No. _____

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

MARISELA HERRERA, ET AL. V. JFK MEDICAL CENTER, ET AL.
8:14-CV-2327-JSM-TBM

On Appeal from the United States District Court
for the Middle District of Florida, Tampa Division
Hon. James S. Moody, Jr.

PLAINTIFFS' PETITION FOR PERMISSIVE APPEAL PURSUANT TO FED. R. CIV. P. 23(f)

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

In compliance with 11th Circuit Rule 26.1-1, the undersigned counsel of record certifies that the following persons and entities have an interest in the outcome of this petition:

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16. HCA Holdco, LLC (stockholder of Palm Beach Healthcare System, Inc.)
17. HCA Holdings, Inc. (Defendant & sole common stockholder of HCA, Inc.) (stock ticker: HCA)
18. HCA, Inc. (sole common stockholder of Healthtrust, Inc. – The Hospital Company)
19. Healthserv Acquisition, LLC (owner of North Florida Regional Medical Center, Inc.)
20. Healthtrust, Inc. – The Hospital Company (stockholder of Palm Beach Healthcare System, Inc.; owner of Galen Holdco, LLC; owner of Healthserv Acquisition, LLC)
21. Hercules Holding II, LLC (stockholder of HCA Holdings, Inc.)
22. Herrera, Marisela (Plaintiff)
23. JFK Medical Center Limited Partnership d/b/a JFK Medical Center (Defendant)
24. KKR & Co. L.P. (affiliated with members of Hercules Holding II, LLC) (stock ticker: KKR)

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30. Memorial Healthcare Group, Inc. d/b/a Memorial Hospital Jacksonville (Defendant)
31. Moody Jr., James S. (United States District Judge, Middle District of Florida)
32. North Florida Regional Medical Center, Inc. (Defendant)
33. Palm Beach Healthcare System, Inc. (sole limited partner of JFK Medical Center Limited Partnership)
34. Sanchez, Luz (Plaintiff)
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38. Wollmen, Penny (Plaintiff)

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I. INTRODUCTION

Without allowing Plaintiffs to take any discovery in this action, the district court decided that individual factual inquiries, particularly with regard to damages, will predominate, making class litigation "highly impractical," and entered an order striking Plaintiffs' class allegations. As demonstrated by application of the *Prado-Steiman v. Bush* factors, the Court should grant review of this decision under Federal Rule of Civil Procedure 23(f). The district court's ruling amounts to an abuse of discretion because it is contrary to this Court's clear precedent that class certification decisions should generally be made on a developed record and that certification should not be denied merely because of individualized damages issues. The propriety of this order, which will effectively sound a death knell for Plaintiffs, should be decided now, rather than on final appeal, to save both the parties and the lower court the time and expense of litigating this matter through jury trial on an individual basis and then again on a class basis. Furthermore, an immediate ruling on the issues presented in this appeal, which arise frequently in class litigation, will not only be helpful to the bar, but will be helpful to the bench as the district court has made prior similar rulings prohibiting a party's ability to seek class treatment merely on the face of the pleadings.

II. STATEMENT OF FACTS AND PROCEDURAL HISTORY

Plaintiffs brought a putative class action against HCA Holdings, Inc., and three of its hospitals, JFK Medical Center, Memorial Hospital Jacksonville, and North Florida Regional Medical Center, for allegedly engaging in a practice of charging unlawfully high rates for emergency room imaging studies, such as CT scans, MRIs, Ultrasounds, and X-rays, provided to Plaintiffs and other similarly-situated patients who received treatment following a motor vehicle accident. (A2; A21). Plaintiffs allege Defendants' conduct in billing such patients, whose radiological services were partially covered through their Florida Personal Injury Protection insurance coverage ("PIP"), imposed rates that grossly exceeded the "reasonable amount" Defendants were permitted to charge under the Florida Motor Vehicle No-Fault Law ("PIP Statute"), *see* § 627.736(5)(a), Fla. Stat., violates Florida's Deceptive and Unfair Trade Practices Act ("FDUTPA"), and amounts to a breach of contract and breach of the implied covenant of good faith and fair dealing. (A2-4).[1]

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[1] Because the district court's ruling on the motion to strike was made on the face of the pleadings at the motion to dismiss stage, the Court must accept all well-pleaded factual allegations in Plaintiffs' Amended Complaint as true. *See Town of River Junction v. Maryland Cas. Co.*, 110 F.2d 278, 279 (5th Cir. 1940) (taking facts alleged as true when reversing district court's order striking portions of defendants' answers); *Stearns v. Select Comfort Retail Corp.*, 763 F. Supp. 2d 1128, 1139–40 (N.D. Cal. 2010) (stating "[a]s with motions to dismiss, when ruling on a motion to strike, the Court takes the plaintiff's allegations as true and must liberally construe the complaint in the light most favorable to the plaintiff").

The PIP Statute requires all residents of Florida who own a motor vehicle to purchase PIP in the amount of $10,000 per person. § 627.736(1), Fla. Stat. Under section 627.736(5)(a) of the PIP Statute, a hospital rendering treatment for a bodily injury covered by PIP may charge the insurer and the injured party "only a reasonable amount" for the services rendered. (A33 at ¶24). The PIP Statute explicitly defines the methodology for determining whether a charge for services or treatment is "reasonable" by allowing consideration of "evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages." (A33 at ¶24) (quoting § 627.736(5)(a)).

Because PIP covers only 80% of the charges incurred as a result of emergency medical care received, up to $10,000, § 627.736(1)(a)(3), Fla. Stat., PIP-covered patients are responsible for part of these charges. (A33 at ¶25). And, once the $10,000 of PIP coverage is exhausted, PIP-covered patients without another form of applicable insurance are responsible for 100% of any additional charges incurred. (A33 at ¶25).

Plaintiffs allege that Defendants, in direct violation of the PIP Statute's "reasonable amount" requirement, bill PIP-covered patients grossly inflated, unreasonable rates for emergency radiological services—sometimes up to 65 times

higher than the hospitals' usual and customary charges and/or payments accepted for similar radiological services provided to non-PIP patients. (A34-35 at ¶28). Although each Plaintiff signed a Conditions of Admission contract prior to receiving radiological services, the contracts do not disclose Defendants' unreasonable pricing scheme, but merely purport to require payments at the rates stated in each hospital's "Charge Master" price list without including those prices in the contract or in an attachment thereto. (A34 at ¶26).

Plaintiffs allege that Defendants' prices for radiological services are grossly excessive and patently unreasonable under each of the criteria set forth by the PIP Statute. (A40-46). For instance, each Plaintiff was billed in excess of $6,000 for a CT scan of the brain, which greatly exceeds the amount Defendants charge non-PIP patients, whether or not they are insured, and greatly exceeds Defendants' cost. Most importantly, it is ***more than 35 times*** the Medicare reimbursement rate. (A42-43 at ¶46). Each of the radiological services Defendants provided to Plaintiffs was billed at a similarly excessive and unreasonable rate, (A40-41 at ¶45; A44-46 at ¶47), such as the charge to Plaintiff Herrera for a lumbar spine x-ray at a rate ***more than 65 times*** the Medicare reimbursement rate. (A45 at ¶48).

Plaintiffs allege that as a direct result of Defendants' billing at exorbitant and unreasonable rates, PIP emergency-care patients are billed more for their out-of-pocket portion of the rates charged for emergency radiological services than

they would have been if such services were provided at reasonable rates. (A34-35 at ¶28). These excessive rates also depleted the PIP coverage available to the patients at a faster rate, resulting in the patients being billed out-of-pocket for additional medical services rendered by Defendants and third-party providers that would have otherwise been covered under PIP. (A34-35 at ¶28). Thus, Plaintiffs sought relief on behalf of themselves and the following class of similarly situated persons:

> All individuals (or their guardians or representatives) who received PIP-covered emergency care radiological services at an HCA-operated facility in Florida and who: (a) were billed by the facility for any portion of the charges for such services; and/or (b) had their $10,000 of PIP coverage prematurely exhausted by the facility's charges for such services and, as a result, were billed for additional medical services rendered by the facility and/or third-party providers that would otherwise have been covered under PIP.

(A4; A47 at ¶52). Plaintiffs identified several questions of law and fact that will be common to the class, including whether: 1) Defendants' charges to PIP patients for radiological services were "reasonable"; 2) Defendants had a policy and practice of pricing, billing, and seeking payment from PIP patients for radiological services at unreasonable rates; 3) Defendants' inclusion of a provision in its Conditions of Admission contracts requiring patients to make payments according to Defendants' Charge Master rates is a violation of the PIP Statute and void as a matter of law; 4) Defendants' practice of overcharging for radiological services is deceptive, unlawful, or unfair in any respect thereby violating FDUTPA; and 5) Defendants'

practice of overcharging for radiological services constituted a breach of contract. (A48 at ¶55).

Defendants moved to dismiss Plaintiffs' action in its entirety, and moved to strike Plaintiffs' class allegations. (A6; A15). The district court denied Defendant HCA's motion to be dismissed from the action after determining that Plaintiffs had sufficiently alleged direct liability on behalf of HCA in setting and enforcing pricing guidelines at its hospitals and ratifying and approving of its hospitals' actions. (A7-8). The court also denied the motion to dismiss Plaintiffs' FDUTPA and breach of contract counts. (A10-14). It held that even though Defendants may be permitted to use a "Charge Master," their charges must still be reasonable, and Plaintiffs had sufficiently alleged they were charged unreasonable rates that were significantly higher than those paid within the community, including by Medicare. (A13-14).

Turning to Defendants' motion to strike Plaintiffs' class allegations, the court claimed it was obligated to determine at this stage "whether a class may stand." (A16). The court held that "[g]iven the nature of the claims and individual factual inquiries required, it is clear the individualized issues are predominant and this suit cannot proceed as a class action." (A16). It explained:

> In this case, the threshold inquiry is whether the Plaintiffs were charged an unreasonable rate for their specific medical service, which would affect the portion of their PIP benefits prematurely depleted and the portion of the charge for which they were individually

> responsible. If this case were to proceed, the most important issue to settle, the reasonableness of the charge for the specific radiological service and the damages incurred by each putative plaintiff, would be highly individualized in nature. What is a reasonable charge for radiological services in one geographical area may not be reasonable for another.
>
> Further, for those class members whose PIP benefits were completely depleted by the Defendant Hospitals' allegedly unreasonable charges, the Plaintiffs seek reimbursement for any payments made to third party providers that would have been covered by their PIP coverage. In those cases, the Court would have to analyze whether each Plaintiff had co-insurance which should have covered those expenses, whether the medical services were reasonable and necessary and related to the motor vehicle accident so that the PIP coverage would apply, and given the allegations in this case, whether the third party provider's charges are "reasonable." After consideration of these factors, the Court's calculation of what constitutes a "reasonable amount" weighs strongly against the use of a class action. *MRI Associates of St. Pete, Inc.* [*v. State Farm Mut. Auto. Ins. Co.*], 755 F. Supp. 2d [1205,] 1208 [(M.D. Fla. 2010) (Moody, J.)] (finding that action for PIP benefits requiring the court to determine what constituted a "reasonable amount" was inappropriate for a class action proceeding) (citing *State Farm Mut. Auto. Ins. Co. v. Sestile*, 821 So. 2d 1244 (Fla. 2d DCA 2002)).

(A16-17). Before striking the class claims, the court reiterated that determining the claims would "clearly require a highly individualized analysis *of the damages issue*, precluding class treatment. . . ." (A18) (emphasis added). It permitted Plaintiff Herrera to proceed with her individual action and dismissed the remaining Plaintiffs without prejudice to file separate individual actions. (A19).

This petition, seeking review of the ruling striking the class allegations pursuant to Rule 23(f), was timely filed.

III. QUESTION PRESENTED

Whether the district court erred as a matter of law in determining the propriety of class certification absent discovery, and by relying upon possible individualized damages issues that should not preclude class treatment.

IV. RELIEF SOUGHT

Plaintiffs request the Court grant their petition for permissive appeal pursuant to Federal Rule of Civil Procedure 23(f). If the Court grants this relief, Plaintiffs will seek reversal of the district court's order striking Plaintiffs' class allegations and request remand with the direction that Plaintiffs be permitted to conduct discovery on the class issues and have the question of class certification decided on a developed record.

