UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA

GEORGE CANSLER, on his own behalf, and on behalf of a class of those similarly situated,	**Case No. 4:22-CV-14-FL**
Plaintiff,	**JURY DEMAND**
v.	
UNIVERSITY HEALTH SYSTEMS OF EASTERN CAROLINA, INC., EAST CAROLINA HEALTH-CHOWAN, INC., HALIFAX REGIONAL MEDICAL CENTER, INC., ROANOKE VALLEY HEALTH SERVICES, INC., PITT COUNTY MEMORIAL HOSPITAL, INC., DUPLIN GENERAL HOSPITAL, INC., EAST CAROLINA HEALTH-BEAUFORT, INC., EAST CAROLINA HEALTH-BERTIE, INC., EAST CAROLINA HEALTH-HERITAGE, INC., THE OUTER BANKS HOSPITAL, INC., VIDANT MEDICAL GROUP AFFILIATES, LLC, VIDANT MEDICAL GROUP, LLC, VIDANT INTEGRATED CARE, LLC, and FIRSTPOINT COLLECTION RESOURCES, INC.,	
Defendants.	

MEMORANDUM OF LAW IN SUPPORT OF THE VIDANT DEFENDANTS' MOTION TO DISMISS

Pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6), University Health Systems of Eastern Carolina, Inc., East Carolina Health-Chowan, Inc., Halifax Regional Medical Center, Inc., Roanoke Valley Health Services, Inc., Pitt County Memorial Hospital, Inc., Duplin General Hospital, Inc., East Carolina Health-Beaufort, Inc., East Carolina Health-Bertie, Inc., East Carolina Health-Heritage, Inc., The Outer Banks Hospital, Inc., Vidant Medical Group Affiliates,

Inc., Vidant Medical Group, LLC, and Vidant Integrated Care, LLC (the "Vidant Defendants") submit this Memorandum of Law in Support of their Motion to Dismiss Plaintiff George Cansler's ("Cansler") putative class action.[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 medical care from an emergency room in the Vidant Defendants' hospital 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 was able to negotiate such discounted rates on Cansler's and other insureds' behalf using the leverage created by the insurer's large membership. When choosing his insurance policy, Cansler made the decision 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 Vidant Chowan Hospital. 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

[1] By filing this Motion, the Vidant Defendants do not intend to waive any of their affirmative or general defenses. The Vidant Defendants' knowledge of third party involvement in this action is limited at this juncture. To the extent this matter progresses (which it should not), the Vidant Defendants specifically assert 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 the Vidant Defendants should be dismissed under Rule 12(b)(7).

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, Vidant 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).

From the time of treatment to the time it billed for its services, Vidant Chowan complied with all of its contractual obligations to both Cansler and his insurer, including specifically charging Cansler the discounted rate his insurer negotiated on his behalf. Despite having been charged the price his insurer agreed to on his behalf, Cansler's Complaint claims that the CT scan he received was unreasonably expensive.[2] He also claims that Vidant Chowan's alleged failure to disclose the potential costs of his treatment -- again, costs his own 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, in the ultimate attempt to make a mountain out of an (imagined) molehill, Cansler seeks to assert his claims on behalf of every patient who crossed the threshold of any of the Vidant Defendants' emergency departments, 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 were allowed to 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

[2] It is telling that Cansler has not attached his insurance policy to his 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 independent reasons separate and apart from any binding or preclusive effect that policy may have on his claims.

committing an unfair and deceptive act or violating EMTALA. For critical access hospitals in rural counties like Vidant Chowan, which depend upon individuals with commercial insurance to survive, such a combination very well could prove fatal.

Thankfully, the Court need not face those systemic risks in this case because Cansler's claims do not pass muster even under the lenient standards applicable to a motion to dismiss. As set forth below, 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, multiple courts have looked at virtually identical circumstances and concluded that no theory of liability -- be it a UDTPA violation, breach of contract, or other similar theory -- exists. Cansler's North Carolina counsel is well-aware of this jurisprudence, as they previously represented a different plaintiff with substantively identical claims that were dismissed by a North Carolina state court. 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 his attempt to find a different result by switching forums should be rejected. For these reasons, Cansler's claims should be dismissed with prejudice.

II. STATEMENT OF ALLEGED FACTS

The Vidant Defendants operate a nonprofit hospital system comprised of nine hospitals located in Eastern North Carolina. (Complaint ("Compl.") at ¶ 4, Docket Entry 1). While the hospitals comprise a single health system, each hospital is a distinct legal entity. (*Id*. at ¶ 43). Cansler's claims relate to his visit to the emergency room at one of those hospitals -- Defendant East Carolina Health-Chowan, Inc. ("Vidant Chowan") -- on June 6, 2018. (*Id*. at ¶ 67).

Vidant Chowan is a nonprofit hospital located in Cansler's hometown of Edenton, North Carolina. (Compl. at ¶¶ 2, 5, Docket Entry 1). Like most medical facilities, Vidant Chowan maintains a list of its standard charges in a document called the "chargemaster." (*Id*. at ¶ 33). However, the prices listed in the chargemaster are not charged to all (or even most) patients because numerous government and commercial insurance programs negotiate alternative payment terms with Vidant Chowan and the other Vidant Defendants.

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. (Compl. at ¶ 27, Docket Entry 1). 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 ¶ 34). When negotiating allowed amounts, commercial health insurers and hospitals typically agree on pricing for a bundle of services, rather than on a service-by-service basis. (*Id*. at ¶ 28). 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 bundle. (*Id*. at ¶ 28).

Under these bundled service arrangements, the hospital agrees to accept the allowed amount as payment in full for any bundled service provided to a member. (Compl. at ¶¶ 28-29, Docket Entry 1). Once a member has received one or more bundled 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*. at ¶¶ 28-29). The portion of the allowed amount paid by the member is dependent upon the member's agreement with his or her commercial health plan.

During the relevant time period, Cansler had a commercial health insurance policy with Blue Cross. (Compl. at ¶ 63, Docket Entry 1). Vidant 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 Vidant Chowan's chargemaster. (*Id*. at ¶¶ 64-66). 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 ¶ 29).

Cansler arrived at Vidant Chowan's emergency department on June 6, 2018, seeking treatment for an unknown pain. (Compl. at ¶ 67, Docket Entry 1). 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."

(*Id*. at ¶ 72; *see* Consent). Cansler's 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, Vidant Chowan provided Cansler with medical tests and treatment, including a CT scan. (*Id*. at ¶ 71).

