HOUSE ENGROSSMENT

By: Nixon, Allen, Capelo, Woolley, Cook of Colorado, et al. H.B. No. 4

A BILL TO BE ENTITLED

AN ACT

relating to reform of certain procedures and remedies in civil actions.

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

ARTICLE 1. CLASS ACTIONS

SECTION 1.01. Subtitle B, Title 2, Civil Practice and Remedies Code, is amended by adding Chapter 26 to read as follows:

CHAPTER 26. CLASS ACTIONS INVOLVING JURISDICTION OF STATE AGENCY

Sec. 26.001. DEFINITIONS. In this chapter:

(1) "Agency statute" means a statute of this state administered or enforced by a state agency.

(2) "Claimant" means a party seeking recovery of damages or other relief and includes a plaintiff, counterclaimant, cross-claimant, or third-party claimant.

(3) "Contested case" has the meaning assigned by Section 2001.003, Government Code.

(4) "Defendant" means a party from whom a claimant seeks recovery of damages or other relief.

(5) "Rule" has the meaning assigned by Section 2001.003, Government Code.

(6) "State agency" means a board, commission, department, office, or agency that:

(A) is in the executive branch of state

trial court shall lower the amount of the security to an amount that will not cause the judgment debtor substantial economic harm.

(d) An appellate court may review the amount of security as allowed under Rule 24, Texas Rules of Appellate Procedure, except that when a judgment is for money, the appellate court may not modify the amount of security to exceed the amount allowed under this section.

SECTION 7.03. The following sections of the Civil Practice and Remedies Code are repealed:

(1) 52.002;

(2) 52.003; and

(3) 52.004.

ARTICLE 8. EVIDENCE RELATING TO SEAT BELTS

SECTION 8.01. Section 545.413(g), Transportation Code, is repealed.

ARTICLE 9. BENEVOLENT GESTURES

SECTION 9.01. Section 18.061(c), Civil Practice and Remedies Code, is repealed.

SECTION 9.02. This article applies only to the admissibility of a communication in a proceeding that begins on or after the effective date of this article. The admissibility of a communication in a proceeding that began before the effective date of the article is governed by the law applicable to the admissibility of the communication immediately before the effective date of this article, and that law is continued in effect for that purpose.

ARTICLE 10. HEALTH CARE

SECTION 10.01. Section 1.03(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by amending Subdivisions (3), (4), and (8) and adding Subdivisions (10)-(22) to read as follows:

(3)(A) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including:

(i) [~~as~~] a registered nurse;

(ii) a [~~,~~] hospital;

(iii) a hospital system;

(iv) a [~~,~~] dentist;

(v) a hospice;

(vi) a [~~,~~] podiatrist;

(vii) a [~~,~~] pharmacist;

(viii) an emergency medical services provider;

(ix) an assisted living facility;

(x) a home and community support services agency;

(xi) an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)), as amended;

(xii) a[~~, or~~] nursing home; or

(xiii) a chiropractor.

(B) The term includes:

(i) [~~, or~~] an officer, director, shareholder, member, partner, manager, owner, or affiliate of a health care provider or physician; and

(ii) an employee, independent contractor, or agent of a health care provider or physician [~~thereof~~] acting in the course and scope of the [~~his~~] employment or contractual relationship.

(4) "Health care liability claim" means a cause of action against a health care provider or physician arising out of or related to [~~for~~] treatment, lack of treatment, or other claimed departure from accepted standards of medical care, [~~or~~] health care, or safety or professional or administrative services which proximately results in injury to or death of a claimant [~~the patient~~], whether the claimant's [~~patient's~~] claim or cause of action sounds in tort or contract.

(8) "Physician" means:

(A) an individual [~~a person~~] licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians;

(C) a partnership or limited liability partnership formed by a group of physicians;

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code; or

(E) a company formed by a group of physicians under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes).

(10) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified person, including any direct or indirect parent or subsidiary.

(11) "Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(12) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the person, whether through ownership of equity or securities, by contract, or otherwise.

(13) "Economic damages" means compensatory damages for any pecuniary loss or damage. The term does not include noneconomic damages.

(14) "Emergency medical care" means bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(15) "Emergency medical services provider" means a licensed public or private provider to which Chapter 773, Health and Safety Code, applies.

(16) "Home and community support services agency" means a licensed public or provider agency to which Chapter 142, Health and Safety Code, applies.

(17) "Intermediate care facility for the mentally retarded" means a licensed public or private institution to which Chapter 252, Health and Safety Code, applies.

(18) "Noneconomic damages" means any loss or damage, however characterized, for past, present, and future physical pain and suffering, mental anguish and suffering, loss of consortium, loss of companionship and society, disfigurement, physical impairment, and any other nonpecuniary loss or damage or element of loss or damage.

(19) "Nursing home" means a licensed public or private institution to which Chapter 242, Health and Safety Code, applies.

(20) "Professional or administrative services" means those duties or services that a physician or health care provider is required to provide as a condition of maintaining the physician's or health care provider's license, accreditation status, or certification to participate in state or federal health care programs.

(21) "Hospice" means a hospice facility or activity to

which Chapter 142, Health and Safety Code, applies.

(22) "Hospital system" means a system of hospitals located in this state that are under the common governance or control of a corporate parent.

SECTION 10.02. Subchapter A, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Sections 1.04 and 1.05 to read as follows:

Sec. 1.04. CONFLICT WITH OTHER LAW AND RULES OF CIVIL PROCEDURE. (a) In the event of a conflict between this Act and another law, including a rule of procedure or evidence or court rule, this Act controls to the extent of the conflict.

(b) Notwithstanding Subsection (a) of this section, in the event of a conflict between this Act and Section 101.023, 102.003, or 108.002, Civil Practice and Remedies Code, those sections of the Civil Practice and Remedies Code control to the extent of the conflict.

(c) Notwithstanding Section 22.004, Government Code, and except as otherwise provided by this Act, the supreme court may not amend or adopt rules in conflict with this Act.

(d) The district courts and statutory county courts in a county may not adopt local rules in conflict with this Act.

Sec. 1.05. SOVEREIGN IMMUNITY NOT WAIVED. This Act does not waive sovereign immunity from suit or from liability.

SECTION 10.03. Section 4.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Subsection (f) to read as

follows:

(f)(1) Notwithstanding the provisions of Rule 202, Texas Rules of Civil Procedure, a deposition may not be taken of a physician or health care provider for the purpose of investigating a health care liability claim before the filing of a lawsuit unless:

(A) upon receipt of written notice as required under this section from a patient, patient's family, or patient's representative, the physician or health care provider has failed, within the 10 days specified in this section, to provide complete, unaltered records;

(B) upon providing the records as required under this section, the records are incomplete, inaccurate, illegible, show evidence of having been changed after the events that they purport to record, or fail to comply with any applicable rules, regulations, standards, policies, or guidelines for proper completion of same; or

(C) upon providing the records as required under this section, it cannot be reasonably determined from the records provided what sequence of events occurred in the relevant treatment or events, or cannot be reasonably determined who was present, involved, participated in, or observed the events in question.

(2) If the physician or health care provider fails to provide the records as required under this section, the patient, the patient's family, or the patient's representative shall, notwithstanding Section 13.01(u) of this Act, be entitled to one deposition under Rule 202, Texas Rules of Civil Procedure, in addition to the deposition allowed under Section 13.01(u) of this

Act, sufficient to provide the information needed for them to appropriately evaluate any potential health care liability claim and make decisions about inclusion or not of potential defendants.

SECTION 10.04. The heading to Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

SUBCHAPTER G. EVIDENTIARY MATTERS [~~RES IPSA LOQUITUR~~]

SECTION 10.05. Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Sections 7.03 and 7.04 to read as follows:

Sec. 7.03. FEDERAL OR STATE INCOME TAXES. (a) Notwithstanding any other law, in a health care liability claim, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, evidence to prove the loss must be presented in the form of a net after-tax loss that either was or should have been paid by the injured party or decedent through which the alleged loss has occurred.

(b) In a health care liability claim, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, the court shall instruct the jury whether any recovery for compensatory damages sought by the claimant is subject to federal or state income taxes.

Sec. 7.04. JURY INSTRUCTIONS IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) In a health care liability claim that involves a

claim of negligence arising from the provision of emergency medical care, the court shall instruct the jury to consider, together with all other relevant matters:

(1) whether the person providing care did not have the patient's medical history or was unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;

(2) the lack of a preexisting physician-patient relationship or health care provider-patient relationship;

(3) the circumstances constituting the emergency; and

(4) the circumstances surrounding the delivery of the emergency medical care.

(b) The provisions of Subsection (a) of this section do not apply to medical care or treatment:

(1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient; or

(2) that is unrelated to the original medical emergency.

SECTION 10.06. The heading to Subchapter I, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

SUBCHAPTER I. PAYMENT OF MEDICAL OR HEALTH CARE EXPENSES [~~ADVANCE PAYMENTS~~]

SECTION 10.07. Subchapter I, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 9.01 to read as

follows:

Sec. 9.01. RECOVERY OF PAST MEDICAL OR HEALTH CARE EXPENSES. Recovery of past medical or health care expenses in a health care liability claim shall be limited to the amount actually paid or incurred by or on behalf of the claimant.

SECTION 10.08. Section 10.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 10.01. LIMITATION ON HEALTH CARE LIABILITY CLAIMS. (a) Notwithstanding any other law and subject to Subsection (b) of this section, no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that, minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided, this subchapter applies to all persons regardless of minority or other legal disability.

(b) A claimant must bring a health care liability claim not later than 10 years after the date of the act or omission that gives rise to the claim. This subsection is intended as a statute of repose so that all claims must be brought within 10 years or they are time barred.

SECTION 10.09. Section 11.02, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Subsections (e) and (f) to

read as follows:

(e) The limitation on health care liability claims contained in Subsection (a) of this section includes punitive damages.

(f) The limitation on health care liability claims contained in Subsection (a) of this section shall be applied on a per-claimant basis.

SECTION 10.10. Section 11.03, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 11.03. LIMITATION ON NONECONOMIC DAMAGES [~~ALTERNATIVE PARTIAL LIMIT ON CIVIL LIABILITY~~]. [~~In the event that Section 11.02(a) of this subchapter is stricken from this subchapter or is otherwise invalidated by a method other than through legislative means, the following shall become effective:~~]

In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for noneconomic damages of the physician or health care provider shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based. This section does not apply to a health care liability claim based solely on intentional denial of medical treatment that a patient is otherwise qualified to receive, against the wishes of a patient, or, if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's

present or predicted age, disability, degree of medical dependency, or quality of life unless the medical treatment is denied under Chapter 166, Health and Safety Code [~~of the physician or health care provider for all past and future noneconomic losses recoverable by or on behalf of any injured person and/or the estate of such person, including without limitation as applicable past and future physical pain and suffering, mental anguish and suffering, consortium, disfigurement, and any other nonpecuniary damage, shall be limited to an amount not to exceed $150,000~~].

SECTION 10.11. Subchapter K, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 11.031 to read as follows:

Sec. 11.031. ALTERNATIVE LIMITATION ON NONECONOMIC DAMAGES. (a) In the event that Section 11.03 of this subchapter is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective:

In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages and losses, other than economic damages, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) Effective before September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $200,000 for each health care liability claim and at least $600,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $500,000 for each health care liability claim and at least $1.5 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(c) Effective September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar

year, or fiscal year for a physician participating in an approved residency program;

(2) at least $300,000 for each health care liability claim and at least $900,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $750,000 for each health care liability claim and at least $2.25 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(d) Effective September 1, 2007, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $500,000 for each health care liability claim and at least $1 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $1 million for each health care liability

claim and at least $3 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(e) Evidence of financial responsibility may be established at the time of judgment by providing proof of:

(1) the purchase of a contract of insurance or other plan of insurance authorized by this state;

(2) the purchase of coverage from a trust organized and operating under Article 21.49-4, Insurance Code;

(3) the purchase of coverage or another plan of insurance provided by or through a risk retention group or purchasing group authorized under applicable laws of this state or under the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as amended, or the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.), as amended, or any other contract or arrangement for transferring and distributing risk relating to legal liability for damages, including cost or defense, legal costs, fees, and other claims expenses; or

(4) the maintenance of financial reserves in or an irrevocable letter of credit from a federally insured financial institution that has its main office or a branch office in this state.

(f) This section does not apply to a health care liability claim based solely on intentional denial of medical treatment that a patient is otherwise qualified to receive, against the wishes of a patient, or, if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or

predicted age, disability, degree of medical dependency, or quality of life unless the medical treatment is denied under Chapter 166, Health and Safety Code.

SECTION 10.12. Section 11.04, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 11.04. ADJUSTMENT OF LIABILITY LIMIT [~~LIMITS~~]. When there is an increase or decrease in the consumer price index with respect to the amount of that index on the effective date of this subchapter, [~~each of~~] the liability limit [~~limits~~] prescribed in Section 11.02(a) [~~or in Section 11.03~~] of this subchapter[~~, as applicable,~~] shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index between the effective date of this subchapter and the time at which damages subject to such limit [~~limits~~] are awarded by final judgment or settlement.

