RECOVERING MEDICAL EXPENSES IN PERSONAL INJURY CASES

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RECOVERING MEDICAL EXPENSES IN PERSONAL INJURY CASES

I. PAID OR INCURRED STATUTE

A. Introduction

Section 41.0105 of the Texas Civil Practice and 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 or 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 healthcare expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.[1]

After the 2003 passage of § 41.0105, trial courts around the state applied it in numerous ways. An informal survey of rulings around the state demonstrated that most trial judges had adopted a fairly simple procedure, which they thought properly implemented the intent of the legislature in passing § 41.0105 while still maintaining the integrity of the collateral source rule.[2] Generally, judges admitted evidence of *charged* medical expenses before the jury as reflected in the plaintiff's medical bills and later conducted a post-trial evidentiary proceeding to determine whether the plaintiff's recovery for past medical expenses should be reduced to reflect the amounts actually *paid* by or on behalf of the plaintiff.

But the Texas Supreme Court rejected this procedure in *Haygood v. Escabedo*.[3] More specifically, the Court held that § 41.0105 limits a claimant's recovery of medical expenses to those that have been or must be paid by or for the claimant.[4] The Court further concluded that the admissible evidence at trial must reflect the amounts that have been or must be paid by or for the claimant and that "only evidence of recoverable medical expenses is admissible at trial."[5]

The Court's opinion initially created many uncertainties for trial judges, practitioners and parties—both plaintiffs and defendants—concerning discovering, proving up, and recovering past medical expenses. Although several post-*Escabedo* appellate court decisions provide some guidance, questions remain. This article identifies some of the practical implications of the Court's decision and addresses additional issues that have arisen as courts have implemented § 40.0105 in the wake of *Escabedo*.

B. Medical bills for past medical expenses are often not finalized at the time of trial and are subject to further adjustments after judgment

A personal injury plaintiff's healthcare is never precisely coeval with the discovery period or the end of trial, and not all payments of medical expenses take place prior to the end of the discovery period or prior to the resolution of the case. As a result, the Court's decision in *Escabedo* raises questions about how damages are to be calculated when past medical expenses are not finalized or are subject to adjustment after the judgment.

It is not uncommon in the real world for medical bills to be unsettled at the time of trial and for healthcare providers and insurers to continue to adjust and modify medical bills even after the underlying personal injury litigation has concluded.[6] This is particularly common when, for example, healthcare providers and insurers discover that a personal injury plaintiff has litigated and recovered for their personal injuries. In an effort to recover for the full amount of the billed medical expenses or their full subrogation interests, the provider and insurer often seek post-judgment adjustments, frequently in the form of "balance billing."[7] In this scenario, it is very difficult for a personal injury plaintiff to prove to a jury what the healthcare provider has "a legal right to be paid"[8] because the amount is a moving target that changes over time, even after the personal injury litigation is resolved.

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[1] Tex. Civ. Prac. & Rem. Code § 41.0105.

[2] *See, e.g.*, *Arrango v. Davila*, Nos. 13-09-00470-CV, 13-09-00627-CV, 20ll WL 1900189 (Tex. App.—Corpus Christi May 11, 2011, pet. denied); *Frontera Sanitation, L.L.C. v. Cervantes*, 342 S.W.3d 135 (Tex. App.—El Paso 2011, no pet.).

[3] *Haygood v. Escabedo*, 356 S.W.3d 390, 399 (Tex. 2011).

[4] *Id.* at 398.

[5] *See id.* at 399.

[6] *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).

[7] Balance billing occurs when a healthcare provider seeks to recover from the patient amounts for services rendered over and above what an insurer paid.

[8] In *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." *Escabedo*, 356 S.W.3d at 391.

These situations are further complicated by the fact that healthcare providers and insurers are not parties to the litigation and they are not legally bound by the verdict or judgment as to what the provider has a legal right to be paid. Unless plaintiffs bring separate declaratory judgment actions against each provider or insurer to determine the amount they are "legally entitled" to recover, the practice of post-judgment adjustments to medical bills and balance billing will continue, and the plaintiff might be left with a recovery only of paid amounts but still have to pay the healthcare providers and subrogation entities for the full charged amounts.

Because the medical billing process does not neatly fit within litigation schedules, there are considerable problems related to proving the recoverable amount of medical expenses at the time of trial. In such situations, the plaintiff's recovery of the reduced amounts paid may be insufficient to reimburse the healthcare provider for the full amount sought by the provider.

The Texas Supreme Court should have clarified how unsettled bills are treated at the time of trial and how a plaintiff can ensure that he or she will not be subject to payment of the full medical bills after litigation. Arguably, because of the impracticability of applying § 41.0105 to bills that are unsettled at the time of trial, the statute should not apply to such bills.

C. What now of the use and effectiveness of § 18.001 affidavits? Does Texas Rule of Evidence 902(10) come to the rescue?

Additional questions raised by the Court's decision in *Escabedo* are whether and how § 18.001 medical affidavits will continue to provide plaintiffs with an effective and efficient means of proving the necessity and reasonableness of medical expenses.

Texas Civil Practice and Remedies Code § 18.001 provides that an affidavit stating that the "amount a person *charged* for a service was reasonable at the time and place that the service was provided and that the service was necessary is sufficient evidence to support a finding of fact by judge or jury that the amount *charged* was reasonable or that the service was necessary."[9] The legislature has even prescribed the form of the affidavit to be used to effectuate these proof requirements.[10]

When the legislature enacted § 41.0105 it did not alter the language in § 18.001 or § 18.002 , and it has not done so since. Thus, it is possible under the Texas Supreme Court's opinion in *Escabedo*, that a practitioner who complies with § 18.001 and 18.002 by filing affidavit of evidence of the reasonableness and necessity of the charged amounts will in fact have "no evidence" to support the plaintiff's recovery of past medical expenses.

In order to address this apparent inconsistency, in 2013, the Texas Supreme Court promulgated a new rule of evidence that prescribes a medical expenses affidavit.[11] In addition to the usual business records affidavit language, the form affidavit prescribes the following language:

> The total amount paid for the services was $____ and the amount currently unpaid but which _____ has a right to be paid after any adjustments or credits is $ _____.

If substantially complied with, this affidavit is supposed to comply with § 41.0105 and *Escabedo*.[12]

D. The *Escabedo* opinion appears to create a new evidentiary rule regarding the claimant's ability to offer evidence of his or her own health insurance

Yet another question about the implications of the Court's decision in *Escabedo* is whether a plaintiff may still waive the collateral source rule. The Court's decision suggests that the answer is "No."

The collateral source rule is not a rule of evidence, but it nevertheless precludes any reduction in a tortfeasor's liability due to benefits received by the plaintiff from a collateral source because the wrongdoer should not have the benefit of insurance independently procured by the injured party. This rule benefits the personal injury plaintiff and as such is the plaintiff's rule to waive. Rule 411, by contrast, prohibits the admission of *liability insurance* for purposes of proving that a party acted negligently or otherwise wrongfully.[13] It is the only rule of evidence related to insurance in the Texas Rule of Evidence, and although it prohibits the admission of evidence of liability insurance for some purposes, such evidence may be admitted for other purposes.[14] Rule 411 says nothing about the admissibility of health insurance.

