject matter of the negotiations about which [Cansler] is both ignorant and unable to discover through reasonable diligence.” *Withers*, 2021 WL 4204332, at *5 (citation omitted). Cansler does not allege that he asked ECU Health how much his treatment would cost and was affirmatively denied such information. Nor is there any allegation that ECU Health knew that Cansler supposedly was unaware of the costs, or that they affirmatively concealed these facts with such knowledge.

The alleged failure to disclose the costs of emergency room services is entirely consistent with ECU Chowan's statutory obligations under EMTALA. *See* 42 U.S.C. § 1395dd. EMTALA imposes an obligation on Medicare participating hospitals, like ECU Chowan, to "provide for an appropriate medical screening examination within the capability of the hospital's emergency department" whenever "any individual . . . comes to the [hospital's] emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition." 42 U.S.C. § 1395dd(a). The federal regulations related to EMTALA prohibit ECU Health from "engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions." 26 C.F.R. § 1.501(r)-4(c)(2); *see* 42 C.F.R. § 489.24(d)(4)(iv) (emergency department registration procedures "may not unduly discourage individuals from remaining for further evaluation"). Cansler has not alleged that he asked any questions about the costs of the treatment that he was receiving, so it would have been incumbent upon ECU Health *not* to disclose or discuss the costs of the services. Doing so would have risked violating EMTALA, discouraging medical treatment, and incurring civil penalties. *See* 42 U.S.C. § 1395dd(d).

For these reasons, Cansler has failed to plead that ECU Health owed him a fiduciary duty to provide further information about the costs of the services described in the Consent. As such, Cansler has failed to plead an essential element of the claim. *See Breedon*, 171 F.R.D. at 196.

3. ECU Health's Alleged Conduct Was Not the Proximate Cause of Cansler's Alleged Injuries Because Cansler Did Not Rely Upon ECU Health's Alleged Conduct.

Finally, Cansler has failed to plead the essential element of proximate cause. If a UDTPA claim is premised upon an alleged misrepresentation or fraudulent concealment, the element of proximate cause requires that "a plaintiff must demonstrate that they detrimentally relied on the

defendant's alleged misrepresentation or deception in order to recover under the statute.” *Dan King Plumbing Heating & Air Conditioning, LLC v. Harrison*, 2022-NCCOA-27, ¶ 30, 281 N.C. App. 312, 320, 869 S.E.2d 34, 43 (2022); see *Bumpers*, 747 S.E.2d at 88. “Reliance, in turn, is comprised of two factors -- actual reliance and reasonableness.” *Dan King*, 869 S.E.2d at 43.

“The first element -- actual reliance -- requires a showing that ‘the plaintiff [] affirmatively incorporated the alleged misrepresentation into his or her decision-making process.’” *Id.* (citing *Bumpers*, 747 S.E.2d at 227). Thus, “the plaintiff must have ‘acted or refrained from acting in a certain manner due to the defendant’s representations.’” *Id.* (quoting *Williams v. United Cmty. Bank*, 218 N.C. App. 361, 368, 724 S.E.2d 543, 549 (2012)). “The second element -- reasonableness -- requires a showing that the plaintiff’s reliance on the defendant’s ‘allegedly false representations [was] reasonable.’” *Id.* (citing *Bumpers*, 747 S.E.2d at 227).

In *Dan King*, the plaintiff claimed that the defendant violated the UDTPA by superimposing plaintiff’s signature on a contract without his knowledge. 869 S.E.2d at 43-44. The defendant argued that the plaintiff’s claim failed the element of proximate cause because the plaintiff admittedly did not see the contract until well after the work at issue was completed, meaning that he could not have relied upon the forgery to his detriment. *Id.* at 44. The court held that the plaintiff failed to establish proximate cause because he had no knowledge of the alleged deceptive act when he made his contractual decision, meaning that he did not rely upon it to his detriment. *Id.* at 45; see *Fazzari v. Infinity Partners, LLC*, 235 N.C. App. 233, 245, 762 S.E.2d 237, 244 (2014) (no actual reliance where plaintiffs “made their decisions to invest in [a] development and contracted to do so without any awareness of, much less reliance on, the [overstated] appraisals,” meaning the wrongdoing did not proximately cause their injuries).

Cansler cannot show that ECU Health’s alleged failure to disclose costs or the alleged corporate policy of refusing to disclose costs proximately caused *his* injuries. Cansler’s allegations make clear that he did not rely upon any non-disclosure or alleged policy. Despite being presented with the Consent, which obligated him to pay the hospitals’ costs but contained no specific price term, Cansler does not allege that he asked any questions about the costs prior to executing the document. Under these circumstances, and particularly considering EMTALA, ECU Health was under no obligation to disclose the treatment costs, nor was their alleged policy of refusing to disclose costs upon inquiry even triggered. As in *Dan King* and *Fazzari*, Cansler made his decision to consent to treatment “without any awareness of, much less reliance on,” ECU Health’s alleged policy of not disclosing prices to patients. *Dan King*, 869 S.E.2d at 44-45; *Fazzari*, 762 S.E.2d at 244. Because Cansler did not rely upon ECU Health’s lack of disclosure or its purported policy of nondisclosure, he has not alleged that these issues proximately caused his injuries. For these reasons, Cansler has failed to plead an essential element of his UDTPA claims.

D. Because Cansler Has Failed to State a Claim for Breach of Contract, Unjust Enrichment, and Violation of the UDTPA, His Claims for Declaratory Judgment and Injunctive Relief Should be Dismissed.