SECTION 10.13. Subchapter L, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 12.02 to read as follows:

Sec. 12.02. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care, the person bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from

accepted standards of medical care or health care only if the person shows by clear and convincing evidence that the physician or health care provider did not use the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.

SECTION 10.14. The heading to Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 13.01. [~~COST BOND, DEPOSIT, AND~~] EXPERT REPORT.

SECTION 10.15. Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by amending Subsections (a), (b), (i), (j), (k), and (l) and adding Subsections (s), (t), and (u) to read as follows:

(a) In a health care liability claim, a claimant shall, not later than the 90th day after the date the claim was [~~is~~] filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the[~~:~~

[~~(1) file a separate cost bond in the amount of $5,000 for each physician or health care provider named by the claimant in the action;~~

[~~(2) place cash in an escrow account in the amount of $5,000 for each physician or health care provider named in the action; or~~

[~~(3) file an expert~~] report for each physician or health care provider against whom a liability claim is asserted [~~with respect to whom a cost bond has not been filed and cash in lieu~~

~~of the bond has not been deposited under Subdivision (1) or (2) of this subsection~~].

(b) If, as to a defendant physician or health care provider, an expert report[~~, cost bond, or cash in lieu of bond~~] has not been served [~~filed or deposited~~] within the period specified by Subsection (a) [~~or (h)~~] of this section, the court, on the motion of the affected physician or health care provider, shall enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider [~~requires the filing of a $7,500 cost bond with respect to the physician or health care provider not later than the 21st day after the date of the order~~];

and

(2) dismisses the claim [~~provides that if the claimant fails to comply with the order, the action shall be dismissed for want of prosecution~~] with respect to the physician or health care provider, with prejudice to the refiling of the claim [~~subject to reinstatement in accordance with the applicable rules of civil procedure and Subsection (c) of this section~~].

(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving [~~filing~~] an expert report by serving [~~filing~~] reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single

expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.

(j) Nothing in this section shall be construed to require the serving [~~filing~~] of an expert report regarding any issue other than an issue relating to liability or causation.

(k) An [~~Notwithstanding any other law, an~~] expert report served [~~filed~~] under this section:

(1) is not admissible in evidence by any party [~~a defendant~~];

(2) shall not be used in a deposition, trial, or other proceeding; and

(3) shall not be referred to by any party [~~a defendant~~] during the course of the action for any purpose.

(l) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective [~~a~~] good faith effort to comply with the definition of an expert report in Subsection (r)(6) of this section.

(s) Until a claimant has served the expert report and curriculum vitae, as required by Subsection (a) of this section, all discovery in a health care liability claim is stayed except for the acquisition of the patient's medical records, medical or psychological studies, or tissue samples through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a) of this section, the restrictions imposed by Subsection (k) of this section on use of the expert report by any party are waived.

(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than one deposition before the expert report is served as required by Subsection (a) of this section.

SECTION 10.16. Section 13.01(r)(5), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 14.01(a) of this Act; [~~or~~]

(B) with respect to a person giving opinion testimony regarding whether [~~about~~] a [~~nonphysician~~] health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 14.02 of this Act;

(C) with respect to a person giving opinion

testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a dentist who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence [~~who has knowledge of accepted standards of care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim~~].

SECTION 10.17. Sections 14.01(e) and (g), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), are amended to read as follows:

(e) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on

which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

(g) In this subchapter [~~section~~], "physician" means a person who is:

(1) licensed to practice medicine in one or more states in the United States; or

(2) a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association only if testifying as a defendant and that testimony relates to that defendant's standard of care, the alleged departure from that standard of care, or the causal relationship between the alleged departure from that standard of care and the injury, harm, or damages claimed.

SECTION 10.18. Subchapter N, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas

Civil Statutes), is amended by adding Sections 14.02 and 14.03 to read as follows:

Sec. 14.02. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST HEALTH CARE PROVIDER. (a) For purposes of this section, "practicing health care" includes:

(1) training health care providers in the same field as the defendant health care provider at an accredited educational institution; or

(2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.

(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person:

(1) is practicing health care in the same field of practice as the defendant health care provider at the time the testimony is given or was practicing that type of health care at the time the claim arose;

(2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether,

at the time the claim arose or at the time the testimony is given, the witness:

(1) is certified by a Texas licensing agency or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and

(2) is actively practicing health care in rendering health care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) of this section in determining whether an expert is qualified to offer expert testimony on the issue of whether the defendant health care provider departed from accepted standards of health care but may depart from those criteria if, under the circumstances, the court determines that there is good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) This section does not prevent a health care provider who is a defendant, or an employee of the defendant health care provider, from qualifying as an expert.

(f) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes

in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

Sec. 14.03. QUALIFICATIONS OF EXPERT WITNESS ON CAUSATION IN HEALTH CARE LIABILITY CLAIM. (a) Except as provided by Subsections (b) and (c) of this section, in a suit involving a health care liability claim against a physician or health care provider, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed only if the person is a physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a dentist and is otherwise qualified to render

opinions on that causal relationship under the Texas Rules of Evidence.

(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a podiatrist and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(d) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's

qualifications.

SECTION 10.19. Section 16.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 16.01. APPLICATION OF OTHER LAW. Notwithstanding Chapter 304, Finance Code [~~Articles 1E.101, 1E.102, and 1E.104-1E.108, Title 79, Revised Statutes~~], prejudgment interest in a judgment on a health care liability claim shall be awarded in accordance with this subchapter.

SECTION 10.20. Sections 16.02(b) and (c), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), are amended to read as follows:

(b) Subject to Subchapter K of this Act [~~In a health care liability claim that is not settled within the period specified by Subsection (a) of this section~~], the judgment must include prejudgment interest on past damages awarded in the judgment [~~found by the trier of fact~~], but shall not include prejudgment interest on future damages awarded in the judgment [~~found by the trier of fact~~].

(c) Prejudgment interest allowed under this subchapter shall be computed in accordance with Section 304.003(c)(1), Finance Code [~~Article 1E.103, Title 79, Revised Statutes~~], for a period beginning on the date of injury and ending on the date before the date the judgment is signed.

SECTION 10.21. The Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) is amended by adding Subchapters R, S, and T to read as follows:

SUBCHAPTER R. PAYMENT FOR FUTURE LOSSES

Sec. 18.01. DEFINITIONS. In this subchapter:

(1) "Future damages" means damages that are incurred after the date of judgment for:

(A) medical, health care, or custodial care services;

(B) physical pain and mental anguish, disfigurement, or physical impairment;

(C) loss of consortium, companionship, or society; or

(D) loss of earnings.

(2) "Future loss of earnings" means the following losses incurred after the date of the judgment:

(A) loss of income, wages, or earning capacity and other pecuniary losses; and

(B) loss of inheritance.

(3) "Periodic payments" means the payment of money or its equivalent to the recipient of future damages at defined intervals.

Sec. 18.02. SCOPE OF SUBCHAPTER. This subchapter applies only to an action on a health care liability claim against a physician or health care provider in which the present value of the award of future damages, as determined by the court, equals or exceeds $100,000.

Sec. 18.03. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court shall order that future damages awarded in a

health care liability claim be paid in whole or in part in periodic payments rather than by a lump-sum payment.

(b) The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages.

(c) The court shall specify in its judgment ordering the payment of future damages by periodic payments the:

(1) recipient of the payments;

(2) dollar amount of the payments;

(3) interval between payments; and

(4) number of payments or the period of time over which payments must be made.

Sec. 18.04. RELEASE. The entry of an order for the payment of future damages by periodic payments constitutes a release of the health care liability claim filed by the claimant.

Sec. 18.05. FINANCIAL RESPONSIBILITY. (a) As a condition to authorizing periodic payments of future damages, the court shall require a defendant who is not adequately insured to provide evidence of financial responsibility in an amount adequate to assure full payment of damages awarded by the judgment.

(b) The judgment must provide for payments to be funded by:

(1) an annuity contract issued by a company licensed to do business as an insurance company;

(2) an obligation of the United States;

(3) applicable and collectible liability insurance from one or more qualified insurers; or

(4) any other satisfactory form of funding approved by

the court.

(c) On termination of periodic payments of future damages, the court shall order the return of the security, or as much as remains, to the defendant.

Sec. 18.06. DEATH OF RECIPIENT. (a) On the death of the recipient, money damages awarded for loss of future earnings continue to be paid to the estate of the recipient of the award without reduction.

(b) Periodic payments, other than future loss of earnings, terminate on the death of the recipient.

(c) If the recipient of periodic payments dies before all payments required by the judgment are paid, the court may modify the judgment to award and apportion the unpaid damages for future loss of earnings in an appropriate manner.

(d) Following the satisfaction or termination of any obligations specified in the judgment for periodic payments, any obligation of the defendant physician or health care provider to make further payments ends and any security given reverts to the defendant.

Sec. 18.07. AWARD OF ATTORNEY'S FEES. For purposes of computing the award of attorney's fees when the claimant is awarded a recovery that will be paid in periodic payments, the court shall:

(1) place a total value on the payments based on the claimant's projected life expectancy; and

(2) reduce the amount in Subdivision (1) to present value.

SUBCHAPTER S. ATTORNEY'S FEES

Sec. 19.01. DEFINITION. In this subchapter, "recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical or health care services incurred by the claimant and the attorney's office overhead costs or charges are not deductible disbursements or costs.

Sec. 19.02. APPLICABILITY. The limitations in this subchapter apply without regard to whether:

(1) the recovery is by settlement, arbitration, or judgment; or

(2) the person for whom the recovery is sought is an adult, a minor, or an incapacitated person.

Sec. 19.03. PERIODIC PAYMENTS. If periodic payments are recovered by the claimant, the court shall place a total value on these payments based on the claimant's projected life expectancy and then reduce this amount to present value for purposes of computing the award of attorney's fees.

SUBCHAPTER T. DECLARATORY JUDGMENTS; INJUNCTIONS; APPEALS

Sec. 20.01. APPLICABILITY. This subchapter applies only to an amendment to this Act that is effective on or after January 1, 2003.

Sec. 20.02. DECLARATORY JUDGMENT. The constitutionality and other validity under the state or federal constitution of all or any part of an amendment to this Act may be determined in an action for declaratory judgment in a district court in Travis County under Chapter 37, Civil Practice and Remedies Code, if it is alleged that the amendment or a part of the amendment affects the rights, status,

or legal relation of a party in a civil action with respect to any other party in the civil action.

Sec. 20.03. ACCELERATED APPEAL. (a) An appeal of a declaratory judgment or order, however characterized, of a district court, including an appeal of the judgment of an appellate court, holding or otherwise determining, under Section 20.02 of this subchapter, that all or any part of an amendment to this Act is constitutional or unconstitutional, or otherwise valid or invalid, under the state or federal constitution is an accelerated appeal.

(b) If the judgment or order is interlocutory, an interlocutory appeal may be taken from the judgment or order and is an accelerated appeal.

Sec. 20.04. INJUNCTIONS. A district court in Travis County may grant or deny a temporary or otherwise interlocutory injunction or a permanent injunction on the grounds of the constitutionality or unconstitutionality, or other validity or invalidity, under the state or federal constitution of all or any part of an amendment to this Act.

Sec. 20.05. DIRECT APPEAL. (a) There is a direct appeal to the supreme court from an order, however characterized, of a trial court granting or denying a temporary or otherwise interlocutory injunction or a permanent injunction on the grounds of the constitutionality or unconstitutionality, or other validity or invalidity, under the state or federal constitution of all or any part of any amendment to this Act.

(b) The direct appeal is an accelerated appeal.

(c) This section exercises the authority granted by Section

3-b, Article V, Texas Constitution.

Sec. 20.06. STANDING OF AN ASSOCIATION OR ALLIANCE TO SUE. (a) An association or alliance has standing to sue for and obtain the relief described by Subsection (b) of this section if it is alleged that:

(1) the association or alliance has more than one member who has standing to sue in the member's own right;

(2) the interests the association or alliance seeks to protect are germane to a purpose of the association or alliance; and

(3) the claim asserted and declaratory relief requested by the association or alliance relate to all or a specified part of the amendment involved in the action being found constitutional or unconstitutional on its face, or otherwise found valid or invalid on its face, under the state or federal constitution.

(b) The association or alliance has standing:

(1) to sue for and obtain a declaratory judgment under Section 20.02 of this subchapter in an action filed and maintained by the association or alliance;

(2) to appeal or otherwise be a party to an appeal under Section 20.03 of this subchapter;

(3) to sue for and obtain an order under Section 20.04 of this subchapter granting or denying a temporary or otherwise interlocutory injunction or a permanent injunction in an action filed and maintained by the association or alliance; and

(4) to appeal or otherwise be a party to an appeal under Section 20.05 of this subchapter.

Sec. 20.07. RULES FOR APPEALS. An appeal under this subchapter, including an interlocutory, accelerated, or direct appeal, is governed, as applicable, by the Texas Rules of Appellate Procedure, including Rules 25.1(d)(6), 26.1(b), 28.1, 28.3, 32.1(g), 37.3(a)(1), 38.6(a) and (b), 40.1(b), and 49.4.