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' bundled services agreement with Vidant Chowan, and, further, that Blue Cross had

[3] The Court may consider the Consent without converting this Motion to Dismiss into a motion for summary judgment because the Consent was incorporated by reference into the Complaint, *Feldman v. L. Enf't Assocs. Corp.*, 779 F. Supp. 2d 472, 486, n. 8 (E.D.N.C. 2011) or, alternatively, because Cansler did not attach the Consent to the Complaint despite it being integral to his claims, *In re FAC Realty Sec. Litig.*, 990 F. Supp. 416, 420 (E.D.N.C. 1997).

paid $1,326.11 on his behalf. (Compl. at ¶ 76, Docket Entry 1). The itemized bill Cansler received from Vidant 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 Vidant Chowan, minus the portion Blue Cross paid on Cansler's behalf as part of their separate insurance plan agreement. (*Id*. at ¶ 78).

Although Cansler does not contend that Vidant Chowan's charges violated any agreement with Cansler or Blue Cross, Cansler disputed the bills he received because, in his opinion, the charges were unreasonable. (Compl. at ¶¶ 83-85, Docket Entry 1). 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 ¶¶ 93-103). As such, Cansler's bill was referred to collections, resulting in continued negotiations and attempts to collect the amount due to Vidant Chowan. (*Id*. at ¶¶ 103-113).

Cansler initiated this lawsuit on February 18, 2022. (Compl., Docket Entry 1). In his Complaint, Cansler asserts that the Vidant Defendants violated the UDTPA, and he requests declaratory and injunctive relief related to those alleged violations. (*Id*. at ¶¶ 124-153). Further, Cansler seeks to represent a proposed class encompassing every patient who signed a Consent and received treatment at ***any*** of the Vidant Defendants' emergency rooms over the last four years. (*Id*. at ¶¶ 124-153). In addition to the allegations that do appear in Cansler's Complaint, it is important to recognize what is absent from his Complaint:

- ***First***, while Cansler complains about the costs of his treatment and alleges that the Vidant Defendants have a policy of not disclosing prices when asked, he does ***not*** allege that he personally asked anyone at Vidant Chowan about the cost of treatment before consenting to the services, nor does he contend that that anyone at Vidant Chowan affirmatively refused to provide him with such information.

- ***Second***, Cansler does ***not*** allege that he was charged anything other than the discounted allowed amount that Vidant Chowan agreed to charge Blue Cross'

members when Blue Cross -- on Cansler and its other members' behalf -- entered into a bundled services agreement. Indeed, Cansler does not allege that Vidant Chowan violated any term of that bundled services agreement that was executed on his and other members' behalf.

- ***Third***, Cansler does ***not*** allege that Vidant Chowan violated any term of the Consent that he executed as a condition of his receiving treatment. Instead, he now attempts to claim, without any justification beyond conclusory legal statements, that the Consent is "unenforceable." (Compl. at ¶ 55, Docket Entry 1).

- ***Fourth***, Cansler does ***not*** allege that Blue Cross -- the party that negotiated the bundled services agreement with Vidant 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 from Cansler in exchange for his acceptance of the discounted rates that were negotiated on his behalf.

In other words, Cansler has not alleged that any contract -- whether with Vidant Chowan or Blue Cross -- has been violated, and, instead, appears to confirm that all parties other than Cansler complied with their relevant contractual obligations. Recognizing that there is no viable breach of contract theory (as discussed herein, that theory and the same UDTPA claim asserted by Cansler here was asserted by Cansler's North Carolina counsel in a prior case in North Carolina state court and was summarily dismissed, with the dismissal upheld on appeal), Cansler has attempted to recast his issue with the charges as a UDTPA claim. As set forth below, such a claim is contrary to applicable law and should be dismissed for a number of independent reasons.

Further, even if the Court were to find that Cansler has stated claims against Vidant Chowan, his claims against the other Vidant Defendants still should be dismissed because Cansler lacks Article III standing against those entities. Specifically, the applicable case law is clear that Cansler does not have standing to assert claims against the Vidant Defendants that have no connection to the damages he claims to have sustained.

III. STANDARD OF REVIEW

"To survive a motion to dismiss" under Federal Rule of Civil Procedure 12(b)(6), "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "Factual allegations must be enough to raise a right to relief above the speculative level." *Twombly*, 550 U.S. at 555. "[The] court accepts all well-pled facts as true and construes these facts in the light most favorable to the plaintiff," but does not consider "legal conclusions, elements of a cause of action, . . . bare assertions devoid of further factual enhancement[,] . . . unwarranted inferences, unreasonable conclusions, or arguments." *Nemet Chevrolet, Ltd. v. Consumeraffairs.com, Inc.*, 591 F.3d 250, 255 (4th Cir. 2009) (citations omitted).

A motion to dismiss under Federal Rule of Civil Procedure 12(b)(1), on the other hand, challenges the court's subject matter jurisdiction. The question of standing asks whether litigants are "entitled to have the court decide the merits of the dispute." *Warth v. Seldin*, 422 U.S. 490, 498 (1975). Only if plaintiffs have standing to sue do they present a case or controversy between themselves and the defendants within the meaning of Article III of the Constitution. *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 102 (1998). Standing, therefore, is a fundamental component of a court's subject matter jurisdiction. *Id.*; *Pye v. United States*, 269 F.3d 459, 466 (4th Cir. 2001). As such, defendants may challenge its existence through a motion under Rule 12(b)(1). *Marshall v. Meadows*, 105 F.3d 904, 905 (4th Cir. 1997). Such a motion may either (1) assert that the complaint fails to state facts upon which subject matter jurisdiction may be based, or (2) attack the existence of subject matter jurisdiction in fact, apart from the complaint. *Adams v. Bain*, 697 F.2d 1213, 1219 (4th Cir. 1982). The plaintiff bears the burden of proof in this context. *See Evans v. B.F. Perkins Co.*, 166 F.3d 642, 647 (4th Cir. 1999).

IV. ARGUMENT

A. 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 -- the Vidant Defendants' 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. The Vidant Defendants' 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)).[4] "[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.

[4] *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).

> (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 *Wheeless 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 "professional service." *Id*. As set forth below, both prongs of the inquiry clearly establish that the Vidant Defendants' alleged misconduct falls squarely within the learned profession exemption.

a. *The Vidant Defendants Are Members 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. Gen. Stat.] § 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 the Vidant Defendants, and in particular the hospital where the alleged wrongdoing took place -- Vidant Chowan, are members of a learned profession. The Complaint collectively identifies the Vidant Defendants as hospitals providing medical care to patients, and alleges that Cansler went to Vidant Chowan seeking medical treatment that he then was provided. (*See* Compl. at ¶¶ 3-17, 67, 71, Docket Entry 1). 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. *The Vidant Defendants' Alleged Conduct Sufficiently 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. *Se. 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 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 has already reached this conclusion in the nearly identical case of *Shelton v. Duke University Health System, Inc.*, 633 S.E.2d 113. 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 of the hospital's rates -- including no information about the amount of such rates -- prior to execution of the consent. *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 filed a putative class action asserting claims for, *inter alia*, breach of contract and UDTPA violations. *Id.* at 115. The following allegations supported the UDTPA claims:

> 54. This is a claim pursuant to the Unfair and Deceptive Trade Practices Act, [N.C.G.S. § 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.G.S. § 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 [the defendant-hospital].
>
> 55. In billing undisclosed and unconscionable amounts for patient services, [the defendant] engaged in conduct in and affecting commerce.
>
> 56. During the pertinent times, [the defendant] engaged in conduct that was unfair and had the capacity or tendency to deceive, including without limitation:
>
> a. failing to disclose to [the 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;
> c. instigating oppressive and humiliating collection practices and lawsuits against uninsured patients; and
> d. other acts or omissions as yet to be discovered.

