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No. 16-0851

In the Supreme Court of Texas

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

v.

CRYSTAL ANN ROBERTS,
Real Part in Interest.

From the Fourteenth Court of Appeals, Cause No. 14-16-00671-CV,
and the 234th Court for Harris County, Texas
Cause No. 2016-17517, Honorable Wesley Ward

BRIEF OF AMICUS CURIAE THE FUENTES FIRM, P.C.

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IDENTITY OF AMICUS CURIAE AND COUNSEL

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STATEMENT OF INTEREST

Amicus Curiae, The Fuentes Firm, P.C., represents trucking companies and their employees in personal injury lawsuits. Often these suits involve referral arrangements between plaintiff law firms and doctors where an insured plaintiff will forego his or her health insurance in receiving treatment. This results in medical bills, which are already artificially inflated, becoming increasingly excessive in the context of personal injury litigation.

The undersigned's interest is based on a legal system that currently prevents defendants from exposing the truth in litigation regarding these arrangements and exorbitantly inflated medical bills. Defendants cannot bring up the fact that a plaintiff has health insurance under the collateral source rule and, under cases like *In Re Siroosian,* are denied access to evidence showing the extent of the referral relationship between the attorney and doctor. Access to information regarding the true amounts medical providers are actually paid would help combat inaccurate medical billing. However, the discoverability of that evidence now depends on the outcome this case.

The issues presented in this case extend beyond the consumer claims in this case to affect all personal injury defendants.

Amicus is paying the fee for preparing this brief.

STATEMENT OF THE CASE

Real Party in Interest Crystal Ann Roberts filed suit against Relator North Cypress alleging causes of action under the Texas DTPA, the Texas Debt Collection Act, the Texas Declaratory Judgment Act, and the Texas Fraudulent Lien Statute. In the course of discovery, Real Party in Interest served Relator with interrogatories and requests for production seeking Relator's contracts with private health insurance companies, Medicare, and Medicaid. Relator objected to the requests and sought a Protective Order, to which Real Party in Interest filed a motion to compel.

Honorable Wesley Ward of the 234th Judicial District Court in Harris County, Texas, orally granted Roberts's motion to compel and orally denied Relator's emergency motion to reconsider.

The Fourteenth Court of Appeals denied Relator's Petition for Writ of Mandamus in an unpublished opinion. *In Re North Cypress Medical Center Operating Co., Ltd.*, No. 14-16-00671-CV (Tex. App.—Houston [14th Dist.], October 20, 2016, pet. filed) (mem. op.).

ISSUES PRESENTED

Amicus asserts that the issue presented in this Mandamus is as follows:

> Whether provider agreements and reimbursement data, which reflect amounts actually paid for medical services, are reasonably calculated to lead to the discovery of admissible evidence regarding the reasonableness of medical expenses.

STATEMENT OF FACTS

Amicus adopts the statement of facts in the Real Party in Interest's Brief in Response filed by Crystal Ann Roberts.

SUMMARY OF THE ARGUMENT

The fair and reasonable value of services is determined by considering what people ordinarily pay for the services. If it is relevant what other providers are paid in the community for the same services, then it is even more relevant what the same provider is paid in that specific facility for the same services. While such evidence may not always be dispositive, it is reasonably calculated to lead to the discovery of admissible evidence.

Relator argues that prices from health plans, including Medicare, are confidential. However, the amounts paid by Medicare to Relator for the same services as in this case are *publicly available*. Public records also reveal that Relator uses Medicare rates to establish its list prices, as well as to calculate amounts to be collected from individual patients and under health insurance plans.

The Texas Supreme Court has explained the difficulty in ascertaining true medical costs based on artificially inflated "list prices." The Texas Legislature has called for greater transparency with regard to medical billing. In the face of calls for greater transparency, and in a system that undeniably is based on artificially inflated medical bills, Relator seeks to be protected from disclosing what it actually gets paid by the overwhelming majority its customers.

