Research and Planning Consultants, LP

DAMAGES FOR PAST MEDICAL EXPENSES IN TEXAS PERSONAL INJURY LITIGATION

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INTRODUCTION

This paper focuses on damages a plaintiff can recover for past medical expenses in personal injury cases in Texas courts.[1] We note damages for future medical expenses raise different issues and that discussion is outside the scope of this paper. To recover for past medical expenses in a Texas personal injury case, the plaintiff must prove the past medical expenses were medically necessary due to the injury that is the subject of the litigation. The plaintiff must also prove the reasonable value of the past medical expenses. We discuss how the courts define reasonable value. We then discuss the discovery courts permit from plaintiffs, their health care providers, and health plans to determine reasonable value. While plaintiffs have a duty to mitigate damages by timely seeking reasonable medical treatment, no Texas court has to date ruled they have a duty to mitigate damages by using their insurance coverage. We discuss the interaction between mitigation of cost and the reasonable value limits on the amount a plaintiff may recover. We discuss how Texas Senate Bill (SB) 1264 and the federal No Surprises Act may affect the determination of reasonable value in personal injury cases. Lastly, we discuss how Texas Civil Practice and Remedies Code (TCPRC) §18.001 affects the recovery of past medical expenses.

WHAT CAN A PLAINTIFF RECOVER?

2. If the defendant is found liable for a personal injury, the plaintiff can recover the reasonable value of expenses for medically necessary goods and services needed due to the injury that is the subject of the litigation. Medical necessity and relatedness are issues for a physician or other clinician to address and are outside the scope of this paper. The reasonable value of the goods and services is an economic or financial question for an economist or other financial expert and is our focus.

[1] Dana Cottone, LLB, MRes, provided substantial research assistance for this paper, and her help is gratefully acknowledged.

3. The starting point for analysis of reasonable value is the provider's bill. Not all providers in personal injury cases bill using standard claim forms,[2] and not all providers include the standard Health Care Procedure Coding System (HCPCS)[3] codes to describe the goods and services provided. Texas Department of Insurance (TDI) rules define the data elements on a "clean claim."[4] Health care providers in personal injury cases are not required to file clean claims, but the TDI rules are relevant to show what it is reasonable to expect a provider to include on a bill to document goods and services. When the provider has not filed a clean claim, the services of a certified coder may be necessary to supply missing codes. When the provider does not provide standard coding or sufficient documentation for a certified coder to assign standard codes, the provider may not have established the services were medically necessary and the charges were reasonable, which would justify a court denying any recovery for those services.

4. There are generally accepted billing rules for how goods and services are billed. Many of the rules, such as those in the National Correct Coding Initiative (NCCI),[5] were developed by the Center for Medicare and Medicaid Services (CMS) to adjudicate Medicare and Medicaid claims. They have since become generally accepted by other public programs and by private health plans. A standard step in reviewing any bill is to check for violations of billing rules, modify improper codes, and delete or adjust improper charges.

Billed Charges

5. The upper limit of damages for past medical expenses is the billed charges of the healthcare provider. Each provider unilaterally sets its billed charges, usually with no limits on how high they may be. Providers are supposed to bill all patients the same charge for the same

[2] "CMS 1500," Centers for Medicare and Medicaid Services (CMS), https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854, accessed February 6, 2023. Helsinn Cares, "Sample CMS-1450 (UB-04) Claim Form," https://helsinnreimbursement.com/pdfs/V-AKYN-US-0079-Sample-CMS-1450-Claim-Form.pdf, accessed February 6, 2023.
[3] "HCPCS Quarterly Update," CMS, https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update, accessed February 6, 2023.
[4] "Subchapter T. Submission of Clean Claims 28 TAC §21.2802 and §21.2803," https://tdi.texas.gov/rules/2007/documents/21.2802-2803.pdf, accessed February 7, 2023.
[5] "The National Correct Coding Initiative (NCCI)," CMS, https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci, accessed February 6, 2023.

service on the same day, even if they expect to be paid differently for each patient. This is referred to as the provider's "usual and customary" charge. There is no presumption by Texas courts that a provider's billed charge is a reasonable charge for services in a medical market or that the billed charge, even if a reasonable charge, is the reasonable value of the service.[6]

Usual, Customary, and Reasonable Charges

6. Reasonable charges are usually determined by comparing one provider's charge for a service to the charges of other providers in the same medical market. This is referred to as a "usual, customary, and reasonable" (UCR) charge. A UCR charge for a service is usually one that falls below the 80th percentile in the medical market. An RPC white paper explains how UCR charges are calculated and the general acceptance of the 80th percentile.[7] If the billed charge is greater than the UCR charge, the upper limit on damages may be the UCR value.

