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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 Party 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

POST-SUBMISSION BRIEF OF AMICUS CURIAE RESEARCH & PLANNING CONSULTANTS, LP ON "REASONABLE CHARGE" LAW AND FACTS

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Amicus Curiae adopts the designation of the identities of the parties and their counsel in the Relator's Brief on the Merits.

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STATEMENT OF INTEREST

In light of the oral argument, Amicus Curiae Research & Planning Consultants, L.P. (RPC) reviewed the briefing, and hopes to provide the Court with additional highly relevant law and facts. Amicus Curiae is paying for this brief.

Ronald T. Luke, J.D., Ph. D., is RPC's president and owner. For thirty years, he has authored studies used in rulemakings and given expert testimony on proper healthcare reimbursement amounts; the relevance of and data available on prices set in network contracts between managed care insurers and healthcare providers, including hospitals; and hospital costs. The Texas Workers' Compensation Commission commissioned and relied on his study in adopting rules setting fees under the Texas workers' compensation statute.

Governor Bush appointed Dr. Luke as an original member of the Texas Healthcare Information Council; he played a major role in developing the Texas hospital discharge data system. Governor Perry appointed Dr. Luke to the Texas Health & Human Services Council, which supervises Texas Medicaid and CHIP, and to the board of the Texas Institute for Healthcare Quality and Efficiency.

Dr. Luke chairs the Health Policy Committee of the Texas Association of Business.

STATEMENT OF THE CASE

Amicus Curiae adopts the Statements of the Case in the briefs of the Real Party in Interest and of another Amicus Curiae, the Fuentes Firm.

ISSUES PRESENTED

Amicus Curiae adopts the Issues Presented in the briefs of the Real Party in Interest and of Amicus Curiae the Fuentes Firm.

STATEMENT OF FACTS

Amicus Curiae adopts the Statements of Facts in the briefs of the Real Party in Interest and of Amicus Curiae the Fuentes Firm.

Amicus Curiae in this brief provides additional facts about hospital charges, costs, payments, and in-network contract prices.

SUMMARY OF THE ARGUMENT

I. The Unjust Enrichment Law of Reasonable Charges

The American Law Institute's Restatement (3rd) of Restitution & Unjust Enrichment (2011) summarizes the law governing what a patient owes for emergency healthcare services when no valid contract, statute or rule sets that amount.

To prevent unjust enrichment of the patient, he or she owes the provider "reasonable charges." For this purpose, "reasonable charges" are the "reasonable value" of the services, and the "reasonable value" of the services is measured by the lesser of their cost or their market value.

In-network contract payments are direct evidence of the market value of hospital services. They have been held "pertinent" in the unjust enrichment context to the determination of a "reasonable rate" to be paid by an insurer for emergency hospital services. *River Park Hospital, Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W. 43 (Tenn. Ct. App. 2002).

II. The Facts Make Charges Irrelevant, and In-network Contract Prices Relevant, to the Reasonable Value of Hospital Services.

A. Hospital charges are irrelevant to costs or reasonable value.

Because hospital charges set unilaterally by the hospital and are paid by almost no one, they reflect neither the costs nor the reasonable value of a hospital's services. *Daughters of Charity v. Linnstaedter*, 226 S.W.3d 409, 410 (Tex. 2007).

B. In-network contract prices are relevant, and not publicly available.

In network contract prices are often among the best measures of the market value of hospital services – they are set in advance of services by voluntary agreement between willing sellers and willing buyers. They are not, however, publicly available. Only the insurer and the hospital have them.

C. Other evidence of the reasonable value or cost of hospital services.

Only managed care in-network prices are at issue in this case. Other ways to estimate the value or the costs of particular hospital services exist and may be appropriate for use in certain circumstances.

Another value indicator is the average payment received by the hospital. Medicare's fee schedule approximates average hospital costs. One may estimate an individual hospital's costs.

ARGUMENT AND AUTHORITIES

Especially for emergency medical services, a hospital often has no contract with the patient, or the patient's insurer, if any, and no statute or rule sets the amount either must pay.[1] Amicus curiae RPC respectfully offers law and facts relevant to the answer and, it believes, not previously provided to the Court.

I. Under the Restatement, the term "reasonable charges" means the "reasonable value" of the services. In-network contract prices are relevant to "reasonable value."

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[1] **A statute may set the amount a particular type of insurer must pay for emergency services. *See, e.g.,*: "A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate."**

A statute may require an agency to apply specific standards in setting the amounts a particular type of insurer must pay for all services. The standards may vary from statute to statute.