SECTION 10.22. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (6) to read as follows:

(6) "Hospital system" means a system of hospitals located in this state that are under the common governance or control of a corporate parent.

SECTION 10.23. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (7) to read as follows:

(7) "Person responsible for the patient" means:

(A) the patient's parent, managing conservator, or guardian;

(B) the patient's grandparent;

(C) the patient's adult brother or sister;

(D) another adult who has actual care, control, and possession of the patient and has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient;

(E) an educational institution in which the patient is enrolled that has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient; or

(F) any other person with legal responsibility for the care of the patient.

SECTION 10.24. Section 84.004, Civil Practice and Remedies Code, is amended by adding Subsection (f) to read as follows:

(f) Subsection (c) applies even if:

(1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or

(2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

SECTION 10.25. Chapter 84, Civil Practice and Remedies Code, is amended by adding Section 84.0065 to read as follows:

Sec. 84.0065. ORGANIZATION LIABILITY OF HOSPITALS. (a) Except as provided by Section 84.007, in any civil action brought against a hospital or hospital system, or its employees, officers, directors, or volunteers, for damages based on an act or omission by the hospital or hospital system, or its employees, officers, directors, or volunteers, the liability of the hospital or hospital system is limited to money damages in a maximum amount of $500,000 for any act or omission resulting in death, damage, or injury to a patient if the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient, signs a written statement that acknowledges:

(1) that the hospital is providing care that is not administered for or in expectation of compensation; and

(2) the limitations on the recovery of damages from the hospital in exchange for receiving the health care services.

(b) Subsection (a) applies even if:

(1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or

(2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

SECTION 10.26. Article 5.15-1, Insurance Code, is amended by adding Section 11 to read as follows:

Sec. 11. VENDOR'S ENDORSEMENT. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer, as that term is defined by Section 82.001, Civil Practice and Remedies Code. A physician or health care provider shall be considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy.

SECTION 10.27. The following provisions are repealed:

(1) Section 11.02(c), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes);

(2) Sections 13.01(c), (d), (e), (f), (g), (h), (m), (n), (o), and (r)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes);

(3) Section 16.02(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes); and

(4) Section 242.0372, Health and Safety Code.

SECTION 10.28. (a) The Legislature of the State of Texas finds that:

(1) the number of health care liability claims (frequency) has increased since 1995 inordinately;

(2) the filing of legitimate health care liability claims in Texas is a contributing factor affecting medical professional liability rates;

(3) the amounts being paid out by insurers in judgments and settlements (severity) have likewise increased inordinately in the same short period of time;

(4) the effect of the above has caused a serious public problem in availability of and affordability of adequate medical professional liability insurance;

(5) the situation has created a medical malpractice insurance crisis in Texas;

(6) this crisis has had a material adverse effect on the delivery of medical and health care in Texas, including significant reductions of availability of medical and health care services to the people of Texas and a likelihood of further reductions in the future;

(7) the crisis has had a substantial impact on the physicians and hospitals of Texas and the cost to physicians and hospitals for adequate medical malpractice insurance has dramatically risen in price, with cost impact on patients and the public;

(8) the direct cost of medical care to the patient and

public of Texas has materially increased due to the rising cost of malpractice insurance protection for physicians and hospitals in Texas;

(9) the crisis has increased the cost of medical care both directly through fees and indirectly through additional services provided for protection against future suits or claims, and defensive medicine has resulted in increasing cost to patients, private insurers, and Texas and has contributed to the general inflation that has marked health care in recent years;

(10) satisfactory insurance coverage for adequate amounts of insurance in this area is often not available at any price;

(11) the combined effect of the defects in the medical, insurance, and legal systems has caused a serious public problem both with respect to the availability of coverage and to the high rates being charged by insurers for medical professional liability insurance to some physicians, health care providers, and hospitals; and

(12) the adoption of certain modifications in the medical, insurance, and legal systems, the total effect of which is currently undetermined, will have a positive effect on the rates charged by insurers for medical professional liability insurance.

(b) Because of the conditions stated in Subsection (a) of this section, it is the purpose of this article to improve and modify the system by which health care liability claims are determined in order to:

(1) reduce excessive frequency and severity of health

care liability claims through reasonable improvements and modifications in the Texas insurance, tort, and medical practice systems;

(2) decrease the cost of those claims and ensure that awards are rationally related to actual damages;

(3) do so in a manner that will not unduly restrict a claimant's rights any more than necessary to deal with the crisis;

(4) make available to physicians, hospitals, and other health care providers protection against potential liability through the insurance mechanism at reasonably affordable rates;

(5) make affordable medical and health care more accessible and available to the citizens of Texas;

(6) make certain modifications in the medical, insurance, and legal systems in order to determine whether or not there will be an effect on rates charged by insurers for medical professional liability insurance;

(7) make certain modifications to the liability laws as they relate to health care liability claims only and with an intention of the legislature to not extend or apply such modifications of liability laws to any other area of the Texas legal system or tort law;

(8) encourage offering services by physicians and hospitals, particularly those involving high risk, that will benefit, in particular, high-cost and low-income groups because lower malpractice insurance rates increase the willingness of physicians and hospitals to provide treatments that carry a relatively high risk of failure but offer the only real prospect of

success for seriously ill patients;

(9) encourage quality of care and discourage defensive medicine;

(10) decrease malpractice insurance premiums, which are a significant part of overall health care cost, and, as the cost savings are reflected in health insurance premiums, make health insurance benefit programs more affordable to businesses, particularly small businesses, and increase employee participation in health insurance programs offered by their employers;

(11) discourage unnecessary services and encourage fewer tests, procedures, and visits so that the direct financial cost to the patient will be reduced as well as time, travel, and other indirect costs;

(12) support health care insurance for employers and employees because malpractice insurance is a component of the overhead costs that providers must take into account in negotiating reimbursement rates with commercial insurers and employers that pay all or a portion of the premiums for their employees will save money and may make the difference in whether an employer can afford to maintain current health insurance benefits for its employees;

(13) reduce the time required for plaintiffs to obtain awards;

(14) reduce malpractice pressure and, as a result, increase the supply of physicians, especially obstetricians and other impacted specialists;

(15) contribute to the viability of community hospitals by lowering malpractice insurance premiums;

(16) free funds in the operating budgets of self-insured hospitals, allowing the hospital to treat more patients;

(17) reduce or eliminate the incentive for physicians to go without insurance;

(18) lower costs for teaching and safety-net hospitals as well as nonprofit community clinics;

(19) decrease the costs for health care facilities that self-insure; and

(20) allow the Texas Medicaid program to save resources that can be used to provide additional health care goods and services.

SECTION 10.29. (a) Subchapter S, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as added by this article, applies only to an attorney's fee agreement or contract that is entered into on or after January 1, 2004. An attorney's fee agreement or contract entered into before January 1, 2004, is governed by the law in effect immediately before the effective date of this article, and that law is continued in effect for that purpose.

(b) This article does not make any change in law with respect to the adjustment under Section 11.04, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), of the liability limit prescribed in Section 11.02(a) of that Act, and that law is continued in effect only for that liability limit.

ARTICLE 10A. RATES FOR PROFESSIONAL LIABILITY INSURANCE FOR

PHYSICIANS AND HEALTH CARE PROVIDERS

SECTION 10A.01. Chapter 5, Insurance Code, is amended by adding Subchapter R to read as follows:

SUBCHAPTER R. RATES FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

Art. 5.161. FINDINGS. The legislature finds that:

(1) the cost of professional liability insurance for physicians and health care providers, as defined by Section 1.03(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), has been a significant factor in the reduced availability of health care in this state;

(2) legislation under consideration by the Regular Session of the 78th Legislature should eliminate or significantly reduce the cost of claims under policies of professional liability insurance for physicians and health care providers, and legislation by future legislatures may have the same effect;

(3) while the monetary effect of these legislative changes can be actuarially determined within a reasonable degree of certainty, insurers will delay implementation of rate reductions until they have data evidencing actual loss experience;

(4) delay in implementation of rate reductions will result in a windfall for the insurers benefited by the changes described by this article, and this benefit should be passed on to insureds; and

(5) legislative action in the public interest and within the police power of the state is required to eliminate

unnecessary delays to pass these benefits on to the insured physicians and health care providers of this state.

Art. 5.162. SCOPE OF SUBCHAPTER. (a) This subchapter applies to any insurer that is authorized to engage in business in this state and that is authorized to write professional liability insurance for physicians and health care providers, including:

(1) a Lloyd's plan;

(2) a reciprocal or interinsurance exchange;

(3) the joint underwriting association established under Article 21.49-3 of this code; and

(4) a self-insurance trust established under Article 21.49-4 of this code.

(b) It is the intent of the legislature that all insurers, as defined by this article, pass through the savings that accrue from the changes described by Article 5.161 of this code to their policyholders on a prospective basis. To monitor compliance with this legislative directive, the commissioner may require information in rate filings, special data calls, informational hearings, and any other means consistent with other provisions of this code applicable to the affected insurers. Information provided under this subsection is privileged and confidential to the same extent as the information is privileged and confidential under this code or other laws for other insurers described by this article licensed and writing the same line of insurance in this state.

(c) This subchapter applies only to professional liability insurance for physicians and health care providers.

Art. 5.163. EQUITABLE RATE REDUCTION

Sec. 1. HEARING. (a) Not later than September 1 of each year, the commissioner shall hold a rulemaking hearing under Chapter 2001, Government Code, to determine the percentage of equitable reductions in insurance rates required on an individual basis of each insurer writing professional liability insurance for physicians and health care providers.

(b) Not later than October 1 of each year, the commissioner shall issue rules mandating the appropriate rate reductions to rates for professional liability insurance for physicians and health care providers and developed without consideration of the effect of the changes described by Article 5.161 of this code.

(c) The commissioner shall set the percentage of the rate reduction for professional liability insurance for physicians and health care providers and may set different rate reductions for different types of policies. The commissioner's order establishing the rate reductions must be based on the evidence adduced at the rulemaking hearing, including the adequacy of the rate at the time of the hearing. Rates resulting from the rate reductions imposed by this article must comply with Section 3(d), Article 5.15-1, of this code.

(d) The rate reductions adopted under this section are applicable to each policy or coverage delivered, issued for delivery, or renewed on and after January 1, 2004, and to each policy or coverage delivered, issued for delivery, or renewed on and after the 90th day after the date of each subsequent rule adopted under this section. An insurer, as defined by Article 5.162

of this code, shall apply the rate reduction to the rates used by the insurer.

(e) Any rule or order of the commissioner that determines, approves, or sets a rate reduction under this section and is appealed or challenged remains in effect during the pendency of the appeal or challenge. During the pendency of the appeal or challenge, an insurer shall use rates that reflect the rate reduction provided in the order being appealed or challenged. The rate reduction is lawful and valid during the appeal or challenge.

Sec. 2. ADMINISTRATIVE RELIEF. (a) Except as provided by Subsection (b) of this section, a rate filed under Articles 5.13-2 and 5.15-1 of this code for professional liability insurance for physicians and health care providers on and after January 1, 2004, and a rate filed under those articles on and after the 90th day following the effective date of a subsequent rule adopted under Section 1(b) of this article, shall reflect each rate reduction imposed under Section 1 of this article.

(b) Notwithstanding Articles 5.13-2 and 5.15-1 of this code, the commissioner shall, after notice and opportunity for hearing, disapprove a filed rate, without regard to whether the rate complies with Articles 5.13-2 and 5.15-1 of this code, if the commissioner finds that the filed rate does not reflect the rate reduction imposed under Section 1 of this article. A proceeding under this section is a contested case under Chapter 2001, Government Code.

(c) The commissioner may approve a filed rate that reflects less than the full amount of the rate reduction imposed by Section 1

of this article if the commissioner determines based on a preponderance of the evidence presented by an insurer that:

(1) the actual or anticipated loss experience for the insurer's rating classifications is or will be different than the presumptive rate reduction;

(2) the insurer will be financially unable to continue writing in a particular line of insurance;

(3) the rate reduction required under this article would likely result in placing the insurer in a hazardous financial condition described by Section 2, Article 1.32, of this code; or

(4) the resulting rates for the insurer would be unreasonable or confiscatory to the insurer.

Sec. 3. DURATION OF REDUCTION. Unless the commissioner grants relief under Section 2 of this article, each rate reduction required under Section 1 of this article remains in effect for the period specified in the commissioner's rule or order.

Sec. 4. MODIFICATION. The commissioner may, by bulletin or directive, based on the evidence accumulated by the commissioner before the bulletin or directive is issued, modify a rate reduction mandated by the commissioner under this article if a final, unappealable judgment of a court with appropriate jurisdiction stays the effect of, enjoins, or otherwise modifies or declares unconstitutional any legislation described by Article 5.161 of this code on which the commissioner based the rate reduction.

Sec. 5. HEARINGS AND ORDERS. Notwithstanding Chapter 40 of this code, a rulemaking hearing under this article shall be held before the commissioner or the commissioner's designee. The

rulemaking procedures established by this section do not apply to any other rate promulgation proceeding.

