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SUPREME COURT OF TEXAS
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No. 16-0851

IN THE SUPREME COURT OF TEXAS

***In re* NORTH CYPRESS MEDICAL CENTER OPERATING CO., LTD.**

Relator

CRYSTAL ANN ROBERTS

Real Party in Interest

On Petition for Writ of Mandamus
from the 234th District Court of Harris County, Texas and
from the Court of Appeals for the Fourteenth District of Texas

MOTION FOR REHEARING

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ISSUES PRESENTED

I. The majority opinion includes at least three material factual errors.

A. First, the majority opinion states that the "liability insurer of the driver at fault. . . attribut[ed] $9,404 to past medical expenses." However, the liability insurer actually attributed $15,245 to past medical expenses. $9,404 was the amount specifically attributed to those medical expenses charged by North Cypress.

B. Second, the majority opinion states: "Because Roberts was uninsured, North Cypress billed her for the services at full 'chargemaster' prices, which totaled $11,037.35. North Cypress also filed a hospital lien for this amount." However, North Cypress never filed a hospital lien stating the amount of $11,037.35. In fact, North Cypress's lien did not specify an amount.

C. Third, the majority opinion states: "The hospital-lien amount remains $11,037.00." However, the hospital lien actually remains at $8,278.31.

II. The majority opinion acknowledges that "relevance" was not the only objection North Cypress made. However, after finding that objection unpersuasive, the majority opinion fails to address the merits of other objections made by North Cypress.

III. The majority opinion erroneously suggests that a hospital's full list rates (also known as "chargemaster" rates) are arbitrarily set.

IV. The majority opinion erroneously suggests that the trial court would have granted a protective order if only North Cypress had requested one.

V. The majority opinion erroneously suggests that the confidentiality of the information could be protected by a protective order.

VI. The majority opinion will: (1) have far-reaching consequences on a hospital's ability to contract with health insurers in a competitive marketplace; (2) disincentivize patients from obtaining insurance coverage; and (3) shift the burden of proving a plaintiff's medical damages to the hospital and away from the plaintiff (via the well-established process by

which the plaintiff proves her medical damages pursuant to Civil Practice & Remedies Code chapter 18, which utilizes affidavits and expert testimony if necessary).

VII. The majority opinion erroneously suggests that a limited disclosure of the contracts would be possible to produce the negotiated rates for only those specific services provided to Roberts.

VIII. The majority opinion will dramatically increase costs for hospitals, and these costs will undoubtedly be passed along to insurance carriers, their insureds, and uninsured patients (via higher "full list rates").

IX. It is unclear if the majority opinion is consistent with—or implicitly overrules—this Court's 2012 *Haygood* decision.

X. While the majority opinion holds that the requested information is relevant, the opinion provides no guidance on how the information is relevant. As such, the majority opinion will lead to extensive litigation about how the opinion should be applied in practice.

ARGUMENT

I. THE MAJORITY OPINION INCLUDES AT LEAST TWO MATERIAL FACTUAL ERRORS AND EVEN STATES ONE OF THE ERRORS TWICE.

A. First, the majority opinion states that the "liability insurer of the driver at fault. . . attribut[ed] $9,404 to past medical expenses." However, the liability insurer actually attributed $15,245 to past medical expenses. $9,404 was the amount specifically attributed to those medical expenses charged by North Cypress.

The majority opinion states that the "liability insurer of the driver at fault. . . attribut[ed] $9,404 to past medical expenses." [Page 2] However, the liability insurer did not attribute $9,404 for **all** past medical expenses. Rather, the liability insurer offered Roberts $15,245 for **all** past medical expenses and considered $9,404 specifically for medical expenses charged by North Cypress. [R 19] ("$9,404 for North Cypress's charges"); [R 84] ("for provider N. Cypress Medical"); [R 87] ("$9,404 . . . for payment of the North Cypress bill"); [R 101] ("considered $9,404 of the North Cypress charges"); [R 102] ("9,404 of the settlement funds specifically for payment of North Cypress Bill")[1]