V. ARGUMENT

A. THE COURT HAS THE DISCRETION TO ACCEPT PLAINTIFFS' APPEAL OF THE DISTRICT COURT'S ORDER STRIKING CLASS ALLEGATIONS

This Court has "'unfettered discretion' to grant or deny" a petition under Rule 23(f), *Shin v. Cobb County Bd. of Educ.*, 248 F.3d 1061, 1065 (11th Cir. 2001) (quoting R. 23(f) Advisory Committee Notes), which allows a court of appeals to permit an appeal from an order granting or denying class-action certification that is filed within 14 days after the order is entered. R. 23(f). The district court's order granting Defendants' motion to strike class allegations is reviewable under Rule 23(f) because it "is the functional equivalent of denying a

motion to certify the case as a class action." *Scott v. Family Dollar Stores, Inc.*, 733 F.3d 105, 111 n.2 (4th Cir. 2013) *cert. denied*, 134 S. Ct. 2871 (2014) (citing *In re Bemis Co., Inc.*, 279 F.3d 419, 421 (7th Cir. 2002)). As Plaintiffs timely filed their petition for permissive appeal within 14 days of the district court's order being entered, this Court has the discretion to accept Plaintiffs' appeal of that order.

B. THE *PRADO-STEIMAN* FACTORS FAVOR IMMEDIATE REVIEW OF THE DISTRICT COURT'S ORDER STRIKING PLAINTIFFS' CLASS ALLEGATIONS ON THE FACE OF THE PLEADINGS

In *Prado-Steiman v. Bush*, 221 F.3d 1266 (11th Cir. 2000), this Court established guideposts to follow in deciding whether to grant immediate review under Rule 23(f). These guideposts direct accepting Plaintiffs' request for immediate review.

1. The district court's ruling is likely dispositive of the litigation by sounding a "death knell" for Plaintiffs.

This Court has recognized a compelling need for immediate review "where the district court's ruling, as a practical matter, effectively prevents the petitioner from pursuing the litigation [such as] where a denial of class status means that the stakes are too low for the named plaintiffs to continue the matter. . . ." *Prado-Steiman*, 221 F.3d at 1274. And, as recognized in the Advisory Committee Notes to Rule 23, a situation "in which the only sure path to appellate review is by

proceeding to final judgment on the merits of an individual claim that, standing alone, is far smaller than the costs of litigation," can be alleviated "at low cost" by immediate review of the order denying class certification.

Here, while each Plaintiff has suffered thousands of dollars in damages, none has suffered enough to warrant protracted litigation against the virtually unlimited resources of Defendant HCA Holdings and its hospitals. And, certainly, the costs of litigating Plaintiff Herrera's claims (the only Plaintiff whose claims were not dismissed by the district court's order), or the other Plaintiffs' claims, on an individual basis through final judgment will be far greater than any potential recovery. For instance, Plaintiff Herrera alleged that she was billed over $6,500 by JFK Medical Center for radiological services and has paid over $4,000 in out-of-pocket medical expenses due to the premature exhaustion of her PIP coverage as a result of Defendants' unreasonable charges. (A36). Plaintiff Sanchez has alleged that she was billed over $2,500 by JFK Medical Center for radiological services and has paid over $2,000 in out-of-pocket medical expenses due to the premature exhaustion of her PIP coverage. (A37). While these damages are certainly significant to the Plaintiffs, the amounts will be dwarfed by the costs of litigating their claims individually.

2. The district court's order constitutes an abuse of discretion that will be reversed on appeal after final judgment.

Upon immediate review, this Court is likely to find the district court abused its discretion by prematurely striking Plaintiffs' class allegations on the face of the pleadings when the question of predominance of common issues generally must be decided on the basis of a developed record. Moreover, the allegations (as noted by the district court) support that Defendants' charges for PIP patients getting routine diagnostic exams were far in excess of what Defendants charged or the payments they accepted for the same services in other instances. These allegations not only support Plaintiffs' causes of action, but commonality as well. The district court's conclusion that there would likely be the need to consider individual charges lacked any support, and could be quickly resolved through discovery. Additionally, the district court abused its discretion in striking Plaintiffs' class allegations primarily for what it determined would be individualized damages issues.

The district court abused its discretion the same way as the court in *Mills v. Foremost Insurance Co.*, 511 F.3d 1300, 1303 (11th Cir. 2008). There, plaintiffs filed a class action complaint against their mobile home insurer after it failed to compensate them for contractors' overhead and profit charges and for state and local taxes on materials incurred by plaintiffs when having their mobile home repaired after it was damaged in a hurricane. *Id.* at 1302. Plaintiffs alleged the insurer engaged in the same conduct with regard to its other insureds that had

suffered hurricane-damaged losses and requested damages and declaratory relief on behalf of themselves and the class. *Id.* The district court held plaintiffs' "claims were inappropriate for class action treatment because 'the individual inquiry of the facts surrounding the property damage claims of thousands of [defendant's] policy holders under thousands of separate insurance policies would predominate and overwhelm any common issue.'" *Id.* at 1303. This Court noted that sometimes a motion to strike class claims is valid, but "that precedent also counsels that the parties' pleadings alone are often not sufficient to establish whether class certification is proper, and the district court will need to go beyond the pleadings and permit some discovery and/or an evidentiary hearing to determine whether a class may be certified." *Id.* at 1309. The Court cited to *Huff v. N.D. Cass Co. of Alabama*, 485 F.2d 710, 713 (5th Cir. 1973), where it stated:

> Maintainability may be determined on the basis of pleadings, but the determination usually should be predicated on more information than the complaint itself affords. The court may, and often does, permit discovery relating to the issues involved in maintainability, and a preliminary evidentiary hearing may be appropriate or essential as a part of the vital management role which the trial judge must exercise in class actions to assure that they are both meaningful and manageable.

Id. (footnotes omitted).

After reviewing the parties' pleadings in *Mills*, the Court determined the "district court's conclusion as to the predominance issue at the complaint stage was speculative at best and premature at least." *Id.* at 1309-10. While the defendant

insurer argued that "individual issues will abound," including "whether the services of a general contractor would be reasonably required under the circumstances" of each class member, *id.* at 1310, plaintiffs claimed that review of the defendant's own documents and its adjusters' estimates would provide proof on common liability issues. *Id.* The differing claims of the parties about the relative ease and practicability of proving plaintiffs' claims on a class-wide basis made the district court's ruling at the complaint-pleading stage improper. *Id.* at 1310-11. Plaintiffs "at least should have been granted an opportunity to conduct limited discovery relevant to the certification issue and thereafter the court should have determined whether an evidentiary hearing was needed to enable the district court to make any necessary factual findings." *Id.* at 1311.

Similarly, here, Plaintiffs assert that Defendant HCA controls the pricing structure of its hospitals such that all HCA hospitals uniformly charge rates for emergency radiological services that greatly exceed any standard of reasonableness provided in the PIP Statute. (A31-32 at ¶¶21- 22; A40-46 at ¶¶45-48). Each HCA hospital charges set rates for the radiological services it provides, such as $6,404 for a CT scan of the brain or $5,900 for a CT scan of the spine. (A36 at ¶31). While these charges do vary by hospital, potentially in relation to the hospital's geographic location, *all* of the charges are alleged to be excessive and unreasonable as a matter of law. (A34 at ¶28). As the district court found, the PIP

statute imposes a duty on Defendants to charge a reasonable price, and "to the extent that Florida law permits hospitals to use a 'charge master,' the prices listed within it must still be reasonable." (A14).

Plaintiffs simply contend that the charges of HCA and its hospitals for all PIP patients are totally unreasonable in that HCA's pricing structure, which varies insignificantly by location and results in charges up to 65 times greater than the Medicare reimbursement rate, is *unreasonable* under the PIP Statute. This question is not "highly individualized in nature," (A16), but can be answered by common proof. (A49 at ¶¶58-59). As the complaint clearly alleges, and the lower court does not seem to question, the rates charged by Defendants are set centrally by a policy common to the class. The reasonableness of these rates, Plaintiffs allege, are set so high as to be unreasonable at each HCA hospital. While Defendants undoubtedly contest the merit of these allegations, and the susceptibility of these claims to class certification, Plaintiffs have plausibly pled allegations of unlawful conduct that could be proved with evidence common to the class. As such, allegations that these claims warrant class treatment should survive dismissal on an undeveloped record. The district court's failure, therefore, to at least allow Plaintiffs to conduct discovery on the issue and then make an evidentiary ruling on the basis of a developed record was an abuse of discretion.

The district court also wrongly focused on the assessment of damages to

scuttle the class allegations before any discovery. "'Whether an issue predominates can only be determined after considering what value the resolution of the class-wide issue will have in each class member's underlying cause of action.'" *Sacred Heart Health Sys., Inc. v. Humana Military Healthcare Servs.*, 601 F.3d 1159, 1170 (11th Cir. 2010) (quoting *Rutstein v. Avis Rent–A–Car Sys.*, 211 F.3d 1228, 1234 (11th Cir. 2000)). Instead of considering what value the resolution of these class-wide issues and other common issues would have in each class member's underlying cause of action, as *Sacred Heart* instructs, the district court focused on the damages element, determining "Plaintiffs' allegations clearly require a highly individualized analysis of the damages issue, precluding class treatment. . . ." (A18). This holding was an abuse of discretion because "the presence of individualized damages issues does not prevent a finding that the common issues in the case predominate." *Allapattah Servs. v. Exxon Corp.*, 333 F.3d 1248, 1261 (11th Cir. 2003), *aff'd sub nom.* 545 U.S. 546 (2005). "It is primarily when there are significant individualized questions going to liability that the need for individualized assessments of damages is enough to preclude 23(b)(3) certification." *Klay v. Humana, Inc.*, 382 F.3d 1241, 1260 (11th Cir. 2004). Extreme cases in which individualized issues regarding damages will be complex and fact-specific enough to defeat class certification will "rarely, if ever, come along." *Id. Accord*, Rubenstein, NEWBERG ON CLASS ACTIONS § 4:54, p. 205 (5th

ed. 2012) (It is a "black letter rule . . . that individual damage calculations generally do not defeat a finding that common issues predominate ...");

In *Allapattah*, this Court affirmed certification of the liability portion of claims brought by 10,000 Exxon dealers who alleged Exxon breached their dealer agreements by overcharging them for fuel purchases. 333 F. 3d at 1257. Certification of the liability issue was proper even though the "determination of the amount that each dealer was overcharged during the class period [had to] take place on an individual basis" due to individualized issues with regard to each class member. *Id.* The existence of common liability issues—namely Exxon's legal duty, breach of that duty, and concealment of that breach—predominated over the individualized damages issues. *Id.* at 1260-61. Thus, even if the district court was correct in this case that it would have to consider individualized damages issues with regard to those Plaintiffs and class members who incurred out-of-pocket medical expenses after Defendants prematurely exhausted their PIP benefits, (A16-17), it was an abuse of discretion for the court to strike Plaintiffs' class allegations on that basis. Just as in *Allapattah*, Defendants engaged in a common course of conduct and the Plaintiffs and class members share a common legal right that they contend Defendants violated. These common issues predominate over any individualized damages issues.

3. The issues in this appeal are likely to arise repeatedly in the future and their early resolution will be beneficial to the bench and bar.

When "an appellate ruling [on an issue] sooner rather than later will substantially assist the bench and bar, as may be the case when an issue is arising simultaneously in related actions involving the same or similarly-situated parties or is one that seems likely to arise repeatedly in the future," the Court will consider taking the matter up on immediate review, particularly when the "unsettled issue relates specifically to the requirements of Rule 23 or the mechanics of certifying a class." *Prado-Steiman*, 221 F.3d at 1275. Given that the errors Plaintiffs raise above both involve the proper application of Rule 23 and are likely to be presented in nearly every action filed on a class basis, this factor militates in favor of the Court accepting Plaintiffs' appeal. This conclusion is made even more evident by the district court's history of deciding the propriety of class treatment merely on the face the pleadings. *See Vandenbrink v. State Farm Mut. Auto. Ins. Co.*, 8:12-CV-897-T-30TBM, 2012 WL 3156596, at *3 (M.D. Fla. 2012) (Moody, J.); *MRI Associates of St. Pete, Inc. v. State Farm Mut. Auto. Ins. Co.*, 755 F. Supp. 2d 1205, 1208 (M.D. Fla. 2010) (Moody, J.).

4. The current nature and status of the litigation favors immediate review of the district court's order striking class allegations on the face of the pleadings.

This case is in a perfect pre-trial posture for immediate review of the district court's order striking Plaintiffs' class allegations. No discovery has been conducted

by the parties and it will be much more cost effective if the issue of Plaintiffs' ability to conduct discovery on class-related issues is decided now, rather than on final appeal, which, if successful, would require the parties to essentially start the litigation over. Additionally, there are four named Plaintiffs in this action, three of whom (Sanchez, Acosta, and Wollmen) the district court dismissed to file individual actions. (A19). As the district court will not have subject matter jurisdiction over their individual actions,[2] none of which will involve more than $75,000 in damages, *see* 28 U.S.C. § 1332(a), or a federal question, *see* 28 U.S.C. § 1331, the dismissed Plaintiffs will have to refile their actions in state court and have all the common legal issues already determined by the district court determined anew. Accepting immediate review of the district court's order could potentially save each of those Plaintiffs, as well as the Defendants, the great time and expense of relitigating their cases from scratch.

