BILL ANALYSIS

C.S.S.B. 30
By: Schwertner
Judiciary & Civil Jurisprudence
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The bill sponsor has informed the committee that successful claimants in personal injury and wrongful death cases may be entitled to recover both economic and noneconomic damages in amounts a jury of their peers determines to fairly and reasonably compensate their injuries. The bill sponsor has further informed the committee that claimants' economic damages may include past and future medical expenses, and that inflated requests for awards of economic damages from past and future medical expenses can correlate with higher awards of noneconomic damages. However, the bill sponsor has informed the committee that given the complexity of medical billing and payment, state law currently lacks clear guidelines on what health-care-expense evidence should be admissible before a jury. C.S.S.B. 30 seeks to address this issue by addressing, among other things, the admissibility of certain evidence and the claimant's disclosure requirements in a civil action in which the claimant seeks recovery of health care expenses in a personal injury or wrongful death action.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the Texas Supreme Court in SECTION 2 of this bill.

ANALYSIS

C.S.S.B. 30 amends the Civil Practice and Remedies Code to revise provisions relating to recovery of health care-related damages in certain civil actions.

Definitions

C.S.S.B. 30 defines the following terms for purposes of provisions governing civil actions in which a claimant seeks health-care related damages relating to a cause of action:

- "health care expenses" as amounts paid or owed or that may be paid or owed to a provider for health care services, supplies, or devices provided to a patient;
- "health care services" as services provided by a provider to an individual to diagnose, prevent, alleviate, cure, treat, or heal the individual's condition, illness, or injury, including rehabilitative services provided to the individual or personal care provided to the individual on a short-term or long-term basis;
- "injured individual" as the individual whose injury or death is the subject of a civil action to which a specified provision applies;
- "letter of protection" as an agreement, regardless of the name, that includes an express or implied promise of payment to a health care provider from a judgment or settlement

of an injured individual's civil action or that makes a payment to the provider contingent on the resolution of the action;

- "physician" as an individual licensed to practice medicine and a professional association, partnership, limited liability partnership, or other type of entity formed or organized by an individual physician or group of physicians to provide medical care to patients;
- "provider" as a person, including an individual, partnership, professional association, corporation, facility, or institution, who is licensed, certified, registered, chartered, or otherwise authorized, in Texas or elsewhere, to provide health care services, including the following:
    - an acupuncturist;
    - a chiropractor;
    - a dentist;
    - a health care institution of a type described by statutory provisions relating to medical liability;
    - a health care collaborative;
    - a nonprofit health organization;
    - a nurse, including a licensed vocational nurse, nurse practitioner, and registered nurse;
    - an occupational therapist;
    - an ophthalmologist;
    - an optometrist;
    - a pharmacist;
    - a physical therapist;
    - a physician;
    - a physician's assistant;
    - a licensed professional counselor;
    - a psychologist;
    - a podiatrist; and
    - a speech therapist; and
- "third-party payor" as an entity, plan, or program that has a legal or contractual obligation to pay, reimburse, or otherwise contract with a provider to pay the provider for the provision of a health care service, supply, or device to a patient, including the following:
    - an insurance company providing health or dental insurance;
    - an employer-provided plan or any other sponsor or administrator of a health or dental plan;
    - a health maintenance organization operating under the Texas Health Maintenance Organization Act, an insurer providing a preferred provider benefit plan under applicable state law, or other similar entity;
    - Medicare;
    - the state Medicaid program, including the Medicaid managed care program operating under applicable state law; and
    - workers' compensation insurance or insurance provided instead of subscribing to workers' compensation insurance.

Admissible Evidence of Health Care Expenses

C.S.S.B. 30 limits the evidence that may be offered for purposes of proving the amount of the economic damages that may be awarded to the claimant to recover health care expenses as economic damages in a personal injury or wrongful death action for a health care service, supply, or device that is paid by a third-party payor and provided to an injured individual to evidence of the amount the third-party payor paid plus amounts paid by an insured for coinsurance, deductibles, or copayments related to the service, supply, or device. The bill establishes that, if a third-party payor did not pay for such services, supplies, or devices, the evidence that may be offered in such an action regarding the reasonable value of the necessary health care services, supplies, or devices provided to the injured individual or that in reasonable probability will need to be provided to the injured individual in the future includes the following:

- evidence of amounts paid by non-third-party payors to providers for each health care service, supply, or device, but not to purchase an account receivable or as a loan, if paid without a formal or informal agreement for the provider to refund, rebate, or remit money to the payor, injured individual, claimant, or claimant's attorney or anyone associated with the payor, injured individual, claimant, or claimant's attorney; and
- any of the following:
    - the Medicare allowable amount applicable at the time and place the service, supply, or device was provided;
    - the maximum allowable reimbursement amount under the medical fee guidelines prescribed by the Texas Workers' Compensation Act, applicable at the time and place the service, supply, or device was provided;
    - the 50th percentile of amounts allowed to participating providers in the geozip and during the calendar quarter in which the service, supply, or device was provided;
    - if, within the time a claimant's affidavit concerning the cost and necessity of services must be served on each other party to the case under applicable state law, the claimant serves a notice of intent to rely on the following:
        - the average amounts collected by the provider during the one-year period preceding the date the service, supply, or device was provided; or
        - the provider's range of contracted rates with commercial insurers regulated by the Texas Department of Insurance (TDI) in effect on the date the service, supply, or device was provided; and
    - the provider's billed charges for the service, supply, or device provided to the injured individual.

C.S.S.B. 30 prohibits a party from compelling a provider by a pretrial discovery request or by subpoena to provide evidence that may be admissible under the bill's provisions with respect to an affidavit concerning the cost and necessity of services unless the claimant serves a notice of intent under those provisions. The bill requires, except as provided by rules adopted by the Texas Supreme Court, a health care provider's statements or invoices submitted into evidence to provide the following for each service, supply, or device provided to the injured individual:

- an industry-recognized billing code;
- a description of the service, supply, or device; and
- the date each service, supply, or device was provided to the injured individual.

C.S.S.B. 30 establishes that, if there is a conflict between the bill's provisions and the statutory provisions limiting the recovery of medical or health care expenses incurred to the amount actually paid or incurred by or on behalf of the claimant, the bill's provisions control.

Claimant Disclosure Requirements in an Action for Health Care Expenses; Certain Matters Admissible

C.S.S.B. 30 requires that a claimant disclose or provide the following, in addition to other items that may be required to be provided by rule, court decision, or other law, to each other party in a civil action in which the claimant seeks recovery of health care expenses as economic damages in a personal injury or wrongful death action:

- any letter of protection related to the action;
- any oral or written agreement under which a provider may refund, rebate, or remit money to a payor, injured individual, claimant, claimant's attorney, or person associated with the payor, injured individual, claimant, or claimant's attorney;
- the identity of any provider who provided health care services to the injured individual in relation to the injury-causing event and provide an authorization to all other parties to the case that will allow those parties to obtain from the provider all of the injured individual's medical records relating to that event; and
- if the injured individual was referred to a provider for services and the provider's medical records, billing statements, or testimony will be presented to the trier of fact in the action:

- the name, address, and telephone number of the person who made the referral, regardless of whether that person is the injured individual's attorney; and
- if the person making the referral was not the injured individual's attorney, the relationship between the person making the referral and the injured individual or the injured individual's attorney.

C.S.S.B. 30 requires a provider who provided a health care service, supply, or device to an injured individual in relation to the injury-causing event that is the subject of such a civil action to provide the following information to all parties to the action, on request by a party to the action:

- an anonymized list of persons an attorney to the action referred to the provider in the preceding two years;
- the date and amount of each payment made to the provider in the preceding two years by, through, or at the direction of the attorney;
- if applicable, each person anonymously described as provided under these provisions on whose behalf a payment to the provider in the preceding two years by, through, or at the direction of the attorney was made; and
- other aspects of any financial relationship between the referring attorney and the provider.

For these purposes, a referral is considered to have been made by the injured individual's attorney even if made by another person when the injured individual's attorney knew or had reason to know that the referral would be made.

C.S.S.B. 30 requires the admission of the following matters into evidence in such a civil action if offered by any party:

- the injured individual's medical records relating to the injury-causing event;
- if a provider's medical records, billing statements, or testimony will be presented to the trier of fact in the action, any letter of protection relating to that provider;
- if the injured individual was referred to a health care provider for services by the injured individual's attorney and that provider's medical records, billing statements, or testimony will be presented to the trier of fact in the action, the information required to be provided under the bill's provisions by a provider on request by a party to the action; and
- treatment guidelines and drug formularies approved by the Workers' Compensation Division of TDI as evidence relating to the necessity of health care services provided to the injured individual.

Rules of Evidence in Action for Health Care Expenses

C.S.S.B. 30 establishes that, except as otherwise provided by the bill's provisions, the Texas Rules of Evidence govern any civil action in which the claimant seeks recovery of health care expenses as economic damages in a personal injury or wrongful death action.