[1] Roberts "received two separate bills, one from the Hospital North Cypress Medical Center ($11,037.75), and the other one from Cypress Emergency Associates ($1,334.00)." [R 162] Long before Roberts filed this lawsuit, she "tendered payment, through her insurance company, to Cypress Emergency Associates for the amount of $1,334.00." [R 4] The bill from Cypress Emergency Associates was for "the emergency room physician." [R 3]

In fact, in its own letter, the liability insurer indicates that it attributed $15,245 for **all** medical expenses which had been incurred. [R 84] The letter, addressed to Roberts's counsel at The Amaro Law Firm, states:

> Thank you for discussing your client, Crystal Roberts, injury claim on January 28, 2016. Per your request, allow this letter to detail the medical submitted by your firm and the medical considered within the injury evaluation for your client. The Amaro Firm submitted $18895.40 for medical expenses incurred. **Our evaluation considers $15245 of the medical expenses.** Specifically for provider N. Cypress Medical $11,037 was submitted. Within our evaluation, we considered $9404 of the charges. Regarding lost wages, your firm submitted $1438 in lost wages. Within our evaluation, we considered $800 of the missed wages.

[R 84] (emphasis supplied)

The professional adjuster for the at-fault driver's liability insurer (Progressive) evaluated North Cypress's $11,037.00 bill and adjusted it down to $9,404.00 specifically to compensate Roberts's treatment at North Cypress. [R 19, 83-84] North Cypress, in turn, adjusted its bill down to $8,278.31 [R 21-22, 276, 324], an amount that is $1,125.69 less than the specific amount Progressive offered to pay Roberts, not for her entire medical bills (and certainly not for her entire damages), but specifically for North Cypress's bill. Even so, the $1,125.69 windfall did not satisfy Roberts. She originally requested that the bill be reduced

to $3,500[2] (which would be a $5,904 windfall) and eventually requested that the bill be reduced to $6,269.33 (which would be $3,134.67 windfall). [R 3, 28, 78, 83, 156] Not being satisfied with a windfall of "only" $1,125.69, Roberts sued North Cypress and filed a motion to compel production of documents showing the amounts North Cypress would have accepted from all other private and public health insurers. [R 1, 161-173]

This factual error in the majority opinion is significant because the majority opinion appears to state that payments under managed-care contracts that do not cover the patient are discoverable to evaluate the reasonableness of a charge even after (1) a professional insurance adjuster under a responsible liability policy evaluates the same charge and (2) the hospital agrees to accept less than the amount determined by the professional insurance adjuster to be a reasonable

[2] At an August 2016 hearing, Roberts's counsel suggested (erroneously) that $3,500 is greater than the amount North Cypress would be paid by an insurance provider if an insured patient had received the same services as Roberts received. [R 339] ("[I]f somebody came with Blue Cross, Medicaid, Medicare, United Health, Aetna, Cigna . . . . What are they actually being reimbursed for the same or similar services my client received? It's probably less than 3500.") This is curious in light of the fact that counsel had previously (in a January 2016 letter) acknowledged that the insurance adjuster was considering $9,404 of North Cypress's $11,037 charges—not $3,500 of the $11,037. [R 83-84] Nevertheless, acknowledging that the insurance adjuster was considering $9,404 of North Cypress's charges, counsel increased the amount of the bill Roberts was willing to pay from $3,500 to $6,269.33. [R 83, 156]

charge.[3] If that is the case, it is difficult to imagine any scenario involving personal injury damages (or any type of action when medical charges are involved in any way) where a hospital cannot be forced to disclose its proprietary contracts. Roberts states only the conclusion that the charges are not reasonable (with no evidentiary support) and fails to propose any plausible method of using the contracts to calculate what she arbitrarily states is the number she hopes to show might be reasonable. As such, North Cypress asks the Court to set forth specific criteria to show how contracts with insurance carriers (such as those at issue in this case) should be used to determine reasonableness of medical charges, and state specifically how they might be relevant to eliminate threats and litigation based on speculation.