Cansler’s requests for declaratory judgment and injunctive relief against ECU Health are based upon the same facts alleged in support of his UDTPA claim. “Given that [Cansler’s] substantive claims fail as a matter of law,” he has “not established entitlement to relief in the form of declaratory judgment [or] injunction.” *Cross v. Ciox Health, LLC*, 438 F. Supp. 3d 572, 591 (E.D.N.C. 2020), *appeal dismissed*, 2020 WL 5203205 (4th Cir. Aug. 31, 2020); *see e.g., Shelton*, 633 S.E.2d at 117 (“Plaintiff argues that she is entitled to a declaratory judgment to determine the actual price she should pay in light of the ambiguity of the price term in the contract. As we have

already held that the price term is not ambiguous, plaintiff's argument fails."); *Sykes*, 828 S.E.2d at 474. His claims for declaratory judgment and injunctive relief should be dismissed.

IV. CONCLUSION

For the foregoing reasons, ECU Health respectfully request that the Court grant its Motion and dismiss Cansler's claims with prejudice.

Respectfully submitted,

/s/ Erin Palmer Polly

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*Counsel for Defendants University Health
Systems of Eastern Carolina, Inc. and East
Carolina Health-Chowan, Inc.*

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing document was served upon all counsel of record via the Clerk of Court's ECF system, this August 25, 2022.

/s/ Erin Palmer Polly

Cansler, George
MRN: [REDACTED], DOB: [REDACTED], Sex: M
Acct #: [REDACTED]
Adm: 6/6/2018, D/C: 6/6/2018

06/06/2018 - ED in Emergency Department (continued)

Documents (continued)



VIDANT HEALTH

AUTHORIZATION & CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

"I," "me," or "my" refers to the patient named below, and where appropriate, refers to the person(s) with the legal right to consent for the patient. "Vidant Health/ECU Physicians" refers to the particular Vidant Health affiliated hospital, clinic, or other service and ECU Physicians to which I have been accepted as a patient, as indicated above. "Medical Staff Members" refers to all physicians and advanced practice professionals who provide medical treatment and surgical services at Vidant Health/ECU Physicians.

AUTHORIZATION FOR TREATMENT: I understand that there are routine diagnostic and therapeutic examinations and procedures that are ordinarily associated with being a patient at Vidant Health/ECU Physicians ("Medical Treatment"). I understand that Medical Staff Members, clinical staff, agents, and personnel will direct my Medical Treatment as necessary for my health benefit according to their professional judgment. I hereby voluntarily request, authorize, and consent to such Medical Treatment. I understand that if more invasive or non-routine procedures or examinations are necessary, I will be informed of the risks and benefits of such necessary additional treatment and will be given the opportunity to consent to each such necessary additional treatment. I understand that the practice of medicine and surgery is not an exact science and that no guarantees have been made as to the results of medical care, treatment, or examination rendered by Vidant Health/ECU Physicians.

PHYSICIANS AS INDEPENDENT CONTRACTORS: I understand that some Medical Staff Members (such as radiologists, pathologists, emergency services physicians, anesthesiologists, etc.) are independent contractors and are not employees or agents of Vidant Health/ECU Physicians.

RELEASE OF INFORMATION: The undersigned authorizes Vidant Health/ECU Physicians to disclose all or any parts of the patient's medical record to any of the following: listed insurance companies, government agencies, the patient's employer or any agency conducting reviews concerning worker's compensation case, any review agency which conducts reviews of hospital utilization under an agreement with the patient's employer or other payment source, and any health care organization, healthcare provider or agency needing medical information to assist in the patient's continuing care. The disclosed medical record may include information regarding the treatment of psychiatric and drug and alcohol abuse conditions, information concerning AIDS, AIDS-related conditions or HIV status. I also understand that I may revoke this authorization by providing written notice to the hospital.

MEDICARE/TRICARE, MEDICAID PATIENT'S INFORMATION: I certify that the information I have given in applying for payment under Title V, XVII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid Claim. I authorize Vidant Health/ECU Physicians and the applicable County Department of Social Services to discuss information about me in the event I apply for financial assistance, including Medicaid. This information includes the following: date of application, application status, the reason my application remains pending, any verification required to complete my application, the date and reason of denial (if applicable). I received the document titled "An Important Message from TRICARE" or "Medicare" at the time of my admission. My signature only acknowledges that I received this message from Vidant Health/ECU Physicians and does not waive any of my rights to request a review or make me liable for any payment.


ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize payment directly to Vidant Health/ECU Physicians and Medical Staff Members involved in my treatment or diagnosis at Vidant Health/ECU Physicians by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of hospitalization or Outpatient Services of the below named patient. I unconditionally assign any insurance benefits to Vidant Health/ECU Physicians and Medical Staff Members involved in my treatment and further authorize both to apply any surplus insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to the Hospital and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt. Vidant Health/ECU Physicians will make every effort to pre-certify and/or pre-authorize treatment with third party payors who conduct Utilization Review as a service to patients; however, Vidant Health/ECU Physicians does not accept responsibility for lack of pre-certification and/or preauthorization and is not responsible for the final payment outcomes or timing restraints. I irrevocably assign to Facility and/or Medical Staff physicians all rights, title and interest in and to any third party liability arising out of injuries sustained by me necessitating the services provided, up to the amount necessary to discharge the debt due Facility and/or Medical Staff physicians. I authorize and direct any person or corporation having notice of this assignment to pay directly to Facility and/or Medical Staff physicians all medical, liability or other insurance or third-party benefits to which I am or may be entitled related to my care up to the amount necessary to discharge my indebtedness to Facility and/or Medical Staff physicians. I hereby appoint Facility, Medical Staff physicians and any agent acting on their behalf as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer or third party liability carrier of any and all benefits due me for the payment of charges associated with my treatment. If any part of this assignment is void as against public policy or in violation of any statute or law of the State of North Carolina, I intend that all other provisions of this assignment remain enforceable.