Sec. 6. PENDING RATE MATTERS. A rate filed pursuant to a commissioner's order issued before May 1, 2003, is not subject to the rate reductions required by this article before January 1, 2004.

Sec. 7. RECOMMENDATIONS TO LEGISLATURE. The commissioner shall assemble information, conduct hearings, and take other appropriate measures to assess and evaluate changes in the marketplace resulting from the implementation of this article and to report findings and recommendations to the legislature.

Art. 5.164. CONTINGENT ROLLBACK. (a) If a $250,000 cap on noneconomic damages in all health care liability claims, without exception, becomes constitutional by voter approval of an amendment to the Texas Constitution or is determined to be constitutional by the supreme court, an insurer, as defined by Article 5.162 of this code, that delivers, issues for delivery, or renews a policy of professional liability insurance for physicians or health care providers in this state on or after the 30th day after the effective date of the constitutional amendment or the date the cap was determined to be constitutional may not charge more for the policy than 85 percent of the amount the insurer charged that insured for the same coverage immediately before the effective date of the constitutional amendment or the date that the cap was determined to be constitutional, or, if the insurer did not insure that insured immediately before that date, 85 percent of the amount the insurer would have charged that insured, provided that the rate was

adequate and not artificially inflated prior to the determination of constitutionality. An insurer may petition the commissioner for an exception to the rate reduction. A proceeding under this article is a contested case under Chapter 2001, Government Code. The commissioner shall not grant the exception unless the insurer proves by a preponderance of the evidence that the rate reduction is confiscatory. If the insurer meets this evidentiary burden, the commissioner may grant the exception only to the extent that the reduction is confiscatory. The contingent rate rollback required by this article does not apply to a policy or coverage delivered, issued for delivery, or renewed for a public hospital in this state.

(b) If the commissioner makes no determination as to a rate reduction in accordance with Section 1, Article 5.163, then an insurer may not charge an insured for professional liability insurance for physicians and health care providers issued or renewed on or after the second anniversary of the 30th day after the effective date of the constitutional amendment containing a $250,000 cap on noneconomic damages in all health care liability claims or the date the cap was determined to be constitutional and before the third anniversary of the 30th day after the effective date of the constitutional amendment or the date the cap was determined to be constitutional an amount that exceeds 80 percent of the amount the insurer charged or would have charged the insured for the same coverage.

(c) If the commissioner makes no determination as to a rate reduction in accordance with Section 1, Article 5.163, then an insurer may not charge an insured for professional liability

insurance for physicians and health care providers issued or renewed on or after the third anniversary of the 30th day after the effective date of the constitutional amendment containing a $250,000 cap on noneconomic damages in all health care liability claims or the date the cap was determined to be constitutional and before the fourth anniversary of the 30th day after the effective date of the constitutional amendment or the date the cap was determined to be constitutional an amount that exceeds 75 percent of the amount the insurer charged or would have charged the insured for the same coverage.

Art. 5.165. FILING OF RATE INFORMATION WITH DEPARTMENT; REPORT TO LEGISLATURE

Sec. 1. PURPOSE. The purpose of this article is to require insurers writing professional liability insurance for physicians and health care providers in this state to annually file with the commissioner of insurance rates and supporting data, including current rates and estimated rates to be charged in the year following the filing date for the purpose of the preparation of a summary report for submission to each legislature and the determination by the commissioner of equitable rate reductions under Article 5.163 of this code. Information submitted under this article must be sufficient for the commissioner to determine the extent of equitable rate reductions under Article 5.163 of this code. The commissioner's report shall contain a review of the rates, presented in a manner that protects the identity of individual insurers:

(1) to inform the legislature as to whether the rates

are just, adequate, and reasonable and not excessive or unfairly discriminatory; and

(2) to assist in the determination of the most effective and efficient regulatory system for professional liability insurance for physicians and health care providers in Texas.

Sec. 2. DEFINITIONS. In this article:

(1) "Insurer" means an insurer described by Article 5.162 of this code.

(2) "Supplementary rating information" means any manual, rating schedule, plan of rules, rating rules, classification systems, territory codes and descriptions, rating plans, and other similar information used by the insurer to determine the applicable premium for an insured. The term includes factors and relativities, such as increased limits factors, classification relativities, deductible relativities, premium discount, and other similar factors and rating plans such as experience, schedule, and retrospective rating.

(3) "Security" or "securities" has the meaning assigned by Section 4, The Securities Act (Article 581-4, Vernon's Texas Civil Statutes).

Sec. 3. RATE INFORMATION. (a) Insurers must file rates for professional liability insurance for physicians and health care providers and supporting information with the commissioner in accordance with the requirements determined by the commissioner under this article.

(b) Filings made by each insurer must be sufficient to

respond to the commissioner's request for information under this article and must provide both current rates and estimated rates for the year following the required filing date of this article based on information reasonably known to the insurer at the time of filing.

(c) The insurer shall file, in a format specified by the commissioner, including an electronic format:

(1) all rates for professional liability insurance for physicians and health care providers, supplementary rating information, underwriting guidelines, reasonable and pertinent supporting information for risks written in the state, and all applicable rating manuals;

(2) actuarial support, including all statistics, data, or other information to support the rates, supplementary rating information, and underwriting guidelines used by the insurer;

(3) the policy fees, service fees, and other fees that are charged under Article 21.35B of this code;

(4) information on the insurer's losses from investments in securities, whether publicly or privately traded, including investments in the securities of companies required by any oversight agency to restate earnings within the 24 months preceding the filing date, possessed and used by the insurer to determine premiums or underwriting for professional liability insurance for physicians and health care providers, as this information relates to the rates described by Section 1 of this article;

(5) information on the insurer's costs of reinsurance

possessed and used by the insurer to determine premiums or underwriting for professional liability insurance for physicians and health care providers, as this information relates to the rates described by Section 1 of this article;

(6) a complete explanation, and an electronic copy, of all computer models used by the insurer not protected by a contract with a third party; and

(7) a complete explanation of any changes to underwriting guidelines, rates, and supplementary rating information since the last filing under this article.

(d) The commissioner shall determine the date on which the filing is due.

(e) The commissioner may require additional information as provided by Section 4 of this article.

(f) The commissioner shall issue an order specifying the information that insurers must file to comply with this article and the date on which the filing is due.

(g) The commissioner is not required to hold a hearing before issuing the order required under Subsection (f) of this section.

(h) The commissioner shall notify an affected insurer of the order requiring the rate filing information under this section on the day the order is issued.

Sec. 4. ADDITIONAL INFORMATION. After the initial rate submission under Section 3 of this article, the commissioner may require an insurer to provide additional, reasonable information for purposes of the clarification or completeness of the initial

rate submission.

Sec. 5. USE OF FILED RATE INFORMATION. (a) Information filed by an insurer with the department under this article that is confidential under a law that applied to the insurer before the effective date of this article remains confidential and is not subject to disclosure under Chapter 552, Government Code, except that the information may be disclosed as provided by Section 552.008, Government Code, relating to information for legislative purposes. Information disclosed pursuant to Section 552.008, Government Code, shall be provided in a commonly used electronic format, including in spreadsheet or comma-delimited format, if so requested. The information may not be released to the public except in summary form in the report required under Section 6 of this article.

(b) Subsection (a) of this section does not preclude the use of information filed under this article as evidence in prosecuting a violation of this code. Confidential information described by Subsection (a) of this section that is used in prosecuting a violation is subject to a protective order until all appeals of the case have been exhausted. If an insurer is found, after the exhaustion of all appeals, to have violated this code, a copy of the confidential information used as evidence of the violation is no longer presumed to be confidential.

Sec. 6. REPORT. (a) The commissioner shall, on a date determined by the commissioner, submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature on the

information collected from the filings required under this article. The report may be created based on a sample of the information provided under Section 3 of this article.

(b) The report required under this section shall provide a summary review of the rates currently charged and estimated to be charged over the year following the date of the report, presented in a manner that protects the identity of individual insurers:

(1) to inform the legislature as to whether the rates are just, adequate, and reasonable and not excessive or unfairly discriminatory; and

(2) to assist the legislature in the determination of the most effective and efficient regulatory system for professional liability insurance for physicians and health care providers in this state.

Sec. 7. NOTIFICATION; NONCOMPLIANCE. The commissioner shall notify the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature of the names of the insurers that the commissioner requested to make the rate filings under this article and the names of the insurers that did not respond in whole or in part to the commissioner's request. This notification shall be made by separate letter on the fourth day following the date on which the commissioner determines the filing is due under Section 3(f) of this article.

Sec. 8. APPLICATION OF CERTAIN LAW. Chapter 40 of this code does not apply to an action of the commissioner under Section 3(f) of this article.

Sec. 9. FAILURE TO COMPLY. An insurer that fails to comply

with any request for information issued by the commissioner under this article is subject, after notice and opportunity for hearing, to sanctions as provided by Chapters 82 and 84 of this code.

SECTION 10A.02. The commissioner of insurance shall commence a hearing under Section 1, Article 5.163, Insurance Code, as added by this article, on September 1, 2003, and shall issue rules mandating any appropriate rate reductions under Section 1, Article 5.163, Insurance Code, not later than October 1, 2003.

ARTICLE 11. CLAIMS AGAINST EMPLOYEES OR VOLUNTEERS OF A GOVERNMENTAL UNIT

SECTION 11.01. Sections 108.002(a) and (b), Civil Practice and Remedies Code, are amended to read as follows:

(a) Except in an action arising under the constitution or laws of the United States, a public servant[~~, other than a provider of health care as that term is defined in Section 108.002(c),~~] is not personally liable for damages in excess of $100,000 arising from personal injury, death, or deprivation of a right, privilege, or immunity if:

(1) the damages are the result of an act or omission by the public servant in the course and scope of the public servant's office, employment, or contractual performance for or service on behalf of a state agency, institution, department, or local government; and

(2) for the amount not in excess of $100,000, the public servant is covered:

(A) by the state's obligation to indemnify under Chapter 104;

FILE COMMITTEE
78th-'03

By: Nixon, et al. (Senate Sponsor - Ratliff) H.B. No. 4

(In the Senate - Received from the House March 31, 2003; March 31, 2003, read first time and referred to Committee on State Affairs; May 14, 2003, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; May 14, 2003, sent to printer.)

COMMITTEE SUBSTITUTE FOR H.B. No. 4 By: Ratliff

A BILL TO BE ENTITLED
AN ACT

relating to reform of certain procedures and remedies in civil actions.

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

ARTICLE 1. CLASS ACTIONS

SECTION 1.01. Subtitle B, Title 2, Civil Practice and Remedies Code, is amended by adding Chapter 26 to read as follows:

CHAPTER 26. CLASS ACTIONS

SUBCHAPTER A. SUPREME COURT RULES

Sec. 26.001. ADOPTION OF RULES BY SUPREME COURT. (a) The supreme court shall adopt rules to provide for the fair and efficient resolution of class actions.

(b) The supreme court shall adopt rules under this chapter on or before December 31, 2003.

Sec. 26.002. MANDATORY GUIDELINES. Rules adopted under Section 26.001 must comply with the mandatory guidelines established by this chapter.

Sec. 26.003. ATTORNEY'S FEES. (a) If an award of attorney's fees is available under applicable substantive law, the rules adopted under this chapter must provide that the trial court shall use the Lodestar method to calculate the amount of attorney's fees to be awarded class counsel. The rules may give the trial court discretion to increase or decrease the fee award calculated by using the Lodestar method by no more than four times based on specified factors.

(b) Rules adopted under this chapter must provide that in a class action, if any portion of the benefits recovered for the class are in the form of coupons or other noncash common benefits, the attorney's fees awarded in the action must be in cash and noncash amounts in the same proportion as the recovery for the class.

[Sections 26.004-26.050 reserved for expansion]

SUBCHAPTER B. CLASS ACTIONS INVOLVING JURISDICTION OF STATE AGENCY

Sec. 26.051. STATE AGENCY WITH EXCLUSIVE OR PRIMARY JURISDICTION. (a) Before hearing or deciding a motion to certify a class action, a trial court must hear and rule on all pending pleas to the jurisdiction asserting that an agency of this state has exclusive or primary jurisdiction of the action or a part of the action, or asserting that a party has failed to exhaust administrative remedies. The court's ruling must be reflected in a written order.

(b) If a plea to the jurisdiction described by Subsection (a) is denied and a class is subsequently certified, a person may, as part of an appeal of the order certifying the class action, obtain appellate review of the order denying the plea to the jurisdiction.

(c) This section does not alter or abrogate a person's right to appeal or pursue an original proceeding in an appellate court in regard to a trial court's order granting or denying a plea to the jurisdiction if the right exists under statutory or common law in effect at the time review is sought.

SECTION 1.02. Section 22.225, Government Code, is amended by amending Subsections (b) and (d) and adding Subsection (e) to read as follows:

(b) Except as provided by Subsection (c) or (d), a judgment of a court of appeals is conclusive on the law and facts, and a

use, transfer, conveyance, or dissipation of assets in the normal course of business.

SECTION 7.03. The following sections of the Civil Practice and Remedies Code are repealed:

(1) 52.002;

(2) 52.003; and

(3) 52.004.