7. HCPCS codes, Ambulatory Payment Classifications (APCs), Diagnosis Related Groups (DRGs) and other standard code sets are used to define similar services. Medical markets can best be defined using market definitions by the Dartmouth Atlas of Healthcare.[8] However, many publishers of UCR values use the first three digits of zip codes, called "geozips," to define market areas.[9] The data used to calculate UCR values for different percentiles can come from public use data files from state or federal agencies or from claims data from one or more health plans. It is necessary to choose a percentile to define the upper bound of a reasonable charge. The 80th percentile is the most frequently used and is the charge percentile referenced by SB 1264 and statutes in other states.[10]

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[6] "[B]ecause of the way chargemaster pricing has evolved, the charges themselves are not dispositive of what is reasonable, irrespective of whether the patient being charged has insurance." *In re N. Cypress Med. Ctr. Operating Co., Ltd.*, 559 S.W.3d 128, 133 (Tex. 2018).
[7] "Determining Usual, Customary, and Reasonable Charges for Healthcare Services," Research and Planning Consultants, LP, July 1, 2022, https://www.rpcconsulting.com/determining-ucr-charges-for-healthcare-providers. (Hereafter cited as RPC UCR White Paper.)
[8] Dartmouth Atlas of Healthcare, Dartmouth Atlas Project, https://www.dartmouthatlas.org, accessed February 6, 2023.
[9] See, e.g., Price Management Information Corporation, *Medical Fees Directory 2023 E-Book*, https://www.pmic online.com/product-page/medical-fees-directory-2023-e-book, accessed June 30, 2022.
[10] RPC UCR White Paper, starting on p. 17.

Paid or Incurred

8. If a medical bill has been paid or is to be paid by a health plan at a rate the provider accepts as payment in full, that amount is the upper limit on the reasonable value of the service. TCPRC §41.0105 states, "Recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the plaintiff."[11] This legislative enactment codified an earlier court decision in *Haygood v. De Escabedo.*[12] In *Haygood*, the Texas Supreme Court (SCOTX) limited the recovery of medical expenses to only those costs actually paid or to be paid, and not the "list price" on the medical bills. The court stated it did not want to create a windfall for the plaintiff and that "to impose a liability for medical expenses that a health care provider is not entitled to charge"[13] would create such a scenario. As explained below, this holding effectively means that a plaintiff's recovery of past medical expenses is capped by what the provider is entitled to be paid, not what it charged, for the service to the plaintiff.

9. TCPRC §41.0105 substantially modifies or eliminates the collateral source rule, at least for insured patients and providers who have agreed to accept negotiated or regulated rates as payment in full. If there is a negotiated or regulated rate, the patient has only incurred that rate as the allowed amount, as the provider has agreed to accept the allowed amount as payment in full. Evidence of insurance coverage and the allowed amount should be discoverable and admissible to determine the amount incurred.

10. When the provider writes off amounts as contractual adjustments, the claimant is not entitled to the unadjusted amount, as these are not considered "paid or incurred." In *Prabhakar v. Fritzgerald*,[14] the court stated, "In other words, amounts written off by medical providers are not amounts 'paid or incurred' under the statute."[15] The jury must award the

[11] Texas Civil Practice and Remedies Code 41.0105, https://statutes.capitol.texas.gov/Docs/CP/htm/CP.41.htm#41.0105.
[12] *Aaron Glenn Haygood v. Margarita Garza De Escabedo*, 356 S.W.3d 390 (Tex. 2011).
[13] Ibid.
[14] *Meenakshi S. Prabhakar, MD, and Infectious Disease Doctors, PA, v. David Fritzgerald*, No. 05-10-00126-CV, 2012 Tex. App. LEXIS 7154 (Tex. App. Aug. 24, 2012).
[15] Ibid.

amount the claimant has actually incurred. This point was also raised in the *Beasley* case,[16] where the plaintiff made a personal injury protection (PIP) claim to his insurer, Farmers Insurance, for the billed charges rather than the lower negotiated rate with his health plan, Blue Cross Blue Shield (BCBS), the provider had accepted as payment in full. The judge denied Beasley the billed charges, stating, "According to Farmers, the medical expenses incurred were not the providers' list rates—they were what the providers accepted as full payment from BCBS."[17] The lower negotiated rate was the expense the claimant actually incurred, not the billed charges.