PERSONAL VALUABLES: If admitted as an inpatient, I hereby release the hospital from any responsibility for valuables, money, personal or other possessions that are not deposited with the hospital for safekeeping.

NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the Notice of Privacy Practices ("NPP") in effect for Vidant Health/ECU Physicians. The Notice of Privacy Practices is a complete description of my privacy rights as a patient of Vidant Health/ECU Physicians.

MEDICAL DEVICES TRACKING PROCESS: Medical device tracking regulations published under the Federal Food, Drug, and Cosmetic Act, as amended, went into effect in August of 1993 to ensure that patients who receive certain medical devices can be notified if problems occur with such devices. In the event that I receive one of the devices which the FDA has labeled for tracking, I agree that Facility has the right to report any and all information in its possession which will assist the FDA in tracking the device, including, but not limited to medical information, name, telephone number, address, and social security number. In the event that I do not agree to this provision, it shall be deemed that I have refused to allow the medical device to be tracked and reported to the FDA.

CANSLER, GEORGE
DOB: [REDACTED] Male
MRN: [REDACTED] HAR: [REDACTED]
Hunter, Thomas, Md
ADMIT: 6/6/2018 0840 E



3014/VH-025

VH-025 General Consent for Admission (page 1 of 2) | Rev 2/16

Cansler, George
MRN: [REDACTED]
SSN: xxx-xx [REDACTED]

EXHIBIT A

Cansler, George
MRN: [REDACTED] DOB: [REDACTED], Sex: M
Acct #: [REDACTED]
Adm: 6/6/2018, D/C: 6/6/2018

06/06/2018 - ED in Emergency Department (continued)


Documents (continued)

BA-Consent Received - Scan on 6/6/2018: BA-Consent Received

Scan (below)

Please check the box to the left of the appropriate Vidant Health location:

<input type="checkbox"/> East Carolina Endoscopy Center	<input type="checkbox"/> Vidant Bertie Hospital	<input type="checkbox"/> Vidant Home Health & Hospice	<input type="checkbox"/> Vidant SurgiCenter
<input type="checkbox"/> Leo W. Jenkins Cancer Center	<input type="checkbox"/> Vidant Chowan Hospital	<input type="checkbox"/> Vidant Medical Center	<input type="checkbox"/> Other _____
<input type="checkbox"/> The Outer Banks Hospital	<input type="checkbox"/> Vidant Duplin Hospital	<input type="checkbox"/> Vidant Medical Group	
<input type="checkbox"/> Vidant Beaufort Hospital	<input type="checkbox"/> Vidant Edgecombe Hospital	<input type="checkbox"/> Vidant Roanoke-Chowan Hospital	



RELIGIOUS INFORMATION (IF ADMISSION TO THE HOSPITAL): For a person admitted to the hospital, Vidant Health may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient's general condition, and the patient's religious affiliation. If you prefer to have your information removed from this list, please initial here _____.

TEXT MESSAGING: By signing this consent form, I authorize Vidant Health, through its vendor texting service, to contact me by SMS text message to serve me better. Texting may include timely reminders about needed doctor visits or Mychart information. If you do not want to get these text messages, please initial here _____.

WIRELESS TELEPHONE NUMBER: Vidant Health, medical staff members, clinical staff, agents, and personnel may contact me by telephone at any number contained in my records, including wireless telephone numbers, for the purpose of servicing my account and collecting amount due. Methods of contact may include pre-recorded or artificial voice messages and the use of automatic dialing services. If you do not want to receive communication through your wireless telephone, please initial here _____.

PHOTOGRAPHS/VIDEO: I give permission to Vidant Health and Medical Staff Members (including agents and contractors) to take photographs or make videos or drawing of me for permissible treatment, payment, or health care operations purposes (may include quality assessment, patient identity, education, and training) as long as consistent with policies and laws that protect my rights. If you do not want to participate in photographs/videos/drawings, please initial:

Photograph _____ Video _____ Drawings _____

DO NOT BILL INSURANCE: I understand that if I have paid entirely out-of-pocket (pay on my own without any insurance) for this medical visit that I may ask not to share related information about the visit with my health insurer by completing a Patient Request for Restriction form. By initialing below, I am asking Vidant Health not to share information about my visit with my health insurer, and that I am agreeing that I will pay all expenses related to this visit within fifteen (15) days of discharge. I understand and agree that if I fail to pay all related charges within 15 days, that Vidant Health may share my information with my health insurer. If you agree to the above and do not wish to bill your insurance, please initial here _____.

DO NOT SURVEY: I understand that as a part of the Vidant Health's performance improvement activities, a survey vendor may contact me to ask about my experience, at which time I may decline to answer questions. If you do not want to be contacted by the survey vendor, please initial here _____.