Purportedly relying upon the collateral source rule, the Texas Supreme Court in *Escabedo* appears to have created a new rule of evidence that prevents the jury from hearing evidence that the plaintiff's injuries will be covered in whole or in part by insurance or that a healthcare provider adjusted its charges because of

[9] Tex. Civ. Prac. & Rem. Code § 18.001 (emphasis added).
[10] Tex. Civ. Prac. & Rem. Code § 18.002.
[11] Tex. R. Evid. 902(10)(c).
[12] *Id.* at cmt.
[13] Tex. R. Evid. 411.
[14] *Id.*

insurance.[15] This new rule seems to conflate Rule 411 with the collateral source rule.

Prior to *Escabedo*, if the plaintiff wanted to offer evidence of collateral source insurance payments and partially or completely waive the collateral source rule, neither the Texas Rules of Evidence nor any other rule prohibited the introduction of such evidence. After *Escabedo*, it is unclear whether the plaintiff may still waive the collateral source rule.

E. What about medical expenses which are disputed by the insurer as being unreasonable or not causally related to the plaintiff's injuries?

How a plaintiff should prove medical damages when the insurer disputes the reasonableness of the charges is also unclear in the wake of *Escabedo*.

While record custodians may be aware of the amounts that have been paid on a medical bill and what an insurance company has agreed to pay, if the insurance company disputes the reasonableness of a medical bill, how will the record custodian have any knowledge of the amount the insured still owes on a medical bill? It may now be necessary for a personal injury plaintiff to obtain discovery from the insurer to determine what amounts are disputed and what the insured may still owe the healthcare provider.

Such matters may be reflected in an Explanation of Benefits ("EOB") received from the insurer. However, EOBs are arguably hearsay and would inject health insurance into the case contrary to the *Escabedo* Court's pronouncement regarding the inadmissibility of evidence related to insurance.

Sometimes insurers dispute claims for injuries it does not believe to be causally related to the injuries for which the plaintiff is seeking recovery. Nevertheless, even though an insurer may dispute the causal relationship, an insurer may not usurp the jury's duty to determine fact issues including causation. Thus, there may arise situations in which the jury determines a causal connection while the insurer still disputes it. *Escabedo* does not provide guidance as to how such disputed claims should be handled at trial.

F. Must testimony from healthcare providers now address the reasonableness of amounts paid by Medicare, Medicaid, or the claimant's insurance company?

Under *Escabedo*, the only reasonable amounts of medical expenses that a plaintiff can recover are those that have been paid by Medicare, Medicaid, or by the plaintiff's insurance company and those the plaintiff has paid or is obligated to pay. Will it now become necessary for a healthcare provider to testify as to the reasonableness of such payments despite the fact that the same healthcare provider would also testify as to the reasonableness of the greater charged amount if the plaintiff was uninsured or not covered by Medicare or Medicaid?

The discrepancies in such testimony could create problems for healthcare providers and potentially lead to liability for charging amounts to uninsured patients that the court has determined are not reasonable. For instance, how is it possible for a healthcare provider to testify to the reasonableness of a bill which is reduced due to the health insurance payments, while at the same time testifying to the reasonableness of a much larger amount for the exact same procedure if the plaintiff was uninsured? Can both the higher amount and the lower amount be reasonable for the same services provided? Or can reasonableness be a range that includes both the paid and the initially charged amounts?

As a practical matter, and as a matter of public policy, it would seem that the insurability of the patient should not determine the reasonableness of the costs of the services provided; but rather, the value of the services should determine the reasonableness of the charges.[16]

G. How are the admissible past medical expenses now used to calculate the exemplary damages cap?

Section 41.008 of the Texas Civil Practice and Remedies Code caps exemplary damages using a formula which includes a calculation based on the economic damages.[17] As a result of the decision in *Escabedo*, the calculation of this cap now varies widely depending on whether the plaintiff is insured or

[15] *Escabedo*, 356 S.W.3d at 399–400 ("[W]e hold that only evidence of recoverable medical expenses is admissible at trial. . . . Of course, the collateral source rule continues to apply to such expenses, and the jury should not be told that they will be covered in whole or in part by insurance. Nor should the jury be told that a health care provider adjusted its charges because of insurance.").

[16] *See generally* 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) (discussing prevalence of healthcare billing practices, which discriminate based on both patient's insurance status and ability to pay).

[17] Tex. Civ. Prac. & Rem. Code § 41.008.

uninsured. Now the personal injury plaintiff whose medical bills are paid by the government, such as a veteran or Medicare beneficiary, is entitled to recover less than an uninsured plaintiff, who would be entitled to recover the entire amount of medical expenses charged. In such situations, given the exact same punitive conduct, a veteran's recovery of exemplary damages could be substantially less than an uninsured plaintiff. *Escabedo* does not answer the question of how such widely varying recoverable medical expenses are to be considered in determining the culpability of arguably exact same punishable conduct.

H. Can a qualified medical expert testify about the reasonableness of another provider's charges if the expert is not privy to the other provider's contract or agreement with an insurer?

Prior to *Escabedo*, a qualified medical expert could testify to the reasonableness of and customary charges for medical services provided by other healthcare providers. But generally, medical experts are not privy to the contracts and arrangements reached between other healthcare providers and insurers for the payment of medical expenses. Again, *Escabedo* leaves unanswered whether the law has changed with respect to the ability of a medical expert to testify as to the reasonableness of other healthcare providers' charges when the expert does not have personal knowledge of the payment arrangements between the healthcare provider and the insurer.

I. Reductions and write-offs not required by law or contract.

Escabedo also leaves unclear how non-contractual write-offs and reductions in a patient's bill are to be handled. For example, does a patient still incur such charges? And can the healthcare provider recover the full amount or only the amount not written-off?

Particularly with respect to uninsured patients, a hospital or healthcare provided may reduce or write-off medical bills. Such reductions are ordinarily not required by statute or by the contractual arrangements reached between the healthcare provider and the insurer.[18] For instance, some reductions are based on charitable write-offs because a patient qualifies as an indigent.[19] Other amounts are written off as bad debt for accounting and tax purposes. These discretionary reductions are quite often adjusted and readjusted even after the plaintiff's litigation is concluded. This is particularly true when a healthcare provider learns that the plaintiff obtained a recovery in litigation. Suddenly the plaintiff is no longer indigent and the debt is no longer bad debt. At this point, re-adjustments are common in order to recover the full amount of the billed medical expenses.

Because the *Escabedo* opinion expressly limits a plaintiff's recovery of past medical expenses to the amounts the holder of the accounts is legally entitled to recover by law or contract, charitable or discretionary write-offs do not fall under § 41.0105.[20] Because the healthcare provider still retains the legal right to recover the full amount of the billed services irrespective of any discretionary or charitable write-offs, the plaintiff may offer evidence of and recover for the full billed amounts.[21]

J. Does *Escabedo* change how future medical expenses are to be calculated?

The language of § 41.0105 and the legislative history of the statute, along with the impracticality of applying the statute to future medical expenses, make it clear that the statute does not apply to damages future medical expenses.[22]

First, the statute uses past tense language: "paid or incurred." In order to apply the statute to future medical expenses, a court would have to ignore the past tense language used in the statute and superimpose by judicial fiat future tense language such as "to be paid," "will pay," "to be incurred," or "will incur."

Second, it would require stacking hypothetical upon hypothetical and speculation upon speculation to attempt to apply the statute to future medical expenses. For instance, one would have to speculate that the injured plaintiff would be able to work in the future despite the injuries sustained or that the plaintiff would work for a company that would provide health insurance or that the plaintiff would obtain insurance another way, such as through the Affordable Care Act. One would then have to consider a hypothetical

[18] *See infra* Part 0 (discussing balance reduction requirements for Charitable Hospitals under the Affordable Care Act).