11. The case of *Adley v Privett* also supports this idea.[18] In *Adley*, the claimant was trying to claim two charges where the cost was eventually adjusted to $0. The court held those initial billed charges could not be claimed, because a claimant "cannot claim paid or incurred if charges were not actually recoverable."[19]

12. The case of *Big Bird Tree v. Gallegos* provides an example of when a provider's billed charges may be recoverable under *Haygood*.[20] In that case, the uninsured, indigent plaintiff had qualified for an indigent charity program that required him to pay only a small amount. The trial court, however, ruled that, with the damages award, the plaintiff would no longer qualify for the indigent care program and would have to pay the full charges. The trial court therefore awarded the plaintiff the billed charges for his medical expenses. The defense apparently did not challenge the reasonableness of the billed charges or introduce evidence on the reasonable value of the services.

13. On appeal, the defendants argued that the plaintiff should not receive the full amount of his medical expenses because the medical expenses were not actually "incurred." The appeals court, however, found, based on *Haygood* and combined with the collateral source rule, that "allowing a negligent tortfeasor to avoid liability for medical expenses born by a charity

[16] *Farmers Texas County Mutual Insurance Company v. Rodney Beasley*, 598 S.W.3d 237 (Tex. 2020).
[17] Ibid.
[18] *Larry Derome Adley v. Kevin Wayne Privett*, No. 05-12-01581-CV, 2014 Tex. App. LEXIS 7447 (Tex. App. July 9, 2014).
[19] Ibid.
[20] *Big Bird Tree Service Inc. v. Julian Gallegos*, No. 05-10-00923-CV, 365 S.W.3d 173 (Tex. App. 2012).

program designed to benefit indigent patients, not only results in a windfall to the tortfeasor, it rewards the tortfeasor for injuring an indigent." The appeals court therefore held the plaintiff could recover the billed charges for his medical expenses as the court considered them to be "incurred."

Reasonable Value

14. The term "reasonable value" is used as a synonym for "fair market value" or "market price." There are many definitions from different sources, but all involve the neoclassical economic concepts of a price freely arrived at by a willing buyer and a willing seller in a competitive market, with both being fully informed and neither under undue pressure. *Black's Law Dictionary* has this definition: "The price that a seller is willing to accept and a buyer is willing to pay on the open market and in an arm's length transaction; the point at which supply and demand intersect (fair market value)."[21] Another common definition of fair market value is found in IRS Revenue Ruling 59-60. The IRS defines fair market value as "the price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts."[22] Because different data points can be considered in determining reasonable value, the term implies a range of values rather than a single value.

15. Markets for medical services are seldom the "perfectly competitive markets" of economic theory. In any geographic market, there are relatively few hospital systems and few physician groups in many specialties. Individual patients have less information and bargaining power than medical providers. Rates set by government programs are negotiated through a political process by provider organizations and elected or appointed officials representing the

[21] Bryan A. Garner, ed., *Black's Law Dictionary*, 5th pocket edition (St. Paul, MN: Thomson Reuters, 2016), *s.v.* "reasonable value."
[22] IRS Revenue Ruling 59-60, 1959-1 CB 237 -- IRC Sec. 2031 (Also Section 2512) (Also Part II, Sections 811(k), 1005, Regulations 105, Section 81.10.)

payor. Individual providers then decide whether they are willing to accept those rates by participating or not participating in the government program.

16. Rates in negotiated contracts between providers and private health plans may be the closest approximation of "the point at which supply and demand intersect." However, a major factor in the negotiated rate in each provider contract is the relative market power of the provider and the health plan. Another factor is the expectations of the provider and health plan on what the effective rate will be in the absence of a contract. The provider would then be an "out-of-network" provider able to balance bill the health plan's subscribers for the difference between billed charges and the health plan's allowed amount.

17. The cost to providers to deliver a service is also relevant in determining reasonable value. CMS considers provider costs in setting Medicare rates.[23] Private health plans have access to cost data for hospitals and other providers that are required to file cost reports with government agencies. They may also be able to construct cost models for physician practices using survey data from physician organizations (e.g., Medical Group Management Association).[24] Reasonable value can be viewed as a range, with Medicare rates at the bottom. Negotiated rates for insurers are the middle of the range. The rates the provider has accepted for patients without insurance and the UCR 80th percentile are toward the top of the range.

DISCOVERY OF INFORMATION RELEVANT TO REASONABLE VALUE

18. In recent years, the Texas Supreme Court has expanded the ability of parties to discover the rates providers have negotiated with health plans, overriding confidentiality clauses in provider contracts. CMS administrative rules require hospitals to make their negotiated rates public.[25] The No Surprises Act requires health plans to publish their negotiated rates for all

[23] "Medicare Rates as a Benchmark: Too Much, Too Little, or Just Right?" Altarum Healthcare Value Hub, Research Brief No. 40, February 2020, https://www.healthcarevaluehub.org/advocate-resources/publications/medicare-rates-benchmark-too-much-too-little-or-just-right, accessed February 6, 2023.
[24] "Benchmarking Data: DataDive Cost and Revenue Data," Medical Group Management Association, https://www.mgma.com/data/benchmarking-data/costs-revenue-data, accessed February 6, 2023.
[25] "Hospital Price Transparency Frequently Asked Questions," CMS, https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf, accessed February 6, 2023.

providers.[26] The federal requirements were only recently implemented and, in practical terms, access is hindered by the noncompliance of a substantial percentage of hospitals and the size and complexity of the health plan data. Therefore, litigants' ability to access negotiated rates through discovery will be important for at least the next several years.