HEALTH INFORMATION EXCHANGE: Vidant Health/Medical Staff Members uses an electronic Health Information Exchange (HIE). This exchange provides a fast, secure, and reliable way to provide health information to providers. I understand my electronic health records may be shared with other providers who are involved in my care. I understand a provider may request and receive my health information using other methods permitted by law, such as fax or mail. If you do not want your electronic health information shared electronically, please initial here _____.

I have read this information and received a copy. I understand the information. I am the patient or I am authorized to act on behalf of the patient, and to sign this document verifying my authorization/consent to the above stated information and terms. I understand that I may revoke this Authorization/Consent by providing written notice to Vidant Health, except to the extent actions taken in reliance on this Authorization/Consent. This Authorization/Consent is effective one year from date signed; however, will not expire for service or claims processing for admissions or visits occurring while it was in effect.

Note: If the services provided are recurrent therapeutic series (rehab/chemo), you will only need to sign one consent form to cover all the recurrent services provided within 90 days from the date of your signature.

Patient: George B Cansler 6/6/2018 8:59 AM
Signature of Patient Date Time
George B Cansler
Print Name of Patient

Representative: _____ _____ _____
Signature of person signing on behalf of Patient Date Time

Print Name of person signing on behalf of Patient State why patient can not sign for him/herself

Guarantor: (person or entity that agrees to be responsible for payment) By signing below as guarantor [does not apply to the patient, spouse (when medical care is necessary), or parents of a minor child], I hereby agree to pay all charges of Facility that are not covered or paid within a reasonable time by any medical insurance/coverage, whether or not I am otherwise legally obligated to pay.

Witness: Candace Shroy 6/6/18 8:59 AM
Signature of Witness Date Time
CANSLER, GEORGE Male
DOB: [REDACTED] HAR: [REDACTED]
MRN: [REDACTED] Hunter, Thomas, Md
ADMIT: 6/6/2018 0840 E

VH-025 General Consent for Admission (page 2 of 2) | Rev 2/16



Cansler, George
MRN: [REDACTED]
SSN: xxx-xx [REDACTED]

0507001985

IN THE GENERAL COURT OF JUSTICE

STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
05-CVS- 001985

DENIECE SHELTON, individually)
And on behalf of a class of all persons similarly)
situated,)

Plaintiff,)

vs.)

DUKE UNIVERSITY HEALTH SYSTEM, INC.)
d/b/a RALEIGH COMMUNITY HOSPITAL,)
d/b/a DUKE HEALTH RALEIGH HOSPITAL,)
d/b/a DUKE UNIVERSITY HOSPITAL,)
d/b/a DUKE UNIVERSITY MEDICAL CENTER,)
AND d/b/a DURHAM REGIONAL HOSPITAL)

Defendants.)

**COMPLAINT
FOR INDIVIDUAL AND
CLASS RELIEF
(Jury Trial Requested)**

CLAIM FOR INDIVIDUAL AND CLASS RELIEF

Plaintiff Deniece Shelton brings this action against Duke University Health System, Inc. ("Duke Health System") and Duke Health System d/b/a Raleigh Community Hospital, Duke Health Raleigh Hospital, Duke University Hospital, Duke University Medical Center and Durham Regional Hospital (collectively "Duke Hospitals"), on behalf of herself and a proposed class of similarly situated persons ("Class Members"), and alleges as follows:

NATURE OF THE ACTION

1. Plaintiff brings this action pursuant to Rule 23 of the North Carolina Rules of Civil Procedure, on behalf of herself and as a representative of similarly situated uninsured and/or underinsured individuals (referred to collectively as

LR046652 DOC

EXHIBIT B

“the uninsured”) who were treated or whose dependant was treated at any of the Duke Hospitals or any of the other hospitals owned and/or managed by Duke Health System in the State of North Carolina during the pertinent times. These uninsured patients are primarily working class individuals who do not qualify for Medicaid, Medicare or charity care, but cannot afford private health insurance and/or cannot obtain health insurance through their employers and/or have health insurance that does not adequately insure them. Because of their insurance status, Plaintiff and Class Members fell victim to an unconscionable and predatory two-tier scheme created by Duke Health System with regard to their charges and collections. Under that scheme, Duke Health System structured dramatically different charges for identical health care services. Specifically, Duke Health System developed and implemented a scheme under which its charges for identical services are: (1) significantly lower for patients covered by health insurance or government-funded health care programs; and (2) significantly higher for patients not fully covered by health insurance or by government-funded health care programs. This scheme allowed Duke Health System, through the Duke Hospitals, to assess Plaintiff and Class Members rates that were several multiples over rates charged to patients covered by health insurance or government programs. These rates were generally many times the actual cost of providing care. By forcing this scheme upon Plaintiff and Class Members without their knowledge, Duke Health System breached its contractual duty to charge reasonable rates for services and materials, breached its duty of good faith and fair dealing, violated the North Carolina Unfair and Deceptive Trade Practices Act, N.C. Gen. Stat. § 75-1.1 *et seq.*, and/or unjustly enriched itself at the expense of the Plaintiff and Class Members.

2. Plaintiff does not allege that there was any medical malpractice or negligence in the professional medical services provided to her or to the class. Plaintiff's claim herein does not relate to improper medical services but, rather, improper billing, charging and collections practices. Plaintiff does not allege a claim herein regarding the quality of the medical care afforded to her, but rather, the improper, unconscionable and unfair charging practices of the Duke Health System.