SECTION 7.04. (a) The changes in law made in Section 7.01 of this article apply to any judgment filed in this state under Chapter 35, Civil Practice and Remedies Code, on or after the effective date of this Act.

(b) The changes in law made in Sections 7.02 and 7.03 of this article apply to any case in which a final judgment is signed on or after the effective date of this Act.

ARTICLE 8. EVIDENCE RELATING TO SEAT BELTS

SECTION 8.01. Sections 545.412(d) and 545.413(g), Transportation Code, are repealed.

ARTICLE 9. RESERVED

ARTICLE 10. HEALTH CARE

SECTION 10.01. Chapter 74, Civil Practice and Remedies Code, is amended to read as follows:

CHAPTER 74. MEDICAL LIABILITY [~~GOOD SAMARITAN LAW: LIABILITY FOR EMERGENCY CARE~~]

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 74.001. DEFINITIONS. (a) In this chapter:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified person, including any direct or indirect parent or subsidiary.

(2) "Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(3) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the person, whether through ownership of equity or securities, by contract, or otherwise.

(4) "Court" means any federal or state court.

(5) "Disclosure panel" means the Texas Medical Disclosure Panel.

(6) "Economic damages" has the meaning assigned by Section 41.001.

(7) "Emergency medical care" means bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency.

(8) "Emergency medical services provider" means a licensed public or private provider to which Chapter 773, Health and Safety Code, applies.

(9) "Gross negligence" has the meaning assigned by Section 41.001.

(10) "Health care" means any act or treatment performed or furnished, or that should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(11) "Health care institution" includes:

(A) an ambulatory surgical center;

(B) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(C) an emergency medical services provider;

(D) a home and community support services agency;
(E) a hospice;
(F) a hospital;
(G) a hospital system;
(H) an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended;
(I) a nursing home; or
(J) an end stage renal disease facility licensed under Section 251.011, Health and Safety Code.

(12)(A) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including:
(i) a registered nurse;
(ii) a dentist;
(iii) a podiatrist;
(iv) a pharmacist;
(v) a chiropractor;
(vii) an optometrist; or
(viii) a health care institution.

(B) The term includes:
(i) an officer, director, shareholder, member, partner, manager, owner, or affiliate of a health care provider or physician; and
(ii) an employee, independent contractor, or agent of a health care provider or physician acting in the course and scope of the employment or contractual relationship.

(13) "Health care liability claim" means a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, health care, or safety which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.

(14) "Home and community support services agency" means a licensed public or provider agency to which Chapter 142, Health and Safety Code, applies.

(15) "Hospice" means a hospice facility or activity to which Chapter 142, Health and Safety Code, applies.

(16) "Hospital" means a licensed public or private institution as defined in Chapter 241, Health and Safety Code, or licensed under Chapter 577, Health and Safety Code.

(17) "Hospital system" means a system of hospitals located in this state that are under the common governance or control of a corporate parent.

(18) "Intermediate care facility for the mentally retarded" means a licensed public or private institution to which Chapter 252, Health and Safety Code, applies.

(19) "Medical care" means any act defined as practicing medicine under Section 151.002, Occupations Code, performed or furnished, or which should have been performed, by one licensed to practice medicine in this state for, to, or on behalf of a patient during the patient's care, treatment, or confinement.

(20) "Noneconomic damages" has the meaning assigned by Section 41.001.

(21) "Nursing home" means a licensed public or private institution to which Chapter 242, Health and Safety Code, applies.

(22) "Pharmacist" means one licensed under Chapter 551, Occupations Code, who, for the purposes of this chapter, performs those activities limited to the dispensing of prescription medicines which result in health care liability claims and does not include any other cause of action that may exist at common law against them, including but not limited to causes of action for the sale of mishandled or defective products.

(23) "Physician" means:
(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians;

(C) a partnership or limited liability partnership formed by a group of physicians;

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code; or

(E) a company formed by a group of physicians under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes).

(24) "Professional or administrative services" means those duties or services that a physician or health care provider is required to provide as a condition of maintaining the physician's or health care provider's license, accreditation status, or certification to participate in state or federal health care programs.

(25) "Representative" means the spouse, parent, guardian, trustee, authorized attorney, or other authorized legal agent of the patient or claimant.

(b) Any legal term or word of art used in this chapter, not otherwise defined in this chapter, shall have such meaning as is consistent with the common law.

Sec. 74.002. CONFLICT WITH OTHER LAW AND RULES OF CIVIL PROCEDURE. (a) In the event of a conflict between this chapter and another law, including a rule of procedure or evidence or court rule, this chapter controls to the extent of the conflict.

(b) Notwithstanding Subsection (a), in the event of a conflict between this chapter and Section 101.023, 102.003, or 108.002, those sections of this code control to the extent of the conflict.

(c) The district courts and statutory county courts in a county may not adopt local rules in conflict with this chapter.

Sec. 74.003. SOVEREIGN IMMUNITY NOT WAIVED. This chapter does not waive sovereign immunity from suit or from liability.

Sec. 74.004. EXCEPTION FROM CERTAIN LAWS. (a) Notwithstanding any other law, Sections 17.41-17.63, Business & Commerce Code, do not apply to physicians or health care providers with respect to claims for damages for personal injury or death resulting, or alleged to have resulted, from negligence on the part of any physician or health care provider.

(b) This section does not apply to pharmacists.

[Sections 74.005-74.050 reserved for expansion]

SUBCHAPTER B. NOTICE AND PLEADINGS

Sec. 74.051. NOTICE. (a) Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the filing of a suit in any court of this state based upon a health care liability claim. The notice must be accompanied by the authorization form for release of protected health information as required under Section 74.052.

(b) In such pleadings as are subsequently filed in any court, each party shall state that it has fully complied with the provisions of this section and Section 74.052 and shall provide such evidence thereof as the judge of the court may require to determine if the provisions of this chapter have been met.

(c) Notice given as provided in this chapter shall toll the applicable statute of limitations to and including a period of 75 days following the giving of the notice, and this tolling shall apply to all parties and potential parties.

(d) All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 45 days from the date of receipt of a written request for such records; provided, however, that the receipt of a medical authorization in the form required by Section 74.052 executed by the claimant herein shall be considered compliance by the claimant with this subsection.

(e) For the purposes of this section, and notwithstanding

Chapter 159, Occupations Code, or any other law, a request for the medical records of a deceased person or a person who is incompetent shall be deemed to be valid if accompanied by an authorization in the form required by Section 74.052 signed by a parent, spouse, or adult child of the deceased or incompetent person.

Sec. 74.052. AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION. (a) Notice of a health care claim under Section 74.051 must be accompanied by a medical authorization in the form specified by this section. Failure to provide this authorization along with the notice of health care claim shall abate all further proceedings against the physician or health care provider receiving the notice until 60 days following receipt by the physician or health care provider of the required authorization.

(b) If the authorization required by this section is modified or revoked, the physician or health care provider to whom the authorization has been given shall have the option to abate all further proceedings until 60 days following receipt of a replacement authorization that must comply with the form specified by this section.

(c) The medical authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

A. I, _____(name of patient or authorized representative), hereby authorize _____(name of physician or other health care provider to whom the notice of health care claim is directed) to obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes:

1. To facilitate the investigation and evaluation of the health care claim described in the accompanying Notice of Health Care Claim; or

2. Defense of any litigation arising out of the claim made the basis of the accompanying Notice of Health Care Claim.

B. The health information to be obtained, used, or disclosed extends to and includes the verbal as well as the written and is specifically described as follows:

1. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____(patient) in connection with the injuries alleged to have been sustained in connection with the claim asserted in the accompanying Notice of Health Care Claim. (Here list the name and current address of all treating physicians or health care providers). This authorization shall extend to any additional physicians or health care providers that may in the future evaluate, examine, or treat _____(patient) for injuries alleged in connection with the claim made the basis of the attached Notice of Health Care Claim;

2. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____(patient) during a period commencing five years prior to the incident made the basis of the accompanying Notice of Health Care Claim. (Here list the name and current address of such physicians or health care providers, if applicable.)

C. Excluded Health Information - the following constitutes a list of physicians or health care providers possessing health care information concerning _____(patient) to which this authorization does not apply because I contend that such health care information is not relevant to the damages being claimed or to the physical, mental, or emotional condition of _____(patient) arising out of the claim made the basis of the accompanying Notice of Health Care Claim. (Here state "none" or list the name of each physician or health care provider to whom this authorization does not extend and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure.)

D. The persons or class of persons to whom the health

information of _____ (patient) will be disclosed or who will make use of said information are:

1. Any and all physicians or health care providers providing care or treatment to _____ (patient);

2. Any liability insurance entity providing liability insurance coverage or defense to any physician or health care provider to whom Notice of Health Care Claim has been given with regard to the care and treatment of _____ (patient);

3. Any consulting or testifying experts employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

4. Any attorneys (including secretarial, clerical, or paralegal staff) employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of _____ (patient).

E. This authorization shall expire upon resolution of the claim asserted or at the conclusion of any litigation instituted in connection with the subject matter of the Notice of Health Care Claim accompanying this authorization, whichever occurs sooner.

F. I understand that, without exception, I have the right to revoke this authorization in writing. I further understand the consequence of any such revocation as set out in Section 74.052, Civil Practice and Remedies Code.

G. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

H. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Signature of Patient/Representative

_____

Date

_____

Name of Patient/ Representative

_____

Description of Representative's Authority

_____

Sec. 74.053. PLEADINGS NOT TO STATE DAMAGE AMOUNT; SPECIAL EXCEPTION; EXCLUSION FROM SECTION. Pleadings in a suit based on a health care liability claim shall not specify an amount of money claimed as damages. The defendant may file a special exception to the pleadings on the ground the suit is not within the court's jurisdiction, in which event the plaintiff shall inform the court and defendant in writing of the total dollar amount claimed. This section does not prevent a party from mentioning the total dollar amount claimed in examining prospective jurors on voir dire or in argument to the court or jury.

[Sections 74.054-74.100 reserved for expansion]

SUBCHAPTER C. INFORMED CONSENT

Sec. 74.101. THEORY OF RECOVERY. In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.

Sec. 74.102. TEXAS MEDICAL DISCLOSURE PANEL. (a) The Texas Medical Disclosure Panel is created to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients

or persons authorized to consent for their patients and to establish the general form and substance of such disclosure.

(b) The disclosure panel established herein is administratively attached to the Texas Department of Health. The Texas Department of Health, at the request of the disclosure panel, shall provide administrative assistance to the panel; and the Texas Department of Health and the disclosure panel shall coordinate administrative responsibilities in order to avoid unnecessary duplication of facilities and services. The Texas Department of Health, at the request of the panel, shall submit the panel's budget request to the legislature. The panel shall be subject, except where inconsistent, to the rules and procedures of the Texas Department of Health; however, the duties and responsibilities of the panel as set forth in this chapter shall be exercised solely by the disclosure panel, and the board or Texas Department of Health shall have no authority or responsibility with respect to same.

(c) The disclosure panel is composed of nine members, with three members licensed to practice law in this state and six members licensed to practice medicine in this state. Members of the disclosure panel shall be selected by the commissioner of health.

(d) At the expiration of the term of each member of the disclosure panel so appointed, the commissioner shall select a successor, and such successor shall serve for a term of six years, or until his successor is selected. Any member who is absent for three consecutive meetings without the consent of a majority of the disclosure panel present at each such meeting may be removed by the commissioner at the request of the disclosure panel submitted in writing and signed by the chairman. Upon the death, resignation, or removal of any member, the commissioner shall fill the vacancy by selection for the unexpired portion of the term.

(e) Members of the disclosure panel are not entitled to compensation for their services, but each panelist is entitled to reimbursement of any necessary expense incurred in the performance of his duties on the panel, including necessary travel expenses.

(f) Meetings of the panel shall be held at the call of the chairman or on petition of at least three members of the panel.

(g) At the first meeting of the panel each year after its members assume their positions, the panelists shall select one of the panel members to serve as chairman and one of the panel members to serve as vice chairman, and each such officer shall serve for a term of one year. The chairman shall preside at meetings of the panel, and in his absence, the vice chairman shall preside.

(h) Employees of the Texas Department of Health shall serve as the staff for the panel.

Sec. 74.103. DUTIES OF DISCLOSURE PANEL. (a) To the extent feasible, the panel shall identify and make a thorough examination of all medical treatments and surgical procedures in which physicians and health care providers may be involved in order to determine which of those treatments and procedures do and do not require disclosure of the risks and hazards to the patient or person authorized to consent for the patient.

(b) The panel shall prepare separate lists of those medical treatments and surgical procedures that do and do not require disclosure and, for those treatments and procedures that do require disclosure, shall establish the degree of disclosure required and the form in which the disclosure will be made.

(c) Lists prepared under Subsection (b) together with written explanations of the degree and form of disclosure shall be published in the Texas Register.

(d) At least annually, or at such other period the panel may determine from time to time, the panel will identify and examine any new medical treatments and surgical procedures that have been developed since its last determinations, shall assign them to the proper list, and shall establish the degree of disclosure required and the form in which the disclosure will be made. The panel will also examine such treatments and procedures for the purpose of revising lists previously published. These determinations shall be published in the Texas Register.