[3] Considering that here: (1) Roberts claimed full list rates as her medical damages, and (2) Progressive evaluated and offered Roberts an amount greater than the amount North Cypress agreed to accept as payment in full, it is unclear if the majority opinion is holding that the circumstances / estoppel principles have no bearing on the determination of what is reasonable or if the ruling is intended to bar the estoppel defense in disputes regarding the reasonableness of medical billing and/or hospital liens.

B. Second, the majority opinion states: "Because Roberts was uninsured, North Cypress billed her for the services at full 'chargemaster' prices, which totaled $11,037.35. North Cypress also filed a hospital lien for this amount." However, North Cypress never filed a hospital lien stating the amount of $11,037.35. In fact, North Cypress's lien did not specify an amount.

The majority opinion states: "Because Roberts was uninsured, North Cypress billed her for the services at full 'chargemaster' prices, which totaled $11,037.35. North Cypress also filed a hospital lien for this amount." [Page 2] However, North Cypress's hospital lien simply does not state a specific amount. [R 76] So, it is not accurate to state that "North Cypress also filed a hospital lien for this amount."

C. Third, the majority opinion states: "The hospital-lien amount remains $11,037.00." However, the hospital lien actually remains at $8,278.31.

The majority opinion states: "The hospital-lien amount remains $11,037.00." [Page 2 n.1] However, the lien states "the amount of this lien is equal to the cost of these hospital services with all payments and/or adjustments credited to the account." [R 76] The "with all payments and/or adjustments credited to the account" language reflects the adjustments that North Cypress made to its charge. And North Cypress adjusted its bill down to $8,278.31. [R 21-22] ("North Cypress reduced its charges to $8,278.31. . . . The outstanding amount due after the reduction of charges has been made to the account is $8,278.31."); [R 276] ("North

Cypress reduced its bill to $8,278.31"); [R 324] ("The total amount of payments, offsets, or adjustments is $2,759.43, and the amount currently unpaid but which NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY, LTD and NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY GP, L.L.C. has a right to be paid after any adjustments or credits is $8,278.32.")

So, the hospital lien actually remains at $8,278.31—not $11,037.00.

II. THE MAJORITY OPINION ACKNOWLEDGES THAT "RELEVANCE" WAS NOT THE ONLY OBJECTION NORTH CYPRESS MADE. HOWEVER, AFTER FINDING THAT OBJECTION UNPERSUASIVE, THE MAJORITY OPINION FAILS TO ADDRESS THE MERITS OF OTHER OBJECTIONS MADE BY NORTH CYPRESS.

The majority opinion notes that in addition to the "relevance" objection discussed in detail in the opinion, North Cypress also objected to the overly-broad nature of Roberts's requests. [Page 3] Notably, the majority opinion does not even acknowledge that North Cypress also objected to Roberts's requests and filed a motion for protective order (1) based on the requests constituting an impermissible fishing expedition; [R 35, 163-166, 169, 207, 272, 278] and (2) based on the requests being unduly burdensome. [R 34-35, 163, 167]

Yet after finding the relevance objection unpersuasive, the majority opinion fails to address the merits of the other objections. Even if the information requested by Roberts were relevant—as the majority holds—North Cypress would

still be entitled to mandamus relief based upon the requests (1) being overly broad; (2) constituting an impermissible fishing expedition; and (3) being overly burdensome.