Applicability

C.S.S.B. 30 applies to an action as follows:

- commenced on or after the bill's effective date; or
- pending on the bill's effective date and in which a trial, or a new trial or retrial following a motion, appeal, or otherwise, begins on or after January 1, 2026.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2025.

COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE

While C.S.S.B. 30 may differ from the engrossed in minor or nonsubstantive ways, the following summarizes the substantial differences between the engrossed and committee substitute versions of the bill.

Affidavit Concerning Cost and Necessity of Services

The substitute does not include the following provisions of the engrossed:

- provisions that made statutory requirements for a controverting affidavit to an affidavit concerning the cost and necessity of services applicable instead to notice of intent to controvert the reasonableness of the amounts charged or the necessity for health care services; and
- the provision that established that, if such notice of intent is served, an affidavit concerning cost and necessity of services has no effect except the affidavit may prove the authenticity of the health care records described by the affidavit.

Accordingly, whereas the engrossed repealed the following provisions relating to a counteraffidavit to an affidavit concerning the cost and necessity of services, the substitute does not repeal these provisions:

- the requirement for the counteraffidavit to give reasonable notice of the basis on which the party serving it intends at trial to controvert the claim reflected by the initial affidavit;
- the requirement for the counteraffidavit to be taken before a person authorized to administer oaths and to be made by a person who is 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;
- the prohibition against the use of counteraffidavit to controvert the causation element of the cause of action that is the basis for the civil action; and
- the requirement for the party offering the counteraffidavit in evidence or the party's attorney to file written notice with the clerk of the court when serving the counteraffidavit that the party or attorney served a copy of the counteraffidavit in accordance with state law.

Affidavit of Health Care Facility or Provider

The substitute does not include the provision of the engrossed that prohibited a party from controverting the reasonableness of the charges for health care services stated in an affidavit concerning cost and necessity of services if, as to each health care service provided by the health care facility or provider to the person whose injury or death is the subject of the action, the following conditions apply:

- the affidavit states one of the following amounts as the reasonable charge for the service:
    - the amounts received from all sources by the facility or provider to pay for the service; or
    - if such amounts are not stated, an amount capped at an amount equal to 300 percent of the Medicare fee schedule for the service, as the schedule existed on May 1, 2025, increased or decreased, as applicable, by multiplying by the percentage increase or decrease in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W: Seasonally Adjusted U.S. City Average-All Items) between May 1, 2025, and the date on which the service was provided; and
- the affidavit is accompanied by an invoice for the service that would comply with the clean claim requirements under Insurance Code provisions governing preferred provider benefit plans.

Accordingly, the substitute does not include the provision of the engrossed that did the following with respect to an affidavit of a health care facility or provider concerning cost and necessity of

services that complies with the prohibition and includes a statement that the facility or provider does not intend to appear at trial to testify regarding the reasonableness of the facility's or provider's charges or the necessity for the facility's or provider's services:

- prohibited a party seeking to obtain through any pretrial discovery procedure information from the facility or provider about the reasonableness of the facility's or provider's charges or the necessity for the facility's or provider's services; and
- required the trial court to exclude trial testimony by the facility or provider regarding the reasonableness of the facility's or provider's charges or the necessity for the facility's or provider's services unless:
    - after the affidavit is served, the facility or provider states an intention to testify at trial or appears at trial to testify;
    - the court finds there is good cause to allow the testimony;
    - the testimony will not unfairly surprise or unfairly prejudice any party to the action; and
    - a party opposing admission of the testimony into evidence is given a reasonable opportunity to conduct discovery and present evidence relevant to the testimony to be offered by the facility or provider.

The substitute does not include the provision of the engrossed that limited the use of an affidavit of a health care facility or provider concerning cost and necessity of services and the statements made in the affidavit to the civil action in which the affidavit is served and excluding their use in other actions or for other purposes.

Judicial Review of Exemplary Damages Awarded

Whereas the engrossed changed the filings that are excepted from statutory requirements for an appellate court's review of an award of exemplary damages from the supreme court's consideration of an application for writ of error to the supreme court's consideration of a petition for review, the substitute does not make this change.