3. Plaintiff and Class Members do not include those who are fully covered by insurance through either a government programs or private health care plan. Instead, the class includes those who do not qualify for such programs, do not have health insurance, or have health insurance that does not fully insure them for all charges and are required to pay unconscionable rates for services received at Duke Health System and the Duke Hospitals in North Carolina. While Plaintiff and Class Members are in the most economically vulnerable position with regard to medical charges, *i.e.*, they have the least ability to pay, nonetheless, Duke Health System has charged them rates far in excess of those charged to patients covered by private health insurance or government insurance programs for the same services.

4. Duke Health System hides its scheme behind a veil of secrecy. Duke Health System and the Duke Hospitals never publish prices charged to the uninsured for services or materials. Instead, the Duke Hospitals treat their price list, sometimes referred to as the "Charge Master," as a closely-guarded secret. In fact, the uninsured do not know the prices the hospital will charge until they receive a bill.

5. Duke Health System and the Duke Hospitals facilitate their overcharges to the uninsured by using adhesive "boiler plate" form contracts. The

standard contracts that Duke Health System and the Duke Hospitals require patients to sign, as a condition of hospital admission, bind the patient to pay the undefined charges levied by Duke Health System and the Duke Hospitals. Since the actual price term is not disclosed, the patient has no choice about any charges Duke Health System might assess, but must rely on the hospital's good faith in charging reasonable fees. Unfortunately, Duke Health System and the Duke Hospitals betray the trust placed in them by the uninsured who are charged unreasonably high rates for services.

6. The rates charged by Duke Health System and the Duke Hospitals vary depending on the particular patient's insurance status. In general, Duke Health System and the Duke Hospitals separate patients into four rate categories: (1) Patients covered by government health programs are charged rates determined by statutory formulas based on the hospital's costs; (2) Patients covered by private health insurance are charged rates for services negotiated by their insurance providers; (3) Patients who are indigent and given charity care at no cost; and (4) Uninsured "self-pay" patients are charged the hospital's highest rates based on undisclosed Charge Master prices.

7. Duke Health System and the Duke Hospitals do not negotiate rates with the uninsured. As a result, the uninsured are unknowingly charged rates for services designed to make up for the rates charged to other categories of patients at lower profit margins. In effect, Duke Health System and the Duke Hospitals subsidize the patient care provided to other patients by overcharging the uninsured. Upon information and belief, Duke Health System has negotiated uniform special agreements with large insurance companies that effectively slash the charges to the insurance companies while maintaining higher charges to the uninsured.

8. The decision by Duke Health System and the Duke Hospitals to charge the uninsured inflated prices is not supported by any rational pricing analysis. Instead, the rates charged the uninsured are the result of Duke Health System's policy of establishing inflated Charge Master prices and refusing to discount prices to those who have no ability to negotiate. By establishing such high Charge Master prices, Duke Health System and the Duke Hospitals are able to maximize revenues received from patients covered by government and private health insurance.

9. Like all hospitals, Duke Health System and the Duke Hospitals receive reimbursements for care given to patients covered by Medicare. In order to determine the rate of Medicare reimbursement, each hospital must first determine its "Cost to Charge Ratio" (the "CCR"). A hospital's CCR is its costs over its charges as reported to the Center for Medicare and Medicaid Services. For instance, if hospital charges listed on its Charge Master are 100 and its costs are 50, a hospital's CCR is .50. The lower the CCR, the larger the gap between the Charge Master prices paid by the uninsured and the discounted prices paid by Medicare patients. The CCR also gives a fair estimate of the gap between rates paid by the uninsured and those paid by private insurance patients who rarely pay more than 25% more than the Medicare reimbursement rate.

10. By establishing high Charge Master prices, Duke Health System and the Duke Hospitals are able to increase revenues received through Medicare outlier payments. These outlier payments are additional Medicare payments made to a hospital when its gross (Charge Master) charges, adjusted by the hospital's CCR, exceed thresholds set by the government for certain groups of services. These diagnosis driven groupings are referred to as Diagnosis Related Groups ("DRGs"). When a hospital's

charges for certain DRGs exceed the established thresholds, the hospital receives outlier payments. This means that by raising the Charge Master prices charged to the uninsured, a hospital is able to increase its Medicare revenues without any actual increase in cost or services.

11. As described above, in their attempts to maximize revenues generated from government and private insurance providers, hospitals establish and impose unreasonable high Charge Master prices and then refuse to discount those prices to the one group that has the least ability to pay – the uninsured.

12. In addition to billing the uninsured at exorbitantly high rates, Duke Health System and the Duke Hospitals often subject Class Members to humiliating collection efforts when the Class Members have difficulty paying Duke Health System's unconscionable charges. In attempting to collect bills sent to the uninsured, Duke Health System sometimes resorts to tactics such as placing liens on patients' homes, seizing bank accounts, destroying patients' credit histories and other such onerous tactics.

13. The hospital industry agrees that the systematic overcharging of the uninsured is one of the most serious problems facing the industry today, but few hospitals have taken steps to rectify the problem. As a justification for this rampant discriminatory pricing practice, industry officials have argued that Medicare rules and regulations prohibit hospitals from offering discounts to the uninsured. Tommy Thompson, Secretary of Health and Human Services, has publicly refuted this assertion. In a February, 2004 letter to the American Hospital Association, Secretary Thompson stated that "[n]othing in the Medicare program rules or regulations prohibit[s] [hospitals from offering] discounts."