For example, the Division of Workers' Compensation (DWC) of the Texas Department of Insurance must, with limited exceptions, set workers' compensation insurer payments to providers based on Medicare. It must, however, also design those payments to ensure quality of care and achieve effective medical cost control; not set fees higher than paid by others on behalf of populations of equivalent standards of living, and consider the increased security of workers' compensation payments. Tex. Labor Code § 413.011.

In such circumstances, the law of unjust enrichment governs, and the patient owes the provider a "reasonable charge." *See* Restatement (3rd) of Restitution and Unjust Enrichment (American Law Institute 2011), Volume I at § 20.[2] The "reasonable charge" is the "reasonable value" of the provider's services.[3] The provider's charges are, at most, prima facie evidence of the reasonable value of its services.[4]

Charges have in some contexts been held not to be even prima facie evidence. For hospital lien purposes this Court has held provider charges "irrelevant to the issue of [tort medical] damages," and thus not

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[2] For emergency services, a professional healthcare provider is "entitled to restitution from the [patient] in an amount sufficient to prevent unjust enrichment," "measured by a reasonable charge for the services in question."

[3] Although Comment a, *id.* at p. 287, says an emergency services provider "has a claim by the rule of this section to its reasonable and customary charge," Comment c. *Measure of benefits*, at p, 290, says "as in most cases of quantum meruit, liability [is] measured by market value (section 50(2)(b))." The cases cited in the Reporter's Note hold that the measure is the "reasonable worth of services," *Cole v. Wagner*, 150 S.E., 339, 342 (NC 1929), or "the reasonable value of the services rendered." *Gardner v. Flowers*, 509 S.W.2d 708, 711 (TN. 1975).

[4] *See, e.g., Cole v. Wagner*, 150 S.E. at 342 ("In the answer it is alleged that the bills rendered are exorbitant and excessive. This is a question for the jury for trial."); *Gardner v. Flowers*, 509 S.W.2d at 711 ("Neither party raises the issue of whether the hospital charges in this case exceed the reasonable value of the services rendered. … Only a fair and reasonable price is to be charged … . Thus the question of the reasonableness of the hospital's charges will be determined on remand."); *Galloway v. Methodist Hospitals*, 658 N.E. 2d 611, 614 (In. App. 1995)(The provider's "statement, while not conclusive, is prima facie proof of the amount owed on the account."); and *Landmark Med. Center v. Gauthier*, 635 A.2d 1145, 1149 (RI 1994)(where it was "undisputed" that the charges "were fair and reasonable," that made out "a prima facie case for the payment of the amount due.")

even admissible evidence. *Haygood v. De Escabedo*, 356 S.W.3d 390, 398 (Tex. 2011).

The Restatement (3rd) § 49(3) sets out the legal standards for measuring the value of services that were not requested by the recipient but were provided under circumstances requiring payment to prevent unjust enrichment of the recipient.

Usually one of two standards controls. Section 49(3)(b) is "the cost to the claimant of providing the services" and 49(3)(c) is "the market value of the services."

When the different measures yield different results, the black letter law is: "Unjust enrichment from unrequested benefits is measured by the standard that yields the smallest liability in restitution." Restatement (3rd) § 50(2)(a). This discourages such providers from rendering unnecessary services, prevents windfalls to such providers, and encourages providers to enter into contracts, which obviate the need for unjust enrichment litigation.

One case from another state holds that in-network contract payments are pertinent evidence of a reasonable rate to be paid by an insurer to a hospital to prevent unjust enrichment.

In *River Park Hospital, Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W. 43 (Tenn. Ct. App. 2002) the hospital declined to renew a network contract with the Medicaid managed care insurer, asserting it was losing money at the contract prices. The parties were unable to agree on a new price. Under federal law,[5] the hospital nevertheless had to provide emergency care. Under its contract with the state, the insurer had to pay for those services, even though no price agreed upon or set by the state.

The court held evidence of the insurer's payments to its in-network providers "pertinent" though "hardly conclusive." *Id.* at 60.

II. The Facts Make Charges Irrelevant, and In-network Contract Prices Relevant, to the Reasonable Value of Hospital Services.

A hospital's charges do not represent its costs or the reasonable value of its services. Often the hospital's in-network contract prices are the best evidence of the market value of its services. They are not publicly accessible. Other measures may be appropriate, depending upon the circumstances.

[5] **The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd.**

Some of these facts are reflected in *Daughters of Charity v. Linnstaedter*, 226 S.W.3d 409 (Tex. 2007) and *Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2011). Amicus curiae will here provide others.

A. Hospital charges are not a measure of the costs or reasonable value of hospital services.

Hospital charges are "devoid of any calculation related to cost." *Linnstaedter,* 226 S.W.3d at 410.