Litigants faced with defending against "list prices" and artificially inflated medical bills should be entitled to relevant discovery to determine, by comparison,

whether amounts charged are in fact reasonable. The Trial Court did not abuse its discretion in denying Relator's motion for protective order and compelling Relator's responses to the disputed discovery requests.

ARGUMENT AND AUTHORITIES

I. The requirement that medical expenses be reasonable demands discovery of data from healthcare reimbursement arrangements.

To recover medical expenses in Texas, there must be proof that the expenses were reasonable.[1] This requirement applies not only to injured plaintiffs seeking compensatory damages, but also to healthcare providers seeking reimbursement for services provided.[2] Further, proof of amounts charged alone is not proof of reasonableness.[3]

Here, Relator seeks to force Real Party in Interest to challenge the reasonableness of the amounts charged using *only the amounts charged* and barring discovery of amounts it normally accepts as payment for the same services.

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[1] *See, e.g.*, *Doctor v. Pardue*, 186 S.W.3d 4, 20 (Tex. App.—Houston [1st Dist.] 2006); *Bashara v. Baptist Memorial Hosp. System,* 685 S.W.2d 307, 309 (Tex. 1985); Tex. Prop. Code Ann. § 55.004.

[2] *Bashara*, 685 S.W.2d at 309; *In re Jarvis,* 431 S.W.3d 129, 137 (Tex. App.—Houston [14th Dist.] 2013); *Haygood v. De Escabedo,* 356 S.W.3d 390, 391 (Tex. 2011).

[3] *McGinty v. Hennen*, 372 S.W.3d 625, 627 (Tex. 2012)(Proving reasonableness of medical expenses "demands more than merely proffering evidence illustrating the nature of the injuries, the character of and need for the services rendered, and the amounts charged for the services."); *Dallas R. & Terminal Co. v. Gossett*, 294 S.W.2d 377, 383 (Tex. 1956).

But those amounts, as expressed through healthcare contracts and reimbursement arrangements, are relevant to determining whether a patient's associated medical expenses are reasonable.[4] In turn, this data is necessary for all parties—including personal injury defendants—to determine whether claimed medical expenses reflect the reasonable value of services provided.

A. Relator Uses Medicare's Rates to Establish Charges.

In *North Cypress Medical Center Operating Company v. Cigna Healthcare,* the Fifth Circuit Court of Appeals stated North Cypress's billing practices in relation to thousands of patients.[5] The Appellant in that case is the same party as the Relator in this case—North Cypress Medical Center Operating Company.

The case dealt with more than 8,000 insurance plans: "some [plans limited] out-of network benefits to a set percentage of a charge based on Medicare pricing . . . while other plans limit[ed] reimbursement to a percentage of rates charged by other providers in the geographic area."[6]

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[4] *See In re Jarvis*, 431 S.W.3d at 137 ("[Real party in interest] is entitled to discovery of the insurance contracts between BCBS and [Relator's] healthcare providers to aid in determining whether the providers are required to accept payments of less than the amounts billed.").

[5] *North Cypress Medical Center Operating Company v. Cigna Healthcare,* 781 F.3d 182 (5th Cir. 2015).

[6] *Id.* at 187.

North Cypress was not under contract with Cigna. Rather, as an out-of network provider North Cypress would apply prompt pay discounts to those patients insured by Cigna.[7] This meant that instead of calculating the total cost of care for a patient based on four to six times Medicare rates, North Cypress would start with a lower base rate of 125% of the Medicare rate.[8] North Cypress would then only collect 20% of the 125% of the Medicare rate, or 25% of the Medicare rate from the out of network patient.[9]

The method used by North Cypress is important for two key reasons. First, by utilizing the Medicare rate as a threshold for calculating its cost of care, North Cypress confirms that these rates are in fact relevant to determining medical billing standards. Second, as an out-of network provider, North Cypress was not under contract with Cigna. This means that patients insured by Cigna who were treated by North Cypress were treated as uninsured for purposes of calculating costs of medical services provided. Consequently, Medicare reimbursement rates—at a minimum—are relevant to Relator in determining the cost of care billed uninsured or out-of network patients.