Even though not considered by the majority opinion, all three of these objections would have merit, especially in light of the amounts of money at issue being relatively modest. North Cypress's bill was $11,037.75. [R 3, 28] Progressive valued North Cypress's services at $9,404 and, based on that valuation, made a $17,380 settlement offer to Roberts (which included $15,245 as compensation for medical expenses which had been incurred). [R 19, 83-84, 156] North Cypress adjusted its $11,037.75 bill down to $8,278.31—less than the $9,404 valuation offered by Progressive as compensation for the North Cypress charges. [R 21-22, 276, 324]

Yet the majority opinion did not even address the merits of these objections. The Court's silence is likely to be misinterpreted as a ruling that these objections are all meritless. If the objections (to Roberts's discovery requests being overly broad, constituting an impermissible fishing expedition, and being overly burdensome) would be meritless in this case, those three objections would seem to be meritless in nearly any future case involving hospital billing, even those to which the hospital is not a party. Every time a hospital generates an invoice, the hospital would risk bearing the expense and burden of this type of discovery,

regardless of how remotely the cause of action may be related to the billing.[4]

If the benefit to requiring North Cypress to respond to the broad discovery requests truly outweighs the burden imposed upon North Cypress, it is important that the majority say so to eliminate frivolous threats and lawsuits based on speculation.

III. THE MAJORITY OPINION ERRONEOUSLY SUGGESTS THAT A HOSPITAL'S FULL LIST RATES (ALSO KNOWN AS "CHARGEMASTER" RATES) ARE ARBITRARILY SET.

The majority opinion states: "Commentators lament the increasingly arbitrary nature of chargemaster prices." [Page 2] Perhaps unintentionally, this language provides guidance to trial court judges by implying that all hospital "full list rates" are arbitrary and defacto unreasonable. Without clarification, the majority opinion will be interpreted as holding that chargemaster rates are unreasonable *per se*. This could not be further from the truth.

A hospital "chargemaster" is a computer program that calculates full list rates based on algorithms which—taking into account the hospital's income, overhead costs, and losses—ensure that the hospital remains solvent. The

[4] A wealth of information about hospital costs is available to the public through the Centers for Medicare Services website. And average health insurance reimbursement rates can be obtained through several sources including websites that compile data for facilities / geographic regions, such as: (1) FairHealth.com; (2) Context4Healthcare; (3) Texas Health Care Information Collection; (4) Dartmouth Atlas for hospital charges; (5) Medical Fees in the United States; and

algorithms provide that, when losses are incurred, the full list rates rise. Far from contributing to arbitrary pricing, the chargemaster is necessary to maintain pricing at a level necessary for sustainability.

The chargemaster rates are subject to audits by the Office of Inspector General, the Centers for Medicare and Medicaid Services (CMS), the Texas Workforce Commission, and private in-network health insurance carriers to ensure that they are accurate and not inflated. A fluctuation of even 1.5 percent can trigger the audit of a chargemaster. Additionally, non-compliance can lead to severe consequences, including termination of contracts, fines, and criminal prosecution.

The majority opinion's suggestion that "chargemaster prices" are "arbitrary" will likely have the unintended consequence of trial courts (which, of course, look to this Court for guidance) treating the "chargemaster prices" as "arbitrary". . . rather than a carefully balanced system to ensure that the hospital remains solvent.

IV. THE MAJORITY OPINION ERRONEOUSLY SUGGESTS THAT THE TRIAL COURT WOULD HAVE GRANTED A PROTECTIVE ORDER IF ONLY NORTH CYPRESS HAD REQUESTED ONE.

The majority opinion states: "Nothing in the record indicates that the trial court is unwilling to issue a protective order in the event that North Cypress requests and demonstrates its entitlement to one." [Page 14] To the contrary, the

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(6) HealthTrans. Moreover, non-profit hospitals in the geographic region publish

record reflects that (1) North Cypress has twice requested a protective order, but the trial court did not grant either request and (2) the trial court ordered the confidential contracts produced without limitation. Specifically, the record reflects that (1) North Cypress objected to the discovery requests and filed a motion for protective order, after which Roberts filed a motion to compel; [R 33, 161, 198-212] and (2) the trial court effectively denied North Cypress's motion for protective order when he orally granted (in large part) Roberts's motion to compel without any limitation; [R 327, 348-350, 353-354]; and (3) North Cypress filed an emergency motion to reconsider, but that motion was denied by the trial court. [R 270, 358, 361]

In support of its trial court motion to reconsider, North Cypress attached an affidavit that informed the trial court of the confidential and proprietary nature of the documents and detailed the harm that would be caused if the trial court did not grant relief. [R 291-292] The affidavit makes it clear that these documents are protected by the trade secret privilege, yet the trial court nevertheless ordered the production, with no apparent limitations, or even a limited granting of the protective order requested by North Cypress.