"Few patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates." *Id.*

In *Temple Univ. Hospital, Inc. v. Healthcare Management Alternatives, Inc.,* 832 A.2d 501, 505-06 (Pa. Super. Ct. 2003), the hospital's CFO testified that it "was paid eighty percent or more of its full published charges only six percent of the time." The insurer's expert testified that the hospital was paid its full charges "only one to three percent of the time." In the first year at issue the hospital's charges "were 172% of its actual costs" and in the next two years they were "300% of the Hospital's costs."

Before health insurance, patients paid with their own money, so charges were often what was paid, and usually close to what was paid. In World War II, the United States prohibited wage increases for the sake of the war effort but allowed employers to provide health insurance. A gap opened between charges and amounts paid.

Later Medicare and then Medicaid were instituted. The gap widened. By the 1980's, government programs and commercial insurers moved away from paying hospitals based on charges. Over time, most healthcare payments have come to be based on Medicare, though often the amounts are set above what Medicare pays.

In 1992, DWC's predecessor adopted the first Texas hospital fee rule that did not set fees as a percentage of charges; it set per diem amounts for three categories of care – acute care, surgery, and ICU/CCU. That rule was struck down for failure to give an adequate reasoned justification. In 1997 the agency adopted a similar rule, with a more detailed explanation.

In 2002 the agency adopted its first Medicare-based fee rule (for doctor and other professional services, not hospitals). In doing so, it repeated why payments could not be based on charges.

Charge-based fees put "determination of the reimbursement solely in the hands of the provider … ." 27 Tex. Reg. 4048, 4092 (May 10, 2002). "The statute's fundamental purposes include effective medical cost control. This cannot be achieved basing payments on charges." 27 Tex. Reg. 12,304, 12,347 (Dec. 27, 2002).

Hospitals demanding payment of their billed charges still present significant problems. The main ones are (1) when an out-of-network hospital demand payment from a patient's managed care insurer, and (2) when a hospital places a lien on a tort recovery by an uninsured patient, like Ms. Roberts in this case, or pursues collection against an uninsured patient thought to have some appreciable assets or income. ***See generally*** **Cooper, Z. and Morton, F. S.,** ***"Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise,"*** **N. Engl. J. Med. 375:20 (Nov. 17, 2016).**

Some hospitals make it their business model to stay out of managed care networks. (Others may not be invited to join one or more insurers' networks.) After rendering service, such a provider bills the insurer and threatens, if the insurer does not pay a high percentage of its charges, to balance bill, and sue, the patient.

Many managed care insurers used to, and some still do, set the amounts they allow for out-of-network claims on a "UCR" basis – "usual, customary, reasonable." Some of those continue to use the 75th or 80th percentile of provider charges in the area as their UCR. (This is not 75% or 80% of the specific provider's charges. It is charges no higher than the highest 75% or 80% of area charges.)

Medicare never paid hospitals on a UCR basis; it always used cost-based payment methods. For physician fees, Medicare abandoned the UCR approach in 1992, adopting a Resource-Based Relative Value System.

The UCR approach results, at best, in a ceiling on reasonable payment for out-of-network services. Since every provider now unilaterally raises its charges aggressively, there is nothing intrinsically "reasonable" about payments at the 75th percentile of area charges. A managed care insurer may pay out of network hospitals on this basis for reasons of convenience.

B. In-network contract prices are relevant and not publicly available.

"Fair market value" is generally defined as a price agreed to between a willing buyer and a willing seller, neither being under

any compulsion and both having reasonable knowledge of relevant facts.[6]

Both qualifications are important here. Emergency care patients are under compulsion, and often incapacitated. In general, even non-emergency patients are not reasonably knowledgeable of the relevant facts.

In network contract prices, in contrast, are agreed to by willing buyers and willing sellers, both knowledgeable. They are often, though not always, one of the best measures of the market value of a hospital's services.[7]

The Texas Labor Code caps payments at the amounts paid on behalf of patients with standards of living equivalent to the workers' compensation population. On the basis of a study by Dr. Luke that it commissioned, the DWC's predecessor determined

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[6] See I. R. S. Regulation § 20.2031-1; *see also Phillips v. Carlton Energy Group, LLC*, 475 S.W.3d 265, 278 (Tex. 2015)("[F]air market value is what a willing buyer would pay a willing seller, neither acting under any compulsion.".

[7] Market defects may limit the usefulness of in-network prices as a measure of the value of a hospital's services in some important circumstances. The hospital may be the only one in the area, or the only one with key types of care, resulting in insurers being under some compulsion to include it. Or the hospital may be one of many in an area, and not included in most insurers' networks, but signatory to one or two network contracts with small insurers, at high prices reflecting convenience to the insurer rather than value.

that there are two such populations, Medicare and managed care. 22 Tex.Reg. 6264, 6270-71 (July 4, 1997).