Sec. 74.104. DUTY OF PHYSICIAN OR HEALTH CARE PROVIDER.

Before a patient or a person authorized to consent for a patient gives consent to any medical care or surgical procedure that appears on the disclosure panel's list requiring disclosure, the physician or health care provider shall disclose to the patient or person authorized to consent for the patient the risks and hazards involved in that kind of care or procedure. A physician or health care provider shall be considered to have complied with the requirements of this section if disclosure is made as provided in Section 74.105.

Sec. 74.105. MANNER OF DISCLOSURE. Consent to medical care that appears on the disclosure panel's list requiring disclosure shall be considered effective under this chapter if it is given in writing, signed by the patient or a person authorized to give the consent and by a competent witness, and if the written consent specifically states the risks and hazards that are involved in the medical care or surgical procedure in the form and to the degree required by the disclosure panel under Section 74.103.

Sec. 74.106. EFFECT OF DISCLOSURE. (a) In a suit against a physician or health care provider involving a health care liability claim that is based on the negligent failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider:

(1) both disclosure made as provided in Section 74.104 and failure to disclose based on inclusion of any medical care or surgical procedure on the panel's list for which disclosure is not required shall be admissible in evidence and shall create a rebuttable presumption that the requirements of Sections 74.104 and 74.105 have been complied with and this presumption shall be included in the charge to the jury; and

(2) failure to disclose the risks and hazards involved in any medical care or surgical procedure required to be disclosed under Sections 74.104 and 74.105 shall be admissible in evidence and shall create a rebuttable presumption of a negligent failure to conform to the duty of disclosure set forth in Sections 74.104 and 74.105, and this presumption shall be included in the charge to the jury; but failure to disclose may be found not to be negligent if there was an emergency or if for some other reason it was not medically feasible to make a disclosure of the kind that would otherwise have been negligence.

(b) If medical care or surgical procedure is rendered with respect to which the disclosure panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law.

Sec. 74.107. INFORMED CONSENT FOR HYSTERECTOMIES. (a) The disclosure panel shall develop and prepare written materials to inform a patient or person authorized to consent for a patient of the risks and hazards of a hysterectomy.

(b) The materials shall be available in English, Spanish, and any other language the panel considers appropriate. The information must be presented in a manner understandable to a layperson.

(c) The materials must include:

(1) a notice that a decision made at any time to refuse to undergo a hysterectomy will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds or otherwise affect the patient's right to future care or treatment;

(2) the name of the person providing and explaining the materials;

(3) a statement that the patient or person authorized to consent for the patient understands that the hysterectomy is permanent and nonreversible and that the patient will not be able to become pregnant or bear children if she undergoes a hysterectomy;

(4) a statement that the patient has the right to seek a consultation from a second physician;

(5) a statement that the patient or person authorized to consent for the patient has been informed that a hysterectomy is a removal of the uterus through an incision in the lower abdomen or

vagina and that additional surgery may be necessary to remove or repair other organs, including an ovary, tube, appendix, bladder, rectum, or vagina;

(6) a description of the risks and hazards involved in the performance of the procedure; and

(7) a written statement to be signed by the patient or person authorized to consent for the patient indicating that the materials have been provided and explained to the patient or person authorized to consent for the patient and that the patient or person authorized to consent for the patient understands the nature and consequences of a hysterectomy.

(d) The physician or health care provider shall obtain informed consent under this section and Section 74.104 from the patient or person authorized to consent for the patient before performing a hysterectomy unless the hysterectomy is performed in a life-threatening situation in which the physician determines obtaining informed consent is not reasonably possible. If obtaining informed consent is not reasonably possible, the physician or health care provider shall include in the patient's medical records a written statement signed by the physician certifying the nature of the emergency.

(e) The disclosure panel may not prescribe materials under this section without first consulting with the Texas State Board of Medical Examiners.

[Sections 74.108-74.150 reserved for expansion]

SUBCHAPTER D. EMERGENCY CARE

Sec. 74.151. LIABILITY FOR EMERGENCY CARE. (a) A person who in good faith administers emergency care, including using an automated external defibrillator, [~~at the scene of an emergency but not in a hospital or other health care facility or means of medical transport~~] is not liable in civil damages for an act performed during the emergency unless the act is wilfully or wantonly negligent.

(b) This section does not apply to care administered:

(1) for or in expectation of remuneration, provided that being legally entitled to receive remuneration for the emergency care rendered shall not determine whether or not the care was administered for or in anticipation of remuneration; or

(2) by a person who was at the scene of the emergency because he or a person he represents as an agent was soliciting business or seeking to perform a service for remuneration.

(c) This section does not apply to a physician or other health care provider whose day-to-day responsibilities include the administration of care in a hospital emergency room for or in expectation of remuneration if [~~If~~] the scene of an emergency is in a hospital or other health care facility or means of medical transport[~~, a person who in good faith administers emergency care is not liable in civil damages for an act performed during the emergency unless the act is wilfully or wantonly negligent, provided that this subsection does not apply to care administered:~~

[~~(1) by a person who regularly administers care in a hospital emergency room unless such person is at the scene of the emergency for reasons wholly unrelated to the person's work in administering health care; or~~

[~~(2) by an admitting or attending physician of the patient or a treating physician associated by the admitting or attending physician of the patient in question~~].

(d) For purposes of Subsections (b)(1) and (c) [~~(c)(1)~~], a person who would ordinarily receive or be entitled to receive a salary, fee, or other remuneration for administering care under such circumstances to the patient in question shall be deemed to be acting for or in expectation of remuneration even if the person waives or elects not to charge or receive remuneration on the occasion in question.

(e) This section does not apply to a person whose negligent act or omission was a producing cause of the emergency for which care is being administered.

Sec. 74.152 [~~74.002~~]. UNLICENSED MEDICAL PERSONNEL. Persons not licensed or certified in the healing arts who in good

faith administer emergency care as emergency medical service personnel are not liable in civil damages for an act performed in administering the care unless the act is wilfully or wantonly negligent. This section applies without regard to whether the care is provided for or in expectation of remuneration.

Sec. 74.153. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency room or department, the person bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the person shows by a preponderance of the evidence that the physician or health care provider did not use the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.

Sec. 74.154. JURY INSTRUCTIONS IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) In an action for damages that involves a claim of negligence arising from the provision of emergency medical care in a hospital emergency room or department, the court shall instruct the jury to consider, together with all other relevant matters:

(1) whether the person providing care did or did not have the patient's medical history or was able or unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;

(2) the presence or lack of a preexisting physician-patient relationship or health care provider-patient relationship;

(3) the circumstances constituting the emergency; and

(4) the circumstances surrounding the delivery of the emergency medical care.

(b) The provisions of Subsection (a) do not apply to medical care or treatment:

(1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient;

(2) that is unrelated to the original medical emergency; or

(3) that is related to an emergency caused in whole or in part by the negligence of the defendant.

[Sections 74.155-74.200 reserved for expansion]

SUBCHAPTER E. RES IPSA LOQUITUR

Sec. 74.201. APPLICATION OF RES IPSA LOQUITUR. The common law doctrine of res ipsa loquitur shall only apply to health care liability claims against health care providers or physicians in those cases to which it has been applied by the appellate courts of this state as of August 29, 1977.

[Sections 74.202-74.250 reserved for expansion]

SUBCHAPTER F. STATUTE OF LIMITATIONS

Sec. 74.251. STATUTE OF LIMITATIONS ON HEALTH CARE LIABILITY CLAIMS. (a) Notwithstanding any other law and subject to Subsection (b), no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that, minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided this section applies to all persons regardless of minority or other legal disability.

(b) A claimant must bring a health care liability claim not later than 10 years after the date of the act or omission that gives rise to the claim. This subsection is intended as a statute of repose so that all claims must be brought within 10 years or they are time barred.

[Sections 74.252-74.300 reserved for expansion]

SUBCHAPTER G. LIABILITY LIMITS

Sec. 74.301. LIMITATION ON NONECONOMIC DAMAGES. (a) In an action on a health care liability claim where final judgment is

rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages for each defendant physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000.

(b) In an action on a health care liability claim where final judgment is rendered against a health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.

(c) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all noneconomic damages shall be limited to an amount not to exceed $750,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

Sec. 74.302. ALTERNATIVE LIMITATION ON NONECONOMIC DAMAGES. (a) In the event that Section 74.301 is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective:

(1) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages for each defendant physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000.

(2) In an action on a health care liability claim where final judgment is rendered against a health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.

(3) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all noneconomic damages shall be limited to an amount not to exceed $750,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) Effective before September 1, 2005, Subsection (a) applies only to a physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician in training in an approved residency program;

(2) at least $200,000 for each health care liability claim and at least $600,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $500,000 for each health care liability claim and at least $1.5 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(c) Effective September 1, 2005, Subsection (a) applies only to a physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care

liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician in training in an approved residency program;

(2) at least $300,000 for each health care liability claim and at least $900,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $750,000 for each health care liability claim and at least $2.25 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(d) Effective September 1, 2007, Subsection (a) applies only to a physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician in training in an approved residency program;

(2) at least $500,000 for each health care liability claim and at least $1 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $1 million for each health care liability claim and at least $3 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(e) Evidence of financial responsibility may be established at the time of judgment by providing proof of:

(1) the purchase of a contract of insurance or other plan of insurance authorized by this state or federal law or regulation;

(2) the purchase of coverage from a trust organized and operating under Article 21.49-4, Insurance Code;

(3) the purchase of coverage or another plan of insurance provided by or through a risk retention group or purchasing group authorized under applicable laws of this state or under the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as amended, or the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.), as amended, or any other contract or arrangement for transferring and distributing risk relating to legal liability for damages, including cost of defense, legal costs, fees, and other claims expenses; or

(4) the maintenance of financial reserves in or an irrevocable letter of credit from a federally insured financial institution that has its main office or a branch office in this state.

Sec. 74.303. LIMITATION ON DAMAGES. (a) In an action for wrongful death on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for damages of the physician or health care provider shall be limited to an amount not to exceed $500,000.

(b) When there is an increase or decrease in the consumer price index with respect to the amount of that index on August 29, 1977, the liability limit prescribed in Subsection (a) shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index, as published by the Bureau of Labor Statistics of the United States Department of Labor, that measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone (CPI-W: Seasonally Adjusted U.S. City Average -- All Items), between August 29, 1977, and the time at which damages subject to such limits are awarded by final judgment or settlement.

(c) Subsection (a) does not apply to the amount of damages

awarded on a health care liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the injury.

(d) The liability of any insurer under the common law theory of recovery commonly known in Texas as the "Stowers Doctrine" shall not exceed the liability of the insured.

(e) In any action on a health care liability claim that is tried by a jury in any court in this state, the following shall be included in the court's written instructions to the jurors:

(1) "Do not consider, discuss, nor speculate whether or not liability, if any, on the part of any party is or is not subject to any limit under applicable law."

(2) "A finding of negligence may not be based solely on evidence of a bad result to the claimant in question, but a bad result may be considered by you, along with other evidence, in determining the issue of negligence. You are the sole judges of the weight, if any, to be given to this kind of evidence."

[Sections 74.304-74.350 reserved for expansion]

SUBCHAPTER H. PROCEDURAL PROVISIONS

Sec. 74.351. EXPERT REPORT. (a) In a health care liability claim, a claimant shall, not later than the 150th day after the date the claim was filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the report for each physician or health care provider against whom a liability claim is asserted. The date for serving the report may be extended by written agreement of the affected parties. Each defendant physician or health care provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the 21st day after the date it was served, failing which all objections are waived.

(b) If, as to a defendant physician or health care provider, an expert report has not been served within the period specified by Subsection (a), the court, on the motion of the affected physician or health care provider, shall, subject to Subsection (c), enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider; and

(2) dismisses the claim with respect to the physician or health care provider, with prejudice to the refiling of the claim.

(c) If an expert report has not been served within the period specified by Subsection (a) because elements of the report are found deficient, the court may grant a 30-day extension to the claimant in order to cure the deficiency. If the claimant does not receive notice of the court's ruling granting the extension until after the 150-day deadline has passed, then the 30-day extension shall run from the date the plaintiff first received the notice.

(d) If, on the motion of a claimant filed before the expiration of the 150-day period referred to in Subsection (a), the court finds that a claimant has been hindered in complying with Subsection (a) because a defendant physician or health care provider has failed to provide timely and complete discovery permitted under Subsection (s) or (u), the court shall extend the deadline until 30 days after complete discovery has been provided.

[Subsections (e)-(h) reserved]

(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving an expert report by serving reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.

(j) Nothing in this section shall be construed to require the serving of an expert report regarding any issue other than an

issue relating to liability or causation.

(k) Subject to Subsection (t), an expert report served under this section:

(1) is not admissible in evidence by any party;

(2) shall not be used in a deposition, trial, or other proceeding; and

(3) shall not be referred to by any party during the course of the action for any purpose.

(l) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective good faith effort to comply with the definition of an expert report in Subsection (r)(6).