(*See Shelton v. Duke University Health System, Inc.* Complaint at ¶¶ 54-57, attached as Exhibit B).

The trial court in *Shelton* dismissed the UDTPA claim on a motion to dismiss, finding that the alleged wrongdoing came within the learned profession exemption. (*Shelton v. Duke University Health System, Inc.* Trial Court Order at ¶ 8, attached as Exhibit C) (citing *Burgess*, 544 S.E. 2d at 23; *Cameron*, 293 S.E.2d at 920). On appeal, the North Carolina Court of Appeals affirmed the trial court's 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.

As the viability of Cansler's UDTPA claim is a North Carolina state law issue, the Court should consider *Shelton* -- and especially the North Carolina's Supreme Court's denial of discretionary review -- 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)). A federal court may also consider lower court opinions, treatises, and the practices of other states. *Id.* at 657. However, it "should not create or expand [a] [s]tate's public policy." *Id.* (quoting *Time Warner Entm't-Advance/Newhouse P'ship v. Carteret-Craven Elec. Membership Corp.*, 506 F.3d 304, 314 (4th Cir. 2007) (first alteration in original)).

The holding in *Shelton* is on all fours with the facts of this case, and undersigned counsel is unaware of any other North Carolina state court decision indicating that the North Carolina Supreme Court would hold otherwise here. As in *Shelton*, Cansler's claims are driven entirely by Vidant Chown's alleged failure to disclose (without inquiry) the cost of medical services, which were then 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. The Vidant Defendants 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 have repeatedly 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, *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 Vidant 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." (Compl. ¶ 72, Docket Entry 1). And, while Cansler asserts the legal conclusion that the Consent is unenforceable because it does not contain specific price terms[5], numerous cases have held that substantively identical hospital consent forms, including those without specific price 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 v. The Charlotte-Mecklenburg Hosp. Auth.*, 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 containing assignment of benefits signed at emergency room was valid and enforceable on its face).

Indeed, "[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*, 2021 WL 2561505, at *8. This is particularly true where, as here, ***there is no allegation that the patient asked any questions about what they would be charged***. *See id*. at *9; *Shelton*, 633 S.E.2d at 123-25. Courts have so held because of the particular circumstances under which people agree to medical care:

> 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

[5] 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). Thus, Cansler's conclusory statement that the Consent is unenforceable need not be accepted by the Court.

> treatment and the costs therefore, or that patients cannot refuse treatment for reasons of cost.

Shelton, 633 S.E.2d at 125. Based on this reasoning, the allegations in Cansler's Complaint make clear that the Consent that Cansler signed is a valid contract, on its face.[6]

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 the Vidant Defendants' chargemaster rate. (*See* Compl. ¶¶ 65-66, 73, Docket Entry 1). 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 the Vidant Defendants attempted to collect

[6] At best, Cansler's allegations regarding the open price term would indicate the contract was merely ambiguous, rather than unenforceable. However, this Court specifically has held that a plaintiff's mere assertion that he or she detrimentally relied upon a misleadingly ambiguous contract provision is insufficient to sustain an action under the UDTPA. (*See UBA, LLC v. Thyssenkrupp Elevator Corporation*, No. 5:15-CV-477-FL, United States District Court for the Eastern District of North Carolina, July 6 Order at 6, attached as Exhibit D (citing *PCS Phosphate Co.*, 559 F.3d at 224) ("[P]laintiff contends that the words of the [contract] created the capacity to mislead and did mislead plaintiff as to the scope of defendant's contractual obligations . . . However, this argument must fail where it elevates every dispute involving an ambiguous contract to the level of a UDTPA violation.")). Thus, Cansler cannot "rest [his] UDTPA claim upon solely the existence of an ambiguous contract." *See id*.

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 the Vidant Defendants should be dismissed.

b. ***To the Extent Cansler's UDTPA Claims Are Premised on a Theory of Fraudulent Concealment, the 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 the Vidant Defendants 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 the Vidant Defendants allegedly failed to disclose the costs of his treatment prior to providing such treatment. This allegation is not sufficient to properly plead fraudulent concealment, however, because Cansler has not adequately pled that the Vidant Defendants owed him a duty to make such a 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 upon presenting to 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 thus held that the plaintiffs' breach of fiduciary duty and constructive fraud claims failed as a matter of law. *Id*. at *14, n.16.

Similarly, in *Gleason v. The Charlotte-Mecklenberg Hosp. Authority*, 2021 WL 2561505, at *3, *9-11, the plaintiff claimed that the defendant hospital breached its fiduciary duty to him by failing to disclose certain charges. The plaintiff signed a consent confirming his agreement 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 v. St. Mary Hosp.*, 530 F.3d 255, 268-69 (3d Cir. 2008); *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*.

Here, any purported UDTPA claim based on fraudulent concealment must fail because the Vidant Defendants 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 the Vidant Defendants' services before signing. Under the above, the Consent was "akin to a form for insurance information or for payment for medication treatment, [so the Vidant Defendants] . . . 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.[7]

In fact, the alleged failure to disclose the costs of emergency room services is entirely consistent with Vidant Chowan's statutory obligations under EMTALA. *See* 42 U.S.C. § 1395dd. EMTALA imposes an obligation on Medicare participating hospitals, like Vidant 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 the Vidant Defendants 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"). In a case like this one, where Cansler has not alleged that he asked any questions about the costs of the treatment that he was receiving, it would have been incumbent upon the Vidant Defendants ***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).

[7] Nor has Cansler alleged that a duty existed because the Vidant Defendants have "taken affirmative steps to conceal material facts from [Cansler]" or that the Vidant Defendants have "'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 the Vidant Defendants how much his treatment would cost and was affirmatively denied such information. Nor is there any allegation that the Vidant Defendants knew that Cansler supposedly was unaware of the costs, or that they affirmatively concealed these facts with such knowledge.

For these reasons, Cansler has failed to plead that the Vidant Defendants 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, and such claims should be dismissed. *See Breeden*, 171 F.R.D. at 196.

3. The Vidant Defendants' Alleged Conduct Was Not the Proximate Cause of Cansler's Alleged Injuries Because Cansler Did Not Rely Upon the Vidant Defendants' Alleged Conduct.