[19] *See, e.g.*, *Big Bird Tree Serv. v. Gallegos*, 365 S.W.3d 173 (Tex. App.—Dallas 2012, pet. denied).

[20] *See id.* at 177.

[21] *See id.*

[22] *See* Jim M. Perdue, Jr., *Maybe it Depends on What Your Definition of "Or" Is?—A Holistic Approach to Texas Civil Practice and Remedies Code § 41.0105, The Collateral Source Rule, and Legislative History*, 28 Tex. Tech L. Rev. 243 (2006).

healthcare provider from whom the plaintiff would receive healthcare and a hypothetical insurance company with which the healthcare provider would enter into a hypothetical contract for the payment of healthcare services. One would then have to guess as to the compensation arrangements such a healthcare provider and insurance company might have based on speculation about the market and economic circumstances that might exist at some point in the future.

Thus, it is evident, that any attempt to apply the statute to future medical expenses is unworkable and likely unintended, which in part explains why the statute is expressly written in the past tense. Accordingly, to recover future damages, a plaintiff must show that there is a reasonable probability that expenses resulting from the injury will be necessary in the future.[23] And the amount of future medical expenses is within the discretion of the jury.[24]

Prior to *Escabedo*, because there are no medical bills to prove up medical expenses that will be incurred in the future, a plaintiff typically proved future medical expenses with reference to, among other things, the amount of past medical expenses.[25].The *Escabedo* opinion does not specifically address whether a plaintiff may still prove future damages with reference to unadjusted medical bills, and leaves open the question of whether such bills are admissible to prove future medical damages.

K. Cases since *Escabedo*[26]

1. *Henderson v. Spann*, 367 S.W.3d 301 (Tex. App.—Amarillo 2012, pet. denied)

The *Henderson* case involved the trial court's admission of evidence of unadjusted medical bills. In assessing damages, the jury awarded $69,583.20 for past medical expenses. The figure represented the amount of unadjusted medical bills introduced into evidence. The admitted medical bills did not reflect $54,379.56 in adjustments and write-offs associated with worker's compensation. After the verdict, the trial court adjusted the award of past medical expenses to reflect only the portion of medical bills that were recoverable: $15,203.64.[27]

Relying upon the Texas Supreme Court's opinion in *Escabedo*, a divided panel of the Amarillo Court of Appeals reversed and remanded the judgment for a new trial.[28] Justice Hancock, writing for the majority, found that the evidence of the unadjusted medical bills was irrelevant and inadmissible and thus concluded that the trial court abused its discretion in admitting such evidence. *Id*. at 304. Applying *Escabedo*, Justice Hancock reasoned that, as a consequence of the trial court's evidentiary ruling, there was no evidence of past medical expenses and, therefore, a judgment awarding past medical damages is improper.

Noting that the post-verdict adjustment method did not adequately account for or remedy any effect the inadmissible evidence of unadjusted past medical expenses may have had on the jury's assessment of non-economic damages, the court further concluded that a post-verdict adjustment of the recoverable medical expenses could not cure the harm of admitting irrelevant evidence.[29] Accordingly, the court held that the trial court's erroneous evidentiary ruling, in conjunction with its post-verdict adjustment of the amount of past medical expenses, probably caused the rendition of an improper judgment and deprived the parties of their constitutional right to trial by jury, and was thus reversible error.[30]

Justice Pirtle concurred in the judgment but wrote separately to encourage further examination by the Texas Supreme Court and to opine that, but for the application of *Escabedo*, the trial court did not err in admitting evidence of unadjusted medical bills or in applying the statutory caps because the *Escabedo* opinion was issued after the trial of the *Henderson* case and therefore the trial court was relying upon applicable case law at that time.[31] Justice Pirtle further noted that a rule of law dictating that "only evidence of *recoverable* medical expenses is admissible at trial" is an illogical construct because the very purpose of the admission of evidence during trial is to determine what damages are in fact recoverable.[32]

Justice Pirtle acknowledged that medical bills can be adjusted, discounted, written-off, reduced, or gratuitously forgiven for any reason.[33] Therefore, it

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[23] *Ibrahim v. Young*, 253 S.W.3d 790, 808 (Tex. App.—Eastland 2008, pet. denied).
[24] *Matbon, Inc. v. Gries*, 288 S.W.3d 471, 484 (Tex. App.—Eastland 2009, no pet.).
[25] *See Matbon, Inc. v. Gries*, 288 S.W.3d 471, 484 (Tex. App.—Eastland 2009, no pet.).
[26] Although not addressed in detail in this paper, in *Cavazos v. Pay and Save, Inc.*, 357 S.W.3d 86, 88 (Tex. App.—Amarillo 2011, no pet.), the court of appeals concluded that the amount of medical expenses that were paid or incurred is calculated before any reduction for the plaintiff's percentage of responsibility.
[27] *Henderson v. Spann*, 367 S.W.3d 301, 302 (Tex. App.—Amarillo 2012, pet. denied).
[28] *Id.* at 305.
[29] *Id.*
[30] *Id.*
[31] *Id.* at 305–306 (Pirtle, J., concurring).
[32] *Id.* at 306 n.3.
[33] *Id.* at 306.

would be impossible to say that evidence of reasonable and necessary medical bills, albeit discounted or written-off, is always going to be irrelevant to the question of a given claimant's economic damages. For instance, evidence of unadjusted past medical expenses may have probative value as to the extent of reasonable and necessary future medical expenses, unless there is evidence that future medical expenses will be adjusted, discounted or written-off on the same basis as current medical expenses.[34]

Justice Pirtle also disagreed with the Texas Supreme Court's pronouncement that the relevance of non-recoverable economic damages is substantially outweighed by the confusion such evidence is likely to generate and that it therefore must be excluded.[35] He opined that unadjusted medical bills have some tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence, and thus should not be inadmissible *per se*.[36] But rather, because the evidence of unadjusted medical bills is relevant, the probative value of such evidence and the balancing of Texas Rule of Evidence 403 factors are questions best left to the trial court on a case-by-case basis.[37]

Citing the dissent in *Escabedo*, Justice Pirtle questioned the characterization of § 41.0105 as is an evidentiary rule and would have described it as a statutory cap on recoverable damages. He expressed the view that, just as with other statutory caps, § 41.0105 could and should be implemented through a post-verdict adjustment made by a trial court.[38] And finally, he proposed that, with appropriate instructions and jury questions, a jury should be able to hear all relevant evidence, including both adjusted and unadjusted medical bills, when determining the amount of appropriate damages in a given case and then the legislative caps can be applied post-verdict.[39]

Chief Justice Quinn concurred in part, agreeing that error had occurred, but dissented from the judgment and would have found that the error was not harmful.[40] Noting that the plaintiffs ultimately received only the past medical expenses that the defendant argued the plaintiff was entitled to recover. Chief Justice Quinn questioned how the post-verdict adjustments affected the outcome, particularly when nothing in the record suggested that the outcome would have been different had the trial court simply admitted only the adjusted bills into evidence.[41]

2. *Big Bird Tree Serv. v. Gallegos*, 365 S.W.3d 173 (Tex. App.—Dallas 2012, pet. denied)

In *Big Bird*, the plaintiff was injured while working on an addition to the defendant's workshop.[42] The injuries required multiple surgeries and the placement of fifteen screws in the plaintiff's foot.[43] In proving up his past medical expenses, the plaintiff relied upon medical expense affidavits with attached billing records from UT Southwestern and Parkland Hospital which stated that the services rendered were reasonable and necessary and that the amounts charged were $67,699.41 and $16,659.50 respectively. The jury awarded the plaintiff these amounts for past medical expenses.[44]