Definitions

The engrossed revised the definitions of the following terms for purposes of provisions governing civil actions in which a claimant seeks damages relating to a cause of action, whereas the substitute does not revise these definitions:

- specified "future damages" are damages that in reasonable probability can be expected to be incurred after the date of the judgment; and
- specified "future loss of earnings" is a pecuniary loss from reductions in income, wages, or earning capacity that in reasonable probability can be expected to be incurred after the date of the judgment and accordingly removed the current specification that the term includes a loss of income, wages, or earning capacity and replaced the current specification that the term includes a loss of inheritance in the term with a provision excluding from the term a loss of inheritance.

The engrossed defined the following terms for purposes of its provisions, whereas the substitute does not:

- "mental or emotional pain or anguish" as grievous and debilitating angst, distress, torment, or emotional suffering or turmoil that causes a substantial disruption in a person's life, including mental or emotional pain or anguish arising from loss of consortium, loss of companionship and society, loss of enjoyment of life, disfigurement, and physical impairment; and
- "physical pain and suffering" as a painful or distressing sensation associated with an injury or damage to a part of a person's body that is consciously felt and either:
    - arises from an observable injury, disfigurement, or impairment or is shown to exist through objectively verifiable medical evaluation or testing; or

- in cases of sexual assault or abuse, is corroborated by medical evidence or a prior consistent statement.

Whereas the engrossed defined "injured individual" as the individual whose injury or death is the subject of a civil action to which provisions of the engrossed relating to the recovery of health care expenses as economic damages apply, the substitute defines "injured individual" as the individual whose injury or death is the subject of a civil action to which a specified provision applies.

While the engrossed and substitute both define "provider" in the same manner, including by specifying the same professionals, for purposes of the bill, the substitute includes a speech therapist among those professionals whereas the engrossed did not.

Admissible Evidence of Health Care Expenses

While the engrossed and substitute both include provisions limiting the evidence that may be offered for purposes of proving the amount of the economic damages that may be awarded to a claimant to recover health care expenses in a personal injury or wrongful death action, the versions differ. With respect to health care services paid by a third-party payor, the substitute does the following:

- does not include the condition in the engrossed that the limitation is in addition to any other limitation provided by law;
- includes among the expenses for which evidence may be offered to prove economic damages a health care supply or device paid by a third-party payor, which the engrossed did not; and
- includes among the evidence that may be offered amounts paid by an insured for coinsurance, deductibles, or copayments related to the health care service, supply, or device, which the engrossed did not.

The engrossed provided the following and specified that it is in addition to any other limitation provided by law:

- limited the evidence that may be offered with respect to health care services paid by the injured individual or paid on behalf of the individual by non-third-party payors to amounts paid by the individual or non-third-party payors, but excluding amounts to purchase an account receivable or as a loan, if paid without a formal or informal agreement for the provider to refund, rebate, or remit money to the payor, injured individual, claimant, or claimant's attorney or anyone associated with the payor, injured individual, claimant, or claimant's attorney;
- if the amounts paid by a third-party payor, the injured individual, or a non-third-party payor described by the engrossed do not apply, limited the evidence that may be offered to amounts capped at amounts equal to 300 percent of the Medicare fee schedule for each service provided to the injured individual, as the schedule existed on May 1, 2025, increased or decreased, as applicable, by multiplying by the percentage increase or decrease in the CPI-W: Seasonally Adjusted U.S. City Average-All Items, between May 1, 2025, and the date the service was provided to the injured individual; and
- limited the evidence that may be offered with respect to health care services that in reasonable probability can be expected to be provided to the injured individual in the future because of the injury-causing event to evidence of the amounts of the reasonable value of necessary services, except that the amounts were capped at 300 percent of the Medicare fee schedule for each service, as the schedule existed on May 1, 2025, increased or decreased, as applicable, by multiplying by the percentage increase or decrease in the CPI-W: Seasonally Adjusted U.S. City Average-All Items, between May 1, 2025, and the date the trial commences.

The substitute does not provide for such limitations of evidence. Instead, the substitute includes a provision establishing that, with respect to health care services, supplies, or devices paid by a non-third-party payor, the evidence that may be offered regarding the reasonable value of the

necessary health care services, supplies, or devices provided to the injured individual or that in reasonable probability will need to be provided to the injured individual in the future includes the following:

- amounts paid by non-third-party payors for each health care service, supply, or device, but excluding amounts to purchase an account receivable or as a loan if paid without such a formal or informal agreement; and
- any of the following:
    - the Medicare allowable amount applicable at the time and place the service, supply, or device was provided;
    - the maximum allowable reimbursement amount under the medical fee guidelines prescribed by the Texas Workers' Compensation Act, applicable at the time and place the service, supply, or device was provided;
    - the 50th percentile of amounts allowed to participating providers in the geozip and during the calendar quarter in which the service, supply, or device was provided;
    - if, within the time a claimant's affidavit concerning the cost and necessity of services must be served on each other party to the case under applicable state law, the claimant serves a notice of intent to rely on the following:
        - the average amounts collected by the provider during the one-year period preceding the date the service, supply, or device was provided; or
        - the provider's range of contracted rates with commercial insurers regulated by TDI in effect on the date the service, supply, or device was provided; and
    - the provider's billed charges for the service, supply, or device provided to the injured individual.