At first implicitly, and in adopting the first Medicare-based healthcare fees explicitly, the agency determined that the statute establishes "a range within which [it] is directed to exercise administrative discretion" in setting reimbursements; Medicare is the floor and managed care in-network prices are the ceiling. ***See*** **27 Tex.Reg. at 12,316.**

In adopting the first hospital fee rule for Texas workers' compensation that was not based on charges, the DWC's predecessor asked the eighty hospitals that in the base year had together accounted for 80% of all Texas hospital revenue to produce their contracts or summaries of the prices.

Almost all refused. The agency ordered them to produce the contracts or summaries. The hospitals sued, but complied after agreement was reached on a protective order. ***See*** **22 Tex. Reg. 6264, 6273 (July 4, 1997).**

C. Other evidence of the reasonable value or cost of hospital services.

This case concerns the relevance only of managed care in-network prices. There are other ways to estimate the value or the costs of particular hospital services. Depending on the situation, such evidence may or may not be appropriate for unjust enrichment purposes; the data needed may or may not be publicly available; and the calculation may or may not require the help of a healthcare economist.

One other measure of value is the average payment received by the hospital. In the *Temple University Hospital* case, the facts were like those in the *River Park Hospital* case. The court held that the "reasonable value" of the hospital's services is "the value paid by the relevant community." 832 A.2d at 510.

Average payments may represent some evidence of the upper end of "market value" in one important sense: the hospital is able and willing to stay in business at such average payment levels. Of course it is possible that the hospital would remain in business at lower average payment levels.

Medicare provides evidence of hospital costs. Medicare sets its hospital fee schedule to cover the average costs of an efficient hospital for each Diagnostic-Related Group of inpatient services or Ambulatory Payment Group of outpatient services.[8] Medicare fees thus give a rough idea of an average hospital's costs for each DRG or APG to which services to a particular patient may be assigned.

For a specific hospital, the cost to deliver the services covered by a particular claim can be estimated by taking the appropriate charge to cost ratio[9] from the hospital's annual Medicare cost report, or from the financial data section of the Texas Annual Hospital Survey, and applying that ratio to the hospital's charges for that claim.

Medicare fees are widely used by other payors, both government (e.g., Medicaid) and private (most network group health contracts), in setting payments for all types of healthcare.

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[8] In adopting its first Medicare-based inpatient fee rule, DWC noted that such fees are intended "to reimburse an efficient facility at an average cost amount," though in individual claims the reimbursement will sometimes be above and other times below cost. *See* 33 Tex. Reg. 364, 414 (Jan. 11, 2008).

[9] Hospitals have an overall CCR and have different CCRs for individual cost centers. The choice of which CCR to use affects the resulting cost estimate.

The amounts paid may, for business or policy reasons, exceed what Medicare pays (in-network contracts and workers' compensation) or be lower (Medicaid).

Most state workers' compensation systems that set fee schedules base their fees on Medicare. The Texas legislature required DWC to do so in 2001.

Basing healthcare payments on Medicare makes sense. Medicare is far and away the largest single healthcare payor. Medicare studies every aspect of healthcare and its costs, with the input of national stakeholders. Medicare updates its fees annually.

In the DWC's view, payments "should not exceed Medicare payments for the same or similar services, absent clear justification based on other statutory standards, such as ensuring covered workers' access to quality care." 27 Tex. Reg. at 12,334. It is a "legitimate means to achievement" of the statutory effective medical cost control goal "to adopt the lowest percentage above the Medicare conversion factor consistent with the safety margin that the Commission considers prudent" for access

purposes. *Id.* at 12,337. The DWC set its first Medicare-based inpatient hospital fees at 143% of Medicare.[10] *See* 28 Tex. Admin. Code § 134.404(f)(1), (g).

Thus, Medicare's fee schedule provides an estimate of the average hospital costs, the individual hospitals' costs can be estimated from hospital-specific reports, the Texas workers' compensation fee schedule reflects multi-factor judgment of the premium above Medicare, but discovery of in-network contract prices is needed for the market value measure of what is needed to prevent unjust enrichment of an emergency services patient.

PRAYER

Amicus curiae Research & Planning Consultants, LP prays that this Court receive and consider this Brief, and deny Relator's petition for writ of mandamus.

[10] 108% if the hospital elects to be paid separately at cost plus 10% for surgical implants and other carve-out items.

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 brief covered by TRAP 9.4(i)(1) there are 3179 words.

/s/ P.M. Schenkkan
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CERTIFICATE OF SERVICE

I certify that, on December 14, 2017, I served a copy of this Amicus Curiae Brief via the e-filing portal on the following:

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