The plaintiff was indigent and qualified for a healthcare charity program. In an offer of proof, the records custodian of UT Southwestern testified that UT Southwestern had a charity contract with Parkland for indigent patients. The records custodian further testified that after a patient qualifies, if they discover the patient is able to pay, the patient will be billed. She also testified that the plaintiff would be liable to UT Southwestern if he recovered for his medical expenses. Such recovery from the patient had been authorized by the Dallas County Parkland Board for UT Southwestern and Parkland.[45]

The defendant argued that it should not be required to pay for the reasonable value of the services rendered to the plaintiff because they were provided free of charge.[46] Rejecting this argument, the Dallas Court of Appeals noted that if medical services are provided gratuitously to a plaintiff, he may still recover them from the tortfeasor. The court further concluded that the collateral source rule reflects the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall to the tortfeasor.[47] *Id.* at 177 (citing *Escabedo*, 356 S.W.3d at 395). Thus, under the collateral source rule, the court concluded that the plaintiff could recover for services paid from a

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[34] *Id.*
[35] *Id.*
[36] *Id.* (citing Tex. R. Evid. 401).
[37] *Id.*
[38] *Id.* at 307.
[39] *Id.*
[40] *Id.* at 307 (Quinn, J., concurring, in part, and dissenting, in part).
[41] *Id.*
[42] *Big Bird Tree Serv. v. Gallegos*, 365 S.W.3d 173, 175 (Tex. App.—Dallas 2012, pet. denied).
[43] *Id.*
[44] *Id.*
[45] *Id.* at 176.
[46] *Id.*
[47] *Id.* at 177 (citing *Haygood v. Escabedo*, 356 S.W.3d 390, 395 (Tex. 2012).

charitable source. *Id.* at 177.

The court further explained that the plaintiff received valuable medical services, the cost of which was born by a charitable program administered by Parkland. *Id.* at 177. Because the plaintiff was indigent and qualified for the charitable program, Parkland agreed to provide the services free of charge. Moreover, there was no evidence of any contract that would have prohibited Parkland or Southwestern from charging the plaintiff for the full value of the services rendered. Therefore, the court could not conclude that the hospital was not entitled to recover for the actual value of the services rendered. In fact, there was testimony suggesting a patient's eligibility for the program can be changed by subsequent events. Specifically, UT Southwestern's custodian of records testified that UT Southwestern expected to be paid if the plaintiff were to recover. She also testified that this was the policy the Parkland Board had authorized for both Parkland and UT Southwestern. Therefore, the court could not say that Parkland has no right to be paid for the services listed in its billing records.[48]

Finally, the court noted that allowing a negligent tortfeasor to avoid liability for medical expenses born by a charity program designed to benefit indigent patients, not only results in a windfall to the tortfeasor, it rewards the tortfeasor for injuring an indigent plaintiff. [49] The court stated that such a result is particularly contrary to public policy in this case where the plaintiff was the defendant's employee and was injured in the scope of his employment with the defendant. To adopt the defendant's position, the court said it "would have to conclude no medical expenses were 'actually' incurred by *or on behalf* of" the plaintiff.[50] Because the court concluded that the expenses to treat the plaintiff were born by the charitable program, such expenses were actually incurred on behalf of the plaintiff. Thus, § 41.0105 did not preclude recovery of the full value of the medical expenses despite the charitable write off.[51]

II. MEDICAL FACTORING

A. Background

In certain situations, after evaluating the risk of recovery, costs of medical expenses, etc., factoring companies will purchase the accounts receivable from a healthcare provider for medical services rendered to a patient. Medical providers interested in turning their accounts receivable into immediate cash routinely sell individual or bundles of receivables to factoring companies. Medical providers are willing to sell their accounts receivable in order to increase or regulate their cash flow and reduce their risk from treating injured patients who have third party claims or lawsuits. In the case of bills for medical treatment rendered to patients with third-party liability claims, factoring is also an effective way for medical providers to provide the necessary care for their patient, while still avoiding the uncertainty of the underlying case or the cost of delay in payment.

"Factoring" is the business of the "buying of accounts receivable at a discount. The price is discounted because the factor (who buys them) assumes the risk of delay in collection and loss on the accounts receivable."[52] "Factoring is a financing tool that reduces the amount of working capital a business needs by reducing the delay between the time of sale and the receipt of payment."[53]

Factoring has been a common practice in many industries, including healthcare, long before the recent "tort reform" movement and the enactment of § 41.0105.[54] The factoring of medical accounts receivable is

[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.*

[52] Black's Law Dictionary 630 (8th ed. 2004).
[53] *Houston Lighting & Power Co. v. City of Wharton,* 101 S.W.3d 633, 636 (Tex. App.–Houston [1st Dist.] 2003, pet. denied).
[54] Factoring has essentially been in existence since the beginning of trade and commerce. It can be traced back to the period of a Mesopotamian king Hammurabi. However, the first widespread, documented use of factoring occurred in the American colonies before the American Revolution. During this time raw materials like cotton, furs, tobacco and timber were shipped from the colonies to Europe. Merchant bankers in London and other parts of Europe advanced funds to the colonists for these raw materials, before they reached the European Continent. This enabled the colonists to continue to harvest their new land, free from the burden of waiting to be paid by their European customers. The practice was very beneficial to the colonists, as they did not have to wait for the money to begin their harvesting again.
History of Accounts Receivable Factoring, http://www.catamountfunding.com/About/HistoryofFactoring.php (last visited Dec. 26, 2013).
There are numerous factoring companies that factor third-party liability claims. MedStar Funding, MedFin Manager, and Key Health Medical Solutions are examples. While these companies may not be the first entities to factor medical receivables in third-party cases, MedFin and Key Health have both been in business years before the enactment of § 41.0105. *See, e.g.*, http://www.manta.com/c/mmg0kql/med-fin-manager; http://investing.businessweek.com/research/stocks/private/snapshot.asp?privcapId=6964612.

similar to the common practice involving the sale and re-sale of home mortgages in the secondary market which is also a type of factoring. Often the lender that initially lends the money to a homebuyer for the purchase of a home will re-sell the mortgage to another lender after closing. Regardless of the terms and conditions of the re-sale, the homebuyer still owes the same amount on the mortgage, just to a different entity. This is similar to a factoring company's purchase of accounts receivable from a healthcare provider. Regardless of the amount the factoring company paid to the healthcare provider to purchase the account, the patient still owes the same amount to the factoring company as reflected in the medical bills. The result is similar to analogous examples in which defendants have purchased liens at a discounted rate but ultimately receive the benefit of the full value of the lien.[55]

Factoring has become an essential tool for medical providers. In the medical industry, providers have frequently used factoring because their services generate significant bills and payment is often delayed whether a patient is insured or not. They have also used it, as an alternative to lending, to ensure that patients receive the necessary level of care without concern that they may not be compensated for their services.

B. Where medical factoring and the paid or incurred statute come together

When a factoring company purchases the accounts receivable from a medical provider, defendants sometime seek to discover information related to the transaction between the factoring company and the healthcare provider in an effort to determine how much the factoring company paid to purchase the account. Section 41.0105 does not address medical providers selling or assigning accounts. The question arises whether, under § 41.0105 and *Escabedo*, information related to the factoring company's purchase of the accounts is discoverable, relevant, or admissible.