The engrossed and substitute also differ as follows:

- the engrossed required health care provider statements or invoices presented for purposes of evidence of health care expenses to be in a form that would comply with the clean claim requirements of Insurance Code provisions governing preferred provider benefit plans, whereas the substitute does not;
- the engrossed established that if a service does not have an industry-recognized billing code, no amount of money may be awarded to the claimant for that service, whereas the substitute does not;
- the substitute includes a provision prohibiting a party from compelling a provider by a pretrial discovery request or by subpoena to provide evidence that may be admissible under the substitute's provisions with respect to an affidavit concerning cost and necessity of services unless the claimant serves a notice of intent under those provisions, whereas the engrossed did not include this prohibition; and
- the substitute includes a requirement that, except as provided by rules adopted by the Texas Supreme Court, a health care provider's statements or invoices submitted into evidence provide certain information for each service, supply, or device provided to the injured individual.

Claimant Disclosure Requirements

In general, while the engrossed and substitute both include provisions relating to claimant disclosure requirements in a civil action to recover health care expenses as economic damages in a personal injury or wrongful death action and both require the claimant to provide certain documents and information to each other party, the substitute requires either the provision or disclosure of that material, whereas the engrossed only required the provision of such material. Moreover, the engrossed required the provision of a copy of the material, whereas the substitute does not make that specification. The versions also differ in that the engrossed includes the requirement that the claimant, in addition to other requirements of law, identify the applicable provider, provide an authorization to allow all other parties to the case to obtain the injured individual's medical records, and disclose certain information, while the substitute instead

includes a requirement that a claimant, in addition to other items that may be required to be provided by rule, court decision, or other law, provide or disclose to each other party certain documents and the identity of the applicable provider, provide the authorization to allow all other parties to the case to obtain the injured individual's medical records, and provide or disclose to each other party certain information.

With respect to the documents and information subject to such provisions, the versions differ as follows:

- the engrossed included among the documents required to be provided to each other party all statements or invoices generated by health care providers showing health care services provided to the injured individual because of the injury-causing event that is the basis for the action, whereas the substitute does not;
- the substitute includes among the documents required to be provided or disclosed to each other party any oral agreement under which a provider may refund, rebate, or remit money to a payor, injured individual, claimant, claimant's attorney, or person associated with the payor, injured individual, claimant, or claimant's attorney, whereas the engrossed did not; and
- whereas the engrossed required a claimant to disclose any unwritten agreement under which a provider may refund, rebate, or remit money to a payor, injured individual, claimant, claimant's attorney, or person associated with the payor, injured individual, claimant, or claimant's attorney, the substitute does not include such a requirement.

The substitute and engrossed include a provision requiring the claimant to provide an authorization to all other parties to the case that will allow those parties to obtain from the applicable provider all of the injured individual's medical records, but the substitute limits the provision's applicability to the individual's medical records relating to the injury-causing event.

With respect to the requirement in both the engrossed and the substitute regarding the provider to whom the injured individual was referred for services and the conditions under which certain contact information of the provider must be applicably disclosed or provided:

- the engrossed made that requirement applicable if the injured individual was referred to a provider for services and the provider will provide testimony that is presented to the trier of fact in the action; whereas
- the substitute makes that requirement applicable if the injured individual was referred to the provider and the provider's medical records, billing statements, or testimony will be presented to the trier of fact in the action.

Whereas the engrossed required a claimant to disclose information relating to persons referred to a provider in the preceding two years, subject to the injured individual having been referred by their attorney to the provider for services and the provider providing testimony that is presented to the trier of fact in the action, the substitute does not include this requirement. Instead, the substitute requires a provider who provided a health care service, supply, or device to an injured individual in relation to the injury-causing event, subject to the request by a party to the action, to provide information relating to persons referred to the provider in the preceding two years to all parties to the action.