[Subsections (m)-(q) reserved]

(r) In this section:

(1) "Affected parties" means the claimant and the physician or health care provider who are directly affected by an act or agreement required or permitted by this section and does not include other parties to an action who are not directly affected by that particular act or agreement.

(2) "Claim" means a health care liability claim.

[(3) reserved]

(4) "Defendant" means a physician or health care provider against whom a health care liability claim is asserted. The term includes a third-party defendant, cross-defendant, or counterdefendant.

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 74.401;

(B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402;

(C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a dentist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence.

(6) "Expert report" means a written report by an expert that provides a fair summary of the expert's opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed.

(s) Until a claimant has served the expert report and curriculum vitae as required by Subsection (a), all discovery in a health care liability claim is stayed except for the acquisition by the claimant of information, including medical or hospital records or other documents or tangible things, related to the patient's health care or a defendant's liability through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a), the restrictions imposed by Subsection (k) on use of the expert report by any party are waived.

(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than two depositions before the expert report is served as required by Subsection (a). The court may allow additional deposition discovery on a showing by a plaintiff that additional information is needed for the completion of an expert report that cannot otherwise practicably be obtained in a timely manner under this subsection and Subsection (s).

Sec. 74.352. DISCOVERY PROCEDURES. (a) In every health care liability claim the plaintiff shall within 45 days after the date of filing of the original petition serve on the defendant's attorney or, if no attorney has appeared for the defendant, on the defendant full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the appropriate standard set of requests for production of documents and things promulgated by the Health Care Liability Discovery Panel.

(b) Every physician or health care provider who is a defendant in a health care liability claim shall within 45 days after the date on which an answer to the petition was due serve on the plaintiff's attorney or, if the plaintiff is not represented by an attorney, on the plaintiff full and complete answers to the appropriate standard set of interrogatories and complete responses to the standard set of requests for production of documents and things promulgated by the Health Care Liability Discovery Panel.

(c) Except on motion and for good cause shown, no objection may be asserted regarding any standard interrogatory or request for production of documents and things, but no response shall be required where a particular interrogatory or request is clearly inapplicable under the circumstances of the case.

(d) Failure to file full and complete answers and responses to standard interrogatories and requests for production of documents and things in accordance with Subsections (a) and (b) or the making of a groundless objection under Subsection (c) shall be grounds for sanctions by the court in accordance with the Texas Rules of Civil Procedure on motion of any party.

(e) The time limits imposed under Subsections (a) and (b) may be extended by the court on the motion of a responding party for good cause shown and shall be extended if agreed in writing between the responding party and all opposing parties. In no event shall an extension be for a period of more than an additional 30 days.

(f) If a party is added by an amended pleading, intervention, or otherwise, the new party shall file full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the standard set of requests for production of documents and things no later than 45 days after the date of filing of the pleading by which the party first appeared in the action.

(g) If information or documents required to provide full and complete answers and responses as required by this section are not in the possession of the responding party or attorney when the answers or responses are filed, the party shall supplement the answers and responses in accordance with the Texas Rules of Civil Procedure.

(h) Nothing in this section shall preclude any party from taking additional non-duplicative discovery of any other party. The standard sets of interrogatories provided for in this section shall not constitute, as to each plaintiff and each physician or health care provider who is a defendant, the first of the two sets of interrogatories permitted under the Texas Rules of Civil Procedure.

[Sections 74.353-74.400 reserved for expansion]

SUBCHAPTER I. EXPERT WITNESSES

Sec. 74.401. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST PHYSICIAN. (a) In a suit involving a health care liability claim against a physician for injury to or death of a patient, a person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of medical care only if the person is a physician who:

(1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose;

(2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care.

(b) For the purpose of this section, "practicing medicine" or "medical practice" includes, but is not limited to, training residents or students at an accredited school of medicine or osteopathy or serving as a consulting physician to other physicians who provide direct patient care, upon the request of such other physicians.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is board certified or has other substantial training or experience in an area of medical practice relevant to the claim; and

(2) is actively practicing medicine in rendering medical care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) in determining whether an expert is qualified to offer expert testimony on the issue of whether the physician departed from accepted standards of medical care, but may depart from those criteria if, under the circumstances, the court determines that there is a good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

(f) This section does not prevent a physician who is a defendant from qualifying as an expert.

(g) In this subchapter, "physician" means a person who is:

(1) licensed to practice medicine in one or more states in the United States; or

(2) a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association only if testifying as a defendant and that testimony relates to that defendant's standard of care, the alleged departure from that standard of care, or the causal relationship between the alleged departure from that standard of care and the injury, harm, or damages claimed.

Sec. 74.402. QUALIFICATIONS OF EXPERT WITNESS IN SUIT

AGAINST HEALTH CARE PROVIDER. (a) For purposes of this section, "practicing health care" includes:

(1) training health care providers in the same field as the defendant health care provider at an accredited educational institution; or

(2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.

(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person:

(1) is practicing health care in a field of practice that involves the same type of care or treatment as that delivered by the defendant health care provider, if the defendant health care provider is an individual, at the time the testimony is given or was practicing that type of health care at the time the claim arose;

(2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is certified by a licensing agency of one or more states of the United States or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and

(2) is actively practicing health care in rendering health care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) in determining whether an expert is qualified to offer expert testimony on the issue of whether the defendant health care provider departed from accepted standards of health care but may depart from those criteria if, under the circumstances, the court determines that there is good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) This section does not prevent a health care provider who is a defendant, or an employee of the defendant health care provider, from qualifying as an expert.

(f) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

Sec. 74.403. QUALIFICATIONS OF EXPERT WITNESS ON CAUSATION IN HEALTH CARE LIABILITY CLAIM. (a) Except as provided by Subsections (b) and (c), in a suit involving a health care liability claim against a physician or health care provider, a person may qualify as an expert witness on the issue of the causal relationship

between the alleged departure from accepted standards of care and the injury, harm, or damages claimed only if the person is a physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a dentist or physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a podiatrist or physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(d) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

[Sections 74.404-74.450 reserved for expansion]

SUBCHAPTER J. ARBITRATION AGREEMENTS

Sec. 74.451. ARBITRATION AGREEMENTS. (a) No physician, professional association of physicians, or other health care provider shall request or require a patient or prospective patient to execute an agreement to arbitrate a health care liability claim unless the form of agreement delivered to the patient contains a written notice in 10-point boldface type clearly and conspicuously stating:

UNDER TEXAS LAW, THIS AGREEMENT IS INVALID AND OF NO LEGAL EFFECT UNLESS IT IS ALSO SIGNED BY AN ATTORNEY OF YOUR OWN CHOOSING. THIS AGREEMENT CONTAINS A WAIVER OF IMPORTANT LEGAL RIGHTS, INCLUDING YOUR RIGHT TO A JURY. YOU SHOULD NOT SIGN THIS AGREEMENT WITHOUT FIRST CONSULTING WITH AN ATTORNEY.

(b) A violation of this section by a physician or professional association of physicians constitutes a violation of Subtitle B, Title 3, Occupations Code, and shall be subject to the enforcement provisions and sanctions contained in that subtitle.

(c) A violation of this section by a health care provider other than a physician shall constitute a false, misleading, or deceptive act or practice in the conduct of trade or commerce within the meaning of Section 17.46 of the Deceptive Trade Practices-Consumer Protection Act (Subchapter E, Chapter 17, Business & Commerce Code), and shall be subject to an enforcement action by the consumer protection division under that act and subject to the penalties and remedies contained in Section 17.47, Business & Commerce Code, notwithstanding Section 74.004 or any other law.

(d) Notwithstanding any other provision of this section, a person who is found to be in violation of this section for the first time shall be subject only to injunctive relief or other appropriate order requiring the person to cease and desist from

such violation, and not to any other penalty or sanction.

[Sections 74.452-74.500 reserved for expansion]

SUBCHAPTER K. PAYMENT FOR FUTURE LOSSES

Sec. 74.501. DEFINITIONS. In this subchapter:

(1) "Future damages" means damages that are incurred after the date of judgment for:

(A) medical, health care, or custodial care services;

(B) physical pain and mental anguish, disfigurement, or physical impairment;

(C) loss of consortium, companionship, or society; or

(D) loss of earnings.

(2) "Future loss of earnings" means the following losses incurred after the date of the judgment:

(A) loss of income, wages, or earning capacity and other pecuniary losses; and

(B) loss of inheritance.

(3) "Periodic payments" means the payment of money or its equivalent to the recipient of future damages at defined intervals.

Sec. 74.502. SCOPE OF SUBCHAPTER. This subchapter applies only to an action on a health care liability claim against a physician or health care provider in which the present value of the award of future damages, as determined by the court, equals or exceeds $100,000.

Sec. 74.503. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court may order that future damages awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump-sum payment.

(b) The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages.

(c) The court shall specify in its judgment ordering the payment of future damages by periodic payments the:

(1) recipient of the payments;

(2) dollar amount of the payments;

(3) interval between payments; and

(4) number of payments or the period of time over which payments must be made.

Sec. 74.504. RELEASE. The entry of an order for the payment of future damages by periodic payments constitutes a release of the health care liability claim filed by the claimant.

Sec. 74.505. FINANCIAL RESPONSIBILITY. (a) As a condition to authorizing periodic payments of future damages, the court shall require a defendant who is not adequately insured to provide evidence of financial responsibility in an amount adequate to assure full payment of damages awarded by the judgment.

(b) The judgment must provide for payments to be funded by:

(1) an annuity contract issued by a company licensed to do business as an insurance company, including an assignment within the meaning of Section 130, Internal Revenue Code of 1986, as amended;

(2) an obligation of the United States;

(3) applicable and collectible liability insurance from one or more qualified insurers; or

(4) any other satisfactory form of funding approved by the court.

(c) On termination of periodic payments of future damages, the court shall order the return of the security, or as much as remains, to the defendant.

Sec. 74.506. DEATH OF RECIPIENT. (a) On the death of the recipient, money damages awarded for loss of future earnings continue to be paid to the estate of the recipient of the award without reduction.

(b) Periodic payments, other than future loss of earnings, terminate on the death of the recipient.

(c) If the recipient of periodic payments dies before all

payments required by the judgment are paid, the court may modify the judgment to award and apportion the unpaid damages for future loss of earnings in an appropriate manner.

(d) Following the satisfaction or termination of any obligations specified in the judgment for periodic payments, any obligation of the defendant physician or health care provider to make further payments ends and any security given reverts to the defendant.

Sec. 74.507. AWARD OF ATTORNEY'S FEES. For purposes of computing the award of attorney's fees when the claimant is awarded a recovery that will be paid in periodic payments, the court shall:

(1) place a total value on the payments based on the claimant's projected life expectancy; and

(2) reduce the amount in Subdivision (1) to present value.

SECTION 10.02. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (6) to read as follows:

(6) "Hospital system" means a system of hospitals and other health care providers located in this state that are under the common governance or control of a corporate parent.

SECTION 10.03. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (7) to read as follows:

(7) "Person responsible for the patient" means:

(A) the patient's parent, managing conservator, or guardian;

(B) the patient's grandparent;

(C) the patient's adult brother or sister;

(D) another adult who has actual care, control, and possession of the patient and has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient;

(E) an educational institution in which the patient is enrolled that has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient; or

(F) any other person with legal responsibility for the care of the patient.

SECTION 10.04. Section 84.004, Civil Practice and Remedies Code, is amended by adding Subsection (f) to read as follows:

(f) Subsection (c) applies even if:

(1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or

(2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

SECTION 10.05. Article 5.15-1, Insurance Code, is amended by adding Section 11 to read as follows:

Sec. 11. VENDOR'S ENDORSEMENT. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer, as that term is defined by Section 82.001, Civil Practice and Remedies Code. A physician or health care provider shall be considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy.

SECTION 10.06. Section 242.0372, Health and Safety Code, is amended by adding Subsection (f) to read as follows:

(f) An institution is not required to comply with this section before September 1, 2005. This subsection expires September 2, 2005.

SECTION 10.07. The Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) is repealed.

SECTION 10.08. Unless otherwise removed as provided by law, a member of the Texas Medical Disclosure Panel serving on the effective date of this Act continues to serve for the term to which the member was appointed.

SECTION 10.09. (a) The Legislature of the State of Texas

finds that:

(1) the number of health care liability claims (frequency) has increased since 1995 inordinately;

(2) the filing of legitimate health care liability claims in Texas is a contributing factor affecting medical professional liability rates;

(3) the amounts being paid out by insurers in judgments and settlements (severity) have likewise increased inordinately in the same short period;

(4) the effect of the above has caused a serious public problem in availability of and affordability of adequate medical professional liability insurance;

(5) the situation has created a medical malpractice insurance crisis in Texas;

(6) this crisis has had a material adverse effect on the delivery of medical and health care in Texas, including significant reductions of availability of medical and health care services to the people of Texas and a likelihood of further reductions in the future;

(7) the crisis has had a substantial impact on the physicians and hospitals of Texas and the cost to physicians and hospitals for adequate medical malpractice insurance has dramatically risen, with cost impact on patients and the public;

(8) the direct cost of medical care to the patient and public of Texas has materially increased due to the rising cost of malpractice insurance protection for physicians and hospitals in Texas;

(9) the crisis has increased the cost of medical care both directly through fees and indirectly through additional services provided for protection against future suits or claims, and defensive medicine has resulted in increasing cost to patients, private insurers, and Texas and has contributed to the general inflation that has marked health care in recent years;

(10) satisfactory insurance coverage for adequate amounts of insurance in this area is often not available at any price;

(11) the combined effect of the defects in the medical, insurance, and legal systems has caused a serious public problem both with respect to the availability of coverage and to the high rates being charged by insurers for medical professional liability insurance to some physicians, health care providers, and hospitals; and

(12) the adoption of certain modifications in the medical, insurance, and legal systems, the total effect of which is currently undetermined, will have a positive effect on the rates charged by insurers for medical professional liability insurance.