The Texas Supreme Court in *Escabedo* noted that under § 41.0105 a plaintiff cannot recover amounts charged by a health care provider that the provider has no legal right to be paid.[56] When a health care provider is required by law (i.e. Medicare) or by contract (i.e. an insurance contract) to reduce its charges from the original billed amounts, generally the provider has no right to be paid the difference between the billed and the reduced amounts.[57] Thus, the court held that "section 41.0105 limits a claimant's recovery of medical expenses to those which have been or must be paid by or for the claimant."[58]

The *Escabedo* case involved an *insurance company's* payments to a healthcare provider. Such payments were made at a reduced rate that were accepted in full by the healthcare provider legally extinguishing any obligation by anyone on any amounts over and above the reduced insurance payments. However, *Escabedo* did not address other commercial transactions outside of the insurance context such as when accounts are sold and assigned to another entity.

Because a plaintiff's recovery of past medical expenses turns on what "[has] been or must be paid by or for the claimant," when a healthcare provider no longer owns the account, the analysis shifts o what the plaintiff is still obligated to pay the holder of the account for the medical services provided.[59] Therefore, when a healthcare provider sells and assigns an account, what the healthcare provider is owed becomes irrelevant, as the provider no longer has a legal right to collect on the account. When a factoring company purchases the account, it is necessary to consider what a patient owes the factoring company on the account.

Even when a healthcare provider sells and assigns its interest in an account to a factoring company, relying on

[55] In *Brandon v. Am. Sterilizer Co.*, a defendant purchased the claimant's worker's compensation lien for $22,000 less than a carrier's paid benefits. *Brandon v. Am. Sterilizer Co.*, 880 S.W.2d 488, 494–95 (Tex. App.—Austin 1994, no writ). The Austin court ultimately held that the defendant was entitled to the entire amount of the lien, not the discounted purchase price. *Id.* at 495. In reaching that decision, the court noted that the defendant entered a contract for the lien and was entitled to the benefits under that agreement. *Id.* As such, the court concluded that limiting recovery to the discounted price would deprive the defendant of the benefit of its bargain, discouraging the practice of settling claims early. *Id.* Another court reached the same conclusion when a defendant purchased an insurer's lien for a discounted rate.
In *Harntett v. Hampton Inns, Inc.*, an insurance company compensated its insured for $186,000 in stolen possessions. *Harntett v. Hampton Inns, Inc.*, 870 S.W.2d 162, 164–65 (Tex. App.—San Antonio 1993, writ denied). Before trial, the insurance company assigned its subrogation rights to the defendant for $150,000. *Id.* The San Antonio court allowed the defendant a credit against the judgment for the full $186,000, stating "[b]ecause the [defendant] stands in [the insurance company's] shoes, it is entitled to recover the" full amount of the insurance company's subrogation claim. *Id.* at 168–69.

[56] *Haygood v. Escabedo*, 356 S.W.3d 390, 396–97 (Tex. 2012).
[57] *See id.* at 396–97.
[58] *Id.* at 398.
[59] *Id.*

Escabedo, defendants sometime assert that the plaintiff's evidence and recovery of past medical expenses is limited to the amounts the healthcare provider is entitled to be paid. In such scenarios, the healthcare provider is not entitled to be paid anything because it sold its rights and interest to the factoring company. It would be incongruent with the purpose of tort law—to make the plaintiff whole—to conclude that a plaintiff could not recover past medical expenses simply because the healthcare provider is no longer entitled to recover anything, having sold its rights and interest to a factoring company, when the plaintiff still owes the factoring company for the full amount of the bills.

Escabedo involved insurance payments and not medical factoring, which are two separate and very distinct commercial transactions. In the case of health insurance, insurers contract with medical providers so that the providers must accept the insurer's reduced payments to completely satisfy the insured's obligations. The insurance company's payment of the patient's medical bills, together with the contracted adjustment, extinguishes the patient's obligation to the healthcare provider. While the patient may have to reimburse the health insurance carrier the amount it paid, no one, including the patient, is obligated to pay the amount written off by the provider.

In contrast, medical factoring companies pay a discounted rate to obtain the right to collect the full amount the healthcare provider actually billed. Medical factoring companies do not charge the claimant a premium or require a claimant to provide out-of-pocket expenses for deductibles in exchange for paying the medical providers as do insurance companies. A factoring company's payment to the healthcare provider is not a payment towards a patient's balance on the account, but rather, the payment is to purchase the providers' rights, title, and interest in the account and the assignment of interest.[60] Unlike with health insurance or government insurance programs, the patient remains liable for the full amount of the healthcare provider's bills, regardless of how much the factoring company paid the healthcare provider, or whether the healthcare provider wrote off the balance after selling the account. After the purchase of the medical bills by the factoring company, instead of owing her medical provider, the patient owes the factoring company for the balance remaining on the medical bills, irrespective of the outcome of her third-party claim or the amount the factoring company paid the medical providers.[61] In such situations, there has been no payment, adjustment, or write-off of the patient's medical expenses. There is simply a transfer of ownership and substitution of the payee on the account.

The effect of § 41.0105 is to prevent a windfall to a claimant. *Escabedo*, 356 S.W.3d at 397. The Texas Supreme Court, therefore, held that medical expenses which a healthcare provider is required to write off pursuant to an agreement with a health insurer, which will never be paid by anyone, do not constitute damages recoverable by a plaintiff. *Id.* at 396–97. In contrast, in a factoring scenario, because the patient is still obligated to pay the factoring company, the risk of a "windfall" to the patient does not exist as it arguably did in cases like *Escabedo* involving insurance payments. Whether a healthcare provider elects to write off or adjust any balance left on their books after selling their bills to a factoring company is merely an administrative decision and does not impact the legal analysis under § 41.0105 concerning what the patient still owes and is entitled to recover.

C. Rulings in other states

The issues related to applying "paid or incurred"-type laws to medical liens/factoring scenarios are not new or novel. While Texas appellate courts have yet to address the issue, other states with laws similar to § 41.0105 addressed the interaction of these issues years ago.

Courts in other states have concluded that, despite similar "paid or incurred" statutes or rules, when a healthcare provider sells its accounts receivable to a

[60] The legal effect of an assignment is to transfer some right or interest from one person to another. *MG Bldg. Materials, Ltd. v. Moses Lopez Custom Homes, Inc.*, 179 S.W.3d 51, 57 (Tex. App.—San Antonio 2005, pet. denied); *University of Tex. Med. Branch at Galveston v. Allan*, 777 S.W.2d 450, 452 (Tex. App.—Houston [14th Dist.] 1989, no writ). There is no question that the right to receive payment for a debt is generally assignable in Texas. *In re FH Partners, L.L.C.*, 335 S.W.3d 752, 761 (Tex. App.—Austin 2011, orig. proceeding); *Cloughly NBC Bank-Sequin, N.A.*, 773 S.W.2d 652, 655 (Tex. App.—San Antonio 1989, writ denied); *Roach v. Schaefer*, 214 S.W.2d 652, 655 (Tex. Civ. App.—Fort Worth 1948, no writ); *see also State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696, 706 (Tex. 1996) (finding that it is usually permissible to assign the legal right to pursue a claim to another).