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[7] *Id.*

[8] *North Cypress Medical Center,* 781 F.3d at 188.

[9] *Id.*

To the extent North Cypress or any other provider wants to distinguish the amounts it gets paid by others from the amounts at issue, it can argue against admissibility at the appropriate juncture. Or, if the evidence is admitted in front of the jury, it can argue why it is entitled to a higher payment for the services at issue in such case. However, the amounts North Cypress accepts from Medicare or other health plans for the same treatment are relevant and reasonably calculated to lead to the discovery of admissible evidence—whether Real Party in Interest is an uninsured patient or not.

B. Because healthcare costs lack transparency, data other than the full charge is *necessary* to determine reasonableness.

Both the Texas legislature and the Texas Supreme Court have acknowledged that real healthcare costs lack transparency.[10] Unlike many products and services in our free market, a provider's full charges are not set to reflect or cover costs, but "devoid of any calculation related to cost."[11] While they are set by a "chargemaster," which forms the basis for hundreds of billions of dollars in health care bills, there is neither process, nor rationale, behind the chargemaster.[12]

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[10] *See Haygood*, 356 S.W.3d 391; *Daughters of Charity Health Services of Waco v. Linnstaedter,* 226 S.W.3d 409, 410 (Tex. 2007); Tex. S.B. 1731, 80th Leg., R.S. (2003) (Author statement); Texas Dept. of Insur., *Available at*: http://www.tdi.texas.gov/; *see also* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy*, 25 HEALTH AFF. 57, 59 (2006) (opining that healthcare charges are difficult to comprehend).

[11] Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME (February 2013).

[12] *Id.*

Providers' rates and medical charges are frequently criticized in this respect.[13]

The Texas Legislature, in enacting enacted Senate Bill 1731, acknowledged the inaccuracy and lack of transparency in healthcare costs:[14]

> **AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**
>
> In recent years, health care costs have consistently increased. The rising cost of health care has been a prevalent point of discussion and debate for employers, providers, health plans, and patients. A major point of this discussion is the potential for inaccurate information and the absence of transparency in the costs of health care services. The disclosure of this information may help patients to make appropriate and cost-effective health choices.

Moreover, this Court in *Haygood* began its opinion stating: "it has become

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[13] *See, e.g.*, *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts. Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (noting that chargemaster prices "bear no relationship to the amount typically paid for those services"); George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers,* 43 PEPP. L. REV. 745 (2016) ("The list prices contained in the chargemaster are truly arbitrary and capricious from the point of view of pricing except in one respect—the higher the list price, the higher the hospital's revenue"); Elisabeth Rosenthal, *As Hospital Prices Soar, A Stitch Tops $500,* N.Y. TIMES (Dec. 2, 2013), http://www.nytimes.com/2013/l2/03/health/as-hospital-costs-soar-single-stitch-tops-5O0.ht1nl?pagewanted:all&_1:0 ("How do hospitals set prices? They set prices to maximize revenue, and they raise prices as much as they can—all the research supports that. . . . Chargemaster prices are basically arbitrary, not connected to underlying costs or market prices . . . . Hospitals 'can set them at any level they want. There are no market constraints.'"); *see also* Reinhardt, 25 HEALTH AFF. at 59 (2006) (noting that chargemaster rates "do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services"); Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 50-52 (2006) (explaining that individual items in the chargemaster are subject to smaller or larger than average increases based on the advice of an "arsenal of consultants and computer software . . . used to determine optimal increases in charges for various services. Optimality implies a higher payoff for a given rate of increase . . . . Over time, a hospital's chargemaster is bent, stretched, and distorted by numerous pressures and responses"). Reinhardt also notes that "chargemaster prices . . . would yield truly enormous profits if these prices were actually paid." Reinhardt, 25 HEALTH AFF. at 57; *see also* Lucette Lagnado, *California Hospitals Open Books, Showing Huge Price Differences*, WALL STREET J. (Dec. 27, 2004), http://www.wsj.com/articles/SB1l04l0465492809649 ("There is no method to the madness. . . . As we went through the years, we had these cockamamie formulas. . . . We multiplied our costs to set our charges").