JURISDICTION AND VENUE

14. Plaintiff brings this action pursuant to the common law of breach of contract, unjust enrichment, and Chapter 75 to recover damages, as well as interest, costs and attorney fees for Duke Health System's wrongful conduct as set forth herein. Jurisdiction over this class action is also proper because Duke Health System's activities giving rise to the instant claims occurred in North Carolina. Duke Health System operates, conducts, engages in, and/or carries on business or business ventures in the State of North Carolina. Personal jurisdiction is proper pursuant to N.C. Gen. Stat. § 1-75.4.

15. Venue is proper in Wake County.

THE PARTIES

16. Plaintiff, Deniece Shelton, is a resident of Raleigh, Wake County, North Carolina and has been so located at all relevant times. Plaintiff is a victim of the practices complained of in this action, all of which occurred in North Carolina. The vast majority of potential Class Members are residents of North Carolina.

17. Duke Health System is a Non-Profit Corporation organized under the laws of the State of North Carolina, with its corporate headquarters in Durham, Wake County, North Carolina, doing business in our State and which may be served with process via its registered agent, David B. Adcock, at 2400 Pratt Street, Suite 4000, Durham, North Carolina 27710.

18. Duke Health System owns and/or operates the Duke Hospitals and various other hospitals and/or medical providers. Upon information and belief, the system-wide policies and practices at issue in this complaint emanated from, and were set

by, Duke Health System. Duke Health System's corporate offices are located in Durham, Wake County, North Carolina.

FACTUAL BACKGROUND

19. On or about July 11, and July 13, 2002, Deniece Shelton was admitted to Raleigh Community Hospital for treatment. Because she did not have health insurance that fully covered her medical expenses, she was responsible for her medical bills.

20. As a condition for her treatment received at Raleigh Community Hospital, Plaintiff was required to execute Raleigh Community Hospital's standard admission forms to agree to pay the charges. Included in those forms was Raleigh Community Hospital's standard Consent and Conditions of Treatment contract in which Ms. Shelton agreed to pay all charges relating to her care that was not paid by any insurance policy (the "Agreement to Pay").

21. The Agreement to Pay executed by Plaintiff is similar in all material respects to the Agreements used by Duke Health System in all of the Duke Hospitals. All members of the Class are parties to Agreements to Pay substantially similar to the Agreement to Pay between Plaintiff and Raleigh Community Hospital.

22. After Ms. Shelton was discharged from Raleigh Community Hospital, she received bills for health care services totaling approximately \$7891.00. At no time prior to receiving these bills was Ms. Shelton advised of the costs Duke Health System or Raleigh Community Hospital would charge for services.

23. The rate at which Ms. Shelton was billed by Duke Health System and Raleigh Community Hospital is exponentially greater than the actual cost of

providing the rendered medical services and an unreasonable multiple of the amount that would have been charged to Ms. Shelton if was fully insured for the medical services.

24. While the Agreement to Pay obligates Ms. Shelton to pay charges for her medical care, neither Duke Health System nor Raleigh Community Hospital ever disclosed the actual charges for the services to be rendered, and Ms. Shelton did not, and could not, have known what those charges would be.

25. Because there was a contract between the parties with an undefined price term, the law implies a reasonable price may be charged. The amount charged by Duke Health System and Raleigh Community Hospital was well beyond reasonable by any measure. The amount was far in excess of what would be billed to a private insurance company for the same services, and far in excess of what Medicare pays for the same services.

26. Alternatively, because the price term in the contract was not stated, no contract was formed. In such a case, the hospital is only permitted to charge the reasonable value of its services, not some multiple thereof.

27. Ms. Shelton has paid in full the amount of medical charges to her by Duke Health System and Raleigh Community Hospital.

28. Ms. Shelton was improperly billed for those charges and paid an amount in excess of reasonable charges.

29. The contract the Plaintiff signed, governing her agreement with Raleigh Community Hospital, is a form agreement that all patients or responsible parties must sign before treatment. Similarly, the collection process is uniform, and the actions taken by Duke Health System and the Duke Hospitals to collect inflated bills are uniform

and mandated by Duke Health System policies and procedures.

CLASS ALLEGATIONS

30. Plaintiff incorporates by reference, as if fully set out herein, paragraphs 1 through 31 above.

31. Plaintiff brings this action on behalf of herself and the class of persons described below pursuant to N.C.R. Civ. P. 23 (the "Class"), subdivided into three subclasses, defined as follows:

Breach of Contract/Unjust Enrichment Subclass:

All of the uninsured patients who received medical treatment from Duke Health System and Duke Hospitals who were charged an inflated and/or undiscounted rate for medical care during the period of three (3) years prior to the commencement of this action.

Unfair and Deceptive Trade Practices Subclass:

All of the uninsured patients who received medical treatment from Duke Health System and Duke Hospitals who were charged an inflated and/or undiscounted rate for medical care during the period of four (4) years prior to the commencement of this action.

Prospective Injunctive Relief Subclass:

All of the uninsured patients who will receive medical treatment from Duke Health System and any Duke Hospital in the future.

Excluded from the Class are Duke Health System, all Duke Hospitals, any officers or directors of Duke Health System and the Duke Hospitals, the legal representatives, heirs, successors, and assigns of Duke Health System and the Duke Hospitals, and any judicial officer assigned to this matter and his or her immediate family.