Finally, Cansler has failed to plead the third essential element of a UDTPA claim -- 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*, 869 S.E.2d 34, 43 (N.C. App. 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 the Vidant Defendants' alleged failure to disclose costs or the alleged corporate policy of refusing to disclose costs proximately caused ***his*** injuries. Rather, Cansler's allegations make clear that he did not actually rely upon such non-disclosure or the alleged policy at all. Indeed, 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, the Vidant Defendants were 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," the Vidant Defendants' 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 actually rely upon the Vidants Defendants' lack of disclosure or their 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, and they should be dismissed as a matter of law.

4. Because Cansler Has Failed to Adequately Allege any of the Elements of His UDTPA Claim, His Claims for Declaratory Judgment and Injunctive Relief Should be Dismissed.

Cansler's requests for declaratory judgment and injunctive relief against the Vidant Defendants 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.

B. Cansler Does Not Have Standing to Pursue a Class Action Against Any of the Vidant Defendants Other Than Vidant Chowan.

To satisfy the "irreducible constitutional minimum" of standing, *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560 (1992), plaintiffs must establish three elements: (1) injury-in-fact; (2) traceability; and (3) redressability. 504 U.S. at 560-61; *Friends of the Earth, Inc. v. Gaston Copper Recycling Corp.,* 204 F.3d 149, 154 (4th Cir. 2000). To satisfy the injury-in-fact requirement, the plaintiff must have suffered an invasion of a legally protected interest that is concrete and particularized, as well as actual or imminent. *Lujan,* 504 U.S. at 560; *Friends of the Earth, Inc.,* 204 F.3d at 154. A plaintiff must demonstrate that the injury was caused by the challenged conduct of the defendant, and not by the independent action of some third party. *Lujan,* 504 U.S. at 560; *Friends of the Earth, Inc.,* 204 F.3d at 154. Finally, a plaintiff must show that it is likely, and not merely speculative, that a favorable decision will remedy the injury. *Lujan,* 504 U.S. at 561; *Friends of the Earth, Inc.,* 204 F.3d at 154.

Standing is a threshold jurisdictional requirement that courts must address before making any determination as to class representation, and standing must be met "at the time the complaint is filed . . ." *See Cent. Wesleyan College v. W.R. Grace & Co.*, 6 F.3d 177, 188 (4th Cir. 1993). Moreover, "a plaintiff must demonstrate standing for each claim he seeks to press and for each form of relief that is sought." *Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734 (2008). "That a suit may be a class action . . . adds nothing to the question of standing, for even named plaintiffs who represent a class 'must allege and show that they personally have been injured, not that injury has been suffered by other, unidentified members of the class to which they belong and which they purport to represent.'" *Lewis v. Casey*, 518 U.S. 343, 357 (1996) (citations omitted).

In a multi-defendant class action, "it is essential that named class representatives demonstrate standing through a 'requisite case or controversy between themselves personally and [each defendant].'" *Cent. Wesleyan Coll.*, 6 F.3d at 188 (quoting *Blum v. Yaretsky*, 457 U.S. 991, 1001 n.13 (1982)); *see also Dash v. FirstPlus Home Loan Owner Tr. 1996-2*, 248 F. Supp. 2d 489, 504 (M.D.N.C. 2003); 1 William B. Rubinstein, Newberg on Class Actions § 2:5 (5th ed. 2021). Standing cannot be acquired through the back door of a class action. *Allee v. Medrano*, 416 U.S. 802, 829 (1974) (Burger, J., concurring in part and dissenting in part); *see also Dash*, 248 F. Supp. 2d at 503 (class action plaintiffs "may not use the procedural device of a class action to bootstrap [themselves] into standing [they] lack[]." (quoting *Weiner v. Bank of King of Prussia,* 358 F. Supp. 684, 694 (E.D. Pa. 1973))). "If plaintiffs lack standing ***against any defendant***, the court must dismiss plaintiffs' claims against it." *Bush v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 124 F. Supp. 3d 642, 656 (E.D.N.C. 2015) (Flanagan, J.) (emphasis added).

Cansler lacks individual standing against the majority of the Vidant Defendants he sued. Cansler asserts UDTPA and declaratory judgment claims against thirteen different Vidant entities,

but he does not and cannot allege that all of the Vidant Defendants caused the harm that he allegedly suffered. While he asserts claims against eight other Vidant hospitals and four other Vidant entities, the wrongdoing he alleges -- the failure to disclose medical costs -- only took place during his visit to the emergency room at Vidant Chowan. Thus, any viable claim (there is not one) would pertain only to alleged wrongdoing by Vidant Chowan. There is no question that the Court lacks subject matter jurisdiction as to the Vidant Defendants as a whole because Cansler cannot demonstrate that he suffered an injury at the hands of each and every Vidant entity he sued. *See Herlihy v. Ply-Gem Indus., Inc.*, 752 F. Supp. 1282, 1291 (D. Md. 1990). Dismissal of his claims against the other Vidant Defendants is warranted.

Garrison v. RevClaims, LLC, 247 F. Supp. 3d 987 (E.D. Ark. 2017), is instructive. There, a patient brought a putative class action against several Arkansas hospitals and the collection agency contracted to perform the hospitals' patient billing, asserting various state law claims, including for violation of the Arkansas Deceptive Trade Practices Act. *Id.* at 988. The defendants moved to dismiss, and the hospitals from which the lead plaintiff did not receive treatment argued that she lacked standing to sue them because she was not injured by their conduct. *Id.* at 989. The court agreed, and dismissed the claims against those defendants because the plaintiff could not show that her "injury is traceable to any conduct of the moving defendants." *Id.* at 991. Cansler similarly lacks standing as to the Vidant Defendants other than Vidant Chowan because his alleged injuries are not traceable to those Defendants.

Courts in the Fourth Circuit and in other jurisdictions have reached the same conclusion outside of the patient billing context. *See Dash*, 248 F. Supp. 2d at 504 ("In the instant matter, the allegations in the Complaint are insufficient to confer standing against Defendants because Plaintiffs do not allege that Defendants hold their loan."); *Crumbling v. Miyabi Murrells Inlet,*

LLC, 192 F. Supp. 3d 640, 646 (D.S.C. 2016) ("Here, because each named plaintiff did not work for each defendant, Defendants contend that the named plaintiffs cannot trace their injuries to those defendants for whom they did not work. Because the named plaintiffs and opt-ins only worked for one Miyabi restaurant location, Defendants assert that Plaintiffs cannot trace their injuries to any of the other Miyabi restaurant entities. The Court agrees."); *Chambers v. King Buick GMC, LLC*, 43 F. Supp. 3d 575, 610 (D. Md. 2014) (class action plaintiff did not have standing to sue used car dealerships from which the plaintiff did not purchase a vehicle); *Lieberson v. Johnson & Johnson Consumer Co., Inc.,* 865 F. Supp. 2d 529, 537 (D.N.J. 2011) (plaintiff lacked standing to pursue putative class action claims of consumer fraud against a baby bath product manufacturer as to any products the named plaintiff did not allege she used or purchased).