5. Early resolution of the issues in this appeal will facilitate the disposition of future claims.

"[I]f the case is likely to be one of a series of related actions raising substantially the same issues and involving substantially the same parties, then early resolution of a dispute about the propriety of certifying a class may facilitate the disposition of future claims." *Prado-Steiman* at 1276. As Plaintiffs have

[2] Defendants removed the instant action to federal court pursuant to the Class Action Fairness Act, 28 U.S.C. § 1453.

alleged that Defendants billed thousands of PIP-covered patients exorbitant, legally unreasonable rates for emergency radiological services, (A47 at ¶ 54), resolution of the issue of whether these patients' claims can be decided on a class-wide basis will help facilitate the disposition of their claims. And, as discussed above, resolution of the appeal at this stage will also help resolve the claims of Plaintiffs Sanchez, Acosta, and Wollmen, who were dismissed with leave to refile individual actions.

VI. CONCLUSION

Application of the *Prado-Steiman* factors demonstrates immediate review of the district court's order striking Plaintiffs' class allegations is warranted. An appeal at this stage of the proceedings will allow the Court to review the district court's decision to strike Plaintiff's class allegations on the face of the pleadings after determining individualized issues, primarily on the issue of damages, will predominate—rulings that amount to an abuse of discretion under this Court's authority. Deciding the propriety of the district court's order now, rather than on final appeal, will save both the parties and the lower court the time and expense of litigating this matter through jury trial on an individual basis and then again on a class basis.

DATED: March 5, 2015

Respectfully submitted,

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NOTICE OF APPENDIX

Pursuant to Rule 5(b)(1)(E) of the Federal Rules of Appellate Procedure, Plaintiffs-Petitioners hereby attach the February 20, 2015 Order striking Plaintiffs' class allegations, beginning at page A1. Additionally, Plaintiffs' Amended Class Action Complaint and Demand for Jury Trial, without exhibits, is attached, beginning at page A20.

CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of March, 2015, the foregoing *Petition for Permissive Appeal Pursuant to Fed. R. Civ. P. 23(f)* was served by U.S. Mail, first-class postage pre-paid, and by electronic mail on the following:

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

MARISELA HERRERA, LUZ SANCHEZ, NICHOLAS ACOSTA and PENNY WOLLMEN,

Plaintiffs,

v. Case No: 8:14-cv-2327-T-30TBM

JFK MEDICAL CENTER LIMITED PARTNERSHIP, *et al.*,

Defendants.

ORDER

THIS CAUSE comes before the Court upon the Defendant HCA Holdings, Inc.'s Motion Requesting Judicial Notice and Incorporated Memorandum of Law (Dkt. #34), Defendant HCA Holdings, Inc.'s Motion to Dismiss Amended Complaint with Prejudice, Motion to Strike Class Allegations, and Joinder in Hospital Defendants' Motion to Dismiss and Motion to Strike, with Incorporated Memorandum of Law (Dkt. #35), Plaintiffs' Response in Opposition to the Motion (Dkt. #44), JFK Limited Center Partnership d/b/a JFK Medical Center, Memorial Healthcare Group, Inc. d/b/a Memorial Hospital Jacksonville, and North Florida Regional Medical Center, Inc.'s Motion to Dismiss and Motion to Strike and Supporting Memorandum of Law (Dkt. #36), and Plaintiffs' Response in Opposition to the Motion (Dkt. #45). Upon review and consideration, it is the Court's

conclusion that the Motion Requesting Judicial Notice should be granted and the remaining Motions should be granted in part and denied in part.

Background

Plaintiffs Marisela Herrera, Luz Sanchez, Nicholas Acosta, and Penny Wollmen filed this putative class action against Defendants HCA Holdings, Inc. (hereinafter "HCA") and JFK Medical Center Limited Partnership d/b/a JFK Medical Center (hereinafter "JFK"), Memorial Healthcare Group, Inc., d/b/a Memorial Hospital Jacksonville (hereinafter "Memorial"), and North Florida Regional Medical Center, Inc. (hereinafter "North Florida") (collectively the "Defendant Hospitals") alleging that they charge unreasonable amounts for emergency radiological services. HCA removed this case to this Court alleging jurisdiction under the Class Action Fairness Act, 28 U.S.C. § 1332(d) and § 1453.

Plaintiffs were patients at the HCA-operated Defendant Hospitals in Florida and received emergency radiological services, including CT scans, X-rays, MRIs, and ultrasounds. The services were covered by their Personal Injury Protection ("PIP") insurance. When Plaintiffs were admitted to the Defendant Hospitals, they signed Conditions of Admission contracts (hereinafter the "Contracts"). The Contracts contain a paragraph titled "Financial Agreement" which provides that the patient or the patient's guarantor:

> promises to pay the patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no

> price listed on the Charge Master.... An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

Herrera alleges that JFK billed $5,900 for the CT scan of her spine; $6,404 for the CT scan of her brain; $3,359 for the lumbar spine X-ray; and $2,222 for the thoracic spine X-ray. Sanchez alleges that JFK billed $5,900 for the CT scan of her spine; $6,404 for the CT scan of her brain; and $2,222 for the thoracic spine X-ray. Acosta alleges that Memorial billed $6,965 for the CT scan of his spine; and $6,277 for the CT scan of his brain. Wollmen alleges that North Florida billed $6,853 for the CT scan of her cervical spine; $6,140 for the CT scan of her brain; and $1,454 for the X-ray of her thoracic spine.

Plaintiffs allege that the charges for these emergency radiological services are up to 65 times higher than the charges for the same services billed to other patients covered under private or government sponsored insurance programs. The charges are so excessive that they prematurely exhausted the PIP insurance benefits depriving Plaintiffs of coverage for other medical services and leaving them with medical expenses in excess of what they would otherwise have to pay.

Plaintiffs allege causes of action for violation of the Florida Deceptive Unfair Trade Practices Act ("FDUTPA"), Fla. Stat. § 501.201 *et seq.*, breach of contract, and breach of implied covenant of good faith and fair dealing. Plaintiffs bring this putative class action on behalf of:

> ...similarly situated individuals who received PIP-covered emergency care radiological services at HCA-operated facilities in Florida who either (a) were billed by the facility for any portion of the charges for such services; and/or (b) had their $10,000 of PIP coverage prematurely exhausted by the facility's charges for such services, and as a result, were billed for additional medical services rendered by the facility and/or third party providers that would otherwise have been covered under PIP.

Plaintiffs previously filed a Motion for Class Certification and Request for Stay of Briefing and Consideration of this Motion and Incorporated Memorandum of Law (Dkt. #3) on the basis that Defendants could pre-empt class certification by making offers of judgment to the Plaintiffs. The Court denied that motion as premature.

Discussion

I. Motion to Dismiss Standard

To warrant dismissal of a complaint under Rule 12(b)(6) of the Federal Rules of Civil Procedure, it must be "clear that no relief could be granted under any set of facts that could be proved consistent with the allegations." *Blackston v. State of Alabama,* 30 F.3d 117, 120 (11th Cir. 1994) (quoting *Hishon v. King & Spalding,* 467 U.S. 69, 73, 104 S.Ct. 2229, 81 L.Ed.2d 59 (1984)). "When considering a motion to dismiss, all facts set forth in the plaintiff's complaint are to be accepted as true and the court limits its consideration to the pleadings and exhibits attached thereto." *Grossman v. Nationsbank,* N.A., 225 F.3d 1228, 1231 (11th Cir. 2000) (internal citations and quotations omitted). "A complaint may not be dismissed pursuant to Rule 12(b)(6) unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Id.*

"Federal Rule of Civil Procedure 8(a)(2) requires only 'a short and plain statement of the claim showing that the pleader is entitled to relief,' in order to 'give the defendant

fair notice of what the ... claim is and the grounds upon which it rests.'" *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 127 S.Ct. 1955, 1964, 167 L.Ed.2d 929 (2007) (quoting Fed.R.Civ.P. 8; *Conley v. Gibson,* 355 U.S. 41, 47, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957)). Further, exhibits are part of a pleading "for all purposes." Fed.R.Civ.P. 10(c); *see Solis–Ramirez v. U.S. Dep't of Justice,* 758 F.2d 1426, 1430 (11th Cir. 1985) (*per curiam*) ("Under Rule 10(c) Federal Rules of Civil Procedure, such attachments are considered part of the pleadings for all purposes, including a Rule 12(b)(6) motion.").

On a motion to dismiss, the Court may consider matters judicially noticed. *La Grasta v. First Union Sec. Inc.,* 358 F.3d 840, 845 (11th Cir. 2004). These matters include documents which are central to plaintiff's claim whose authenticity is not challenged, whether the document is physically attached to the complaint or not, without converting the motion into one for summary judgment. *Speaker v. U.S. Dept. of Health and Human Services Centers for Disease Control and Prevention*, 623 F.3d 1371, 1379 (11th Cir. 2010); *SFM Holdings. Ltd. v. Banc of America Securities, LLC*, 600 F.3d 1334, 1337 (11th Cir. 2010).

II. Motion for Judicial Notice

HCA filed its Motion for Judicial Notice requesting that the Court take judicial notice of the following documents: Certificate of Incorporation (DE) of HCA, Certificate of Limited Partnership (DE) – JFK, Articles of Incorporation (FL) - Memorial, Articles of Incorporation (FL) - North Florida, HCA's Form 10-K for Fiscal Year 2013, JFK's application and renewals (FL) re: fictitious name, Memorial's application and renewals (FL) re: fictitious name, North Florida's application and renewals (FL) re: fictitious name,

JFK – Agency for Healthcare Administration ("AHCA") License, Memorial - AHCA License, North Florida - AHCA License, Webpage, "Healthy Work Environment", and Webpage, "Pricing and Financial Information". These documents are filed in support of its Motion to Dismiss. Plaintiffs do not object to the Motion. The Court grants the Motion and will take judicial notice of the attached documents.

III. The Motions to Dismiss

HCA argues that since it is the ultimate parent company of the Defendant Hospitals it has no direct liability for the Defendant Hospitals' actions. Plaintiffs fail to allege a single action or inaction taken by HCA, nor do they allege any other basis for disregarding the corporate form rendering HCA liable for the alleged acts of the Defendant Hospitals. Ultimately, it argues that Plaintiffs' allegations do not state a cause of action under an alter-ego theory, agency theory, or direct liability theory. Further, it argues that Plaintiffs' FDUTPA claims fail because Plaintiffs did not and cannot allege that HCA was engaged in "trade or commerce" as required by the statute. Further, the breach of contract and breach of covenant of good faith and fair dealing claims do not state a cause of action because HCA is not a party to the Contracts.

The Defendant Hospitals argue that the Amended Complaint fails to state a claim for violation of the FDUTPA because Plaintiffs do not allege any "deceptive" or "unfair" conduct by the Defendant Hospitals. They also fail to allege breach of contract and breach of the implied covenant of good faith and fair dealing because Plaintiffs do not allege the Defendant Hospitals breached any of the express provisions in the Contracts.

IV. Parent-Subsidiary Liability

The Court finds *In re Managed Care Litigation* instructive on this issue . 298 F. Supp. 2d 1259 (S.D. Fla. 2003). Plaintiffs in that case brought a class action suit alleging ten separate causes of action against a parent company and its subsidiary hospitals based on their improper billing practices with respect to radiological services. Plaintiffs in that case also alleged that the parent company implemented the policy and instructed the subsidiary hospitals to carry out the practice. The court held that the plaintiffs sufficiently pled a cause of action for direct liability of the parent corporation where they alleged that "all of the substantive practices, policies, and procedures of the Defendants' health plans are established, implemented, monitored, and ratified by the Defendants *themselves*." *Id.* at 1309.

The Court finds this reasoning persuasive. Plaintiffs' allege, among other things, that:

> HCA is directly involved in setting and enforcing hospital guidelines and is specifically involved in the billing practices of these hospitals.... all HCA-owned and operated Florida hospitals, medical centers, and surgical centers, including Defendant Hospitals, acted as the agents of Defendant HCA and acted in the course and scope of their agency and were acting with the consent, permission, authorization, satisfaction, and knowledge of HCA, which ratified and approved of the actions of its hospitals, medical centers, and surgical centers.