Claimant's Obligation of Proof Not Affected

The substitute does not include the provision of the engrossed that established that nothing in the engrossed version relating to the recovery of health care expenses as economic damages affects the claimant's obligation to prove that the health care services provided to the injured individual were necessary and causally connected to a defendant's acts or omissions.

Matters Admissible Into Evidence

While the engrossed and substitute both provide for the admission of certain matters into evidence by any party in a civil action in which the claimant seeks recovery of health care expenses as economic damages in a personal injury or wrongful death action, the versions differ as follows:

- whereas the engrossed established that the matters are admissible by any party, the substitute mandates the admission of the matter if offered by any party;
- whereas the engrossed included among the matters that may be admitted a document or information provided to each other party by the claimant under bill provisions relating to claimant disclosure requirements, the substitute does not;
- the substitute includes among the matters that may be admitted the injured individual's medical records relating to the injury-causing event, whereas the engrossed did not;
- the substitute includes among the matters that may be admitted any letter of protection relating to a provider, if the provider's medical records, billing statements, or testimony will be presented to the trier of fact in the action, whereas the engrossed did not; and
- with respect to the condition that triggers the admissibility of information relating to persons referred to the provider in the preceding two years, subject to a referral of the injured individual to a health care provider for services by the injured individual's attorney, the substitute omits the condition that the provider will provide testimony that is presented to the trier of fact in the action, as in the engrossed, and includes a condition that the provider's medical records, billing statements, or testimony will be presented to the trier of fact in the action.

Rules of Evidence in Action for Health Care Expenses

Whereas the engrossed established that, except as otherwise provided by provisions of the engrossed relating to matters admissible into evidence, the Texas Rules of Evidence apply to any civil action in which the claimant seeks recovery of health care expenses as economic damages in a personal injury or wrongful death action, the substitute instead establishes that, except as otherwise provided by provisions of the substitute relating to admissible evidence of health care expenses and claimant disclosure requirements and certain matters admissible, the Texas Rules of Evidence govern such an action.

Noneconomic Damages

The substitute does not include the following provisions of the engrossed setting out standards for an award of damages for physical pain and suffering or mental or emotional pain or anguish:

- the requirement that the award of such damages provide fair and reasonable compensation to a claimant for the claimant's injury for the period of time the pain, suffering, or anguish has persisted or reasonably can be expected to persist in the future;
- the requirement that the award of such damages be based on evidence of the nature, duration, and severity of the injury and reflect a rational connection, grounded in the evidence, between the injury suffered and the dollar amount necessary to provide fair and reasonable compensation to a claimant;
- the prohibition against the use of the award of such damages to penalize or punish a defendant, make an example to others, or serve a social good; and
- the prohibition against the award of such damages from including amounts that are properly considered economic losses, such as lost earnings caused by physical impairment or medical expenses incurred for emotional or psychological care.

The substitute does not include the following provisions included in the engrossed:

- the provision that established that in an action in which a claimant seeks damages relating to a cause of action, it is a reversible error for a court to allow an attorney, witness, or other person through argument, the introduction of evidence, or otherwise to state or suggest that the trier of fact should determine the amount of damages to award

to a claimant for physical pain and suffering or mental or emotional pain or anguish by referring to objects, values, units of time, or other metrics having no rational connection to the facts of the case; and

- the provision that established that, except to the extent of a conflict, the provisions of the engrossed setting out standards for recovery of damages for physical pain and suffering or mental or emotional pain or anguish supplements court decisions and rules of procedure and evidence.

Jury Instructions

The substitute does not include the requirement of the engrossed for a court, in a trial to a jury in which noneconomic damages are sought, to provide the jury definitions and instructions required by provisions governing damages and other law and to ask the jury, if appropriate, to determine the amount of money that will fairly and reasonably compensate the claimant for the following:

- past physical pain and suffering;
- future physical pain and suffering;
- past mental or emotional pain or anguish;
- future mental or emotional pain or anguish;
- past injury to reputation; and
- future injury to reputation.

Prejudgment Interest Required in Certain Cases

Whereas the engrossed provided that the prejudgment interest earned by a judgment in a wrongful death, personal injury, or property damage case applies to amounts awarded in the judgment for economic losses, calculated from the date the health care expenses are actually paid by the claimant, if applicable, or other economic losses are actually suffered by the claimant, the substitute does not include this provision.

Applicability

Whereas the engrossed provided that an action commenced before the bill's effective date is governed by the law applicable to the action immediately before the bill's effective date and that law is continued in effect for that purpose, the substitute does not include this provision.