Some courts frame the standing question in multi-defendant class actions as an issue of injury in fact, while others frame it as an issue of traceability and redressability. *Compare Bailey v. Atl. Auto. Corp.*, 992 F. Supp. 2d 560, 566 (D. Md. 2014) ("When a named plaintiff in a putative class action seeks to pursue claims against defendants with whom the named plaintiff did not have direct dealings, significant questions arise as to whether the plaintiff can establish an injury in fact with respect to those defendants."), *with Crumbling*, 192 F. Supp. 3d at 646 (holding that because each named plaintiff did not work for each defendant, the named plaintiffs could not trace their injuries to those defendants for whom they did not work); *Miller v. Pac. Shore Funding*, 224 F. Supp. 2d 977, 995 (D. Md. 2002), *aff'd*, 92 Fed. Appx. 933 (4th Cir. 2004) ("Even if the Millers and Mr. Gilbert-Iheme could establish sufficient injury in fact, they fail to satisfy the latter two requirements, traceability and redressability. Fundamentally, none of the plaintiffs alleges any contractual relationship whatsoever with Amaximis, Homeq, Banc One, or Bankers Trust."). Regardless of how the Court frames the dispute here, the result is the same -- absent a Vidant

Defendant's failure to disclose medical costs, Cansler cannot possibly show that his alleged injuries are traceable to the conduct of the Vidant Defendants as a whole, nor can he show that a judicial ruling in his favor as to the services he received at Vidant Chowan likely would redress his alleged injuries as to the other Vidant Defendants.

Even though Cansler alleges that other Vidant hospitals and entities engage in similar billing practices, he does not have standing to sue those Defendants because they have nothing to do with the injury he allegedly suffered. A class action may only challenge conduct that injured the named plaintiffs -- named plaintiffs lack standing to challenge ***conduct that did not cause*** their injury. *Blum*, 457 U.S. at 999; *see also Herlihy,* 752 F. Supp. at 1291. There is no dispute that the conduct of the Vidant hospitals and entities other than Vidant Chowan did not cause his injury. Allowing Cansler to pursue claims against the Vidant Defendants would upend the Article III standing requirement. *Miller,* 224 F. Supp. 2d at 996. Cansler does not have standing to challenge theoretical injuries other individuals may have suffered at other facilities, and his claims against the Vidant Defendants other than Vidant Chowan must be dismissed.

V. CONCLUSION

For the foregoing reasons, the Vidant Defendants respectfully request that the Court grant their Motion and dismiss Cansler's claims with prejudice.

Respectfully submitted,

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Counsel for Defendants University Health Systems of Eastern Carolina, Inc.; East Carolina Health-Chowan, Inc.; Halifax Regional Medical Center, Inc.; Roanoke Valley Health Services, Inc.; Pitt County Memorial Hospital, Inc.; Duplin General Hospital, Inc.; East Carolina Health-Beaufort, Inc.; East Carolina Health-Bertie, Inc.; East Carolina Health-Heritage, Inc.; The Outer Banks Hospital, Inc.; Vidant Medical Group Affiliates, Inc.; Vidant Medical Group, LLC; and Vidant Integrated Care, LLC

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 May 20, 2022.

/s/ Erin Palmer Polly

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] [redacted] Male
MRN [redacted] HAR: [redacted]
Hunter, Thomas, Md
ADMIT: 6/6/2018 0840 E

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

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EXHIBIT A

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:

☐ East Carolina Endoscopy Center	☐ Vidant Bertie Hospital	☐ Vidant Home Health & Hospice	☐ Vidant SurgiCenter
☐ Leo W. Jenkins Cancer Center	☐ Vidant Chowan Hospital	☐ Vidant Medical Center	☐ Other _____
☐ The Outer Banks Hospital	☐ Vidant Duplin Hospital	☐ Vidant Medical Group	
☐ Vidant Beaufort Hospital	☐ Vidant Edgecombe Hospital	☐ Vidant Roanoke-Chowan Hospital	

VIDANT HEALTH™

RELIGIOUS INFORMATION (IF ADMITTED 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 — *Signature of Patient*; 6/6/2018 — *Date*; 8:59 AM — *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.

_____ *Signature of Guarantor*; _____ *Print name of Guarantor*

Witness: _____ *Signature of Witness*; 6/6/18 8:59 AM — *Date* *Time*

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CANSLER,GEORGE [redacted] 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

05CV001985

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

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 hers 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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STATE OF NORTH CAROLINA

WAKE COUNTY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
05-CVS-001985

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

Plaintiff,

v

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.

MEMORANDUM ORDER ALLOWING DEFENDANT'S MOTION TO DISMISS

This cause came on to be heard by the undersigned Superior Court Judge presiding at the June 30, 2005 civil session of the Wake County General Court of Justice, Superior Court Division, upon the motion of defendant Duke University Health System, Inc., alleged to be doing business under certain hospital or medical center names ("Duke" or "defendant"), to dismiss the complaint of plaintiff, Deniece Shelton ("Ms. Shelton" or "plaintiff") pursuant to Rule 12(b)(6) of the North Carolina Rules of Civil Procedure;

And the Court having reviewed and considered the pleadings and the briefs submitted by the parties as well as the argument of counsel at the June 30, 2005 hearing,

It appears to the Court that Duke's motion should be allowed;

NOW THEREFORE, the Court rules as follows:

EXHIBIT C

1. A motion to dismiss under N.C R. Civ. P. 12(b)(6) tests the legal sufficiency of the complaint by determining "whether, as a matter of law, the allegations of the complaint, treated as true, are sufficient to state a claim upon which relief can be granted under some legal theory." *Lynn v. Overlook Dev*, 328 N.C 689, 692, 403 S.E.2d 469, 471 (1991). Dismissal of a complaint under Rule 12(b)(6) is proper where the complaint on its face reveals that no law supports plaintiff's claim, facts sufficient to make out a claim are absent, or facts included in the complaint necessarily defeat plaintiff's claim. *Burgess v. Your House of Raleigh, Inc.*, 326 N C. 205, 209 388 S.E.2d 134, 136 (1990), *Jackson v. Bumgardner*, 318 N C 172, 175, 347 S.E 2d 743, 745 (1986). Applying these standards, plaintiff's complaint should be dismissed

2 Plaintiff's claims arise out of treatment she alleges she received on or about July 11 and 13, 2002, at Raleigh Community Hospital. See Complaint for Individual and Class Relief ¶ 19 (Feb. 14, 2005) ("Complaint"). Plaintiff alleges that, each time she presented for treatment, plaintiff and/or her legal representative signed a "Consent to Terms and Agreement to Treatment," a document that plaintiff refers to as the "Agreement to Pay." *Id.* ¶ 20. Plaintiff alleges that, pursuant to the Agreement to Pay, she "agreed to pay all charges relating to her care that was [*sic*] not paid by any insurance policy . . ." *Id.* Since the "Agreement to Pay" is referenced in the complaint, it may properly be considered by the Court under Rule 12(b)(6). *Coley v. N.C. Nat'l Bank*, 41 N.C. App. 121, 254 S.E.2d 217 (1979).