The Court will permit Plaintiffs to proceed with its claims against HCA. *See also Jackam v. Hosp. Corp. of Am. Mideast, Ltd.,* 800 F.2d 1577 (11th Cir. 1986) (allegations that parent company established policies that subsidiary corporation executed as parent company's agent sufficiently stated cause of action, based on agency theory, to hold parent corporation

directly liable for subsidiary corporation's alleged breach of contract); *Teytelbaum v. Unum Group*, 8:09-CV-1231-T-33TBM, 2010 WL 4689818 at *1 (M.D. Fla. Nov. 11, 2010) (stating that it was a "fact intensive inquiry whether the parent company could be responsible for its subsidiary's breach of contract, and in any event, plaintiff alleged that both acting together caused the injuries.) Therefore, the Court denies HCA's motion to dismiss on this basis.

V. FDUTPA

In Count I of the Amended Complaint, Plaintiffs allege that Defendants violate the FDUTPA by using the unfair practice of charging unreasonable rates for PIP-covered radiological services following motor vehicle accidents. Plaintiffs' argue that the Defendants' actions are also deceptive because they conceal, or at a minimum do not disclose, their practice of charging the unreasonable prices to PIP-insured patients. Plaintiffs further allege that the Defendants "require emergency care patients, including Plaintiffs and the putative Class members, to sign contracts of adhesion that purport to expressly incorporate Defendants' Charge Master price list, but fail to contain a list of the Charge Master prices or otherwise provide notification of what the amounts of those prices are."

FDUTPA provides a civil cause of action for "[u]nfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce." Fla. Stat. § 501.204(1). To state a FDUTPA claim, a plaintiff must allege: "(1) a deceptive act or unfair practice; (2) causation; and (3) actual damages." *City First Mortg. Corp. v. Barton*, 988 So. 2d 82, 86 (Fla. 4th DCA 2008).

"The Florida Supreme Court has noted that 'deception occurs if there is a representation, omission, or practice that is likely to mislead the consumer acting reasonably in the circumstances, to the consumer's detriment.' " *Zlotnick v. Premier Sales Grp., Inc.*, 480 F.3d 1281, 1284 (11th Cir. 2007) (quoting *PNR, Inc. v. Beacon Prop. Mgmt.*, Inc., 842 So. 2d 773, 777 (Fla. 2003)). "An unfair practice is one that offends established public policy and one that is immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers." *Rollins, Inc. v. Butland*, 951 So. 2d 860, 869 (Fla. 2d DCA 2006) (internal quotation marks omitted). Under the FDUTPA , trade or commerce is defined as "the advertising, soliciting, providing, offering, or distributing, whether by sale rental, or otherwise, of any good or service, or any property, whether tangible or intangible, or any other article, commodity, or thing of value, wherever situated." Fla. Stat. § 501.203(8).

The Defendants argue that the Contracts expressly incorporate the Charge Master as the contractual price term. Since this information is readily apparent on the face of the Contracts, it negates Plaintiffs' contention that the Defendant Hospitals materially deceived them about the charges. Further, Plaintiffs do not allege that they ever requested copies of the Defendant Hospitals' price list. Defendants point to Section 395.301(1), Florida Statutes, which requires hospitals to "notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request." The statute further provides that hospitals must provide a good faith estimate of reasonably anticipated charges upon request for nonemergency medical services only. The Defendant Hospitals notify

patients of this right in the Contracts, and therefore maintain that they have met their obligation under the statute.

The Court has serious doubts that the Defendant Hospitals' practice of incorporating the Charge Master into the Contracts by reference rises to the level of unfairness and deception as contemplated by the FDUTPA. Nonetheless, the Court will give Plaintiffs an opportunity to prove their case recognizing that other courts have held that these types of allegations support a FDUTPA claim. *See Urquhart v. Manatee Mem'l Hosp.*, 8:06-cv-1418T-17EAJ, 2007 WL 781738, at *5 (M.D. Fla. Mar. 13, 2007) (although ultimately dismissing the FDUTPA claim because plaintiff failed to allege an injury, stating that uninsured plaintiff could allege an unfair practice under the FDUTPA in a case filed against a hospital and its parent corporation based on policy of charging objectively unreasonable prices); *Colomar v. Mercy Hosp., Inc.*, 461 F.Supp. 2d 1265, 1268 (S.D. Fla. 2006) (allegations of hospital's unreasonable pricing supported cause of action for an unfair practice under the FDUTPA). The Court denies HCA and the Defendant Hospitals' motions to dismiss Count I of the Amended Complaint and will revisit this issue at summary judgment.

VI. Breach of Contract

In Count II of their Amended Complaint, Plaintiffs allege a breach of contract based on incorporation of the PIP statute into the Contracts as a matter of Florida law. The PIP statute mandates that "[a]... hospital, ... lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance *may charge the insurer and injured party only a reasonable amount* pursuant to this section for the services and

supplies rendered. . . . such a charge may not exceed the amount the person or institution customarily charges for like services or supplies." Fla. Stat. § 627.736(5)(a) (emphasis added).

Section 627.736(5)(a) further provides that:

> [i]n determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

Plaintiffs allege that the Defendants breached the Contracts because they charged unreasonable rates. Further, Plaintiffs were not provided a copy of the Charge Master at the time of admission. Based on the foregoing, Plaintiffs argue that the Contracts contain a "vague, ambiguous, undefined, and nondescript pricing term," which "implies a contractual obligation on Plaintiffs to pay no more than the reasonable value [of the] services provided under the Contracts, and a corresponding obligation on Defendants to bill for no more than the reasonable value of the services provided under the Contracts."

Plaintiffs rely on *Florida Beverage Corp. v. Div. of Alcoholic Beverages & Tobacco, Dept. of Bus. Regulation*, for the proposition that the PIP statute is incorporated into the Contracts. 503 So. 2d 396, 398 (Fla. 1st DCA 1987) ("The laws in force at the time of the making of a contract enter into and form a part of the contract as if they were expressly incorporated into it."). Therefore, Plaintiffs argue that since the PIP statute requires that hospitals charge a reasonable rate, that obligation is an "express term" of the

Contracts which Defendants violated. At oral argument, the Plaintiffs explicitly stated that they are not proceeding under an adhesion contract theory.

Defendants first argue that the PIP statute should not be incorporated into the Contracts because it only provides a remedy to PIP insurers to challenge the reasonableness of the charges. Specifically, the statutory scheme provides that insurers can either pay a percentage of the hospital's "usual and customary charges" or dispute the reasonableness of the charges and submit the matter to a fact-finder. Further, Defendants argue, the PIP statute provides the insured only one private cause of action; a claim against the insurer for benefits owed.

To the extent that the Court does read the PIP statute into the Contracts, the Defendant Hospitals maintain that the PIP statute's reasonableness requirement is not in conflict with the Charge Master rates, because it reflects their usual and customary charges. Therefore, according to the Defendant Hospitals, their usual and customary charges are the upper limit of what is reasonable. Any differential in the charges are due to discounted rates negotiated by private insurance companies or mandated by the government under its Medicaid or Medicare programs.

The general doctrine regarding incorporation of statutes is that "where parties contract upon a subject which is surrounded by statutory limitations and requirements, they are presumed to have entered into their engagements with reference to such statute, and the same enters into and becomes a part of the contract." *Citizens Ins. Co. v. Barnes*, 98 Fla. 933, 124 So. 722, 723 (1929). *See also Weldon v. All Am. Life Ins. Co.*, 605 So. 2d 911, 914 (Fla. 2d DCA 1992) (applying the general principle to determine the extent to which a

chiropractor's services were covered under an insurance policy). PIP coverage is highly regulated by a comprehensive statutory scheme. *See Custer Med. Center v. United Auto. Ins. Co.*, 62 So. 3d 1086, 1089 n.1 (Fla. 2010) ("PIP insurance is markedly different from homeowner's/tenants insurance, property insurance, life insurance, and fire insurance, which are not subject to statutory parameters and are simply a matter of contract not subject to statutory requirements.").

The Southern District of Florida and various Florida state courts have held that allegations that a hospital charged unreasonable rates for its services support a breach of contract claim. *See Colomar*, 461 F. Supp. 2d 1265 (allegations that patients with insurance and government benefits received significant discounts in price they paid for hospital's services supported plaintiff's claim for breach of contract for unreasonable pricing); *Payne v. Humana Hospital*, 661 So. 2d 1239 (Fla. 1st DCA 1995) (reversing dismissal of putative class action suit premised on unreasonable rates charged by a hospital even though contract required the payment of "prevailing rates" and "regular charges," but did not "express prices within the four corners of the document." The court described the charge master as a "complicated and unobtainable master charge list containing hundreds of items"); *Mercy Hospital v. Carr*, 297 So. 2d 598 (Fla. 3rd DCA 1974) (holding that although plaintiff was liable for medical services rendered he was not bound by the amount of the charges listed in the admission contract as he was entitled to question the reasonableness of the charges).

In this case, the PIP statute imposes a duty on hospitals to charge a reasonable price to PIP patients for medical services. Although the statute explicitly provides a remedy to insurers to challenge the charges under its particular statutory scheme, it does not preclude

an insured from also challenging the reasonableness of the charges. Further, to the extent that Florida law permits hospitals to use a "charge master," the prices listed within it must still be reasonable.

Contrary to the Defendants' argument, even if the charges do not exceed the usual and customary charges for like services or supplies, the charges are not automatically reasonable. The statute itself provides guidance on determining the reasonableness of a specific charge, and includes other factors such as payments accepted by the hospital and charges within the community. *See* Fla. Stat. § 627.736(5)(a). Further, the Court rejects the argument that a PIP insurer's decision to pay a percentage of the billed charges implies that the insurer finds the charges reasonable. An insurer's business decision to pay rather than litigate does not preclude the patient from challenging the reasonableness of the charges, particularly when the patient is responsible for a percentage of those charges.

Therefore, the Court concludes that Plaintiffs may proceed with a breach of contract claim which incorporates the PIP statute's reasonableness requirement into the Contracts. Plaintiffs will have the opportunity to prove that the Defendant Hospitals' rates are unreasonable. The Court denies HCA and the Defendant Hospitals' motions to dismiss Count II of Plaintiffs' Amended Complaint.

VII. Breach of Covenant of Good Faith and Fair Dealing

In Count III of the Amended Complaint, Plaintiffs allege that the Defendants breached their duty of good faith and fair dealing by charging them unreasonable rates for medical services. Defendants maintain that Plaintiffs may not properly make this claim because they did not allege that Defendants breached an express term in the Contracts.

Florida contract law recognizes the implied covenant of good faith and fair dealing. *Anthony Distribs. v. Miller Brewing Co.*, 941 F.Supp. 1567, 1574 (M.D. Fla. 1996). However, "a claim for breach of the implied covenant of good faith and fair dealing cannot be maintained under Florida law absent an allegation that an express term of the contract has been breached." *Id.* Essentially, any claim of breach of the implied covenant of good faith and fair dealing is really a breach of contract claim, and "no independent cause of action exists under Florida law for breach of the implied covenant of good faith and fair dealing." *Burger King Corp. v. Weaver*, 169 F.3d 1310, 1317 (11th Cir. 1999). Accordingly, HCA and the Defendant Hospitals' motions to dismiss Count III of Plaintiffs' Amended Complaint for failure to state a claim is granted.

VIII. Motions to Strike Class Allegations

HCA and the Defendant Hospitals move to strike the class allegations because individual issues predominate, Plaintiffs lack standing to assert claims on behalf of patients treated at facilities other than those operated by the Defendant Hospitals and the geographic diversity and dispersion of the facilities preclude class treatment.

Although a plaintiff will typically move for class certification, the complaint's class action allegations create a court's "independent obligation to decide whether an action was properly brought as a class action, even where ... neither party moves for a ruling on class certification." *Martinez–Mendoza v. Champion Intern. Corp.*, 340 F.3d 1200, 1216 n. 37 (11th Cir. 2003) (citing *McGowan v. Faulkner Concrete Pipe Co.*, 659 F.2d 554, 559 (5th Cir. Unit A 1981). *See also MRI Assocs. of St. Pete, Inc. v. State Farm Mut. Auto. Ins. Co.*,

755 F.Supp. 2d 1205, 1207 (M.D. Fla. 2010) (Moody, J.) ("Where the propriety of a class action procedure is plain from the initial pleadings, a district court may rule on this issue prior to the filing of a motion for class certification."). Therefore, it is appropriate to review the class allegations at this juncture to determine whether a class may stand.

Given the nature of the claims and individual factual inquiries required, it is clear the individualized issues are predominant and this suit cannot proceed as a class action. Individualized money claims belong in Rule 23(b)(3) class action suits. *Wal–Mart Stores, Inc. v. Dukes*, 131 S.Ct. 2541, 2558 (2011). The standard for a 23(b)(3) suit is "that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy." Fed.R.Civ.P. 23(b)(3).