19. In 2018, the *North Cypress* case helped pave the way for more discovery regarding reasonableness of medical charges by allowing negotiated rates to be discoverable in a medical lien case.[27] Here, the patient was admitted to a hospital emergency department without insurance after a car accident, and the hospital filed a lien for billed charges. After settling with the defendant's insurance company, the plaintiff tried to discharge the lien by negotiating an amount less than the billed charges.

20. When they could not agree, the plaintiff requested to see the negotiated rates for patients who received similar services but had private insurance or Medicare/Medicaid. The hospital objected to the discovery requests and refused to produce the information. The SCOTX held that the requested information was discoverable because, (1) under the lien statute, the hospital was entitled to be paid only the *reasonable* value of its services, and (2) the requested information was relevant to determining the reasonable value of the services.

21. In *K&L Auto Crushers*, the SCOTX expanded the ruling in *North Cypress* to personal injury cases. The plaintiff had a letter of protection with one or more providers, and the medical bills were about $1.2 million for multiple spine and shoulder surgeries.[28] The defendants sought discovery of the plaintiff's providers' negotiated rates as evidence of the reasonable value of the services. The SCOTX allowed the defendants to discover the providers' negotiated rates for similar services with commercial insurers as evidence of what the providers considered the reasonable value of their services.

[26] "Frequently Asked Questions for Providers About the No Surprises Rules," CMS, https://www.cms.gov/files/document/faq-providers-no-surprises-rules-april-2022.pdf, April 6, 2022, accessed February 6, 2023.
[27] *In re North Cypress Medical Center Operating Co.*, 559 S.W.3d 128 (Tex. 2018).
[28] *In re K & L Auto Crushers, LLC*, 627 S.W.3d 239 (Tex. 2021).

22. Another recent case, *In re ExxonMobil Corp.*,[29] also addressed whether defendants in a personal injury case can discover the negotiated rates that the plaintiff's medical providers have with insurance providers. The defendants argued that medical providers typically ask for chargemaster rates in letters of protection, but those rates are not the rates the providers negotiated with health plans. The defendants argued that discovery of the provider contracts was necessary to see the rates the providers had agreed to accept as payment in full. The plaintiffs argued that discovery would expose trade secrets and confidential information. The court allowed discovery of the provider contracts.

23. Before *North Cypress*, *K&L Auto Crushers*, and *ExxonMobil*, defendants were usually denied discovery of medical providers' charges for certain medical services. These decisions by the SCOTX establish (1) plaintiffs are entitled to recover only reasonable value of past medical expenses, (2) a provider's negotiated rates with health plans are relevant and admissible evidence to establish reasonable value, and (3) defendants are entitled to reasonable discovery or a provider's negotiated rates as evidence of what it considers the reasonable value of its services, even when the plaintiff is uninsured and not entitled to those negotiated rates.

24. A case now before the SCOTX, *In re Kuraray America, Inc.*, is a mandamus action in a personal injury case in which the defendant requested discovery from several medical providers of the amounts the medical providers actually accept as full payment for medical procedures for patients of health plans with which it has a contract and for self-pay patients. Defendants requested corporate representative depositions on the same topics. The trial court and court of appeals denied discovery. The plaintiffs in this case are uninsured, just like the plaintiff in *In re North Cypress*. Given the three SCOTX decisions, there seems to be no reason for a Texas court to deny discovery of provider contracts or corporate representative depositions on those contracts.

25. The new issue in this case is whether discovery is permitted of amounts providers accept as payment in full from self-pay patients. To quote the relator's petition on this point, "It

[29] *In re ExxonMobil Corp*., No. 20-0849, 635 S.W.3d 631 (Tex. 2021).

would be entirely illogical to conclude that a defendant is entitled to discover the amounts a provider actually accepts for services from third-party-providers (such as insurance companies) in litigation brought by plaintiffs who disclaim insurance coverage, but is *not* entitled to discover the amounts those same providers actually accept from self-pay patients who are similarly situated to the plaintiffs. Indeed, one federal court has twice applied *K&L* in self-pay situations. *Zuniga v. Tri-National, Inc.*, 2022 WL 255427 (W.D. Tex., Jan. 27, 2022); *Acuna v. Covenant Transp., Inc.*, 2022 WL 95241 (W.D. Tex., Jan. 10, 2022)."[30]

26. However, in the two federal cases, the court ordered the providers to produce contracts and rates with health insurance companies. The court was not asked to order the production of data showing the amounts the providers accepted as payment in full from self-pay patients. Therefore, the court in these two cases did not order production of the self-pay data the defendants seek in *In re Kuraray America, Inc.* There appears to be no reason the SCOTX should not order production of the self-pay data. It is relevant to establish the reasonable value of the services. It is not available from public sources. Most, if not all, providers could produce claims-level data from their billing systems showing the charges, payments, and write-offs for self-pay patients with no undue burden.