3. Ms. Shelton incurred $7,891.00 in charges for the medical treatment she received. Complaint ¶ 22. Ms. Shelton "has paid in full the assessment of medical charges to her by [Duke]." *Id.* ¶ 27.

4. Ms. Shelton's complaint contains four separately numbered counts. Count I, entitled "Breach of Contract," claims that Duke breached an express contract, the Agreement to

Pay, because Duke charged an allegedly "unreasonable" amount for the medical services provided to Ms Shelton. Complaint ¶ 46. Ms. Shelton contends that the amount was unreasonable because it was greater than "the reasonable prices charged to patients fully covered by health insurance." *Id.* ¶ 45. Count II, entitled "Unjust Enrichment," claims that, if the Court finds that a contract between Ms. Shelton and Duke did not exist, then Duke has been unjustly enriched by overcharging Ms. Shelton for the treatment she received *Id.* ¶¶ 49-52. Count III, entitled "Unfair and Deceptive Trade Practices," claims that Duke engaged in practices that violate N.C. Gen. Stat. § 75-1.1, *et seq.* *Id.* ¶¶ 54-58. Count IV, entitled "Declaratory and Injunctive Relief," seeks prospective declaratory and injunctive relief as to the actions complained of in Counts I-III. *Id.* ¶¶ 59-63.

5. The Agreement to Pay is an express contract between Ms. Shelton and Duke which states that Ms. Shelton "obligates [her]self to the payment of the Hospital account incurred by the patient in accordance with the regular rates and terms of the Hospital at the time of the patient's discharge." The contract is not ambiguous. Ms. Shelton had a duty to read the contract and to exercise reasonable care for her own protection. *Davis v. Davis,* 256 N.C. 468, 471, 124 S.E.2d 130, 133 (1962). Since there is no claim of fraud, undue influence, duress or coercion in the execution of the contract, Ms. Shelton's signature, as a matter of law, charged her with full knowledge and assent to the contents of the Agreement to Pay, which in this case means the "regular rates" of the hospital, whether or not she had actual knowledge of the precise rate. *Harris v. Bingham*, 246 N.C. 77, 79, 97 S.E.2d 453, 454 (1957); *Martin v. Vance* 133 N.C. App. 116, 121, 514 S.E.2d 306, 310 (1999).

6. The fact, as alleged by plaintiff, that the hospital's charges to Ms. Shelton may have been higher than its charges to various insurance companies who were financially

responsible for paying the hospital bills of other patients does not, as a matter of law, constitute a breach of the express contract between the parties. Duke had no legal obligation to inform Ms. Shelton of the financial terms of its contracts with those insurance companies. *See* N.C. Gen. Stat. § 131E-99 (2004). The fact, as alleged by plaintiff, that the charges to Ms. Shelton exceeded the hospital's actual costs in providing her with medical care does not, as a matter of law, constitute a breach of the express contract between the parties. Therefore, pursuant to N.C. R. Civ. P. 12(b)(6), Count I of the complaint fails to state a claim upon which relief can be granted and should be dismissed.

7. Because the Agreement to Pay is an express contract between Ms. Shelton and Duke, plaintiff cannot assert a claim for unjust enrichment. *See Verco Concrete Co. v. Troy Lumber Co.*, 256 N.C. 709, 713, 124 S.E.2d 905, 908 (1962). Furthermore, even if a theory of unjust enrichment could be asserted, plaintiff does not allege any facts that Duke was unjustly enriched. Different charges to groups of patients with differing types of insurance or lack of insurance does not constitute unjust enrichment. Therefore, pursuant to N.C. R. Civ. P. 12(b)(6), Count II of the complaint fails to state a claim upon which relief can be granted and should be dismissed.

8. Count III of the complaint is for relief under the Unfair and Deceptive Trade Practices Act, N.C. Gen. Stat. § 75-1.1 (2000). However, the actions complained of in the complaint are not included within the statutory definition of "commerce" because they are covered by the statutory exclusion for services rendered by members of a learned profession. *See Burgess v. Busby*, 142 N.C. App. 393, 407, 544 S.E. 2d 4, 23, *appeal dism'd*, 354 N.C. 351, 553 S.E.2d 679 (2001); *Cameron v. New Hanover Mem. Hosp.*, 58 N.C. App. 414, 445-46, 293 S.E.2d 901, 920, *appeal dism'd*, 307 N.C. 127, 297 S.E.2d 399 (1982). Even if Chapter 75

applied to this case, the complaint does not, as a matter of law, allege an unfair or deceptive trade practice. Duke's alleged failure to disclose information that the General Assembly has deemed "confidential," is not deceptive or unfair. *See* N.C Gen Stat. § 75-1.1 (2000) Therefore, pursuant to N.C. R Civ. P 12(b)(6), Count III of the complaint fails to state a claim upon which relief can be granted and should be dismissed.

9 Count IV of the complaint is wholly dependent upon the viability of Counts I, II and/or III and therefore is moot

10 The complaint acknowledges that Ms. Shelton received bills for the services rendered to her by Raleigh Community Hospital and that Ms. Shelton paid such bills "in full." Complaint ¶¶ 22, 27. The complaint further alleges that such charges were "well beyond reasonable by any measure." *Id.* ¶ 25. These facts, as alleged in plaintiff's complaint, establish as a matter of law that one or more of Ms. Shelton's claims would be barred by the doctrine of voluntary payment. *See Guerry v. Am. Trust Co.*, 234 N.C. 644, 647, 68 S.E.2d 272, 274 (1951), *Thompson v. Shoemaker*, 7 N.C. App. 687, 688, 173 S E.2d 627, 629 (1970)

NOW, THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED, that defendant's motion to dismiss be, and hereby is, ALLOWED;

FURTHER, IT IS HEREBY ORDERED, ADJUDGED AND DECREED, that plaintiff's complaint in the above-captioned action be, and hereby is, DISMISSED WITH PREJUDICE.

This, the 11, day of July, 2005.

RONALD L. STEPHENS
SUPERIOR COURT JUDGE PRESIDING

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION

NO. 5:15-CV-477-FL

UBA, LLC, Plaintiff, v. THYSSENKRUPP ELEVATOR CORPORATION, Defendant.	)	ORDER

Having noticed the parties that the court is considering entering partial summary judgment in favor of defendant on plaintiff's claims for specific performance and violation of the North Carolina Unfair and Deceptive Trade Practices Act ("UDTPA"), N.C. Gen Stat. 75-1.1 et seq., with benefit now of plaintiff's brief in opposition thereto and defendant's brief in support thereof, issues raised are ripe for ruling.[1]

[1] After denying plaintiff's motion for summary judgment, (DE 44), the court held telephonic conference March 2, 2017, pursuant to Rule 16 of the Federal Rules of Civil Procedure, (DE 48), to discuss remaining pretrial issues. At conference, question was raised by counsel as to the effect of the court's denial of plaintiff's motion for summary judgment. The court denied request to comment further upon its prior order, and instead gave notice pursuant to Federal Rule of Civil Procedure 56(f) that the court is considering issuance of sua sponte summary judgment in favor of defendant on plaintiff's specific performance claim and its claim pursuant to the UDTPA. (DE 49).