[14] Tex. S.B. 1731, 80th Leg., R.S. (2003) (Author statement).

increasingly difficult to determine what expenses are reasonable. Health care providers set charges they maintain are reasonable while agreeing to reimbursement at much lower rates determined by insurers to be reasonable, resulting in great disparities between amounts billed and payments accepted."[15] This Court explained that health care charges, "once based on the provider's costs and profit margin, have more recently been driven by government regulation and negotiations with private insurers."[16] A two-tier structure resulted: "list" or "full" rates, which patients rarely pay, and reimbursement rates.[17] This leads to hospitals being incentivized to increase their charges "as high as possible" to increase the reimbursement rates, which are customarily paid.[18]

The full charges in *Haygood* were four times the reimbursement rate.[19] In indicating its disapproval, this Court stated:

> Although reimbursement rates have been determined to be reasonable under Medicare or other programs, or have been reached by agreements between willing providers and willing insurers, providers nevertheless maintain that list rates are also reasonable . . . The providers testified the charges billed to Haygood were reasonable, even though those charges were four times the amount they were

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[15] *Haygood*, 356 S.W.3d 391.

[16] *Id.* at 393–94.

[17] *Id.*

[18] *Id.*

[19] *Id.* 395–97.

entitled to collect.[20]

This Court acknowledged that full charges are not intended to be reasonable from their onset; but are artificially inflated only to leverage higher reimbursement rates, being the amounts paid with respect to medical services.[21]

Haygood was not the first time our High Court criticized full charges and acknowledged the lack of transparency in healthcare charges. In *Linnstaedter*, this Court doubted full charges could be even considered "charges" given their inaccuracy and how infrequently they are paid.[22] This Court noted, "[t]he labels for these charges, 'regular,' 'full,' or 'list,' are misleading, because in fact they are actually paid by less than five percent of patients nationally."[23]

This comes as no surprise given that a full charge for treating a patient is "generally at least double and may be up to eight times what the hospital would accept as payment in full for the same services from Medicare, Medicaid, HMOs,

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[20] *Haygood*, 356 S.W.3d at 394.

[21] *Id.*

[22] *Linnstaedter,* 226 S.W.3d 409, 410 n.1.

[23] *Id.* (citing *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured,* 94 KY. L. J. 101, 120 (2005–2006)); *see also Vencor Inc. v. National States Insurance Co.,* 303 F.3d 1024, 1029 n. 9 (9th Cir. 2002) ("It is worth noting that in a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, providers' supposed ordinary or standard rates may be paid by a small minority of patients."); *Shahin v. Mem'l Hermann Health Sys.*, 01-16-00128-CV, 2017 WL 2590277, at *3 (Tex. App.—Houston [1st Dist.] June 15, 2017, pet. filed) ("Because of the nature of medical billing, a medical statement may or may not be a final bill that a medical provider can collect on."); *Metro. Transit Auth. v. McChristian,* 449 S.W.3d 846, 852–54 (Tex. App.—Houston [14th Dist.] 2014, no pet.).

or private insurers."[24] Amicus Curiae has seen providers charge uninsured patients:

- 19 times what both Aetna and Medicare would have paid for an Anterior Cervical Discectomy;
- 21 times for same with respect to Blue Cross Blue Shield; and
- 29 times for same with respect to Cigna.

Because such charges are rarely, if ever, paid in full, the "charged amount" is little more than mere fiction. However, without more data to determine reasonableness (or lack thereof), litigants disputing these excessive medical bills are exposed to medical bills that are unchecked and only require the *ipse dixit* from the medical provider that these medical charges are reasonable.