32. Class Members are so numerous that joinder of all Class Members is impractical and inefficient such that the requirements of N.C.R. Civ. P. 23(a) are met. Plaintiff does not know the exact number of Class Members, but is informed and believes

that thousands of the uninsured have been charged unreasonably high prices by Duke Health System and the Duke Hospitals and qualify as Class Members. Many of the Class Members have also been subjected to unconscionable collection practices by Duke Health System, the Duke Hospitals and their agents. Plaintiff is informed and believes that the identities of the Class Members may be ascertained from the files and records of Duke Health System, the Duke Hospitals and other information sources.

33. There are common questions of law and fact affecting Class Members, including but not limited to:
- (a) Whether Class Members were charged prices by Duke Health System and/or the Duke Hospitals that violated the form contracts between Duke Health System, the Duke Hospitals and Class Members;
 - (b) Whether Class Members were charged prices by Duke Health System and/or the Duke Hospitals that were so high as to be unreasonable and unconscionable;
 - (c) Whether Duke Health System and/or the Duke Hospitals have been unjustly enriched by charging Class Members unreasonably high rates for services and materials and using unconscionable methods to collect those bills;
 - (d) Whether Duke Health System and/or the Duke Hospitals have engaged in unfair and deceptive trade practices by charging Class Members exorbitant undisclosed prices for medical services and materials;
 - (e) Whether the Plaintiff and other Class Members are entitled to restitution of overcharges collected by Duke Health System and/or the Duke Hospitals; and
 - (f) Whether the Court should grant injunctive relief to Class Members to prevent the continuation of the foregoing acts and conduct of Duke Health System and the Duke Hospitals.
34. As the representative plaintiff, Ms. Shelton's claims and

allegations herein are typical of the claims of the Class Members as a whole. Ms. Shelton and Class Members have suffered harm due to the unfair, deceptive and unconscionable pricing and collection practices of Duke Health System and the Duke Hospitals.

35. The representative plaintiff will fairly and adequately protect the interest of the Class Members. The interest of the representative plaintiff is consistent with and not antagonistic to the interest of the Class Members. The representative plaintiff has retained counsel experienced in prosecuting class actions and complex consumer litigation.

36. The prosecution of separate actions by individual Class Members would create a risk that inconsistent or varying adjudications with respect to individual Class Members would establish incompatible standards of conduct for the parties opposing the Class Members and would substantially impair or impede the interest of the other Class Members to protect their interest.

37. Plaintiff is informed and believes that Duke Health System has acted on grounds generally applicable to the Class Members thereby making appropriate final injunctive relief or declaratory relief with respect to the Class Members as a whole.

38. This class action is superior to other available methods for the fair and efficient adjudication of the controversy between the parties. Plaintiff is informed and believes that the interest of Class Members in individually controlling the prosecution of a separate action is low, in that most Class Members would be unable to individually prosecute any action at all. Plaintiff is informed and believes that the amounts at stake for individuals are sufficiently small for most or all Class Members that

separate suits would be impracticable, and most members of the Class Members would not be able to find counsel to represent them. Plaintiff is informed and believes that it is desirable to concentrate all litigation in one forum because it will promote judicial efficiency to resolve the common questions of law and fact in one forum rather than multiple courts.

39. Individualized litigation also presents the potential for inconsistent or contradictory judgments. By contrast, the class action device presents far fewer management difficulties; allows the hearing of claims which might otherwise go unaddressed because of the relative expense of bringing individual lawsuits; and provides the benefits of single adjudication, economies of scale, and comprehensive supervision by a single court.

40. Upon information and belief, the files and records of Duke Health System and the Duke Hospitals contain, in computer readable format, a last known address, other identifying information for Class Members, and information necessary and convenient to identify Class Members, determine their economic damages and prosecute this case expeditiously as a class action.

CAUSES OF ACTION

COUNT I **BREACH OF CONTRACT**

41. Plaintiff incorporates by reference the allegations contained in the preceding paragraphs 1 through 42 above as if fully set forth herein.

42. Ms. Shelton and each Class Member signed a standard form contract containing material terms substantially similar to the contracts used by Duke

Health System and all Duke Hospitals. That contract obligated Ms. Shelton and Class Members to pay Duke Health System and the Duke Hospitals charges for its services.

43. Prior to sending Ms. Shelton and Class Members a bill, Duke Health System never disclosed the rates it intended to charge for services and materials. While there was a contract formed between Ms. Shelton and other Class Members and Duke Health System, it had an undefined price term. Therefore, a price term implied in the contract must be based on the reasonable value of the services and materials provided to Ms. Shelton and other Class Members.

44. The contracts and billing practices used by Duke Health System are substantially similar to the contracts and practices of all Duke Hospitals. Thus all Class Members should have been billed only for the reasonable value of services and materials provided by the Duke Hospitals.

45. By any measure, the prices charged to the Class Members for hospital services were unreasonable and unconscionable. The Charge Master prices established by Duke Health System bear no relationship to the cost of providing hospital services or to what parties who agree on price terms (third party payors) pay as the result of informed, arms-length negotiations. Instead, the prices Duke Health System charged Ms. Shelton and all other Class Members were an unconscionable multiple of the reasonable prices charged to patients fully covered by health insurance.

46. By imposing these unreasonable charges, Duke Health System has breached its contracts with Ms. Shelton and all other Class Members.

47. As a result of Duke Health System's breach of contract, Ms. Shelton and all other Class Members have incurred damages in the amount of the

overcharges levied by Duke Health System. Class Members are entitled to contract damages, injunctive relief and other relief as set forth in the Prayer for Relief below, in excess of \$10,000.00.

