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EMERGING TRENDS IN AUTO CLAIMS:

LITIGATION STRATEGIES CURRENTLY USED TO RECOVER MEDICAL EXPENSES IN THE AFTERMATH OF *HAYGOOD V. DE ESCABEDO*, THE IMPACT HEATH CARE REGULATIONS HAVE HAD ON THE RECOVERY OF MEDICAL EXPENSES AND COVERGE ISSUES IN AUTO CLAIMS AND LAWSUITS

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I. INTRODUCTION

This discussion will focus on the litigation strategies currently used to recover medical expenses in the aftermath of *Haygood v. De Escabedo*, the impact health care regulations have had on the recovery of medical expenses, as well as coverage issues in auto claims and lawsuits.

II. Tex. Civ. Prac. & Rem. Code § 41.0105

Section 41.0105 of the Texas Civil Practice & Remedies Code was enacted as part of the "tort reform" legislation known as House Bill 4 ("HB4") to clarify what medical expenses a jury may consider when making an award to a plaintiff. The statute, known as the "paid/incurred" provision, is awkwardly drafted, defining a term, "incurred," with itself:

> "Evidence Relating to Amount of Economic Damages"
>
> In addition to any other limitation under law, recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant. TEX. CIV. PRAC. & REM. CODE § 41.0105.

Since the passage of § 41.0105 in 2003, trial courts around the state have applied it in numerous different ways. An informal survey of rulings around the state demonstrate that most trial judges had adopted a fairly simple procedure that they thought properly implemented the legislature's intent while maintaining the integrity of the collateral source rule. Generally, judges admitted evidence of charged medical expenses to the jury and later conducted a post-trial evidentiary proceeding to determine whether the plaintiff's recovery for past medical expenses would be reduced.

This rather simple, efficient procedure had been used with very little confusion all over the state. However, that changed when the Texas Supreme Court issued its ruling in *De Escabedo* on July 1, 2011. *Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2011). Since then, practitioners and trial judges around the state have expressed utter confusion as to how to procedurally implement § 41.0105. The court's opinion creates so many complexities for practitioners that parties -- plaintiffs and defendants -- are now finding it incredibly difficult to determine how to go about discovering, proving up, and recovering past medical expenses. This article enumerates some of the practical implications and resulting application of the court's opinion.

A. Medical bills for past medical expenses

1. Recoverable amounts change during the course of discovery, even after discovery is closed.

Even with the introduction of the Affordable Care Act, many personal injury plaintiff's remain uninsured and look to health care providers (specifically hospitals) for charity programs. The plaintiff may be either pre-qualified for a charitable program or enter the emergency room as a cash patient. Either way, a substantial amount of the medical bill is commonly written off by the provider.

The Emergency Medical Treatment and Active Labor Act (EMTALA) is an act of the United States Congress, passed in 1986 as part of the Consolidated Omnibus

Budget Reconciliation Act (COBRA). 42 U.S.C. § 1395dd. It requires hospital Emergency Departments that accept payments from Medicare/Medicaid to provide an appropriate medical screening examination (MSE) to individuals seeking treatment for a medical condition, regardless of citizenship, legal status, or ability to pay. There are no reimbursement provisions. Because there are very few hospitals that do not accept Medicare/Medicaid, the law applies to nearly all hospitals. Nearly all hospitals subject to (EMTALA) have adopted financial policies, or Charity Care Policies, which provide for charity adjustments to be completely or partially reversed in the event of a recovery from a third-party or other source.

This results in some practical considerations for lawyers on both sides. First, the health care provider is usually not aware of litigation involving a former patient. However, the providers are notified of a lawsuit once a personal injury attorney requests an 18.001 affidavit.[1] At that point, the provider may provide a 18.001 affidavit which includes all of the charges billed for the care of the patient without any write-offs or adjustment. Some providers may provide an 18.001 affidavit on the current amount due, including write offs/ adjustments, then reverse the charitable write offs later at times unbeknownst to plaintiff's attorney. This practice often makes the amount plaintiff is legally entitled to recover a moving target. *See Big Bird Tree Serv. V. Gallegos*, S.W.3d 173 (Tex. App.—Dallas 2012, no pet.).

2. Subject to further adjustments after judgment.

A personal injury plaintiff's health care is never precisely coeval with the discovery period or the end of trial. Moreover, not all payments of medical expenses take place prior to the end of the discovery period or prior to the resolution of the case.

It is not uncommon in the real world for medical bills to be unsettled at the time of trial and for health care providers and insurers to continue to adjust and modify medical bills even after the underlying personal injury litigation has concluded. *See Progressive County Mut. Ins. Co. v. Delgado*, 335 S.W.3d 689 (Tex. App.—Amarillo 2011, pet. denied); *Mills v. Fletcher*, 229 S.W.3d 765 (Tex. App.—San Antonio 2007, no pet.)(Stone, J., dissenting). This is particularly common when health care providers and insurers discover that a personal injury plaintiff has litigated and recovered for their personal injuries. The provider and insurer often seek post judgment adjustments, frequently in the term of balance billing[2] in an effort to recover for the full amount of the billed medical expenses or their full subrogation interests. In this scenario, it is very difficult for a personal injury plaintiff to prove to a jury what the health care provider has "a legal right to be paid"[3] because the amount is a moving target that changes over time, even after the personal injury litigation is resolved. This is especially true with health insurers who will often times refuse to negotiate the amount of its subrogation

[1] Texas Civil Practice and Remedies Code § 18.001

[2] Balance billing occurs when a health care provider seeks to recover from the patient amounts for services rendered over and above what an insurer paid. While a health care provider is arguably prohibited by statute from balance billing in the context of Medicare, health care providers are not so prohibited in the context of private insurance.

[3] In *De Escabedo*, the Texas Supreme Court determined that § 41.0105 limits recovery and evidence at trial to expenses "the provider has a legal right to be paid." *De Escabedo*, 356 S.W.3d at 391.

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