[61] Once an assignee has been assigned an interest in a debt or claim, he stands in the shoes of the assignor, and so has the same right as the assignor to assert the claim against the defendant. *Gulf Ins. Co. v. Burns Motors, Inc.*, 22 S.W.3d 417, 424–25 (Tex. 2000); *Jackson v. Thweatt*, 883 S.W2d 171, 174 (Tex. 1994); *Burns v. Bishop*, 48 S.W.3d 459, 466 (Tex. App.–Houston [14th Dist.] 2001, no pet.). Texas has had a long history of supporting the strong public policy in favor of assignability of contracts. *See, State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696, 706–07 (Tex. 1996).

factoring company, a plaintiff can present and recover the full amount of the bills that are owed to the factoring company. Moreover, the plaintiff's recovery is not limited by the amount a factoring company pays the healthcare provider to purchase the accounts.[62]

III. THE AFFORDABLE CARE ACT

Since becoming law in 2010, the Patient Protection and Affordable Care Act ("ACA"), more commonly referred to as the "Affordable Care Act" or "Obamacare," has been alternately criticized and lauded ad nauseum.[63] Whatever your political leanings, it is widely accepted that the ACA represents the most significant regulatory overhaul of the United States healthcare system since the 1965 passage of Medicare and Medicaid.

Lost in much of the noise and political punditry is any meaningful analysis of how the 2014 implementation of the individual mandate and the anticipated surge in the ranks of the insured will affect the recovery of medical damages in tort cases.[64]

As we have previously discussed, a tort plaintiff in Texas may only recover medical expenses that were either actually paid (e.g., copayments, out of pocket direct payments, insurance payments) or actually incurred (i.e., expenses not adjusted, written off as required by law or contract, or discharged in bankruptcy).[65] Thus, when a medical bill is adjusted by a hospital or other provider in accordance with a contractually agreed upon reimbursement rate, only the adjusted bill (and not the bill reflecting the medical provider's chargemaster prices) is admissible to prove damages. And to avoid violating the collateral source rule, such bills are generally admitted as a summary exhibit or in redacted form.[66]

How the ACA will affect the calculation of recoverable medical damages and the application of the related collateral source rule remains to be seen. But given the existing "actually paid or incurred" scheme, the implementation of the individual mandate raises some questions, including:

(1) Will people who purchase subsidized plans be deemed to incur the same costs as those covered by other private insurance plans (e.g., employer-provided plans)?

(2) Will all uninsured individuals still be able to recover all medical charges incurred? Or will ACA mandated discounts lead to an across-the-board reduction in chargemaster prices? and

(3) How will the "willfully uninsured" be treated? Should they be entitled to recover medical expenses based on chargemaster rates when they knowingly failed to maintain minimum essential coverage?

For now, the answers to these questions (and many others) are impossible to predict with certainty. But current law may provide some guidance if not predict the likely outcome under some of these scenarios.

A. The ACA and the Individual Mandate Basics

At the outset, it is useful to have a basic understanding of some of the relevant ACA provisions.

The ACA was enacted with the goals of increasing the quality and affordability of health insurance, achieving "near-universal" insurance coverage for all Americans, and reducing the costs of healthcare.[67] To achieve those goals, the ACA, among other things, imposes numerous insurance reforms, requires employers to provide coverage meeting higher standards, incentivizes Medicare providers to reduce health care costs and improve patient outcomes, expands Medicaid coverage, at each state's option[68],

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[62] *See, e.g.*, *Rojas v. Romero*, No. F053995, 2009 WL 189848, *5–9 (Cal. Ct. App. 5th Feb. 6, 2009); *Codner v. Wills*, Nos. B198675, B202091, 2009 WL 4915839, *7–8 (Cal. Ct. App. 2nd Dec. 22, 2009); *Katiuzhinsky v. Perry*, 152 Cal. App. 4th 1288, 1296–98 (Cal. Ct. App. 3rd 2007); *Miller v. J-M Mfg. Co., Inc.*, CV-05-1499-ST, 2008 WL 356932, *4–6 (D. Or. Feb. 7, 2008).

[63] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111–148, 124 Stat. 119 (2010) (codified as amended in various sections of 21, 25, 26, 29 and 42 U.S.C.) [hereinafter ACA § __].

[64] Some commentators have considered these questions, but none that we identified had discussed the effect of the ACA on the recoverability of tort damages under Texas's "actually paid or incurred scheme." *See, e.g.*, Ann S. Levin, *The Fate of the Collateral Source Rule After Healthcare Reform*, 60 U.C.L.A. L. Rev. 739 (2013); Adam G. Todd, *An Enduring Oddity: The Collateral Source Rule in the Face of Tort Reform, the Affordable Care Act, and Increased Subrogation*, 43 McGeorge L. Rev. 965 (2012).

[65] Tex. Civ. Prac. & Rem. Code § 41.0105; *see, e.g.*, *Haygood v. De Escobedo*, 356 S.W.3d 390, 398 (Tex. 2012).

[66] *See id.* at 398–400 ("[W]e hold that only evidence of recoverable medical expenses is admissible at trial. . . . Of course, the collateral source rule continues to apply to such expenses, and the jury should not be told that they will be covered in whole or in part by insurance. Nor should the jury be told that a heath care provider adjusted its charges because of insurance.").

[67] ACA § 1501(a)(2)(D).

[68] In *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601 (2012), the United States Supreme Court struck down the ACA's provisions requiring states to expand Medicaid or

and mandates that certain individuals maintain "minimal essential [health insurance] coverage."[69]

The individual mandate requires "applicable individuals," as that term is defined, to purchase and maintain health insurance.[70] Exempted from this requirement are people who cannot afford coverage, taxpayers with income under 100% of the poverty line, and members of Indian tribes. Also excluded from the definition of "applicable individual" are non-citizens, U.S. Nationals living abroad, incarcerated individuals, and people who qualify under the religious conscience exemption.[71]

"Applicable individuals" may satisfy the requirement to maintain "minimum essential coverage" by obtaining government (e.g., Medicare and Medicaid) or employer sponsored plans, by purchasing plans through the Health Insurance Marketplace (the "Marketplace"), or by maintaining some other approved plan.[72] Some non-exempt individuals who purchase insurance through the Marketplace, particularly low-income individuals whose income is between 100% and 400% of poverty level, will receive federal subsidies, to reduce monthly premiums, or a tax credit.[73] Individuals who are not exempt from the individual mandate, yet fail to maintain "minimum essential coverage," will be required to pay a penalty to the IRS.[74]

B. The impact of the individual mandate: Who will be insured and uninsured?

The Congressional Budget Office ("CBO") estimates that as a result of the ACA and the individual mandate, nearly 94% of non-elderly individuals (the elderly are covered by Medicare) will be insured.[75] Although this statistic is not specific to Texas, it is fair to assume that the number of uninsured Texans will (eventually) decrease either because they will have employer-provided or government-sponsored insurance, or because they will purchase private insurance plans through the Marketplace.

However, despite the sweeping reach of the individual mandate, there will still be many uninsured individuals. Even prior to the ACA, for purposes of discussing health care policy, the uninsured were generally divided into two groups—the poor or indigent uninsured and the non-poor non-indigent uninsured.[76] Undoubtedly, the ACA will reduce the number of individuals falling into these categories, but as a group, the uninsured will not disappear completely. In fact, the CBO estimates that approximately 26 million U.S. residents will remain uninsured after the ACA has been fully implemented.[77] Among those who will remain uninsured are:

(1) exempt individuals (e.g., people with religious exemptions, undocumented immigrants, Native American tribes, people whose incomes are so low they are not required to pay income tax, and incarcerated individuals);
(2) people eligible for Medicaid but not enrolled;
(3) individuals who are not required to purchase insurance because, after taking into account employer contributions or federal subsidies, coverage would cost more than 8% of household income,
(4) individuals who do not qualify for Medicaid or subsidized coverage (in states opting not to expand Medicaid coverage); and

lose all federal Medicaid funding. 132 S. Ct. at 2601–607 ("Congress is not free . . . to penalize States that chose not to participate in the new program by taking away their existing Medicaid funding."), *invalidating* 42 U.S.C. § 1396c. Despite the ruling numerous states, but not Texas, have opted to voluntarily expand state-run Medicaid programs in accordance with the ACA. *See Obamacare: Enrollment Numbers and Medicaid Expansion*, (Dec. 12, 2013, 4:53 PM), http://www.cnn.com/interactive/2013/09/health/map-obamacare (last visited Dec. 13, 2013).