C. Data from healthcare plans and reimbursement schemes are relevant and necessary to all parties—contracting or not.

The amounts a medical provider routinely accepts for the same services in the same locale are relevant to the reasonableness of healthcare expenses—regardless of a party being under contract or uninsured. Other courts and scholars agree.[25]

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[24] *Haygood*, 356 S.W.3d at 393 n.17; *Linnstaedter*, 226 S.W.3d at 410 n.1.

[25] *See e.g.,* George A. Nation, III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425 (2013); *Stanley v. Walker,* 906 N.E.2d 852, 857–858 (Ind. 2009) (Reasonable value of medical services is not exclusively based on actual amount paid or amount originally billed, though these figures may serve as evidence as to reasonable value of medical services.); *Martinez v. Milburn Enterprises, Inc.*, 290 Kan. 572, 233 P.3d 205 (2010); *Robinson v. Bates,* 112 Ohio St.3d 17, 857 N.E.2d 1195, 1200–1201 (2006); *Temple University Hospital v. Healthcare Management,* 832 A.2d 501, 505 (Pa. Super. Ct. 2003); *Children's Hospital Central California v. Blue Cross of California,* 226 Cal. App. 4th 1260 (2014).

For example, in *Bowen v. The Medical Center, Inc*., the Georgia Supreme Court decided the exact question at issue in the present matter.[26] In *Bowen,* the question was whether information and records related to The Medical Center's ("TMC") pricing agreements with Medicare, Medicaid, and private insurers was discoverable.[27] Bowen was uninsured and injured in an automobile accident. After she was treated, TMC billed her $21,409.59.[28] Bowen later sued the rental car company, which prompted TMC to file a hospital lien for $21,409.59.[29] Being unable to agree on an allocation of any settlement amount to release the hospital lien, Bowen filed a crossclaim against TMC to invalidate its lien—alleging that the bill was grossly excessive and did not reflect the reasonable value of her treatment.[30]

During discovery, Bowen requested information and records regarding the amounts TMC charged for similar treatments, such as TMC's pricing agreements with health insurance companies and other materials related to TMC's charges of

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[26] *Bowen v. The Medical Center,* 773 S.E.2d 692 (Ga. 2015).

[27] *Id.*

[28] *Bowen,* 773 S.E.2d 693.

[29] *Id.*

[30] *Id.*

insured and uninsured patients.[31] TMC objected to the discovery, and Bowen filed a motion to compel, which was granted by the trial court.[32] On appeal, the court of appeals reversed, finding the requested records and information to be irrelevant to the patient's claim.[33]

The Georgia Supreme Court granted certiorari, and reversed the court of appeals finding Bowen's discovery requests were proper.[34] In support, the court focused on whether the information requested was "relevant" in the broad sense of discovery rather than in "the narrower trial sense of [the reasonableness of TMC's charges]."[35] The court cited the statutory rule that parties in Georgia may obtain discovery on "any matter, not privileged, which is relevant to the subject matter involved in the pending action."[36]

Accordingly, the court concluded that, although the amounts TMC had charged other patients for the same type of care may not be dispositive for whether Bowen's charges were "reasonable," that did not mean the amounts TMC charged

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[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *Id.*

[35] *Id.* at 696.

[36] *Id.* at 695. This rule is identical to Tex. R. Civ. P. 192.3(a).

other patients were "entirely irrelevant."[37] As a result, Bowen was entitled to see what the information and documents showed to determine whether the discovery supported her claims that charges were unreasonable.[38]

Similarly, in *Colomar v. Mercy Hospital,* plaintiff brought a putative class action on behalf of uninsured patients alleging breach of contract and a violation of Florida's Deceptive and Unfair Trade Practices Act based on a claim of unreasonable medical expenses.[39] The court, in denying defendant's motion to dismiss, held that there are several factors relevant to the question of whether medical charges are in fact reasonable: "(1) an analysis of the relevant market for hospital services (including the rates charged by other similarly situation hospitals for similar services); (2) the usual and customary rate [a provider] charges and receives for its hospital services; and (3) [a provider's] internal cost structure."[40]

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[37] *Id.* at 697.