EXHIBIT D

COURT'S DISCUSSION[2]

The court proceeds immediately to its analysis of the issues, with deference to the standard of review pertaining to summary judgment as set forth in prior order.

A. Specific Performance

As held in the court's February 9, 2017, order denying plaintiff's motion for summary judgment, specific performance is not available even if plaintiff successfully demonstrates at trial that its reading of the 11/8/2012 work order is correct. The court incorporates its prior analysis by reference as to availability of specific performance and addresses plaintiff's renewed and expanded contentions as follows.

Plaintiff argues that where the North Carolina Supreme Court has not specifically forbade specific performance as a remedy for breach of services contracts, this court should consider the remedy theoretically available. However, as held in the court's prior order, where the undisputed facts demonstrate that plaintiff's claims do not embrace a type of property identified under North Carolina law as giving rise to a specific performance remedy, see Crawford v. Allen, 189 N.C. 434, 526 (1925) (specific performance available in real property transactions); Paddock v. Davenport, 107 N.C. 710, 710 (1890) (specific performance available for property unique or difficult to value); Cavenaugh v. Cavenaugh, 317 N.C. 652, 658 (1986) (specific performance available for dispute

[2] The court here incorporates by reference "Background," "Statement of Facts," and Appendices A and B, in order denying plaintiff's motion for summary judgment dated February 9, 2017. Where the facts pertinent to issues resolved herein are undisputed, the facts, now viewed in the light most favorable to plaintiff, may be summarized as in prior order, with the exception that, on plaintiff's view, no representative of defendant explained that repairs contemplated in the work order serving as the basis for the parties' relationship ("11/8/2012 work order") would be performed by an independent machine shop. (See DE 44 at 2).

involving disputes and child custody), plaintiff's remedy at law is adequate. Accordingly, an order directing specific performance will not issue. See Bell v. Smith Concrete Prods., Inc., 263 N.C. 389, 390 (1965) ("To invoke equitable jurisdiction, it must appear that the party injured by the breach cannot be adequately compensated by monetary payment."); Restatement (second) Contracts § 359(1) (same).

Nonetheless, plaintiff renews its contention that a damages award constitutes an inadequate remedy. Specifically, plaintiff cites Whalehead Properties v. Coastland Corp., which holds that a trial court may not categorically deny specific performance "without the necessary facts to determine whether damages would" constitute an adequate remedy. 299 N.C. 270, 283 (1980). However, in Whalehead, the trial court's decision to deny the remedy of specific performance was held erroneous because the trial court did not first consider whether the counter-claimant's remedy at law was adequate. Id. ("Here with the issue of damages not even before the court, [the court] could not consider all the facts and circumstances of the case and determine if equitable relief was proper."). Moreover, Whalehead, involved a dispute concerning two neighboring businesses' use of real property, which, as held in Crawford, North Carolina courts consider as having sufficiently unique characteristics to justify equitable relief where monetary damages are considered incommensurable with harms inflicted upon real property. 189 N.C. at 526 (1925) ("[A] binding contract to convey land will be specifically enforced by the courts."); see also In re Thompson, 799 S.E. 2d 658, 663–64 (N.C. Ct. App. 2017) (upholding grant of specific performance involving contract to convey land); Paddock, 107 at 710 (1890) ("[Specific performance is available] where there is a peculiar value attached to the subject of the contract which is not compensable in damages."). Accordingly, plaintiff's invocation of Whalehead is inapposite.

Finally, specific performance is unavailable based upon "the undesirability of compelling the continuance of personal association after disputes have arisen and confidence and loyalty are gone and, in some instances, imposing what might seem like involuntary servitude." Restatement (second) of Contracts § 367 cmt. (a) cited in Williams v. Habul, 219 N.C.App. 281, 291 (N.C. Ct. App. 2012). Additionally, specific performance is undesirable to the extent it imposes upon the court an ongoing duty to supervise performance by an unwilling party, id. § 366, especially in cases where the contract in question is not sufficiently clear to enable the court to determine whether performance rendered complies with terms of the contract or consequent specific performance order. See North Carolina Med. Soc. V. North Carolina Bd. of Nursing, 169 N.C.App. 1, at 11–12 (N.C. Ct. App. 2005) (quoting 12 Arthur L. Corbin, Corbin on Contracts § 1174, at 335 (2002) ("Specific performance will not be decreed unless the terms of the contract are so definite and certain that the acts to be performed can be ascertained and the court can determine whether or not the performance rendered is in accord with the contractual duty assumed."); Munchak Corp. (Delaware) v. Caldwell, 46 N.C.App. 414, 419 (N.C. Ct. App. 1980) ("A court of equity is not authorized to order the specific performance of a contract which is not certain, definite and clear, and so precise in all of its material terms that neither party can reasonably misunderstand it."); see also Cummings v. Dosam, Inc., 273 N.C. 28, 33 (1968) ("if the nature and extent of the intended [restrictive covenant] cannot be determined with reasonable certainty from the language of the covenant, it will not serve as the basis for the issuance of an injunction . . .").

In the instant matter, where adequacy of performance of the 11/8/2012 work order turns on defendant's exercise of judgment and expertise in elevator repair, the parties' evident loss of "confidence and loyalty" makes compulsion of continued association via specific performance

undesirable. See Williams, 219 N.C.App. at 291. Additionally, the 11/8/2012 work order, is not sufficiently determinate to justify award of specific performance even if a jury finds that defendant breached the work order. Specifically, where the 11/8/2012 work order requires, at most, that plaintiff's "[g]enerator and [e]xciter [] be repaired[,]" (DE 29-3 at 3), the work order supplies no objective standards by which to judge any such repair in the event plaintiff seeks enforcement of a specific performance order. That is, because the work order neither includes nor makes reference to any standards of workmanship, specific requirement of durability, schematics to guide repair, or any other standards the court might use to evaluate defendant's performance, "the nature and extent of the intended [obligation] cannot be determined from the language of the" work order; therefore, "it will not serve as the basis for the issuance of an injunction." See Cummings, 273 N.C. at 33.

For the foregoing reasons, summary judgment shall issue in favor of defendant as to plaintiff's claim for specific performance.

B. UDTPA

Regarding plaintiff's claim arising under the UDTPA, this court held in prior order that plaintiff cannot recover under the UDTPA because, at most, plaintiff's evidence demonstrates breach of contract. (DE 44 at 15). The court addresses plaintiff's renewed and expanded contentions as follows.

