89R31559 SCL-D

By:  Schwertner, et al. S.B. No. 30

(Bonnen)

Substitute the following for S.B. No. 30:

By:  Leach C.S.S.B. No. 30

A BILL TO BE ENTITLED

AN ACT

relating to recovery of health care-related damages in certain civil actions.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1.  Section 41.001, Civil Practice and Remedies Code, is amended by adding Subdivisions (6-a), (6-b), (6-c), (6-d), (14), (15), and (16) to read as follows:

(6-a)  "Health care expenses" means 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.

(6-b)  "Health care services" means services provided by a provider to an individual to diagnose, prevent, alleviate, cure, treat, or heal the individual's condition, illness, or injury, including:

(A)  rehabilitative services provided to the individual; or

(B)  personal care provided to the individual on a short-term or long-term basis.

(6-c)  "Injured individual" means the individual whose injury or death is the subject of a civil action to which Section 14.015 applies.

(6-d)  "Letter of protection" means 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.

(14)  "Physician" means:

(A)  an individual licensed to practice medicine; and

(B)  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.

(15)  "Provider" means a person, including an individual, partnership, professional association, corporation, facility, or institution, who is licensed, certified, registered, chartered, or otherwise authorized, in this state or elsewhere, to provide health care services, including:

(A)  an acupuncturist;

(B)  a chiropractor;

(C)  a dentist;

(D)  a health care institution of a type described by Section 74.001(a)(11);

(E)  a health care collaborative;

(F)  a nonprofit health organization;

(G)  a nurse, including a licensed vocational nurse, nurse practitioner, and registered nurse;

(H)  an occupational therapist;

(I)  an ophthalmologist;

(J)  an optometrist;

(K)  a pharmacist;

(L)  a physical therapist;

(M)  a physician;

(N)  a physician's assistant;

(O)  a licensed professional counselor;

(P)  a psychologist;

(Q)  a podiatrist; and

(R)  a speech therapist.

(16)  "Third-party payor" means 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:

(A)  an insurance company providing health or dental insurance;

(B)  an employer-provided plan or any other sponsor or administrator of a health or dental plan;

(C)  a health maintenance organization operating under Chapter 843, Insurance Code, an insurer providing a preferred provider benefit plan under Chapter 1301, Insurance Code, or other similar entity;

(D)  Medicare;

(E)  the state Medicaid program, including the Medicaid managed care program operating under Chapter 540, Government Code; and

(F)  workers' compensation insurance or insurance provided instead of subscribing to workers' compensation insurance.

SECTION 2.  Chapter 41, Civil Practice and Remedies Code, is amended by adding Sections 41.015, 41.016, and 41.017 to read as follows:

Sec. 41.015.  ADMISSIBLE EVIDENCE OF HEALTH CARE EXPENSES. (a) This section applies 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.

(b)  If there is a conflict between this section and Section 41.0105, this section controls.

(c)  If a third-party payor paid for a health care service, supply, or device provided to an injured individual, the evidence that may be offered to prove the amount of the economic damages that may be awarded to the claimant for that service, supply, or device is limited 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.

(d)  If Subsection (c) does not apply, 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:

(1)  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

(2)  any of the following:

(A)  the Medicare allowable amount applicable at the time and place the service, supply, or device was provided;

(B)  the maximum allowable reimbursement amount under the medical fee guidelines prescribed by Subtitle A, Title 5, Labor Code, applicable at the time and place the service, supply, or device was provided;

(C)  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;

(D)  if, within the time a claimant's affidavit under Section 18.001(d) must be served, the claimant serves a notice of intent to rely on the following:

(i)  the average amounts collected by the provider during the one-year period preceding the date the service, supply, or device was provided; or

(ii)  the provider's range of contracted rates with commercial insurers regulated by the Texas Department of Insurance in effect on the date the service, supply, or device was provided; and

(E)  the provider's billed charges for the service, supply, or device provided to the injured individual.

(e)  A party may not compel a provider by a pretrial discovery request or by subpoena to provide evidence that may be admissible under Subsection (d)(2)(D) unless the claimant serves a notice of intent under that subsection.

(f)  Except as provided by rules adopted by the supreme court, for each service, supply, or device provided to the injured individual, a health care provider's statements or invoices submitted into evidence must provide:

(1)  an industry-recognized billing code;

(2)  a description of the service, supply, or device; and

(3)  the date each service, supply, or device was provided to the injured individual.

Sec. 41.016.  CLAIMANT DISCLOSURE REQUIREMENTS IN ACTION FOR HEALTH CARE EXPENSES; CERTAIN MATTERS ADMISSIBLE. (a) In addition to other items that may be required to be provided by rule, court decision, or other law, in an action to which Section 41.015 applies, a claimant shall disclose or provide to each other party:

(1)  any letter of protection related to the action;

(2)  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;

(3)  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

(4)  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:

(A)  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

(B)  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.

(b)  On request by a party to an action to which Section 41.015 applies, 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 the action shall provide the following information to all parties to the action:

(1)  an anonymized list of persons an attorney to the action referred to the provider in the preceding two years;

(2)  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;

(3)  if applicable, each person anonymously described under Subdivision (1) on whose behalf a payment described by Subdivision (2) was made; and

(4)  other aspects of any financial relationship between the referring attorney and the provider.

(c)  For purposes of Subsection (b), 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.

(d)  In an action to which Section 41.015 applies, the following matters shall be admitted into evidence if offered by any party:

(1)  the injured individual's medical records relating to the injury-causing event;

(2)  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;

(3)  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 disclosed under Subsection (b); and

(4)  treatment guidelines and drug formularies approved by the Workers' Compensation Division of the Texas Department of Insurance as evidence relating to the necessity of health care services provided to the injured individual.

Sec. 41.017.  RULES OF EVIDENCE IN ACTION FOR HEALTH CARE EXPENSES. Except as otherwise provided by Sections 41.015 and 41.016, the Texas Rules of Evidence govern an action to which Section 41.015 applies.

SECTION 3.  The changes in law made by this Act apply to an action:

(1)  commenced on or after the effective date of this Act; or

(2)  pending on the effective date of this Act and in which a trial, or a new trial or retrial following a motion, appeal, or otherwise, begins on or after January 1, 2026.

SECTION 4.  This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2025.