[38] *Id.*

[39] *Colomar v. Mercy Hosp., Inc.,* 461 F. Supp. 2d 1265 (S.D. Fla. 2006).

[40] *Colomar,* 461 F. Supp. 2d at 1269; *see e.g., Doe v. HCA Health Serv. of Tenn*., 46 S.W.3d 191, 198 (2001) (canvassing cases from other jurisdictions to conclude that " 'reasonable value [of hospital services] ... is to be determined by considering [among other things] similar charges of other hospitals in the community.' ")*; Galloway v. Methodist Hosp., Inc*., 658 N.E.2d 611, 614 (Ind.App.1995) (considering evidence of charges by other area hospitals in deciding reasonableness of hospital charges); *Victory Mem. Hosp. v. Rice,* 493 N.E.2d 117, 120 (1986) (inquiry into reasonableness of pricing for hospital services includes consideration of whether charges are comparable to other area hospitals); *Temple Univ. Hosp., Inc. v. Healthcare Management Alternatives, Inc.,* 832 A.2d 501, 510 (Pa. Super. Ct. 2003) ("Reasonable value [of hospital services]... is the value paid by the relevant community. The relevant community in this

Notably, plaintiff alleged that patients with insurance and government benefits received significant discounts in the price they paid for the subject medical services, which suggested that the value of the services provided were significantly less than defendant charged plaintiff.[41] "This allegation, *if borne out during discovery,* would be evidence in support of the conclusion that the charges imposed on [p]laintiff are unreasonable."[42] In this respect, the court identified that data and information from healthcare plans and market rate charges were relevant to determining the reasonable value of services—regardless of whether a patient is insured or not.

In *Temple University Hospital v. Healthcare Management* the issue was whether the Hospital was entitled to recover its "published rates" (also known as list prices) from the non-contracting insurance carrier, Healthcare Management, under the doctrine of unjust enrichment.[43] Resolving the issue required the Superior Court of Pennsylvania to specifically address whether the published rates

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case comprises the Hospital's patients who are covered by insurance policies and federal programs.").

[41] *Id.* at 1272.

[42] *Id.* (emphasis added).

[43] *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501 (Pa. Super. Ct. 2003).

represented a "reasonable value for the services."[44] The court calculated a reasonable value by considering "what the services are ordinarily worth in the community. Services are worth what people ordinarily pay for them . . . While the Hospital's published rates for services may be the same or less than rates at other Philadelphia hospitals, *the more important question is what healthcare providers actually receive for those services*."[45] As the Hospital rarely recovered its published rates, "those rates cannot be considered the value of the benefit conferred because that is not what people in the community ordinarily pay for medical services."[46]

In *Children's Hospital Central California v. Blue Cross of California*, the Court of Appeals for the Fifth District of California held that the trial court improperly limited evidence of the reasonable and customary value to a hospital's "full billed charges."[47] During the discovery period, the hospital objected, on grounds that they were irrelevant, to Blue Cross's requests inquiring into its contracts with other insurance carriers, the number of patients receiving care for whom Hospital received its full billed charges as payment, and the name of any

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[44] *Id.* at 506.

[45] *Id.* at 508 (emphasis added).

