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Texas Supreme Court: Under Sec. 41.0105, TEX. CIV. PRAC. & REM. CODE, Injured Plaintiff's Medical Bills Before Required Health Plan or Medicare Write Offs/Reductions Are Not Only Not Recoverable as Damages, But Full Bill Amounts Before Such Write Offs/Reductions Not Even Admissible At Trial

Section 41.0105, enacted in 2003, provides that recovery of medical or health care expenses by an injured plaintiff is limited to the amount "actually paid or incurred by or on behalf of the claimant." The purpose of the statute was to avoid windfalls to plaintiffs created by the modern health care reality that the amount of an initial bill from a hospital or doctor is usually reduced significantly pursuant to health insurance or Medicare reimbursement schedules if the plaintiff has such coverage. While Texas courts have fairly consistently applied the statute, as written, to limit actual recoveries to the amounts actually "paid or incurred," four courts of appeals have held that notwithstanding the statute's limit on the actual recovery, plaintiffs could present evidence to the jury of the full, un-reduced billed amount and then deal with the required reduction as a post-verdict issue. Obviously, if the jury hears evidence about very large medical bills incurred as a result of the injury, they may be inclined to award more for other types of damages (*i.e*,. pain, suffering, mental anguish, future medical) whereas if they only are allowed to hear evidence of the much lower amount that has actually been paid or is required to be paid, this may lower the other damage awards, as well.

In *Haygood v. De Escabedo*, 2011 WL 2601363 (Tex., July 1, 2011), a 7-2 majority of the Texas Supreme Court resolved the split among the courts of appeals and held that evidence of full billed amounts of medical expenses that cannot actually be recovered by the plaintiff was irrelevant and, thus, evidence should be limited to the amounts that have actually been paid or are payable by or on behalf of the plaintiff after any contractually or statutorily required reductions, write-offs or write-downs. According to the majority opinion, such a rule did not violate the "collateral source" rule, even though, as pointed out by the dissenters, the reductions/write-downs are due to the fact that the plaintiff purchased health insurance or is covered by Medicare. The majority cautioned, however, that the jury still should not be informed that the amounts presented into evidence involve *insurance* reductions. The dissenting justices pointed out that the majority's holding leads to the irony that a completely uninsured injured plaintiff is likely to recover more in damages for the same injury as compared to an insured plaintiff since the bills incurred by the no-insurance plaintiff will be based on the full-billed rate, whereas the bills incurred by the insurance-covered plaintiff will likely be significantly reduced off of the fully-billed amount.

This is a big deal. For example, we recently defended an 18-wheeler owner and driver in a trucking case where an injured plaintiff's total medical bills incurred before any adjustments were over $1M, but because the plaintiff had health coverage through his employer and was treated "in network" under the health plan, the amount of the bills actually paid or payable after the required provider contract adjustments was only about $450,000. In *Haygood*, similarly, the total bills incurred by the injured plaintiff, according to the opinion, were $110,000, but because of the lower Medicare reimbursement rates, the actual allowable Medicare-adjusted amount was only $27,000. Obviously, if a jury believes that a plaintiff's medical expenses necessitated by

his/her injury are $1M instead of $450,000 (our case) or $110,000 instead of $27,000 (*Haygood*), they are likely to be much more generous on the other elements of damages.

Practical Pointers—Defendants and their liability insurers need to make sure in estimating the value of injury cases that they find out the amount of the medical bills that are actually paid or payable after any Medicare or health insurance reimbursement limits/adjustments rather than just looking at the initial bills generated by the providers. The write-downs/reductions typically do not show up in the very first bill but instead show up as credits/reductions in second or even later bills, so don't be content with just obtaining initial billings upon discharge and insist on obtaining the subsequent payment and write-down/credit information, as well. Since the statute was enacted in 2003, we have also recommended that if medical bills are procured via deposition on written questions and subpoena with the standard "business record" prove-up questions, additional written questions should be included to the provider to find out how much of the medical bill total amount has been written off or reduced, how much has actually been paid, and how much is still actually owed by or on behalf of the plaintiff. It is often surprising how much lower the "actual paid or incurred" amount is as compared to the amount that some providers will want to claim as owing from an initially billed but unadjusted amount. Finally, since plaintiffs are now clearly foreclosed from attempting to sway the jury with evidence of before-reduction bill amounts, plaintiffs may now be more willing to agree with defendants' proposals, if appropriate, to just stipulate as to the reasonable and necessary medical bill amount and dispense with proof of same.

If you wish to discuss any insurance-related issues or needs, please feel free to contact Schubert & Evans, P.C. at 214.744.4400 or visit our website at www.schubertevans.com.