TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

April 6, 2021

Testimony on HB 1617
Before the House Committee on Judiciary and Civil Jurisprudence
Submitted by Texas Medical Association

Dear Chairman Leach and committee members:

The Texas Medical Association submits this testimony ***ON*** HB 1617. As a non-profit organization with over 55,000 physician and medical student members, we have a great interest in this legislation. HB 1617 was introduced to address allegations regarding inflated or "outlier damages" claimed by plaintiffs relating to care provided by health care providers and hospitals in personal injury lawsuits. Specifically, the claim is that some health care providers bill, in lieu of immediate payment, more for services in personal injury lawsuits in exchange for receiving part of an anticipated jury award or settlement. HB 1617 is intended to focus on medical and health care expenses incurred but not yet paid by a claimant.

As drafted, HB 1617 goes well beyond addressing alleged issues with "outlier damages". While we appreciate it appears to place some parameters on amounts paid, HB 1617 expands what information is discoverable through nonparty subpoenas for amounts incurred (but not yet paid), allowing defense attorneys to target irrelevant, proprietary, and other confidential information such as private contract and government reimbursement rates. Physicians typically must hire an attorney to respond to these requests, review documents for responsiveness and determine if objections apply, and to prepare for any connected deposition or trial testimony, which can be very costly (plus the costs to the physician to take time from providing care to gather documents and prepare for and testify in a deposition and trial).

One strategy employed by attorneys in these personal injury lawsuits is to make the subpoena requests as cumulative and confusing as possible, such as by submitting multi-page, 70-plus document requests in general and vague terms. The intent is to deter objections or to try to make it as burdensome as possible on the plaintiff and the plaintiff's witnesses. The hope is that these tactics will make the plaintiff more inclined to drop the case or take a cheaper settlement, or that the recipients of the subpoenas becomes so overwhelmed they waive their objection rights and turn over everything (which in a physician's case, can have severe consequences). Physicians caught in these types of litigious cases can spend thousands of dollars in attorneys' fees (in addition to administrative fees) trying to take shelter from the crossfire. If they want to protect their interests, they may ultimately have to pay more money for their attorney to prepare a motion and dispute the discovery requests before a court, which can add on additional thousands of dollars to their costs.

The committee substitute we have seen does not address this concern. While on its face it appears to limit discovery in instances where an amount has been paid or when the amount is below a certain threshold, the practical application of the substitute language falls short for at least three reasons:

First, the language in proposed Section 41.0105(c) is vague and does nothing to limit discovery for amounts incurred but not yet paid. Instead, the language appears to weaken the existing law governing admissibility of relevant evidence. For example, a judge generally has discretion to exclude certain pieces of evidence, even if relevant, if they would be confusing or needlessly cumulative. This language does not clearly preserve that exception.

Second, the carve outs proposed in Chapter 18 do not significantly reduce the discovery burdens we are concerned about for amounts incurred but not yet paid. While we appreciate it appears there is some movement towards reducing discovery in cases where the amount is incurred but not yet paid, the thresholds proposed in the committee substitute are unfairly low and would leave a significant number of physicians and health care providers out of the carve out.

Third, even to the extent the carve outs apply, the defense would have 120 days (or approximately four months) after filing its answer to serve its notice of intent to controvert the plaintiff's affidavit on reasonableness of the expenses. That is a significant period of time to allow for discovery on reasonableness before the deadline would pass, which brings up the first issue again on the broad language of what evidence can be introduced to challenge reasonableness for amounts incurred but not yet paid.

Another issue with the committee substitute separate from the discovery burden is it repeals certain sections of Chapter 18 that qualify who can controvert an affidavit to make sure the court and jury are comparing (attempted) apples-to-apples. Under existing law, for example, if a physician submits an affidavit on the reasonableness of the medical expenses, a person who tries to controvert that must be "qualified, by knowledge, skill, experience, training, education, or other expertise, to testify in contravention of all or part of any of the matters contained in the initial affidavit."[1] HB 1617 proposes to remove this guardrail. This is especially concerning because, as drafted, HB 1617 would also allow notice of intent to challenge the reasonableness of medical expenses to <u>also negate any affidavit evidence of medical necessity</u>, even if medical necessity is not being challenged.[2]

The committee substitute, like the introduced version, will likely increase discovery disputes, resulting in higher costs for the courts, litigants, and nonparty participants, and of course delay proceedings.

When individuals are injured, regardless of cause or fault, it is critical that they have access to quality care. Texas physicians should be focused on providing such care. Their time and resources should not be unfairly wasted when caught between litigant crossfire. Therefore, we have four key asks for this piece of legislation:

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[1] Tex. Civ. Prac. Rem. Code 18.001(f) (proposed to be repealed).
[2] *See* Committee Substitute, page 3, proposed subsection (b-1).

1. Expressly limit the law to only personal injury and wrongful death cases, which appear to be the source of the alleged "outlier damages" concern to ensure this legislation does not impact other claims involving medical or health care expenses. The legislation is intended to address a very specific category of cases but as drafted threatens all cases involving medical or health care expenses to broad discovery.

2. Treat amounts actually paid to the physician or health care provider as reasonable except where there is a formal or informal agreement that the physician or health care provider will wholly or partly refund, rebate, or remit any amount of money or give anything of value to the payor, the claimant, or the claimant's attorney.

3. For unpaid amounts, create an exclusive, limited set of relevant evidence that can be introduced on the issue of reasonableness of the medical or health care expenses. The following limited list, based largely on the arbitration factors in SB 1264 (86R) in existing law, is complete, fair, and helpful on the issue of reasonableness—importantly, it also protects proprietary, nonparty private contract and duplicative, irrelevant requests for government reimbursement rate information:

   – Circumstances and complexity of claimant's particular case;
   – Physician or health care provider's level of training, education, and experience;
   – Billed charge of the physician or health care provider for the services;
   – Amount that would have been paid by cost sharing, a health benefit plan, workers' comp, employer-provided plan, Medicaid, Medicare, or other person/entity legally obligated to pay for the services at the time they were provided, if applicable;
   – Availability of insurance or coverage if available at the time and the patient did not disclose or use it; and
   – 80th percentile of all billed charges reported in a benchmarking database (*like Fair Health*) for same or substantially similar services provided in the same geozip.

4. Preserve the current affidavit process, or at minimum, maintain Section 18.001(f) and ensure that a notice of intent filed to challenge the reasonableness of medical or health care *expenses* does not impact the evidentiary weight of an affidavit on medical *necessity*.

We look forward to continuing to work with stakeholders on HB 1617, and we thank you for your time and consideration. If you have any questions, please do not hesitate to contact Dan Finch, Vice President, Advocacy, by email at dan.finch@texmed.org or by phone at (512) 370-1355.