IS THERE A DUTY TO MITIGATE THE COST OF MEDICAL CARE?

27. According to TCPRC §147.123, "The court shall instruct the finder of fact regarding a plaintiff's duty to mitigate or avoid damages in a manner appropriate to the action."[31] In personal injury cases, the purpose of the mitigation of damages doctrine is to encourage the plaintiff to act reasonably to avoid or reduce the harm from the defendant's actions. When a plaintiff does not act reasonably to mitigate damages, "recovery is not permitted as to that part of damages that could have been avoided or was incurred as a result of the failure to mitigate."[32]

[30] *In re Kuraray America, Inc.*, Relator's Petition for Writ of Mandamus, August 11, 2022, p. 2.
[31] TCPRC §147.123, https://statutes.capitol.texas.gov/Docs/CP/htm/CP.147.htm.
[32] *Pinson v. Red Arrow Freight Lines Inc.*, 801 S.W.2d 14 (Tex. App. 1990). See also: *Alexander & Alexander of Texas Inc. v. Bacchus Industries Inc. and U.S. Insurance Group*, 754 S.W.2d 252 (Tex. App. 1988); *R.A. Corbett Transport Inc. v. Oden*, 678 S.W.2d 172 (1984).

However, the burden of proof lies on the defendant as to whether the plaintiff did not mitigate their damages and to what extent their failure caused or further increased their damages.[33]

28. There are two types of mitigation of damages for past medical expenses. The first is delay in medical treatment, which causes the plaintiff's condition to worsen and requires more expensive treatment.[34] That type of mitigation is outside the scope of this paper. The second type is the plaintiff's failure to mitigate by paying or agreeing to pay more for medical services than was reasonable or necessary by not taking advantage of regulated or negotiated rates to which the plaintiff is entitled. In a series of cases that preceded the SCOTX cases just discussed, Texas courts held that plaintiffs do ***not*** have a duty to use insurance available to them after the injury to mitigate the cost of past medical services:[35]

> **Private Insurance:** In *Grant v. CRST Expedited Inc.*, a federal court applying its understanding of Texas law found the plaintiff did not fail to mitigate his damages when he did not use his health insurance when receiving medical treatment. The federal court based this finding on the collateral source rule and its reading of *Haygood.* It did not cite or discuss TCPRC §41.0105.[36]
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> **Provider Cash Discount:** However, the *Grant* court found the plaintiff had a duty to mitigate by not agreeing to pay higher amounts under a letter of protection than he would have paid under the provider's cash discount arrangement. The court said the collateral source rule did not apply, and the defendant could introduce evidence on the amount paid or incurred under the cash discount arrangement (*Grant v. CRST Expedited Inc*., 2020).[37]
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> **Workers Compensation:** Defendants "suggest that [plaintiff] in fact had workers' compensation insurance available to him under his employers' Texas Mutual Insurance Company policy, and failed to avail himself of the insurance when he obtained medical care, and also that [plaintiff] failed to obtain insurance under the

[33] Ibid.
[34] *Alamo Ambulance Services Inc. v. Philip J. Moulton et al*., 402 S.W.2d 200 (Tex. Civ. App. 1966).
[35] *Emory Grant v. CRST Expedited Inc. and Karl O. Brooks*, No. 1:18-CV-433, 2021 U.S. Dist. LEXIS 61977 (E.D. Tex. 2021); *Sprester v. Bartholow Rental Co*., No. A-14-CV-00955-LY, 2016 U.S. Dist. LEXIS 19498 (W.D. Tex. Feb. 18, 2016); *Jaime Guzman, Derrick Lambert v. Melvin Jones, Celadon Trucking Services Inc*., 804 F.3d 707 (5th Cir. 2015); *City of Fort Worth et al. v. Don Barlow et al.*, 313 S.W.2d 906 (Tex. Civ. App. 1958).
[36] *Grant v. CRST Expedited, Inc*., No. 1:18-CV-433, 2020 WL 9720500, at *7 (E.D. Tex. Dec. 2, 2020).
[37] Ibid.