[69] ACA § 5000A(a).
[70] *Id.*, at § 5000A(d).
[71] *Id.*,at § 5000A(d) & (e).
[72] *Id.*, at § 5000A(f).
[73] *See id*, at § 1411 (determining eligibility fro tax credits and subsidies).
[74] *Id.*, at § 5000A(b).

[75] *See* Congressional Budget Office, Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act, at 3 (March 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf [hereinafter CBO Revised Estimates]; Congressional Budget Office, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, at 3 (July 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf [CBO Revised Estimates II].
[76] Nation, *supra* note 16, at 433.
[77] *See* CBO Revised Estimates & CBO Revised Estimates II, *supra* note 75.

(5) people who are required to obtain insurance through the Health Insurance Marketplace but opt-out and pay the penalty.

The ACA does not apply to individuals falling into category (1). These individuals are generally excluded under the definition of "applicable individual,"[78] and are not eligible to buy plans in the Marketplace. They are also not required to pay a penalty for failing to maintain minimum essential coverage.

Similarly, people falling into categories (2), (3), and (4) will remain uninsured after the ACA is implemented because they are (a) eligible for Medicaid but not enrolled, (b) are not eligible for Medicaid, or (c) cannot afford to purchase coverage in the Marketplace. The ACA does not penalize these individuals for failing to maintain minimum essential coverage. Although there is no generally accepted definition for the "poor uninsured" when it comes to health insurance policy, these individuals would most likely fit into that category.[79] Because Texas, like at least 21 other states, has opted not to expand Medicaid coverage,[80] there may be proportionally more "poor-uninsured" individuals than states with expanded Medicaid coverage.[81]

Also uninsured will be people in category (6). These non-exempt individuals will continue to be uninsured because, although they are required to maintain minimum essential coverage, they opt to pay the penalty instead of obtaining private insurance through the Marketplace or through some other means.[82] Some commentators have distinguished these individuals from the poor uninsured by identifying them as the "willfully uninsured."[83] The willfully uninsured are those "who have the obligation to obtain coverage but refuse to do so."[84]

C. How will the ACA impact the recoverability of past medical damages?

Given these categories of insured, excluded, and uninsured individuals, we are left to ask whether (and if so, how) the changes implemented by the ACA will impact tort recoveries under Texas's "actually paid or incurred" scheme.

1. Insured plaintiffs

More likely than not, nothing will change for insured plaintiffs (aside from there likely being more of them). Beginning with its decision in *Haygood*, the Texas Supreme Court has made clear that a "torfeasor is not liable to a health care provider or its patients for medical expenses the patients were not required to pay the provider."[85] This is because any adjustment of the amount a health care provider charges because of a contract or agreement with the insurer is not an expense that is "actually incurred" by the plaintiff.[86] Put another way, an insured plaintiff does not actually pay or actually incur expenses that are adjusted down or written off as required by law or contract. This is true whether the plaintiff is privately insured, or, as in *Haygood*, insured through a government-sponsored program.[87]

Thus, regardless of the type of insurance coverage—Medicare, Medicaid, plans purchased in the Marketplace (whether subsidized or unsubsidized), or employer provided plans—plaintiffs seeking to recover past medical damages cannot recover more than what was actually paid or incurred.[88] And they are not permitted to recover medical expenses that a health care provider is not entitled to charge.[89]

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[78] Individuals who cannot afford coverage, taxpayers with income under 100% of the poverty line, and members of Native American Indian tribes fall within the definition of "applicable individual" but are not required to maintain minimum essential coverage and are not subject to a penalty for failing to do so. ACA § 5000A(d) &(e).

[79] *See* Nation, *supra* note 16, at 432.

[80] *See Obamacare: Enrollment Numbers and Medicaid Expansion*, *supra* note 68.

[81] *See* Rachel Nardin, et al, *The Uninsured After Implementation of the Affordable Care Act: A Demographic and Geographic Analysis*, Heath Affairs Blog (July 6, 2013), http://healthaffairs.org/blog/2013/06/06/the-uninsured-after-implementation-of-the-affordable-care-act-a-demographic-and-geographic-analysis (last visited Dec. 13, 2013) (estimating that 4,986,000 Texans will be uninsured after the implementation of the individual mandate).

[82] ACA § 5000A(b).

[83] Rebecca Levenson, Comment, *Allocating the Costs of Harm to Whom They are Due: Modifying the Collateral Source Rule After Health Care Reform*, 106 U. Pa. L. Rev. 921, 935, n.68 (2012); *see also* Nation, *supra* note 16, at __..

[84] Levenson, *supra* note 83, at 935, n.68.

[85] *Haygood v. De Escobado*, 356 S.W.3d 390, 397 (Tex. 2012).

[86] *Id.*

[87] *See id.* at 392. The plaintiff in *Haygood* was covered by Medicare Part B. *Id.* Haygood's health care providers adjusted his bills to conform with the applicable Medicare rate. *Id.*

[88] *Haygood v. De Escobado*, 356 S.W.3d 390, 396 (Tex. 2012).

[89] *Id.* ("'[A]ctually paid and incurred' means expenses that have been or will be paid, and excludes the difference between such amount and charges the service provider bills but has no right to be paid.'"

2. Excluded plaintiffs and poor-uninsured plaintiffs

With respect to Plaintiffs who are not required to maintain coverage under the ACA, including both the exempt and poor-uninsured plaintiffs, the impact of the ACA on tort recoveries may also be limited.

An injured uninsured plaintiff who receives care from a hospital or other health care provider may be billed at the hospital or other health care provider's full chargemaster rate.[90] Because these plaintiffs do not have insurance, the discounted reimbursement rates negotiated between the health care provider and a private insurer or imposed by the government do not apply.[91]

Although some of these plaintiffs may ultimately not pay for medical services, they will still incur the hospital's or health care provider's full fee and presumably would be entitled to recover the full amount charges as damages because the hospital or service provider would still be entitled to recover the value of the services rendered. For example, in *Big Bird Tree Serv. v. Gallegos*, the Dallas Court of Appeals, noting that a plaintiff can recover past medical expenses even when medical services are provided gratuitously, held that an indigent plaintiff actually incurred the costs of services that were paid for by a charitable program administered by the hospital.[92] The court reasoned that because there was no contract prohibiting the hospital from charging the full value of the services rendered, the plaintiff was entitled to recover the "actual value of the services rendered."[93]

In general, the ACA does not change or require healthcare providers to lower their chargemaster rates, so in general, uninsured plaintiffs likely will still be entitled to recover as damages any amount that has not been adjusted or written off as required by law or contract.

However, certain hospitals seeking to qualify as "charitable hospitals," must, among other things, establish a financial assistance policy ("FAP") that includes eligibility criteria for determining if certain uninsured individuals qualify for financial assistance.[94] Under the ACA, charitable hospitals are prohibited from charging "gross charges." and they must also agree to limit amounts charged for emergency or other medically necessary care provided to uninsured individuals under the FAP to "not more than the lowest amounts charged to individuals who have insurance covering such care."