COUNT II
UNJUST ENRICHMENT

48. Plaintiff incorporates by reference the allegations contained in the preceding paragraphs 1 through 49 above as if fully set forth herein.

49. In the alternative to Count I herein, the purported agreement between Ms. Shelton and Duke Health System, like the agreements between all Class Members and Duke Health System and the Duke Hospitals, does not contain a defined price term which is necessary to the formation of an enforceable contract. As a result, there is no contract between Class Members and Duke Health System or the Duke Hospitals for medical services.

50. In the absence of an enforceable contract, Duke Health System and the Duke Hospitals are only entitled to receive the reasonable value of the benefit bestowed upon the Class Members.

51. The charges billed by Duke Health System and the Duke Hospitals to the Class Members greatly exceed the reasonable value of the benefit bestowed. As a result, Duke Health System has been unjustly enriched by the overcharges it has levied against Class Members through the improper and/or illegal acts alleged in this complaint.

52. Ms. Shelton and all other Class Members seek the disgorgement of Duke Health System's illicit profits, restitution in the amount of excess charges levied by Duke Health System and other relief as set forth in the Prayer for Relief below, in excess of \$10,000.00.

COUNT III
UNFAIR AND DECEPTIVE TRADE PRACTICES

53. Plaintiff incorporates by reference the allegations contained in the preceding paragraphs 1 through 54 above as if fully set forth herein.

54. This is a claim pursuant to the Unfair and Deceptive Trade Practices Act, N.C. Gen. Stat. § 75-1.1 *et seq.* This claim relates solely to the charging and collection of hospital bills, and Plaintiff does not herein allege a claim subject to the “professional services” exemption found at N.C. Gen. Stat. § 75-1.1(b). Plaintiff does not allege that there was any medical malpractice or negligence in the professional medical services provided to her or to any Class Member. Plaintiff’s claim herein does not relate to improper medical services but, rather, improper billing practices. Plaintiff does not allege a claim herein regarding the quality of the medical care afforded to her, but rather, the improper, wrongful and deceptive billing practices of Duke Health System.

55. In billing undisclosed and unconscionable amounts for patient services, Duke Health System engaged in conduct in and affecting commerce.

56. During the pertinent times, Duke Health System engaged in conduct that was unfair and had the capacity or tendency to deceive, including without limitation:

- a. failing to disclose to Plaintiff and Class Members that they were being billed and charged much higher amounts than fully insured patients;
- b. charging Class Members unconscionable rates for medical services and materials;
- c. instigating oppressive and humiliating collection practices and lawsuits against uninsured patients; and

d. other acts or omissions as yet to be discovered.

57. As a direct and proximate result of Duke Health System's unfair and deceptive trade practices, Ms. Shelton and Class Members suffered actual damages in the form of excessive billing charges.

58. Plaintiff and the class are entitled to entry of an order awarding actual damages in excess of \$10,000, as well as treble damages and attorneys' fees pursuant to Chapter 75 as a result of Duke Health System's unfair and deceptive practices.

COUNT IV
DECLARATORY AND INJUNCTIVE RELIEF

59. Plaintiff incorporates by reference the allegations contained in the preceding paragraphs 1 through 60 above as if fully set forth herein.

60. As a result of Duke Health System's discriminatory and unconscionable charging and collection practices as described above, Plaintiff and all Class Members have suffered, and will continue to suffer, severe and irreparable harm and injury.

61. Pursuant to the North Carolina Declaratory Judgment Act, N.C. Gen. Stat. § 1-253 *et seq.*, this Court has the power to declare rights, status and other legal relations, whether or not further relief is claimed. N.C. Gen. Stat. § 1-253. This Court furthermore has power to enter a declaratory judgment determining questions regarding the legal status of parties under any purported contracts or other writings. N.C. Gen. Stat. § 1-254. Further relief may be granted where necessary or proper. N.C. Gen. Stat. § 1-259.

62. Accordingly, Plaintiff and Class Members respectfully ask this

Court to enter a preliminary and/or permanent injunction, ordering Duke Health System to cease and desist its practice of charging Class Members unconscionable prices for medical care, at rates far in excess of rates charged to insured patients, and utilizing abusive and harassing tactics to collect those exorbitant bills.

63. Class Members seek a prospective order from the Court requiring Duke Health System to: (1) cease the charging of unreasonable rates to the uninsured; and (2) to cease its attempts to collect outstanding medical bills beyond what are reasonable charges from Class Members.

PRAYER FOR RELIEF

Based on all the foregoing claims, Plaintiff, on behalf of herself and all Class Members, seeks judgment and relief as follows:

- A. For an order certifying the Class, designating Plaintiff as the class representative and her attorneys as class counsel;
- B. For a liability judgment on each claim against Duke Health System on behalf of the Class;
- C. For compensatory, treble, and all other allowable damages under the causes of action asserted herein all exceeding \$10,000.00;
- D. For an order requiring restitution of overpayments made by Plaintiff and Class Members to Duke Health System and the Duke Hospitals, and disgorgement of the money Duke Health System has improperly collected;
- E. For permanent injunctive relief enjoining Duke Health System from participating in the improper and/or unlawful acts alleged herein;
- F. For trial by jury of all issues so triable;

- G. For reasonable attorneys' fees, costs of court and other expenses;
- H. That this action be consolidated with the concurrently pending District Court Action, No. 04-CVD-3163; and
- H. For such other and further relief as the Court may deem appropriate.

Respectfully submitted, this the 14th day of February, 2005.

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