> Affordable Care Act, all of which would have reduced the costs of his medical care." The court held that "evidence of what [plaintiff's] medical costs would have been had he obtained or used insurance" was "inadmissible at trial" (*Sprester v. Bartholow*, 2016).[38]
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> **Government Insurance:** "Plaintiff was entitled to a finding of probable, reasonable cost of such services in his home county…. [I]n no event, can [defense] claim, in mitigation of damages, that plaintiff might receive cheaper care, or even gratuitous care in a veterans hospital" (*Forth Worth v. Barlow*, 1958).[39]

29. These cases may no longer be good law after the SCOTX decisions in *North Cypress, K&L Auto Crushers,* and *ExxonMobil*. These recent cases affirm that the most the plaintiff or provider can recover is the reasonable value of the services, regardless of the charges. They also confirm that the negotiated rates of providers are relevant and admissible evidence on reasonable value. The courts in *Grant* and *Sprester* appear to have ignored how TCPRC §41.0105 repeals the collateral source rule and makes insurance rates relevant to determine the amount the plaintiff owes or the amount the provider is obligated to accept as payment in full. Whether the damages are limited by failure to mitigate under the common law or are limited to reasonable value under the statute, the effect on the damages a plaintiff can recover may be similar: a defendant is liable only for the reasonable value of medical care, not necessarily the cost billed to, or paid by, the plaintiff.

RECENT STATUTES AND REASONABLE VALUE

30. Within the last several years, a Texas statute and a federal statute were passed with a focus on eliminating balance billing of patients in certain situations by certain out-of-network providers. The statutes also created procedures to follow and the criteria to consider in deciding the reasonable amount the health plans should pay. The federal and state procedures may not apply directly to medical bills incurred in personal injury cases in Texas. However, the criteria are legislative statements of the factors that should be considered in determining

[38] *Sprester v. Bartholow Rental Co.*, No. A-14-CV-00955-LY, 2016 U.S. Dist. LEXIS 19498 (W.D. Tex. Feb. 18, 2016).
[39] Ibid.

reasonable value and reasonable payment for medical services. Therefore, Texas plaintiffs' and defendants' experts may cite these criteria to support opinions about the reasonable value of past medical services.

SB 1264

31. In 2019, Texas enacted SB 1264,[40] which protects consumers with state-regulated health care plans from receiving "surprise" medical bills—when the patient did not select the provider and in emergency situations.[41] The purpose of the bill is to create "a mechanism for providers to resolve billing disputes directly with health plans" and to prohibit "balance billing consumers for these services."[42] SB 1264 applies to the roughly 20 percent of Texans with health care plans regulated by TDI and those who are covered under state employee and teacher retirement plans.

32. The bill created two dispute resolution processes: "arbitration for physicians and other similar providers and mediation for facilities and labs."[43] The results of arbitration are binding on the practitioner and the health plan, while the results of mediation are not.

33. The legislation lists these ten factors the arbitrator or mediator must consider in reaching a decision on a reasonable payment amount:[44]

1) Whether there is a gross disparity between the fee billed by the out-of-network provider and fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region

[40] SB 1264, https://capitol.texas.gov/tlodocs/86R/billtext/html/SB01264F.htm.
[41] See §1.08, where SB 1264 gives a long overview of what is covered in emergency situations, with references to insurance codes.
[42] Texas Department of Insurance, "Senate Bill 1264 2021 Midyear Report," https://www.tdi.texas.gov/reports//documents/SB1264-2021-midyear-update.pdf, July 2021, accessed January 20, 2023.
[43] Ibid.
[44] Texas Medical Association, "A General Overview of SB 1264 (86th Texas Legislature) and Texas' New Arbitration Process for Certain Out-of-Network Claims," rev. December 19, 2019; Tex. Ins. Code § 1467.083(b), https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1467.htm.

2) The level of training/education/experience of the provider
3) The provider's usual billed charge for comparable services or supplies in comparison to other enrollees
4) The circumstances and complexity of the enrollee's particular case
5) Individual enrollee characteristics
6) The 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database [selected by TDI]
7) The 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database [selected by TDI]
8) The history of network contracting between the parties
9) Historical data for the percentiles
10) An offer made during the [required] informal settlement teleconference

34. While in theory arbitrators consider several factors in their decision-making process, reports indicate that arbitrators in other states seem to favor the 80th percentile in the final payment amount.[45]

No Surprises Act[46]

35. The federal No Surprises Act covers some health plans not covered under SB 1264. Most importantly, it covers employer-sponsored plans not regulated by TDI. The Act took effect January 1, 2022, to provide balance billing protections to consumers with other types of health care coverage. It "protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency

[45] USC Schaeffer Center, "Arbitration Decisions in New Jersey Surprise Billing Cases Result in Large Payouts," January 5, 2021, https://healthpolicy.usc.edu/article/new-study-finds-arbitration-decisions-in-new-jersey-surprise-billing-cases-result-in-large-payouts; Loren Adler, "Experience with New York's Arbitration Process for Surprise Out-of-Network Bills," Brookings, October 24, 2019, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills.
[46] H.R. 3630 – No Surprises Act, 116th Congress (2019–2020), https://www.congress.gov/bill/116th-congress/house-bill/3630/text.

services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers."[47]

36. The No Surprises Act instructs arbitrators to consider several factors:

- The "qualifying payment amount," which, as described further below, is generally the insurer's median in-network rate for similar services in that geographic region as of 2019, inflated forward by the Consumer Price Index for All Urban Consumers (CPI-U)
- Demonstrations of good-faith efforts (or lack thereof) to reach a network agreement and any contracted rates between the two parties during the previous four years
- Market shares of both parties
- Patient acuity
- The level of training, experience, and quality of the clinician, or the teaching status, case mix, and scope of services offered by the facility

37. For air ambulance services, the arbitrator is also instructed to consider:

- The ambulance vehicle type
- The population density at the pickup location.[48]

38. Several provider groups have filed lawsuits challenging the rules CMS adopted to implement the Act. Although there are several pending lawsuits challenging the rules adopted to implement the Act,[49] the statute itself has not been challenged, and the statutory factors listed above can therefore be cited in determining reasonable value in personal injury cases.

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[47] "No Surprises: Understand Your Rights Against Surprise Medical Bills," CMS, January 3, 2022, https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills.
[48] Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Benedic Ippolito, and Erin Trish, "Understanding the No Surprises Act," Brookings, March 9, 2022, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act, accessed January 21, 2023.
[49] [49] In December 2021, the American Hospital Association and the American Medical Association filed suit alleging the rules implementing the independent dispute resolution (IDR) process favors insurers. See *American Medical Association et al. v. U.S. Department of Health and Human Services et al. (2021)*.[49] The Texas Medical Association (TMA) has filed three lawsuits challenging the different aspects of the rule. One suit challenges the administrative rules on how the qualifying payment amount (QPA) is calculated. See *Texas Medical Association and Dr. Adam Corley, Plaintiffs, v. United States Department of Health And Human Services, Department of Labor, Department of the Treasury,*

SECTION 18.001 AND REASONABLE VALUE

39. TCPRC §18.001 allows a plaintiff's medical provider to submit an affidavit stating the services were medically necessary and the charges were reasonable. The affidavit may be signed by the provider's clerical employees and requires no showing the signer has any expertise on either medical necessity or reasonableness of charges. If the defendant does not challenge the affidavit, it is sufficient evidence to support a jury finding that the amount charged was reasonable and that the service was necessary.

40. If the defendant serves a counter-affidavit challenging the medical necessity and/or the reasonableness of charges in a plaintiff's affidavit, then the plaintiff may not rely solely on the affidavit, but must offer expert testimony to prove those issues at trial. Unlike the original affidavit, the counter-affidavit must be signed by a person with the expertise to make the statements in the counter-affidavit and must give reasonable notice of the basis for the opinions expressed.

41. In a recent decision, *In re Allstate*,[50] the SCOTX addressed two important questions: (1) Who is qualified to testify on the reasonableness of medical charges? (2) What limits does the absence of a counter-affidavit have on the defendant's ability to offer evidence challenging past medical expenses at trial?

42. In *Allstate*, the plaintiff filed an 18.001 affidavit covering bills with charges totaling $41,000 for past medical expenses. Allstate filed a counter-affidavit contesting the reasonableness of the charges. The person who signed the counter-affidavit had over twenty years' experience as a registered nurse and extensive experience as a medical biller. The plaintiff

Office of Personnel Management, and the Current Heads of those Agencies in Their Official Capacities (2021).[49] Other suits have challenged parts of the rule the TMA sees as giving excessive weight to the QPA compared to other factors the statute says should be considered. See *Texas Med. Ass'n. v. United States Dep't. of Health & Hum. Servs*., No. 22-40264, 2022 WL 1632580 (5th Cir., May 3, 2022), *Texas Medical Association et al. v. United States Department of Health and Human Services et al. (2021)*.

[50] *In re Allstate Indemnity Company*, 2021 WL 1822946 (Tex., May 7, 2021).

moved to strike the counter-affidavit on the basis the counter-affiant was not qualified to opine on the reasonableness of medical charges.