3. Willfully uninsured plaintiffs

As discussed above, the "willfully uninsured" are those who are required to obtain insurance coverage under the ACA but refuse to do so and choose instead to pay the penalty.[95] Under the current "actually paid or incurred" scheme, willfully uninsured plaintiffs could be treated the same as the poor-uninsured. That is, the willfully uninsured plaintiff would be entitled to recover the full value of his or her incurred medical expenses, despite the availability and affordability of insurance coverage.

Some commentators have suggested that there may be justification for treating the willfully uninsured differently.[96] More specifically, in order to avoid a windfall to the extent the plaintiffs' expenses would have been covered under an available insurance plan, the plaintiff's recovery could be limited to the amount that could have been recovered had the plaintiff secured a bronze plan (the minimum coverage plan acceptable under the ACA).[97] In other words, had the plaintiff secured insurance as required by law, the recovery would have been limited to the amounts "incurred" from expenses permitted under the bronze plan. The justification for this reduction in the amount of recoverable damages is two-fold: first the plaintiff should not benefit from his or her knowing refusal to comply with the individual mandate; second, the plaintiff would not have incurred the same medical expenses as other uninsured plaintiffs if he or she had purchased a plan as required by law.

However, the counter-argument to such an approach would be that the willfully uninsured do not unjustly benefit from a full recovery. That is, there is no windfall to a willfully uninsured plaintiff if he or she recovers the full value of the medical services provided because the hospital or health care provider would be entitled to recover the full amount of its charges if the plaintiff prevailed. Moreover, the prior argument suggests that a person would willfully hazard life or limb for the "benefit" of recovering the full medical expenses from the tortfeasor, simply to have the opportunity to repay the healthcare provider for the full

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[90] Nation, *supra* note 16, at 433–34.
[91] *Id.* at 434.
[92] *Big Bird Tree Serv. v. Gallegos*, 365 S.W.3d 173, 176–77 (Tex. App.—Dallas 2012, pet. denied) (citing *Tex. Power & Light Co. v. Jacobs*, 323 S.W.2d 483, 494–95 (Tex. Civ. App.—Waco 1959, writ ref'd n.r.e.)).
[93] *Id.* There was also testimony that the hospital would seek recovery of any award paid to the plaintiff. *Id.*
[94] ACA § 9007.
[95] Levenson, *supra* note 83, at 935, n.68.
[96] Nation, *supra* note 16, at 466–67; Levenson, *supra* note 83, at 949.
[97] Levenson, *supra* note 83, at 949.

medical expenses. It is highly unlikely that people approach what can be devastating life-altering personal injuries in such an illogical manner.

Ultimately, how the ACA will effect tort recoveries remains to be seen. Given Texas's established "actually paid or incurred" scheme the impact for the insured and uninsured plaintiff may very well analogize well under current Texas case law.

IV. CONFLICTING MEDICAL AFFIDAVITS

The context of medical affidavits vis-à-vis recoverability of medical expenses differs depending on the type of case and evidence presented. Often, whether the expenses are reasonable and necessary is not at issue. Sometimes, a defendant will challenge the reasonable amount or necessary nature of expenses. Each scenario is easily handled and well established in the law. For the former, there will typically not be an issue since the affidavits (or amounts) are stipulated to in advance of trial, and often the affidavits themselves become irrelevant or even unnecessary. For the latter, a defendant will presumably (timely) object to the affidavits. Again, this is not an issue on recoverability of damages since at that point what the evidence established at trial becomes the guide as to whether these expenses are recoverable.

But other scenarios are not so clear. For example, under the gray area noted above under the ACA, how should medical expense affidavits be handled? Or, what if the defendant has no objection to the expenses as reasonable and necessary, but is challenging whether they are related to the incident itself (causation)?

A. Does paid or incurred affect how to handle objecting to medical affidavits?

The short answer is if you are arguing to reduce recoverability of medical expenses based on paid or incurred, it may be advisable to object to medical affidavits. Medical affidavits speak to the reasonable and necessary nature of the care for which the bills are related. Paid or incurred would not affect the necessity of the treatment.

But it could very well affect the reasonableness of the expenses. It begs the question: does reasonable in this context mean what would be reasonable to charge an uninsured private pay patient, or what would be reasonable to charge *this* patient (given their current insured/uninsured status)? One might assume that the paid or incurred scheme takes care of this issue by limiting recovery. But for gray area scenarios, the authors are not so sure.

Simply put, defendants have to be very careful to correlate any arguments seeking to reduce the recoverability of medical expenses under paid or incurred with objections to medical affidavits advocating amounts in excess of these paid or incurred amounts. It may very well be that the paid or incurred scheme "trumps" the necessity to object to such affidavits, but a plaintiff's attorney could argue that stipulated reasonable and necessary affidavits stipulate to the amounts of expenses as reasonable (and at a minimum put the issue before the jury).

B. What does reasonable and necessary really mean?

Reasonable relates to the amount of the expenses. Necessary means it was, well, necessary (i.e. the patient needed the treatment or procedure). But necessary for what? Is there any implication that can be made from stipulating to the necessity of a procedure or treatment? Such a question is currently pending before the Dallas Court of Appeals in *Gracia v. Davis*.[98]

Gracia is a case arising from a car wreck that was tried to a jury. The defendant stipulated to liability, admitting that he did not act as an ordinary and prudent driver. The defendant also stipulated to the reasonable and necessary medical affidavits for past medical expenses. The stipulation did not include causation or damages. In other words, the defendant asserted that he did not cause all of the damages for which the plaintiff sought recovery, and conversely, that some damages (including some past medical expenses) were unrelated to the car accident.

The plaintiff moved for a directed verdict at trial on all past medical expenses. All of the past medical expenses were proven up by stipulated reasonable and necessary medical affidavits. Some of these expenses were stipulated as related to the car accident (those expenses incurred within a few months of the accident). But some past medical expenses were incurred more than a year after the accident, and were close in time to the plaintiff beginning a new job that involved heavy lifting. The plaintiff offered testimony from a

[98] *See Gracia v. Davis*, No. 05-12-01147-CV (Tex. App.—Dallas). This case is currently pending before the court, oral argument having occurred on November 20, 2013. While the authors believe they have taken due care to address this appeal objectively—particularly since it is currently pending before the Dallas Court of Appeals—the authors note that co-author Mike Yanof is lead appellate counsel for the defendant in this appeal.

chiropractor expert that all of these past medical expenses (including those more than a year after the accident) were caused by the car accident. The defendant did not offer expert testimony, but did cross-examine the chiropractor expert.

After all evidence was presented, the plaintiff moved for a directed verdict on all past medical expenses. In doing so, the plaintiff relied on the stipulated medical expense affidavits, and the testimony from the chiropractor expert. The defendant responded that causation was not stipulated, and that there was evidence indicating the later treatments were not related to the accident, but instead related to the plaintiff's new job started approximately a year after the accident. The defendant argued that these later treatments were for the jury to decide whether they were caused by the accident, as opposed to the new job.

The trial court granted the plaintiff's directed verdict.[99] The jury went on to award other damages as well. The defendant has asserted on appeal that the trial court erred in granting directed verdict because causation was not stipulated, and there was conflicting evidence on causation. Should the Dallas Court of Appeals affirm the trial court's judgment, defendants may need to change their practice of stipulating to medical expense affidavits while still challenging whether the expenses were caused by the incident at issue.

[99] The trial court also went on to type in the amount of the past medical expenses, essentially instructing the jury that she had found these amounts in favor of plaintiff as a matter of law. This too is a basis for the defendant's appeal.