In this case, the threshold inquiry is whether the Plaintiffs were charged an unreasonable rate for their specific medical service, which would affect the portion of their PIP benefits prematurely depleted and the portion of the charge for which they were individually responsible. If this case were to proceed, the most important issue to settle, the reasonableness of the charge for the specific radiological service and the damages incurred by each putative plaintiff, would be highly individualized in nature. What is a reasonable charge for radiological services in one geographical area may not be reasonable for another.

Further, for those class members whose PIP benefits were completely depleted by the Defendant Hospitals' allegedly unreasonable charges, the Plaintiffs seek reimbursement for any payments made to third party providers that would have been

covered by their PIP coverage. In those cases, the Court would have to analyze whether each Plaintiff had co-insurance which should have covered those expenses, whether the medical services were reasonable and necessary and related to the motor vehcile accident so that the PIP coverage would apply, and given the allegations in this case, whether the third party provider's charges are "reasonable." After consideration of these factors, the Court's calculation of what constitutes a "reasonable amount" weighs strongly against the use of a class action. *MRI Associates of St. Pete, Inc.*, 755 F. Supp. 2d at 1208 (finding that action for PIP benefits requiring the court to determine what constituted a "reasonable amount" was inappropriate for a class action proceeding) (citing *State Farm Mut. Auto. Ins. Co. v. Sestile*, 821 So. 2d 1244 (Fla. 2d DCA 2002)).

The Eleventh Circuit is clear on this issue. When "significant individualized issues with respect to breach, materiality, and damages" exist, plaintiff cannot satisfy the predominance element required for class certification. *Vega v. T-Mobile USA,* Inc., 564 F.3d 1256, 1274 (11th Cir. 2009). *See also Shenandoah Chiropractic, P.A. v. National Specialty Insurance Company*, 526 F. Supp. 2d 1283 (S.D. Fla. 2007) (striking class allegations based on breach of contract claim under PIP statute). Since the individual factual inquiries will predominate in this litigation, making any sort of class litigation highly impractical, the class allegations will be stricken. *See Vandenbrink v. State Farm Mut. Auto. Ins. Co.*, 8:12-CV-897-T-30TBM, 2012 WL 3156596, at *3 (M.D. Fla. Aug. 3, 2012) (Moody, J.) (striking class allegations where individual issues predominated.)

Conclusion

Plaintiffs' allegations are minimally sufficient to plead a cause of action under the FDUTPA, and are sufficient to support a breach of contract action against all Defendants. However, there is no independent cause of action for breach of implied covenant of good faith and fair dealing. Because Plaintiffs' allegations clearly require a highly individualized analysis of the damages issue, precluding class treatment, the Court need not determine Plaintiffs' Article III standing.

It is therefore **ORDERED AND ADJUDGED** that:

1. Defendant HCA Holdings, Inc.'s Motion Requesting Judicial Notice and Incorporated Memorandum of Law (Dkt. #34) is GRANTED.
2. Defendant HCA Holdings, Inc.'s Motion to Dismiss Amended Complaint with Prejudice, Motion to Strike Class Allegations, and Joinder in Hospital Defendants' Motion to Dismiss and Motions to Strike, with Incorporated Memorandum of Law (Dkt. #35) is GRANTED in part.
3. JFK Limited Center Partnership d/b/a JFK Medical Center, Memorial Healthcare Group, Inc. d/b/a Memorial Hospital Jacksonville, and North Florida Regional Medical Center, Inc.'s Motion to Dismiss and Motion to Strike and Supporting Memorandum of Law (Dkt. #36) is GRANTED in part.
4. The Court dismisses Count III of the Amended Complaint.
5. The Court strikes Plaintiffs' class allegations.

6. Marisela Herrera may proceed with this action. The remaining Plaintiffs are dismissed without prejudice and may file separate individual actions.

DONE and **ORDERED** in Tampa, Florida, this 20th day of February, 2015.

JAMES S. MOODY, JR.
UNITED STATES DISTRICT JUDGE

Copies furnished to:
Counsel/Parties of Record

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

MARISELA HERRERA, LUZ SANCHEZ, NICHOLAS ACOSTA, and PENNY WOLLMEN, individually and on behalf of others similarly situated,

Plaintiffs,

v.

CASE NO: 8:14-cv-02327-T30-JSM

CLASS ACTION

JFK MEDICAL CENTER LIMITED PARTNERSHIP d/b/a JFK MEDICAL CENTER; MEMORIAL HEALTHCARE GROUP, INC., d/b/a MEMORIAL HOSPITAL JACKSONVILLE; NORTH FLORIDA REGIONAL MEDICAL CENTER, INC., and HCA HOLDINGS, INC.,

Defendants.
_____/

AMENDED CLASS ACTION COMPLAINT
AND DEMAND FOR JURY TRIAL

Pursuant to Rule 15(a)(1)(B) of the Federal Rules of Civil Procedure, Plaintiffs MARISELA HERRERA, LUZ SANCHEZ, NICHOLAS ACOSTA, and PENNY WOLLMEN, individually and on behalf of all others similarly situated, hereby file suit against Defendants, JFK MEDICAL CENTER LIMITED PARTNERSHIP; MEMORIAL HEALTHCARE GROUP, INC.; NORTH FLORIDA REGIONAL MEDICAL CENTER, INC., and HCA HOLDINGS, INC., and allege:

I. INTRODUCTION

1. Plaintiffs Marisela Herrera, Luz Sanchez, Nicholas Acosta, and Penny Wollmen bring this Class Action Complaint against JFK Medical Center Limited Partnership, doing business under the name JFK Medical Center; Memorial Healthcare Group, Inc., doing business under the name Memorial Hospital Jacksonville; North Florida Regional Medical Center, Inc.; and HCA Holdings, Inc., challenging Defendants' unreasonable, unconscionable, and unlawful pricing and billing practices with respect to Plaintiffs and other similarly-situated patients who received emergency medical treatment at an HCA-operated facility in Florida following a motor vehicle accident and were billed exorbitant and unreasonable charges for radiological services partially covered through their Florida Personal Injury Protection insurance coverage ("PIP").

2. PIP is required of all drivers in Florida. By statute, hospitals treating patients covered by PIP may charge the insurer and the injured party only a "reasonable amount" for services and supplies rendered. § 627.736(5)(a), Fla. Stat. The charge for such services and supplies "may not exceed the amount the person or institution customarily charges for like services or supplies" and the "reasonable amount" for such services and supplies is directly related to the "usual and customary charges and payments accepted by the provider" for such services and supplies, as well as "reimbursement levels in the community" and "federal and state medical fee schedules." *Id.*

3. With numerous emergency care facilities in Florida, Defendants see thousands of patients each year, many of whom receive imaging studies, such as CT scans, MRIs, Ultrasounds, and X-rays (collectively referred to as "Radiological Services").

4. In direct contravention of the Florida Motor Vehicle No-Fault Law ("PIP Statute"), HCA-operated facilities in Florida, including, but not limited to, Defendants JFK Medical Center, Memorial Hospital Jacksonville, and North Florida Regional Medical Center, charge well in excess of the "reasonable amount" for Radiological Services provided to PIP-covered patients. Upon information and belief, the HCA hospitals and emergency facilities charge PIP patients rates for Radiological Services that are up to 65 times higher than the hospitals' usual and customary charges and/or payments accepted for similar Radiological Services for non-PIP patients.

5. These exorbitant and unreasonable charges harm Plaintiffs in two different ways. First, because PIP covers only 80% of the emergency medical care received, up to $10,000, § 627.736(1)(a)(3), Fla. Stat., the exorbitant and unreasonable charges leave Plaintiffs responsible for part of Defendants' inflated bills. Second, the exorbitant and unreasonable charges prematurely exhaust the PIP coverage available to Plaintiffs, resulting in Plaintiffs having to pay out of pocket for additional medical services that would otherwise have been covered under PIP.

6. Plaintiffs bring this class action on behalf of themselves and all other similarly-situated individuals (or their guardians or representatives) who received PIP-covered emergency care Radiological Services at an HCA-operated facility in Florida and who either: (a) were billed by the facility for any portion of the charges for such services; and/or (b) had their $10,000 of PIP coverage prematurely exhausted by the facility's charges for such services and, as a result, were billed for additional medical services rendered by the facility and/or third-party providers that would otherwise have been covered under PIP.

II. JURISDICTION

7. This is a class action for damages that exceed $5,000,000, exclusive of interest and costs.

8. Plaintiff Herrera is a citizen and resident of Florida, over the age of eighteen years, and otherwise *sui juris*.

9. Plaintiff Sanchez is a citizen and resident of Florida, over the age of eighteen years, and otherwise *sui juris*.

10. Plaintiff Acosta is a citizen and resident of Florida, over the age of eighteen years, and otherwise *sui juris*.

11. Plaintiff Wollmen is a citizen and resident of Florida, over the age of eighteen years, and otherwise *sui juris*.

12. Defendant JFK Medical Center Limited Partnership is a Delaware partnership, whose partners are not citizens of Florida, authorized to do business and doing business in Florida. Its principal place of business is One Park Plaza, Nashville, Tennessee. It is a subsidiary or affiliate of Defendant HCA Holdings, Inc., and owns JFK Medical Center, located in Atlantis, Florida. JFK Medical Center Limited Partnership, which does business under the JFK Medical Center, is engaged in substantial, continuous, systematic, and non-isolated business activity within the state of Florida. It is subject to personal jurisdiction in the state of Florida because it regularly conducts business in the state of Florida and it committed the tortious acts alleged herein in the state of Florida. On its website, JFK openly acknowledges its affiliation with HCA.

13. Defendant Memorial Healthcare Group, Inc., is a Florida corporation whose principal place of business is One Park Plaza, Nashville, Tennessee, and, therefore, is a citizen of both Florida and Tennessee under 28 U.S.C. § 1332(c)(1). It is a subsidiary or affiliate of Defendant HCA Holdings, Inc., and owns Memorial Hospital Jacksonville, located in Jacksonville, Florida. Defendant Memorial Healthcare Group does business under the name Memorial Hospital Jacksonville. On its website, Memorial Hospital Jacksonville openly acknowledges its affiliation with HCA.

14. Defendant North Florida Regional Medical Center, Inc., is a Florida corporation whose principal place of business is One Park Plaza, Nashville, Tennessee, and, therefore, is a citizen of both Florida and Tennessee under 28 U.S.C. § 1332(c)(1). It is a subsidiary or affiliate of Defendant HCA Holdings, Inc., and owns North Florida Regional Medical Center, located in Gainesville, Florida. On its website, North Florida Regional Medical Center openly acknowledges its affiliation with HCA.

15. Defendant HCA Holdings, Inc., ("HCA") is a Delaware corporation whose principal place of business is One Park Plaza, Nashville, Tennessee. HCA is authorized to do business and doing business throughout Florida through approximately 80 HCA-owned and operated hospitals, medical centers and surgical centers, among them JFK Medical, Memorial Hospital Jacksonville, and North Florida Regional Medical Center. Venue is proper in this District, where HCA maintains an agent or other representative, and conducts business through its numerous subsidiaries, including hospitals, medical centers and surgical centers owned or operated by subsidiaries or affiliates of HCA. These facilities include Tampa Community Hospital, Memorial Hospital in Tampa, Brandon Regional Hospital,

Brandon Regional Hospital Emergency Center at Plant City, South Bay Hospital, Blake Medical Center, Central Florida Regional Hospital, Edward White Hospital, Fawcett Memorial Hospital, Ocala Regional Medical Center, and Osceola Regional Medical Center. HCA is engaged in substantial, continuous, systematic and non-isolated business activity within the state of Florida. HCA is subject to personal jurisdiction in the state of Florida because it regularly conducts business in the state of Florida and it committed the tortious acts alleged herein in the state of Florida.

16. Defendant HCA owns, operates and controls the activities of the other hospital defendants, and shares the same location as its principal place of business—One Park Plaza, Nashville, Tennessee. In public documents, HCA makes clear that it does more than simply monitor its subsidiary hospitals – to the contrary, HCA is directly involved in setting and enforcing hospital guidelines and is specifically involved in the billing practices of these hospitals. In HCA's Annual Report for 2013, filed with the Securities and Exchange Commission, HCA explains that as of "December 31, 2013, [*it*] operated 165 hospitals, comprised of 159 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital."[1]

17. HCA's strict control of its subsidiary hospitals is further confirmed in its 2013 Annual Report where it notes that HCA imposes a "Code of Conduct" that is applicable to all its directors, officers, and employees.[2] The Code of Conduct is found on HCA's Website,

[1] HCA's 2013 Annual Report to Stockholders, *available at* http://investor.hcahealthcare.com/sites/hcahealthcare.investorhq.businesswire.com/files/report/file/HCA_2013_Annual_Report.pdf, at p. 3.
[2] *Id.* at 84.

and attached hereto as Exhibit A. HCA's Code of Conduct delineates and specifies HCA's mission for quality patient care and the conduct it expects from its hospital employees. In its Code of Conduct, HCA states that: "Our Code of Conduct provides guidance to all HCA colleagues and assists us in carrying out our daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with patients, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors, consultants, and one another." (Ex. A at 4).