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the average of their top three contractual reimbursement rates.

V. THE MAJORITY OPINION ERRONEOUSLY SUGGESTS THAT THE CONFIDENTIALITY OF THE INFORMATION COULD BE PROTECTED BY A PROTECTIVE ORDER.

The majority opinion suggests that the confidentiality of the information could be protected by a protective order. [Page 14] As discussed above, the trial court is simply not willing to provide a protective order. But even if the trial court were willing to provide a protective order, the order would not be effective to protect the confidential managed care contracts at issue.

Specifically, based on the majority opinion, it will become commonplace to force hospitals to disclose the terms of managed care contracts again-and-again. Consequently, if a hospital is forced to disclose these contracts to many different parties, it will be difficult, if not impossible, to determine which party breached the protective order. For example, if a hospital is required to disclose its contract with Blue Cross to 100 different parties in 100 different cases—even if the trial courts in those 100 cases all impose protective orders—if the contract becomes publically-circulated, how would the hospital ever be able to definitely determine which party disclosed the contract?

VI. THE MAJORITY OPINION WILL: (1) HAVE FAR-REACHING CONSEQUENCES ON A HOSPITAL'S ABILITY TO CONTRACT WITH HEALTH INSURERS IN A COMPETITIVE MARKETPLACE; (2) DISINCENTIVIZE PATIENTS FROM OBTAINING INSURANCE COVERAGE; AND (3) SHIFT THE BURDEN OF PROVING A PLAINTIFF'S MEDICAL DAMAGES TO THE HOSPITAL AND AWAY FROM THE PLAINTIFF (VIA THE WELL-ESTABLISHED PROCESS BY WHICH THE PLAINTIFF PROVES HER MEDICAL DAMAGES PURSUANT TO CIVIL PRACTICE & REMEDIES CODE CHAPTER 18, WHICH UTILIZES AFFIDAVITS AND EXPERT TESTIMONY IF NECESSARY).

For the reasons discussed above, the majority opinion will lift the cloak of privilege from managed care contracts and create an environment wherein (1) all hospitals will know the reimbursement rates negotiated by other hospitals with various insurance carriers, weakening the hospitals' bargaining power and denying them the benefit of their bargains; (2) all insurance carriers will know the reimbursement rates negotiated by other insurance carriers with various hospitals; and (3) all patients will know these reimbursement rates as well, either discouraging them from purchasing health insurance (as they can simply demand the adjustment without paying premiums) or leading to disputes concerning the entitlement to the adjustments of one plan over the other. As such, the majority opinion will have far-reaching consequences on a hospital's abilities to contract with health insurers. It is possible that the majority considered that its opinion could lead to massive changes in the negotiating strengths of various parties (hospitals, insurance carriers, and the consumer in the insurance marketplace)

statewide. However, based on the fact that the majority opinion suggests—erroneously, as explained above—that the confidentiality of the information could be protected by a protective order, [Page 14] it is likely that the majority did not fully appreciate that its opinion would have such far-reaching consequences.

VII. THE MAJORITY OPINION ERRONEOUSLY SUGGESTS THAT A LIMITED DISCLOSURE OF THE CONTRACTS WOULD BE POSSIBLE TO PRODUCE THE NEGOTIATED RATES FOR ONLY THOSE SPECIFIC SERVICES PROVIDED TO ROBERTS.

The majority opinion suggests that it would be possible to produce the negotiated rates for only those specific services provided to Roberts. [Page 13] ("Roberts seeks reimbursement rates only for the specific services she received.") However, there would be no way for North Cypress to comply with the trial court's order without disclosing the confidential contracts in their entirety.