[46] *Id.*

[47] *Children's Hosp. Cent. California v. Blue Cross of California*, 226 Cal. App. 4th 1260, 172 Cal. Rptr. 3d 861 (2014).

non-contracted managed care organization that paid Hospital's full billed charges for certain services.[48] The trial court denied Blue Cross's motion to compel and at trial, the hospital supported its damages claim by arguing its full-billed charges "represented the reasonable and customary value of the services provided."[49]

The jury awarded the hospital the amount of its full-billed charges less the amount that Blue Cross had already paid.[50] On appeal, the Court of Appeals stated "[a]ll rates that are the result of contract or negotiation, including rates paid by government payors, are relevant to the determination of reasonable value."[51] "The full range of fees is relevant. The scope of the rates accepted by or paid to Hospital by other payors indicates the value of those services in the marketplace."[52]

These courts have recognized amounts a medical provider routinely accepts and market charges for the same services in the same locale are relevant to both insured and uninsured patients. Therefore, health insurance data and differential pricing are relevant to determining true and reasonable medical costs and should be discoverable.

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[48] *Id.* at 1268.

[49] *Id.* at 1269–70.

[50] *Id.*

[51] *Id.* at 1270.

[52] *Id.* at 1277 (emphasis added).

D. Access to the data sought will help prevent windfalls.

A plaintiff can prove the reasonable charges for his medical damages by either using expert testimony or the affidavit process under section 18.001 of the Texas Civil Practices & Remedies Code. In turn, a defendant may serve a controverting affidavit to dispute the reasonableness and necessity of medical expenses at issue.[53] However, the fact that the reasonableness of disputed medical expenses can be shown through expert testimony does not make other forms of proof irrelevant—or undiscoverable.[54]

Amici, Parkland Health and Hospital System and Hunt Regional Medical Center, argue, "[i]f this Court allows a patient to use one standard for the reasonableness of charges in her personal injury claim, but another in her dealings with the hospital, the patient will gain a windfall while a hospital's interest in the hospital lien will be reduced."[55] This, however, is not limited to the context of the present case. Rather, this will occur in every instance where a challenge to the reasonableness of medical expenses is warranted. If parties—including tort defendants—do not also have the requested discovery relevant to proving

[53] Tex. Civ. Prac. & Rem. Code 18.001.

[54] *Bowden,* 773 S.E.2d at 296.

[55] Parkland and Hunt Amicus Brief, 29-30.

reasonableness, then billing decisions by hospitals and providers will go unchallenged.

It is not enough for Relator to merely say, "trust me," in providing self-serving affidavits that amounts billed are reasonable while also resisting access to evidence that amounts billed are at its regular rate.[56] Because parties to a dispute may challenge the reasonableness of medical expenses—be it an insurance company, personal injury defendant, or uninsured patient—the discovery sought here is relevant and should be available to prevent windfalls.

E. Conclusion

This is a matter of common-sense discovery. Providers artificially inflate their medical charges. The lack of transparency in medical billing makes it difficult—if not impossible—to determine the true and reasonable value of healthcare services. This reality demands discoverability of amounts providers are *actually paid* for similar services in the same locale.[57] Real Party in Interest seeks discovery that is not just relevant—but necessary—to determining reasonableness of medical expenses. Therefore, the Trial Court did not abuse it discretion in

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[56] Tex. Civ. Prac. & Rem. Code 18.001(c)(2)(A); *Republic Ins. Co. v. Davis,* 856 S.W.2d 158, 161 (Tex. 1993) ("[a party] cannot use one hand to seek affirmative relief. . . and with the other lower an iron curtain of silence against otherwise pertinent and proper questions which have bearing upon its right to maintain his action.").

[57] *Temple*, 832 A.2d at 505; *Children's Hospital,* 226 Cal. App. 4th at 1268; *Bowden,* 773 S.E.2d 692.

compelling Relator's responses to the disputed discovery requests.

PRAYER

Amicus prays that this Court consider this Brief and affirm the Trial Court's orders denying Relator's motion for protective order and granting Real Party in Interest's motion to compel.

Respectfully submitted,

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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 4,312 words.

/s/Robert Fuentes
Robert Fuentes

CERTIFICATE OF SERVICE

I certify that, on November 8, 2017, I served a copy of this Amici Curiae Brief via the e-filing portal to the following:

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