18. With respect to patient care, HCA states the following in its Code of Conduct:

a. "We are committed to providing quality care that is sensitive, compassionate, promptly delivered, and cost effective." (Ex. A at 7);

b. "Our mission is to provide high quality, cost effective healthcare to all of our patients. To that end, we are committed to the delivery of safe, effective, efficient, compassionate and satisfying patient care. We treat all patients with warmth, respect, and dignity and provide care that is both necessary and appropriate. HCA has a comprehensive program to promote the quality objectives of the organization." (Ex. A at 8);

c. "Each patient is provided with a written statement of patient rights and a notice of privacy practices. Whenever possible, this notice of patient rights is provided before providing or stopping care in a language or manner that the patient (or patient's representative) can understand." (Ex. A at 9);

d. "HCA facilities maintain an ongoing, proactive patient safety effort for the identification of risk to patient safety and the prevention, reporting and reduction of healthcare errors." (Ex. A at 10);

e. "We collect information about the patient's medical condition, history, medication, and family illnesses in order to provide quality care." (Ex. A at 11);

f. "We have implemented policies, procedures and systems to facilitate accurate billing to government payers, commercial insurance payers, and patients." (Ex. A at 15); and

g. "We expect those physicians [who treat patients in our facilities] to provide us with complete and accurate information in a timely manner." (Ex. A at 15).

19. HCA's website also contains a "Guiding Principles" brochure where HCA delineates certain requirements and procedures for all HCA employees working at its hospitals, such as: 1) work schedules must be posted at least 14 days in advance; 2) employees shall be off at least one-half of the weekends, unless an employee requests a "weekend only" schedule; 3) a staff Call-off policy; 4) an RN Floating Policy; and 5) a mandatory overtime policy. (See Brochure, attached hereto as Exhibit B, at pp. 10-11). The brochure concludes with the following statement, "We are committed to making our facility a better place to work…a place where you can feel empowered to contribute to providing the best patient care possible. Thank you for being part of the HCA family, and know we are working hard to be an organization that makes you proud to be a part of it." (Ex. B at 12).

20. HCA's control over its hospital subsidiaries is further explained in its 2013 Annual Report whereby HCA notes that:

a. "Our[3] general, acute care hospitals typically provide a full range of services to accommodate such medical specialties as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics and obstetrics, as well as diagnostic and emergency services." (HCA's 2013 Annual Report to Stockholders at 3);

b. "We are committed to providing the communities we serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our stockholders. To achieve these objectives, we align our efforts around the following growth agenda:

   i. Grow our Presence in Existing Markets. . . .

   ii. Achieve Industry-Leading Performance in Clinical and Satisfaction Measures. . . .

   iii. Recruit and Employ Physicians to Meet the Need for High Quality Health Services. . . .

   iv. Continue to Leverage our Scale and Market Positions to Enhance Profitability. . . .

   v. Selectively Pursue a Disciplined Development Strategy. . . ." (*Id.* at 60-61);

c. "We receive payments for patient services from the federal government under the Medicare program, state governments under their respective Medicaid or similar

[3] In the Annual Report, the terms "Company," "HCA," "we," "our" or "us" refer to HCA and its "affiliates." "Affiliates" means its direct and indirect subsidiaries of HCA. (HCA's 2013 Annual Report to Stockholders at p. 3). Moreover, the terms "facilities" and "hospitals" explicitly refer to entities owned and operated by affiliates of HCA. *Id.*

programs, managed care plans, private insurers and directly from patients." (*Id.* at 5);

d. "Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including private insurance companies, employers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other managed care plans, including plans offered through the American Health Benefit Exchanges ("Exchanges"). These discount programs generally limit our ability to increase revenues in response to increasing costs." (*Id.* at 6);

e. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care under our charity care policy. These discounts are similar to those provided to many local managed care plans. In implementing the uninsured discount policy, we attempt to qualify uninsured patients for Medicaid, other federal or state assistance or charity care under our charity care policy. If an uninsured patient does not qualify for these programs, the uninsured discount is applied." (*Id.* at 6);

f. "Although physicians may at any time terminate their relationship with a hospital we operate, our hospitals seek to retain physicians with varied specialties on the hospitals' medical staffs and to attract other qualified physicians. We believe physicians refer patients to a hospital on the basis of the quality and scope of services it renders to patients and physicians, the quality of physicians on the medical staff, the location of the hospital and the quality of the hospital's facilities, equipment and employees. Accordingly, we strive to maintain and provide quality facilities, equipment, employees and services for physicians and patients." (*Id.* at 17);

g. "Our facilities are heavily concentrated in Florida and Texas, which makes us sensitive to regulatory, economic, environmental and competitive conditions and changes in those states. We operated 165 hospitals at December 31, 2013, and 78 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities' combined revenues represented approximately 46% of our consolidated revenues for the year ended December 31, 2013." (*Id.* at 49) (emphasis removed);

h. "We are committed to providing the communities we serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our stockholders." (*Id.* at 60);

i. "At December 31, 2013, we owned and operated 42 hospitals and 32 surgery centers in the state of Florida. Our Florida facilities' revenues totaled $7.545 billion, $7.336 billion and $6.989 billion for the years ended December 31, 2013, 2012 and 2011, respectively." (*Id.* at 68).

21. Upon information and belief, Defendant HCA exercises control over its hospitals, medical centers, and surgical centers, including Defendants JFK Medical Center, Memorial Hospital Jacksonville, and North Florida Regional Medical Center, by developing and controlling pricing practices, including pricing policies and practices for PIP-insured patients, and exerting control over its member hospitals' pricing policies, including the policy and practice to impose unreasonable and inflated rates upon PIP-insured patients. The fact that HCA controls the subsidiary hospital defendants' pricing can be found on HCA's own website (which currently is linked to each of the Defendant Hospitals' websites), which states:

> HCA is pleased to introduce our pricing transparency initiative. To best serve patients and provide a meaningful estimate of out of pocket expenses, our information is specific to each hospital.
>
> Clicking on a hospital name below will take you to the *Patient Financial Resource* site for that facility. (You can also access your HCA hospital's *Patient Financial Resource* site by visiting that hospital's Web site and clicking on the "Patient Financial Information" button on the main page.) There you can get a pricing estimate for our most frequently used healthcare services, payment options and alternatives available to patients without healthcare coverage and contact information to call us directly for a pricing estimate.
>
> This is a groundbreaking healthcare initiative and we hope, through the information found on our site and our toll-free phone line to our Service Representatives, patients can learn more Pricing and Financial Information about the financial side of their healthcare needs.[4]

[4] *Available at* http://hcahealthcare.com/pricing-financing/.

22. In addition to HCA's control of the subsidiary hospital defendants (as noted above), at all times and for all acts material hereto, all HCA-owned and operated Florida hospitals, medical centers, and surgical centers, including Defendants JFK Medical Center, Memorial Hospital Jacksonville, North Florida Regional Medical Center, also acted as the agents of Defendant HCA, and acted in the course and scope of their agency and were acting with the consent, permission, authorization, satisfaction, and knowledge of HCA, which ratified and approved of the actions of its hospitals, medical centers, and surgical centers. As noted above, HCA acknowledged that each of these subsidiary hospitals were acting for the benefit of HCA when they provided services to the Plaintiffs; each subsidiary hospital acknowledged this; and HCA exercised control of the hospital subsidiaries with respect to its billing practices.

III. FACTUAL ALLEGATIONS

A. The Florida PIP Statute

23. The Florida Motor Vehicle No-Fault Law requires all residents of Florida who own a motor vehicle to purchase PIP in the amount of $10,000 per person. § 627.736(1), Fla. Stat. PIP covers loss resulting from bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle if, *inter alia*, a physician, dentist, physician assistant, or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition. § 627.736(1)(a)(3), Fla. Stat.

24. Under section 627.736(5)(a) of the PIP Statute, a physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by PIP may charge the insurer and the injured party "only a reasonable amount pursuant to this section for the services and supplies rendered." Further, such charge "may not exceed the amount the person or institution customarily charges for like services or supplies." §627.736(5)(a), Fla. Stat. The PIP Statute also explicitly defines the methodology for determining whether a charge for services or treatment is "reasonable":

> [C]onsideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

Id.

25. PIP covers only 80% of the charges incurred as a result of emergency medical care received, up to $10,000, § 627.736(1)(a)(3), Fla. Stat., thus leaving PIP-covered patients responsible for part of these charges. Once the $10,000 of PIP coverage is exhausted, PIP-covered patients without another form of applicable insurance are responsible for 100% of any additional charges incurred.

B. HCA's Violation of PIP

26. When emergency care patients arrive at Defendant HCA's Florida hospitals, including the Defendant hospitals, they are required to sign contracts of adhesion governing the conditions of admission and treatment. Upon information and belief, emergency care patients at all HCA facilities in Florida are required to sign the same or substantially similar contracts as those used at JFK Medical Center, Memorial Hospital Jacksonville, and North Florida Regional Medical Center. Although the contracts contain generic financial liability provisions, they do not identify, describe, or specify the pricing terms or financial liability for any signing patient. Although the contracts purport to require payments at the rates stated in the hospital's "Charge Master" price list, the contracts do not contain a list of the Charge Master prices or otherwise provide notification of what the amounts of those prices are.

27. Because Defendants have never disclosed their Charge Master prices to Plaintiffs, it is impossible for Plaintiffs to know whether they were billed at Defendants' Charge Master rates for their PIP-covered emergency Radiological Services. Regardless, pursuant to the PIP Statute, the Defendant hospitals may charge only a "reasonable amount" for emergency services and that amount "may not exceed the amount the [hospital] customarily charges for like services or supplies." §627.736(5)(a), Fla. Stat. Any contractual provision that purports to allow Defendants to charge in excess of the amount allowed by the PIP statute is void as a matter of law.

28. In direct contrast to the PIP Statute's requirement that hospitals charge only a "reasonable amount," Defendants bill for emergency Radiological Services provided to PIP-covered patients at grossly inflated, unreasonable rates. Upon information and belief, the

HCA hospitals and emergency facilities charge PIP patients rates for Radiological Services that are up to 65 times higher than the hospitals' usual and customary charges and/or payments accepted for similar Radiological Services for non-PIP patients. As a direct result of Defendants' billing at exorbitant and unreasonable rates, PIP emergency-care patients are billed more for their out-of-pocket portion of the rates charged for emergency Radiological Services than they would have been if such services were provided at reasonable rates. Defendants' exorbitant and unreasonable rates also deplete the PIP coverage available to the patients at a faster rate, resulting in the patients being billed out-of-pocket for additional medical services rendered by Defendants and third-party providers that would have otherwise been covered under PIP.

C. Plaintiff Herrera's Experience with HCA

29. On or about April 9, 2013, Ms. Herrera was involved in an automobile accident. As a result of the accident, Ms. Herrera needed medical care and treatment, which she received through the emergency department at JFK Medical Center. Upon admission, Ms. Herrera executed a "Conditions of Admission" form (attached as Exhibit C). Among other things, the "Conditions of Admission" form had Ms. Herrera acknowledge that she agreed to pay "the rates stated in the hospital's price list (known as the 'Charge Master')." The so-called "price list," however, was never provided to Ms. Herrera.

30. The emergency room physician who treated Ms. Herrera ordered a CT scan of her cervical spine without contrast; a CT scan of her brain without contrast; an x-ray of her lumbar spine with 4 views; and an x-ray of her thoracic spine with 3 views.

31. JFK Medical Center billed the following exorbitant and unreasonable charges for these Radiological Services: $5,900 for the CT scan of her spine; $6,404 for the CT scan of her brain; $3,359 for the lumbar spine x-ray; and $2,222 for the thoracic spine x-ray. (See Exhibit D).

32. Because of the exorbitant and unreasonable amounts of these charges, Plaintiff Herrera's PIP coverage of $10,000 was prematurely exhausted, she was billed by JFK Medical Center for Radiological Services that were not paid by her PIP insurer, and she had to pay out of pocket for other medical services rendered by third party providers that would have otherwise been covered by her PIP benefits if not prematurely exhausted by the hospital's unreasonable charges. To date, Plaintiff Herrera has been billed over $6,500 by JFK Medical Center for Radiological Services. She has also separately paid over $4,000 out of pocket for medical services rendered by third parties related to her automobile accident, and these charges would have been covered in full or in part by her PIP benefits if not prematurely exhausted by the exorbitant and unreasonable amounts of the hospital's charges.