Managed care contracts do not list line item descriptions for each service which a hospital performs. Instead, the contractual terms are broad and must be considered as a whole, along with other factors outside the four corners of the contract. As such, it would be difficult to determine with accuracy what Roberts would have paid had she been insured under any particular plan due to the unknown variables that would have to be considered to make that determination.

Other factors determine the reimbursement rate, which would involve evaluating the entire contractual agreement and reviewing the individual member

plan to determine the ultimate patient responsibility and reimbursement rate for any particular patient or service. For example, reimbursement may be based on a diagnostic related grouping (DRG) often utilized by Medicare and private health insurance companies, in which costs are categorized to determine how much to pay for a patient's hospital stay. Under DRG, a fixed amount is paid based on the diagnosis. If the hospital ultimately spends less than the DRG amount, the hospital makes a profit; however, if the patient requires more extensive treatment, the hospital loses money on that treatment. Additionally, a contract may provide for a "capitation payment" (a per capita payment for the members of the health insurance plan in the area) wherein an in-network hospital receives a fixed, pre-arranged monthly payment amount per patient enrolled in the plan whether the member receives treatment or not.

VIII. THE MAJORITY OPINION WILL DRAMATICALLY INCREASE COSTS FOR HOSPITALS, AND THESE COSTS WILL UNDOUBTEDLY BE PASSED ALONG TO INSURANCE CARRIERS, THEIR INSUREDS, AND UNINSURED PATIENTS (VIA HIGHER "FULL LIST RATES").

The majority opinion provides incentive for plaintiffs' attorneys to manipulate the system and gain a windfall for the uninsured plaintiff. By utilizing strategic timing, as is the case here with Roberts, the uninsured patient can benefit from the full list rates (by citing this Court's *Haygood* decision), obtain compensation based on full list rates from the tortfeasor with no adjustments, and

then employ post-settlement negotiation threats to file harassing litigation and discovery against the hospital (by citing the majority opinion in *In re North Cypress*) to avoid payment of the charges and circumvent the hospital lien statute. If this seems improbable, note that North Cypress adjusted its $11,037.75 bill down to $8,278.31—less than the $9,404 valuation assigned by the professional claims adjuster at Progressive specifically to compensate Roberts for the North Cypress charges—and that Roberts thereafter sent a demand letter (1) seeking to have the North Cypress charges reduced to $3,500, based on her counsel's unsupported belief that this is the reimbursement rate of "Blue Cross, Medicaid, Medicare, United Health, [and] Cigna"; [R 156, 339] (2) threatening to file suit; and [R 156] (3) threatening that this suit would cause North Cypress to incur "anywhere from legal $10,000 to $100,000 in completely unnecessary attorney's fees" [R 156] . . . and that Roberts made good on her threat to file this lawsuit. [R 1]

Roberts's counsel acknowledges that this is what occurred and why he filed the lawsuit:

> THE COURT: [W]hy did you file this lawsuit?
> . . . .
> MR. AMARO, JR: [M]y job is to get as much money as I can in my client's pocket. In order to do so, I've got to . . . go and get a settlement offer from the tortfeasor, right? So, I did that. We asked for a reduction. They didn't want to reduce passed [sic] 8200 bucks.

[R 337]

Just like North Cypress had to do in this case, under the majority opinion, other hospitals will need to hire counsel to respond to discovery requests, attend hearings, and assert privileges (or negotiate protective orders). Further, because turning over its confidential agreements with various insurance carriers would have devastating business consequences for the hospital, the hospital would have no choice but to capitulate to plaintiffs' demands to reduce its charges to whatever plaintiffs arbitrarily choose as the amount they would like to pay.

IX. IT IS UNCLEAR IF THE MAJORITY OPINION IS CONSISTENT WITH—OR IMPLICITLY OVERRULES—THIS COURT'S 2012 *HAYGOOD* DECISION.