Plaintiff renews its contention that defendant's acts of conduct constitute deception and extortion, where defendant drafted an ambiguous contract; performed only part of the obligation plaintiff understands to be required; and submitted a second work order proposing additional work for additional consideration, which additional work plaintiff believes constituted preexisting duty. To draw from the foregoing facts a conclusion that defendant violated the UDTPA, plaintiff

characterizes defendant's failure to draft a clearer contract as a calculated plot to deceive plaintiff into signing the 11/8/2012 work order, gain possession of plaintiff's elevator parts, then coerce plaintiff into signing the 2/11/2013 work order via threat to withhold the parts.

The foregoing theory rests on the type of re-characterization of ordinary breach of contract as a UDTPA violation that the Fourth Circuit held impermissible in PCS Phosphate Co., Inc. V. Norfolk Southern Corp., 559 F.3d 212, 224 (4th Cir. 2009) (holding that a claimant may "multiply the damages for an ordinary breach of an agreement by re-characterizing the breach as a violation of the UDTPA"), and Broussard v. Meineke Discount Muffler Shops, Inc., 155 F.3d 331, 347 (4th Cr. 1998) (same). Furthermore, where plaintiff's accusations of defendant's untruthfulness rest solely upon characterization as such and not upon any evidence demonstrating defendant's inconsistency or falsehood, the characterization does not satisfy plaintiff's burden to establish the existence of a genuine dispute of material fact. See Lovelace, 681 F.2d at 241 ("it is the duty of the court to withdraw the case from the [factfinder] when the necessary inference is so tenuous that it rests merely upon speculation and conjecture").

Taking plaintiff's arguments seriatim, plaintiff first contends that "the [a]greement drafted by [defendant] is ambiguous at best." (DE 50 at 10). From this observation, plaintiff contends that the words of the 11/8/2012 work order created the capacity to mislead and did mislead plaintiff as to the scope of defendant's contractual obligations. (Id.). However, this argument must fail where it elevates every dispute involving an ambiguous contract to the level of a UDTPA violation. See PCS Phosphate, 559 F.3d at 224. Accordingly, plaintiff may not rest its UDTPA claim upon solely the existence of an ambiguous contract. See id.

Second, plaintiff contends that, although defendant offered to return plaintiff's elevator parts, this offer was part of a post hoc litigation strategy that cannot mitigate the deceptiveness of defendant's conduct when the 11/8/2012 work order was formed. However, this argument fails for at least two reasons. First, the 11/8/2012 work order itself, which the parties executed well before plaintiff initiated litigation, provides, in reference to elevator equipment, "[i]t is agreed that [defendant] does not assume possession or control of any part of the equipment and that such remains [plaintiff]'s exclusively as the owner, lessor, lessee, possessor, or manager thereof." (DE 21-1 at 4). Accordingly, where the 11/8/2012 work order expressly affirms plaintiff's ongoing ownership of parts associated with repair and was executed before plaintiff initiated litigation, plaintiff's characterization of defendant's willingness to return the parts as a post hoc litigation strategy is contradicted by the undisputed evidence of record.

Moreover, plaintiff has proffered no evidence that defendant ever refused to return plaintiff's elevator parts, and complaint alleges no such refusal. (See e.g., Compl. ¶ 14, DE 1-2, at 4 ("Defendant retains plaintiff's generator and exciter, and refuses to repair and reinstall the same . . .") (emphasis added)). Rather, the only evidence addressing defendant's readiness to return plaintiff's elevator parts consists in the contractual provision quoted above and defendant's July 14, 2014, letter stating that "defendant, however, is also willing to reinstall the exciter and generator upon the written acknowledgment of [plaintiff] to certain matters." (DE 32-5 at 1). In context, the requested "acknowledgment of certain matters" means that defendant did not offer to guarantee its workmanship because defendant did not intend such reinstallation to constitute a repair, but only a restoration of plaintiff's equipment to the status quo ante. (Id.). There is no allegation or evidence that defendant demanded money or other consideration in exchange for this return. (See id.).

Accordingly, where the 11/8/2012 work order and defendant's July 14, 2014, letter give rise to a prima facie showing that defendant did not engage in any attempt to elicit additional money from plaintiff based upon defendant's possession of plaintiff's property, and where plaintiff has submitted no evidence that defendant at any time maintained such posture, plaintiff has not met its burden to "come forward with specific facts showing that there is a genuine issue for trial" as to plaintiff's UDTPA claim. Matsushita 475 U.S. at 586–87.

Finally plaintiff asserts there exists evidence that defendant's interpretation of the 11/8/2012 work order constitutes a disingenuous cover for the deception plaintiff alleges. In particular, plaintiff observes that defendant's employee Jeff Slatcoff, Jr. ("Slatcoff") stated at deposition that at times before November 8, 2012, he was not aware that defendant would use a third-party repair shop to repair plaintiff's elevator parts. (DE 29-11 at 14). From this observation, plaintiff concludes that defendant cannot genuinely maintain belief that the 11/8/2012 work order contemplates third-party repair. However, the foregoing does not constitute "a justifiable inference to be drawn in [non-movant's] favor[,]" Anderson 477 U.S. at 255; rather, it is a non sequitur. That is, the fact that Slatcoff stated that he was unaware, prior to inspecting plaintiff's property, that third-party repair would be necessary does not support a conclusion that the statement itself or later drafted contractual terms were deceptive. More specifically, plaintiff does not allege Slatcoff affirmatively represented that third-party repair was unnecessary, only later to reverse course. Rather plaintiff alleges that Slatcoff stated he did not know third-party repair would be necessary, and then, later, expressed judgment that third-party repair was in fact needed. Where Slatcoff's statements, later factual developments, and the 11/8/2012 work order's language each are consistent with one another,

plaintiff's allegations of deception rest on no evidentiary ground. Accordingly, defendant is entitled to summary judgment as to plaintiff's UDTPA claim. See Matsushita 475 U.S. at 586–87.

For the foregoing reasons, summary judgment shall be granted in defendant's favor as to plaintiff's UDTPA claim.

CONCLUSION

Based on the foregoing, summary judgment is GRANTED in favor of defendant as to plaintiff's claims for specific performance and UDTPA violations. With partial summary judgment now decided, and no other motions pending, in accordance with the Case Management Order entered January 5, 2016, the case now is ripe for entry of an order governing deadlines and procedures for final pretrial conference and trial. The parties are DIRECTED to confer and file within **14 days** of entry of this order a joint status report informing of estimated trial length; particular pretrial issues which may require court intervention in advance of trial, if any; the parties' suggested three alternative trial dates; and whether the parties wish to promote further opportunity for alternative dispute resolution in advance of pending pretrial activities and, if so, how this court may assist the parties in such effort.

SO ORDERED, this the 3rd day of July, 2017.

LOUISE W. FLANAGAN
United States District Judge