D. Plaintiff Sanchez's Experience with HCA

33. On or about May 1, 2013, Ms. Sanchez was involved in an automobile accident. As a result of the accident, Ms. Sanchez needed medical care and treatment, which she received through the emergency department at JFK Medical Center. Upon admission, Ms. Sanchez executed a "Conditions of Admission" form (attached as Exhibit E). Among other things, the "Conditions of Admission" form had Ms. Sanchez acknowledge that she agreed to pay "the rates stated in the hospital's price list (known as the 'Charge Master')." The so-called "price list," however was never provided to Ms. Sanchez.

34. The emergency room physician who treated Ms. Sanchez ordered a CT scan of her cervical spine without contrast; a CT scan of her brain without contrast; and an x-ray of her thoracic spine with 3 views.

35. JFK Medical Center billed the following exorbitant and unreasonable charges for these Radiological Services: $5,900 for the CT scan of her spine; $6,404 for the CT scan of her brain; and $2,222 for the thoracic spine x-ray. (See Exhibit F).

36. Because of the exorbitant and unreasonable amounts of these charges, Plaintiff Sanchez's PIP coverage of $10,000 was prematurely exhausted, she was billed by JFK Medical Center for Radiological Services that were not paid by her PIP insurer, and she had to pay out of pocket for other medical services rendered by third party providers that would have otherwise been covered by her PIP benefits if not prematurely exhausted by the hospital's unreasonable charges. To date, Plaintiff Sanchez has been billed over $2,500 by JFK Medical Center for Radiological Services. She has also separately paid over $2,000 out of pocket for medical services rendered by third parties related to her automobile accident, and these charges would have been covered in full or in part by her PIP benefits if not prematurely exhausted by the exorbitant and unreasonable amounts of the hospital's charges.

E. Plaintiff Acosta's Experience with HCA

37. On or about October 11, 2013, Mr. Acosta was involved in an automobile accident. As a result of the accident, Mr. Acosta needed medical care and treatment, which he received through the emergency department at Memorial Hospital Jacksonville. Upon admission, Mr. Acosta executed a "Conditions of Admission" form (attached as Exhibit G). Among other things, the "Conditions of Admission" form had Mr. Acosta acknowledge that he agreed to pay "the rates stated in the hospital's price list (known as the 'Charge Master')." The so-called "price list," however was never provided to Mr. Acosta.

38. The emergency room physician who treated Mr. Acosta ordered a CT scan of his cervical spine without contrast and a CT scan of his brain without contrast.

39. Memorial Hospital Jacksonville billed the following exorbitant and unreasonable charges for these Radiological Services: $6965 for the CT scan of his spine; $6277 for the CT scan of his brain. (See Exhibit H).

40. Because of the exorbitant and unreasonable amounts of these charges, Plaintiff Acosta's PIP coverage of $10,000 was prematurely exhausted, he was billed by Memorial Hospital Jacksonville for Radiological Services that were not paid by his PIP insurer, and he had to pay out of pocket for other medical services rendered by third party providers that would have otherwise been covered by his PIP benefits if not prematurely exhausted by the hospital's unreasonable charges. To date, Plaintiff Acosta has been billed over $7,000 by Memorial Hospital Jacksonville for Radiological Services. He has also been billed for medical services rendered by third parties related to his automobile accident, and these

charges would have been covered in full or in part by his PIP benefits if not prematurely exhausted by the exorbitant and unreasonable amounts of the hospital's charges.

F. Plaintiff Wollmen's Experience with HCA

41. On or about February 5, 2014, Ms. Wollmen was involved in an automobile accident. As a result of the accident, Ms. Wollmen needed medical care and treatment, which she received through the emergency department at North Florida Regional Medical Center. Upon admission, Ms. Wollmen executed a "Conditions of Admission" form (attached as Exhibit I). Among other things, the "Conditions of Admission" form had Ms. Wollmen acknowledge that she agreed to pay "the rates stated in the hospital's price list (known as the 'Charge Master')." The so-called "price list," however was never provided to Ms. Wollmen.

42. The emergency room physician who treated Ms. Wollmen ordered a CT scan of her cervical spine without contrast; a CT scan of her brain without contrast; and an x-ray of her thoracic spine with 3 views.

43. North Florida Regional Medical Center billed the following exorbitant and unreasonable charges for these Radiological Services: $6853 for the CT scan of her cervical spine; $6140 for the CT scan of her brain; and $1454 for the x-ray of her thoracic spine. (See Exhibit J).

44. Because of the exorbitant and unreasonable amounts of these charges, Plaintiff Wollmen's PIP coverage of $10,000 was prematurely exhausted and she had to pay out of pocket for other medical services rendered by third party providers that would have otherwise been covered by her PIP benefits if not prematurely exhausted by the hospital's unreasonable charges. For instance, Plaintiff Wollmen has been billed for visits to a chiropractor for treatment related to her automobile accident, and these charges would have been covered in full or in part by her PIP benefits if not prematurely exhausted by the exorbitant and unreasonable amounts of the hospital's charges.

G. Plaintiffs and All Class Members Have Been Charged Unreasonable Rates for Radiological Services

45. Defendants' charges to Plaintiffs Herrera, Sanchez, Acosta, and Wollmen, and to the Class Members, for CT scans of the cervical spine without contrast are unreasonable, exorbitant, and unfairly inflated:

a. Each Plaintiff was billed in excess of $5,000 for a CT scan of the cervical spine without contrast.

b. The Florida Medicare rates for a CT scan of the cervical spine without contrast range from approximately $213 to $220. Defendants billed the Plaintiffs at a rate more than 25 times higher than the Medicare rate for the performance of a CT scan of the cervical spine without contrast.

c. Upon information and belief, Defendants' charges for CT scans of the cervical spine without contrast greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by a private non-PIP insurer, such as an HMO or private medical insurer, including insurers that do not have a contract with Defendant HCA or the particular hospital that rendered the CT scan.

d. Upon information and belief, Defendants' charges for CT scans of the cervical spine without contrast greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by an uninsured patient.

1. JFK Medical Center represents that it charges uninsured patients between $1,596 - $3,464 for a diagnostic CT Scan.[5]
2. Memorial Hospital Jacksonville represents that it charges uninsured patients between $1,696 - $1,924 for a diagnostic CT Scan.[6]
3. North Florida Regional Center represents that it charges uninsured patients between $1,881 - $3,326 for a diagnostic CT Scan. [7]

[5] *See* JFK's Pricing Estimates and Information - Uninsured Patients, *available at* http://jfkmc.com/patient-financial/index.dot?page_name=pricing_print, *last accessed* October 9, 2014.

[6] *See* Memorial Hospital Jacksonville's Pricing Estimates and Information - Uninsured Patients, *available at* http://memorialhospitaljax.com/patient-financial/index.dot?page_name=pricing_print, *last accessed* October 9, 2014.

[7] *See* North Florida Regional Medical Center's Pricing Estimates and Information - Uninsured Patients, *available at* http://nfrmc.com/patient-financial/index.dot?page_name=pricing_print, *last accessed* October 9, 2014.

e. Upon information and belief, Defendants' charges for CT scans of the cervical spine without contrast greatly exceed the average amount non-HCA hospitals in the same market charge and accept for the same service.

f. Upon information and belief, Defendants' charges for CT scans of the cervical spine without contrast greatly exceed Defendants' costs in providing such service.

46. Defendants' Defendants' charges to Plaintiffs Herrera, Sanchez, Acosta, and Wollmen, and to the Class Members, for CT scans of the brain without contrast are unreasonable, exorbitant, and unfairly inflated:

a. Each Plaintiff was billed in excess of $6,000 for a CT scan of the brain without contrast.

b. The Florida Medicare rates for a CT scan of the brain without contrast range from approximately $164 to $169. Defendants billed the Plaintiffs at a rate over 35 times higher than the Medicare rate for the performance of a CT scan of the brain without contrast.

c. Upon information and belief, Defendants' charges for a CT scan of the brain without contrast greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by a private non-PIP insurer, such as an HMO or private medical insurer, including insurers that do not have a contract with Defendant HCA or the particular hospital that rendered the CT scan.

d. Upon information and belief, Defendants' charges for a CT scan of the brain without contrast greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by an uninsured patient.

    1. JFK Medical Center represents that it charges uninsured patients between $1,596 - $3,464 for a diagnostic CT Scan.[8]

    2. Memorial Hospital Jacksonville represents that it charges uninsured patients between $1,696 - $1,924 for a diagnostic CT Scan.[9]

    3. North Florida Regional Center represents that it charges uninsured patients between $1,881 - $3,326 for a diagnostic CT Scan. [10]

e. Upon information and belief, Defendants' charges for a CT scan of the brain without contrast greatly exceed the average amount non-HCA hospitals in the same market charge and accept for the same service.

f. Upon information and belief, Defendants' charges for a CT scan of the brain without contrast greatly exceed Defendants' costs in providing such service.

[8] *See* JFK's Pricing Estimates and Information - Uninsured Patients, *available at* http://jfkmc.com/patient-financial/index.dot?page_name=pricing_print, *last accessed* October 9, 2014.

[9] *See* Memorial Hospital Jacksonville's Pricing Estimates and Information - Uninsured Patients, *available at* http://memorialhospitaljax.com/patient-financial/index.dot?page_name=pricing_print, *last accessed* October 9, 2014.

[10] *See* North Florida Regional Medical Center's Pricing Estimates and Information - Uninsured Patients, *available at* http://nfrmc.com/patient-financial/index.dot?page_name=pricing_print, *last accessed* October 9, 2014.

47. Defendants' charges to Plaintiffs Sanchez, Herrera, and Wollmen, and to the Class Members, for thoracic spine x-rays with 3 views is unreasonable, exorbitant, and unfairly inflated:

a. Plaintiffs Sanchez and Herrera were billed in excess of $2,200 for thoracic spine x-rays with 3 views, and Plaintiff Wollmen was billed in excess of $1,400.

b. The Florida Medicare rates for an x-ray of the thoracic spine with 3 views are approximately $40. Defendants billed the Plaintiffs at a rate more than 36 times higher than the Medicare rate for the performance of an x-ray of the thoracic spine with 3 views.

c. Upon information and belief, Defendants' charges for x-rays of the thoracic spine with 3 views greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by a private non-PIP insurer, such as an HMO or private medical insurer, including insurers that do not have a contract with Defendant HCA or the particular hospital that rendered the x-ray.

d. Upon information and belief, Defendants' charges for x-rays of the thoracic spine with 3 views greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by an uninsured patient.

e. Upon information and belief, Defendants' charges for x-rays of the thoracic spine with 3 views greatly exceed the average amount non-HCA hospitals in the same market charge and accept for the same service.

f. Upon information and belief, Defendants' charges for x-rays of the thoracic spine with 3 views greatly exceed Defendants' costs in providing such service.

48. Defendants' charges to Plaintiff Herrera and the Class Members for lumbar spine x-rays with 4 views are unreasonable, exorbitant, and unfairly inflated:

a. Plaintiff Herrera was billed in excess of $3,000 for a lumbar spine x-ray with 4 views.

b. The Florida Medicare rates for an x-ray of the lumbar spine with 4 views are approximately $50. Defendants HCA and JFK Medical Center billed Plaintiff Herrera at a rate more than 65 times higher than the Medicare rate for the performance of an x-ray of the lumbar spine with 4 views.

c. Upon information and belief, Defendants' charge for x-rays of the lumbar spine with 4 views greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by a private non-PIP insurer, such as an HMO or private medical insurer, including insurers that do not have a contract with Defendant HCA or the particular hospital that rendered the x-ray.

d. Upon information and belief, Defendants' charges for x-rays of the lumbar spine with 4 views greatly exceed the amount Defendants usually and customarily charge for and the payment usually and customarily accepted for such service when billed to and paid by an uninsured patient.

e. Upon information and belief, Defendants' charges for x-rays of the lumbar spine with 4 views greatly exceed the average amount non-HCA hospitals in the same market charge and accept for the same service.

f. Upon information and belief, Defendants' charges for x-rays of the lumbar spine with 4 views greatly exceed Defendants' costs in providing such service.

49. At no time prior to their admission to the emergency department were the Plaintiffs advised by Defendants that they would be charged such exorbitant and unreasonable prices for the Radiological Services that they required. Furthermore, as a matter of law, Plaintiffs could not agree to the Defendants' exorbitant and unreasonable pricing for emergency Radiological Services in violation of the PIP Statute.

50. As a direct result of Defendants' billing at exorbitant and unreasonable rates, Plaintiffs were damaged in at least one of two different ways: (a) they were billed more for their out-of-pocket portion of the rates charged for Radiological Services than they would have been if such services were provided at reasonable rates; and (b) their PIP coverage was exhausted at a faster rate, resulting in Plaintiffs being billed for additional medical services rendered by Defendants and third party providers that would have otherwise been covered under PIP.