In the 2012 *Haygood v. De Escabedo* case, this Court held that any billing adjustment (the difference between the hospital's charge and the amount of the negotiated reimbursement rate) belongs to the individual's insurance carrier—not to the individual/patient insured under the plan. *Haygood v. De Escabedo*, 356 S.W.3d 390, 395 (Tex. 2012). In light of this holding, an insurance carrier's negotiated reimbursement rates would appear to be irrelevant to a patient who **is** covered by insurance. (For example, Blue Cross's negotiated reimbursement rates would be irrelevant to a patient insured by Blue Cross because the difference between the hospital's charge and the amount of the negotiated reimbursement rate belongs to Blue Cross rather than to the patient insured by Blue Cross.)

In light of this, it would seem incongruent to have the insurance carrier's negotiated reimbursement rates be relevant to a patient who **is not** covered by that insurance carrier. As such, the majority opinion suggests that *Haygood* has been implicitly overruled. If *Haygood* has not been implicitly overruled, it is unclear how the majority opinion is consistent with with *Haygood*.

Haygood also holds that Texas Civil Practice and Remedies Code section 41.0105—which provides that "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant"—limits evidence to expenses that the provider has a legal right to be paid. *Id.* at 391 (citing TEX. CIV. PRAC. & REM. CODE § 41.0105). In light of this holding, an insurance carrier's negotiated reimbursement rates would appear to be irrelevant to a patient who **is** covered by insurance. (For example, Blue Cross's negotiated reimbursement rates would be irrelevant to a patient insured by Blue Cross because the difference between the hospital's charge and the amount of the negotiated reimbursement rate belongs to Blue Cross rather than to the patient insured by Blue Cross.)

It would seem incongruent to have the insurance carrier's negotiated reimbursement rates be relevant to a patient who **is not** covered by that insurance carrier. As such, the majority opinion suggests that *Haygood* has been implicitly overruled. If *Haygood* has not been implicitly overruled, it is unclear how the

majority opinion harmonizes with *Haygood*.

In fact, the majority opinion holding that an insurance carrier's negotiated reimbursement rates are relevant to a patient who *is not* covered by that insurance carrier would seem to suggest that "paid or incurred" is no longer a sufficient standard for recovering medical damages, and that the discovery of hospital contracts are necessary any time the reasonable amount of medical charges are an issue. Specifically, under the majority opinion, even if a patient actually pays or incurs a bill, the defense may still challenge the bill as unreasonable outside the normal process (i.e., TEX. CIV. PRAC. & REM. CODE § 18.001), and the burden of proving up medical damages will shift to the hospital, further raising full list rates, and circumventing the purpose of the hospital lien statute.[5]

Prior to the majority opinion, all that was required from the medical provider was that it supply records supported by a "low cost affidavit" upon request. Any disputes from the opposition required an expert, who would gather the figures that Roberts erroneously believes that the contracts will provide from reliable publicly available sources that compile reimbursement rates and cost data in the region.

The efficient and cost-effective process under Civil Practice & Remedies Code section 18.001 will be replaced with a costly, time consuming, and confusing discovery process involving the medical provider and speculative, inconsistent results from the fact finders.

Despite the fact that the majority went to great lengths to explain that it was not ruling that the discovery was admissible and was not rendering an opinion as to the reasonableness of North Cypress's charges, other courts have already begun expanding and misinterpreting the majority opinion so as to attribute great weight to the relevance of managed-care contracts. Perhaps this can be attributed to the fact that the majority opinion did not elaborate on the fact that the "abuse of discretion" standard on mandamus review is a very low threshold and that it would be possible for another trial court judge to appropriately find that there is no probative value or that some privilege is applicable. Without such an explanation, the majority opinion can easily be interpreted as holding that these documents are indisputably relevant and can never be privileged.