43. The trial court ruled in favor of the plaintiff, but the SCOTX ruled in favor of the defendant. The court found that, so long as the person signing the counter-affidavit has "sufficient knowledge, skill, experience, training, or education" related to that field, they can testify as an expert and therefore challenge the "reasonableness" of the charges. The court had earlier held that an insurance adjuster was qualified to make a counter-affidavit challenging reasonableness of charges because of the adjuster's familiarity with medical billing and medical databases.[51] The counter-affiant need not be a clinician or have any particular academic degree. The court required only that the counter-affiant have experience and knowledge of medical billing practices and medical charge data.

44. The other holding in *Allstate* is much more important. The court held that the defendant's ability to offer evidence at trial challenging the reasonableness of the medical charges is not constrained by whether or not it filed an 18.001 counter-affidavit or whether the trial court accepted that counter-affidavit. The court held in *Allstate* that "the claimant's decision to file initial affidavits *may* relieve her of the burden to adduce expert trial testimony on reasonableness and necessity, but the opposing party's failure to serve a compliant counter affidavit has *no* impact on its ability to challenge reasonableness or necessity at trial" (emphasis in the original).[52] For defendants to challenge reasonableness of charges at trial, they must designate an expert whose qualifications and opinions can withstand a plaintiff's motion to strike challenging the admissibility of the testimony.[53] This may cause defendants to choose to file expert reports on the reasonable value of past medical services instead of counter-affidavits on the reasonableness of charges.

[51] Ibid.
[52] *In re Allstate Indem. Co.*, 622 S.W.3d 870, 881 (Tex. 2021) at [12].
[53] *E.I. du Pont de Nemours & Co. v. Robinson*, 923 S.W.2d 549 (Tex. 1995).

CONCLUSION

45. The law on the amount a plaintiff may recover for past medical expenses in Texas personal injury cases has seen major developments in recent years. These developments generally favor defendants and should reduce the size of awards for this element of damages. In summary:

- Regardless of what a practitioner or facility charges, the plaintiff is only entitled to recover the reasonable value of the goods and services. A provider's billed charges are not presumed to be the reasonable value.
- A range rather than a single amount defines the reasonable value of specific services.
- The upper end of the range is usually the lesser of the billed charge or the usual, customary, and reasonable (UCR) charge at the 75th or 80th percentile. Charges are relevant to establishing reasonable value because some health plans continue to use the UCR method to set the allowed amount for out-of-network providers and some state statutes adopt this method for certain situations.
- If the plaintiff or someone acting on the plaintiff's behalf has paid or incurred an amount for goods or services, the reasonable value cannot exceed the amount paid or incurred.
- The lower end of the range is usually the reasonable cost for providers to deliver the goods or services. Because Medicare rates are intended to cover the reasonable costs of a reasonably prudent provider, Medicare may be used as an approximation of the lower end of the range.
- Fair market value often means a price arrived at through arm's length negotiations between a willing buyer and a willing seller with both being well informed and neither under undue pressure to buy or sell. Healthcare markets are far from perfect economic markets, but the best evidence of fair market value is found in the negotiated rates of provider contracts with health plans.
- This evidence of fair market value is not limited to negotiated rates available to the plaintiff in a personal injury case. Several types of negotiated rates can be relevant:

  - The negotiated rates available to an insured plaintiff for a specific provider, whether or not the plaintiff filed a claim with the insurer
  - All negotiated rates the plaintiff's provider had with health plans, whether or not the plaintiff had access to these rates
  - All negotiated rates of health plans for the plaintiff's specific service in the plaintiff's medical market

- Texas courts have not found that plaintiffs have a duty to mitigate damages for past medical expenses by filing insurance claims to take advantage of negotiated or regulated rates. If they do not file claims, however, the negotiated or regulated rates may be the reasonable value of the services and may thus limit recovery.
- The Texas Supreme Court has allowed defendants to discover provider contracts and negotiated rates from the plaintiff's health plan and the plaintiff's providers and the health plans with which they contract. Provider contract confidentiality and non-disclosure terms will not prevent discovery.
- Texas SB 1264 and the federal No Surprises Act do not specifically apply to personal injury cases. However, they contain legislative statements of criteria that courts can consider in determining the reasonable value of services. For instance, Texas SB 1264 has UCR80 as one of nine criteria used to determine reasonable value. However, the federal No Surprises Act excludes billed or UCR charges as a factor in determining payment.
- An affidavit on the reasonableness of charges for past medical services filed by a plaintiff under TCPRC §18.001 is sufficient to support a jury finding, unless the defendant serves a counter-affidavit by an expert. However, regardless of whether the defendant serves a counter-affidavit or the trial court strikes the counter-affidavit, Section 18.001 does not affect the defendant's ability to present expert testimony or other evidence at trial on the reasonable value or medical necessity of past medical services.