IV. CLASS ACTION ALLEGATIONS

51. Plaintiffs re-allege and incorporate by reference herein all of the allegations contained in paragraphs 1 through 50.

52. Pursuant to Florida Rules of Civil Procedure 1.220(a) and 1.220(b)(3), Plaintiffs bring this action on behalf of themselves and a class of all other persons similarly situated and defined as follows:

> All individuals (or their guardians or representatives) who received PIP-covered emergency care radiological services at an HCA-operated facility in Florida and who: (a) were billed by the facility for any portion of the charges for such services; and/or (b) had their $10,000 of PIP coverage prematurely exhausted by the facility's charges for such services and, as a result, were billed for additional medical services rendered by the facility and/or third-party providers that would otherwise have been covered under PIP.
>
> Excluded from the Class are Defendants, any officers or directors thereof, together with the legal representatives, heirs, successors, or assigns of any Defendant, and any judicial officer assigned to this matter and his or her immediate family.

53. This action has been brought and may properly be maintained as a class action as it satisfies the numerosity, commonality, typicality, adequacy, and superiority requirements. Plaintiffs seek to represent an ascertainable Class with a well-defined community of interest in the questions of law and fact involved in this matter.

54. Although the precise number of Class members is unknown and can only be determined through appropriate discovery, Plaintiffs believe and, on that basis, allege that the proposed Class is so numerous that joinder of all members would be impracticable. Based on the number of patients that Defendants treat in their emergency care facilities following automobile accidents, it is apparent that thousands of consumers have been billed exorbitant prices for the medical services referenced herein such that the number of individual plaintiffs would make joinder impossible.

55. Questions of law and fact common to the Plaintiff Class exist that predominate over questions affecting only individual members, including *inter alia*:

a. Whether Defendants' charges to PIP patients for Radiological Services were "reasonable";

b. Whether Defendants had a policy and practice of pricing, billing, and seeking payment from PIP patients for Radiological Services at unreasonable rates;

c. Whether Defendants' inclusion of a provision in its Conditions of Admission contracts requiring patients to make payments according to Defendants' Charge Master rates a violation of the PIP Statute and void as a matter of law;

d. Whether Defendants' practices of overcharging for Radiological Services were deceptive, unlawful, or unfair in any respect thereby violating Florida's Deceptive and Unfair Trade Practices Act. (FDUPTA), Fla. Stat. § 501.201, *et seq.*;

e. Whether Defendants' practices of overcharging for Radiological Services constituted a breach of contract; and

f. Whether Defendants' conduct injured the putative Class members and, if so, the extent of the damages.

56. Plaintiffs are members of the putative Class. The claims asserted by the Plaintiffs in this action are typical of the claims of the members of the putative Class, as the claims arise from the same course of conduct by the Defendants and the relief sought is common. Defendants overcharged Plaintiffs for the same Radiological Services and received only partial payment for those services from the Plaintiffs' PIP insurance carriers. Plaintiff were then left with the remaining outstanding balance on their hospital bills and/or were billed for

additional medical services rendered by Defendants and third party providers that would have otherwise been covered under PIP had Defendants' inflated charges not prematurely exhausted the coverage.

57. Plaintiffs will fairly and adequately represent and protect the interests of the members of the putative Class, as their interests are coincident with, not antagonistic to, the other Class members. Plaintiffs have retained counsel competent and experienced in both consumer protection and class action litigation.

58. Certification of the Class is appropriate pursuant to Florida Rule of Civil Procedure 1.220 because questions of law or fact common to the respective members of the Class predominate over questions of law or fact affecting only individual members. This predominance makes class litigation superior to any other method available for the fair and efficient adjudication of these claims including consistency of adjudications. Absent a class action it would be highly unlikely that the members of the Class would be able to protect their own interests because the cost of litigation through individual lawsuits might exceed the expected recovery.

59. A class action is an appropriate method for the adjudication of the controversy in that it will permit a large number of claims to be resolved in a single forum simultaneously, efficiently, and without the unnecessary hardship that would result from the prosecution of numerous individual actions and the duplication of discovery, effort, expense, and the burden of the courts that individual actions would create.

60. The benefits of proceeding as a class action, including providing a method for obtaining redress for claims that would not be practical to pursue individually, outweigh any difficulties that might be argued with regard to the management of the class action.

COUNT I – Violation of Florida's Deceptive and Unfair Trade Practices Act Against All Defendants

61. Plaintiffs re-allege and reaffirm herein all of the allegations contained in paragraphs 1 through 60.

62. In Florida, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce are unlawful.

63. Plaintiffs, individually, and the members of the putative Class are "consumers" within the meaning of Florida Statute Section 501.203.

64. Defendants' practice of charging exorbitant and unreasonable rates for PIP-covered Radiological Services following motor vehicle accidents constitutes unfair, deceptive, or unconscionable trade practices in violation of Florida's Deceptive and Unfair Trade Practices Act ("FDUTPA") as provided by §§ 501.201-.213, Florida Statutes.

65. Failure to disclose material information may cause deception within the meaning of FDUTPA. Such deception has occurred here as Defendants have failed to disclose important material information concerning their inflated pricing scheme to PIP-insured patients prior to or at the time of the provision of emergency medical treatment and services, including the failure to provide Plaintiffs with the Charge Master price list despite purporting to incorporate those prices into the contracts of adhesion that Plaintiffs were required to sign prior to receiving emergency medical services.

66. Defendants engage in the unfair and deceptive trade practices described herein in violation of the PIP Statute, which prohibits them from charging more than a "reasonable amount" for emergency medical services billed under PIP. Defendants utilize the patients' PIP coverage as a means to bill and be paid for unreasonable, inflated charges for emergency Radiological Services.

67. Defendants' pricing practices with regard to PIP-insured patients are unconscionable and constitute unfair and deceptive methods of competition in violation of one or more of the following:

a. The standards of unfairness and deception set forth and interpreted by the Federal Trade Commission or by the federal courts, as set forth in FDUTPA, §§ 501.203(3)(b) and 501.204; and/or

b. The law against unfair and deceptive trade practices set forth in 15 U.S.C. §§ 45(a)(1) and incorporated into FDUTPA under §501.204(2), or the law against unfair and deceptive trade practices as set forth in FDUTPA § 501.203(3)(c); and/or

c. The violation of § 627.736(5)(a), Florida Statutes, which prohibits hospitals and other medical providers from charging more than a reasonable amount for treating PIP-covered patients; and/or

d. The violation of § 627.736(5)(a), Florida Statutes, which prohibits hospitals and other medical providers from charging for PIP-covered medical services at rates in excess of their customary charges for like services.

68. Defendants' conduct amounts to "unfair" business practices insofar Defendants fail to charge Plaintiffs and Class members reasonable rates as required by the PIP Statute. Defendants' practices offend established public policies, and are immoral, unethical, oppressive, and unscrupulous. Once Defendants' emergency facilities' billing department determines that a patient's medical care will be covered by PIP insurance, Defendants' practice of overcharging the patient is triggered and carried out by the submission of the bills to the PIP insurance carrier.

69. Defendants' conduct also constitutes "deceptive" business practices within the meaning of FDUTPA in that Defendants fail to inform and/or conceal from PIP-insured patients their uniform policy of billing unreasonable rates and requiring payment for Radiological Services covered by PIP at rates several times higher than Defendants' usual and customary rates for and/or payments accepted for the same or substantially similar services; and/or at rates substantially higher than the cost to Defendants for the provision of the services.

70. Defendants' conduct also constitutes an unfair or deceptive business practice within the meaning of FDUTPA in that Defendants require emergency care patients, including Plaintiffs and the putative Class members, to sign contracts of adhesion that purport to expressly incorporate Defendants' Charge Master price list, but fail to contain a

list of the Charge Master prices or otherwise provide notification of what the amounts of those prices are.

71. As a result of these unfair and deceptive trade practices, Plaintiffs individually, and the members of the putative Class, have suffered actual damages in that they have paid and/or become obligated to pay excessive and artificially inflated medical bills for emergency radiological services as a result of Defendants' billing policies, and are entitled to their actual damages, and/or have paid or become obligated to pay other health care providers out-of-pocket because the Defendants' inflated rates prematurely exhausted their PIP coverage.

72. As a result of the aforementioned conduct, Plaintiffs individually, and the members of the putative Class, are entitled to permanent injunctive relief to prevent Defendants from continuing to engage in these unfair and deceptive trade practices and to stop all efforts to collect excess unpaid charges.

73. Pursuant to Florida Statute Section 501.2105, Plaintiffs, individually, and as members of the putative Class, are entitled to recover costs and reasonable attorneys' fees in this action.

COUNT II – Breach of Contract Claim Against All Defendants

74. Plaintiffs re-allege and reaffirm herein all of the allegations contained in paragraphs 1 through 60.

75. Plaintiffs entered into a contract with Defendants' emergency care facilities titled "Conditions of Admission" upon entering the emergency department. Each of the Plaintiffs entered into the exact same or substantially similar contract with the Defendants with the

same or substantially similar terms. Each of the putative Class members entered into the same or substantially similar contract with one of Defendant HCA's Florida facilities. A copy of each of the Plaintiffs' contracts is attached hereto. (Exs. C, E, G, I).

76. The "Conditions of Admission" contract provides that Plaintiffs "promise to pay the patient's account at the rates stated in the hospital's price list (known as the 'Charge Master') effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account."

77. Plaintiffs were not provided a copy of the hospital's price list at the time of their admission. As a result of the Contracts' vague, ambiguous, undefined, and nondescript pricing term, applicable law implies a contractual obligation on Plaintiffs to pay for no more than the reasonable value services provided under the Contracts, and a corresponding obligation on Defendants to bill for no more than the reasonable value of the services provided under the Contracts.

78. Moreover, as the substance of the Contracts is the subject of statutory regulation under the PIP Statute, the parties are presumed to have entered into their agreement with reference to such statutory regulation. The requirement on Defendants to bill no more than a reasonable amount for PIP-covered services, as provided in the PIP Statute, is therefore part of the contract between Defendants and Plaintiffs, and any contractual clause that purports to allow Defendants to bill more than a reasonable rate is void as a matter of law.

79. Under Florida law, Defendants breached the Contracts by charging unreasonable amounts for PIP-covered Radiological Services that are several times higher than

reimbursement rates from other categories of patients signing the same Contract, several times higher than the cost to Defendants for providing the treatment and services, and several times higher than the reasonable value of the treatment and services provided.

80. As a result of Defendants' breach of contract, Plaintiffs have been damaged in that they have paid and/or become obligated to pay excessive, artificially inflated, and unreasonable medical bills for Radiological Services or other PIP-covered medical services.

COUNT III –Breach of the Implied Covenants of Good Faith and Fair Dealing Against All Defendants

81. Plaintiffs re-allege and reaffirm herein all of the allegations contained in paragraphs 1 through 60.

82. As the substance of the Conditions of Admission contracts is the subject of statutory regulation under the PIP Statute, the obligation that statute imposes on Defendants to charge no more than a reasonable rate is incorporated into the contracts. The requirement on Defendants to bill no more than a reasonable amount for PIP-covered services, as provided in the PIP Statute, is therefore part of the contract between Defendants and Plaintiffs and Class Members.

83. As a result of Defendants' breach of the implied covenant of good faith and fair dealing, Plaintiffs have been damaged in that they have paid and/or become obligated to pay excessive, artificially inflated, and unreasonable medical bills for Radiological Services or other PIP-covered medical services.

WHEREFORE, Plaintiffs Marisela Herrera, Luz Sanchez, Nicholas Acosta, and Penny Wollmen, individually and on behalf of all others similarly-situated, demand judgment against Defendants, JFK Medical Center Limited Partnership, doing business under the name JFK Medical Center; Memorial Healthcare Group, Inc., doing business under the name Memorial Hospital Jacksonville; North Florida Regional Medical Center, Inc.; and HCA Holdings, Inc., for injunctive relief, damages, interest, and costs and, all other relief deemed just and proper under the circumstances.

DEMAND FOR TRIAL BY JURY

Plaintiffs hereby demand a trial by jury on all matters triable as of right by a jury.

DATED this 15th day of October, 2014.

Respectfully submitted,

s/Theodore J. Leopold

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CERTIFICATE OF SERVICE

I hereby certify that on Wednesday, October 15, 2014, I electronically filed the foregoing document with the Clerk of the Court using *CM/ECF*. I also certify that the foregoing document is being served this day on all counsel of record identified on the following Service List via transmission of Notices of Electronic Filing generated by *CM/ECF*.

s/Theodore J. Leopold
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