To illustrate the far-reaching impact of the majority opinion, on May 31, 2018, the Twelfth Court of Appeals at Tyler issued a decision citing the majority

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[5] The hospital lien statute was originally enacted due to the fact that "the hospitals of the State of Texas are losing vast sums of money which amounts to the taking of property without compensation therefor, creates an emergency." *Baylor Univ. Med. Ctr. v. Travelers Ins. Co.*, 587 S.W.2d 501, 504 (Tex. Civ. App.—Dallas

opinion in support the court of appeals holding that "Because of the evolution of list prices, the charges themselves are not dispositive of what is reasonable, irrespective of whether the patient being charged has insurance. This fact makes the amounts a hospital accepts as payment from other patients, including those covered by private insurance and government benefits, relevant to whether the charges encompassed in a hospital lien are reasonable." *East Texas Med. Ctr. Athens v. Hernandez*, No. 12-17-00333-CV, 2018 WL 2440508, at *4 (Tex. App.—Tyler May 31, 2018, no pet. h.) (internal citation omitted).

X. WHILE THE MAJORITY OPINION HOLDS THAT THE REQUESTED INFORMATION IS RELEVANT, THE OPINION PROVIDES NO GUIDANCE ON HOW THE INFORMATION IS RELEVANT. AS SUCH, THE MAJORITY OPINION WILL LEAD TO EXTENSIVE LITIGATION ABOUT HOW THE OPINION SHOULD BE APPLIED IN PRACTICE.

It was made evident at oral argument that disclosing the contracts will lead to extensive litigation about their relevance. Specifically, Justice Lehrmann questioned Roberts's counsel as to how the negotiated rates (which differ from one hospital to another in the same community) would relate to what is reasonable. Counsel responded that the rate at which a health insurer pays a hospital is what the hospital has the legal right to recover from anyone (regardless of whether the patient has chosen to purchase health insurance). As explained above, this logic

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1979, writ ref'd n.r.e.) (quoting the original act creating article 5506a in 1933, Tex. Gen. Laws, ch 85, at 182).

appears to be inconsistent with this Court's 2012 *Haygood v. De Escabedo* holding.

Counsel further responded that chargemaster rates are "illusory." However, upon questioning by Justice Guzman, counsel acknowledged that he had done no investigation of the process by which hospitals determine their full list rates (a/k/a chargemaster rates).

Finally, counsel responded that Roberts intends to prove that the charges sought are unreasonable because (he claims) the charges sought are in excess of what anyone has ever paid for the services at issue. However, the negotiated rates are in no way evidence of this. Rather, to prove to this, Roberts would need to be provided a complete payment history of every patient who has ever received the same services as Roberts received. Of course, even the extremely broad discovery sought by Roberts in this case would not include the payment history of every patient who has ever received the same services as Roberts received. Unfortunately, the majority opinion opens the door for a trial court to permit discovery of that information every time medical bills are at issue in any cause of action.

PRAYER

Relator North Cypress Medical Center Operating Co., Ltd. prays that this Court withdraw its opinion, grant the petition for writ of mandamus, and order the

trial court to (1) vacate its orders denying North Cypress's motion for protective order and granting Roberts's motion to compel and (2) enter orders granting North Cypress's motion for protective order and denying Roberts's motion to compel. North Cypress also prays for its costs and for all other relief to which it may be entitled.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 52.3(j)

I certify that I have reviewed this document and that I have concluded that every factual statement herein is supported by competent evidence included in the mandamus record (filed on October 20, 2016).

/s/ Shelli Morrison
Shelli Morrison

CERTIFICATE OF COMPLIANCE WITH RULE 9.4(i)(3)

I certify that, according to my word processor's word-count function, in the sections of this document covered by TRAP 9.4(i)(1), there are 4,460 words.

/s/ Shelli Morrison
Shelli Morrison

CERTIFICATE OF SERVICE

I certify that, on June 13, 2018, I served a copy of this document via the e-filing portal to the following counsel for Real Party in Interest Crystal Ann Roberts:

R. James Amaro
2500 E. TC Jester Boulevard
Suite 525
Houston, Texas 77008

/s/ Shelli Morrison
Shelli Morrison