(b) Because of the conditions stated in Subsection (a) of this section, it is the purpose of this article to improve and modify the system by which health care liability claims are determined in order to:

(1) reduce excessive frequency and severity of health care liability claims through reasonable improvements and modifications in the Texas insurance, tort, and medical practice systems;

(2) decrease the cost of those claims and ensure that awards are rationally related to actual damages;

(3) do so in a manner that will not unduly restrict a claimant's rights any more than necessary to deal with the crisis;

(4) make available to physicians, hospitals, and other health care providers protection against potential liability through the insurance mechanism at reasonably affordable rates;

(5) make affordable medical and health care more accessible and available to the citizens of Texas;

(6) make certain modifications in the medical, insurance, and legal systems in order to determine whether or not there will be an effect on rates charged by insurers for medical professional liability insurance; and

(7) make certain modifications to the liability laws as they relate to health care liability claims only and with an

intention of the legislature to not extend or apply such modifications of liability laws to any other area of the Texas legal system or tort law.

ARTICLE 11. CLAIMS AGAINST EMPLOYEES OR VOLUNTEERS OF A GOVERNMENTAL UNIT

SECTION 11.01. Sections 108.002(a) and (b), Civil Practice and Remedies Code, are amended to read as follows:

(a) Except in an action arising under the constitution or laws of the United States, a public servant [~~, other than a provider of health care as that term is defined in Section 108.002(c),~~] is not personally liable for damages in excess of $100,000 arising from personal injury, death, or deprivation of a right, privilege, or immunity if:

(1) the damages are the result of an act or omission by the public servant in the course and scope of the public servant's office, employment, or contractual performance for or service on behalf of a state agency, institution, department, or local government; and

(2) for the amount not in excess of $100,000, the public servant is covered:

(A) by the state's obligation to indemnify under Chapter 104;

(B) by a local government's authorization to indemnify under Chapter 102;

(C) by liability or errors and omissions insurance; or

(D) by liability or errors and omissions coverage under an interlocal agreement.

(b) Except in an action arising under the constitution or laws of the United States, a public servant [~~, other than a provider of health care as that term is defined in Section 108.002(c),~~] is not liable for damages in excess of $100,000 for property damage if:

(1) the damages are the result of an act or omission by the public servant in the course and scope of the public servant's office, employment, or contractual performance for or service on behalf of a state agency, institution, department, or local government; and

(2) for the amount not in excess of $100,000, the public servant is covered:

(A) by the state's obligation to indemnify under Chapter 104;

(B) by a local government's authorization to indemnify under Chapter 102;

(C) by liability or errors and omissions insurance; or

(D) by liability or errors and omissions coverage under an interlocal agreement.

SECTION 11.02. Chapter 261, Health and Safety Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. LIABILITY OF NONPROFIT MANAGEMENT CONTRACTOR

Sec. 261.051. DEFINITION. In this subchapter, "municipal hospital management contractor" means a nonprofit corporation, partnership, or sole proprietorship that manages or operates a hospital or provides services under a contract with a municipality.

Sec. 261.052. LIABILITY OF A MUNICIPAL HOSPITAL MANAGEMENT CONTRACTOR. A municipal hospital management contractor in its management or operation of a hospital under a contract with a municipality is considered a governmental unit for purposes of Chapters 101, 102, and 108, Civil Practice and Remedies Code, and any employee of the contractor is, while performing services under the contract for the benefit of the hospital, an employee of the municipality for the purposes of Chapters 101, 102, and 108, Civil Practice and Remedies Code.

SECTION 11.03. Section 285.071, Health and Safety Code, is amended to read as follows:

Sec. 285.071. DEFINITION. In this chapter, "hospital district management contractor" means a nonprofit corporation, partnership, or sole proprietorship that manages or operates a hospital or provides services [~~as a part of a rural health network~~

CONFERENCE COMMITTEE REPORT FORM

Austin, Texas

May 31, 2003
Date

Honorable David Dewhurst
President of the Senate

Honorable Tom Craddick
Speaker of the House of Representatives

Sirs:

We, Your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on HB 4 have had the same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

Bill Ratliff

Ken Armbrister

Robert Duncan

Chris Harris

On the part of the Senate

Jane Nelson

Joe Nixon

Dan Curtis

Phil King

Vilma Luna

Beverly Woolley

On the part of the House

Note to Conference Committee Clerk:

Please type the names of the members of the Conference Committee under the lines provided for signature. Those members desiring to sign the report should sign each of the six copies. Attach a copy of the Conference Committee Report and a Section by Section side by side comparison to each of the six reporting forms. The original and two copies are filed in house of origin of the bill, and three copies in the other house.

CONFERENCE COMMITTEE REPORT

3rd Printing

H.B. No. 4

A BILL TO BE ENTITLED

AN ACT

relating to reform of certain procedures and remedies in civil actions.

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

ARTICLE 1. CLASS ACTIONS

SECTION 1.01. Subtitle B, Title 2, Civil Practice and Remedies Code, is amended by adding Chapter 26 to read as follows:

CHAPTER 26. CLASS ACTIONS

SUBCHAPTER A. SUPREME COURT RULES

Sec. 26.001. ADOPTION OF RULES BY SUPREME COURT. (a) The supreme court shall adopt rules to provide for the fair and efficient resolution of class actions.

(b) The supreme court shall adopt rules under this chapter on or before December 31, 2003.

Sec. 26.002. MANDATORY GUIDELINES. Rules adopted under Section 26.001 must comply with the mandatory guidelines established by this chapter.

Sec. 26.003. ATTORNEY'S FEES. (a) If an award of attorney's fees is available under applicable substantive law, the rules adopted under this chapter must provide that the trial court shall use the Lodestar method to calculate the amount of attorney's fees to be awarded class counsel. The rules may give the trial court discretion to increase or decrease the fee award calculated by using the Lodestar method by no more than four times based on

(b) The changes in law made in Sections 7.02 and 7.03 of this article apply to any case in which a final judgment is signed on or after the effective date of this Act.

ARTICLE 8. EVIDENCE RELATING TO SEAT BELTS

SECTION 8.01. Sections 545.412(d) and 545.413(g), Transportation Code, are repealed.

ARTICLE 9. RESERVED

ARTICLE 10. HEALTH CARE

SECTION 10.01. Chapter 74, Civil Practice and Remedies Code, is amended to read as follows:

CHAPTER 74. MEDICAL LIABILITY [~~GOOD SAMARITAN LAW; LIABILITY FOR EMERGENCY CARE~~]

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 74.001. DEFINITIONS. (a) In this chapter:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified person, including any direct or indirect parent or subsidiary.

(2) "Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(3) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the person, whether through ownership of equity or securities, by contract, or otherwise.

(4) "Court" means any federal or state court.

(5) "Disclosure panel" means the Texas Medical Disclosure Panel.

(6) "Economic damages" has the meaning assigned by Section 41.001.

(7) "Emergency medical care" means bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency.

(8) "Emergency medical services provider" means a licensed public or private provider to which Chapter 773, Health and Safety Code, applies.

(9) "Gross negligence" has the meaning assigned by Section 41.001.

(10) "Health care" means any act or treatment performed or furnished, or that should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(11) "Health care institution" includes:

(A) an ambulatory surgical center;

(B) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(C) an emergency medical services provider;

(D) a health services district created under Chapter 287, Health and Safety Code;

(E) a home and community support services agency;

(F) a hospice;

(G) a hospital;

(H) a hospital system;

(I) an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended;

(J) a nursing home; or

(K) an end stage renal disease facility licensed under Section 251.011, Health and Safety Code.

(12)(A) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including:

(i) a registered nurse;

(ii) a dentist;

(iii) a podiatrist;

(iv) a pharmacist;

(v) a chiropractor;

(vi) an optometrist; or

(vii) a health care institution.

(B) The term includes:

(i) an officer, director, shareholder, member, partner, manager, owner, or affiliate of a health care provider or physician; and

(ii) an employee, independent contractor, or agent of a health care provider or physician acting in the course and scope of the employment or contractual relationship.

(13) "Health care liability claim" means a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, or health care, or safety or professional or administrative services directly related to health care, which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.

(14) "Home and community support services agency" means a licensed public or provider agency to which Chapter 142, Health and Safety Code, applies.

(15) "Hospice" means a hospice facility or activity to which Chapter 142, Health and Safety Code, applies.

(16) "Hospital" means a licensed public or private institution as defined in Chapter 241, Health and Safety Code, or licensed under Chapter 577, Health and Safety Code.

(17) "Hospital system" means a system of hospitals located in this state that are under the common governance or

control of a corporate parent.

(18) "Intermediate care facility for the mentally retarded" means a licensed public or private institution to which Chapter 252, Health and Safety Code, applies.

(19) "Medical care" means any act defined as practicing medicine under Section 151.002, Occupations Code, performed or furnished, or which should have been performed, by one licensed to practice medicine in this state for, to, or on behalf of a patient during the patient's care, treatment, or confinement.

(20) "Noneconomic damages" has the meaning assigned by Section 41.001.

(21) "Nursing home" means a licensed public or private institution to which Chapter 242, Health and Safety Code, applies.

(22) "Pharmacist" means one licensed under Chapter 551, Occupations Code, who, for the purposes of this chapter, performs those activities limited to the dispensing of prescription medicines which result in health care liability claims and does not include any other cause of action that may exist at common law against them, including but not limited to causes of action for the sale of mishandled or defective products.

(23) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians;

(C) a partnership or limited liability partnership formed by a group of physicians;

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code; or

(E) a company formed by a group of physicians under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes).

(24) "Professional or administrative services" means those duties or services that a physician or health care provider is required to provide as a condition of maintaining the physician's or health care provider's license, accreditation status, or certification to participate in state or federal health care programs.

(25) "Representative" means the spouse, parent, guardian, trustee, authorized attorney, or other authorized legal agent of the patient or claimant.

(b) Any legal term or word of art used in this chapter, not otherwise defined in this chapter, shall have such meaning as is consistent with the common law.

Sec. 74.002. CONFLICT WITH OTHER LAW AND RULES OF CIVIL PROCEDURE. (a) In the event of a conflict between this chapter and another law, including a rule of procedure or evidence or court rule, this chapter controls to the extent of the conflict.

(b) Notwithstanding Subsection (a), in the event of a conflict between this chapter and Section 101.023, 102.003, or 108.002, those sections of this code control to the extent of the conflict.

(c) The district courts and statutory county courts in a county may not adopt local rules in conflict with this chapter.

Sec. 74.003. SOVEREIGN IMMUNITY NOT WAIVED. This chapter does not waive sovereign immunity from suit or from liability.

Sec. 74.004. EXCEPTION FROM CERTAIN LAWS. (a) Notwithstanding any other law, Sections 17.41-17.63, Business & Commerce Code, do not apply to physicians or health care providers with respect to claims for damages for personal injury or death resulting, or alleged to have resulted, from negligence on the part of any physician or health care provider.

(b) This section does not apply to pharmacists.

[Sections 74.005-74.050 reserved for expansion]

SUBCHAPTER B. NOTICE AND PLEADINGS

Sec. 74.051. NOTICE. (a) Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the filing of a suit in any court of this state based upon a health care liability claim. The notice must be accompanied by the authorization form for release of protected health information as required under Section 74.052.

(b) In such pleadings as are subsequently filed in any court, each party shall state that it has fully complied with the provisions of this section and Section 74.052 and shall provide such evidence thereof as the judge of the court may require to determine if the provisions of this chapter have been met.

(c) Notice given as provided in this chapter shall toll the

applicable statute of limitations to and including a period of 75 days following the giving of the notice, and this tolling shall apply to all parties and potential parties.

(d) All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 45 days from the date of receipt of a written request for such records; provided, however, that the receipt of a medical authorization in the form required by Section 74.052 executed by the claimant herein shall be considered compliance by the claimant with this subsection.

(e) For the purposes of this section, and notwithstanding Chapter 159, Occupations Code, or any other law, a request for the medical records of a deceased person or a person who is incompetent shall be deemed to be valid if accompanied by an authorization in the form required by Section 74.052 signed by a parent, spouse, or adult child of the deceased or incompetent person.

Sec. 74.052. AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION. (a) Notice of a health care claim under Section 74.051 must be accompanied by a medical authorization in the form specified by this section. Failure to provide this authorization along with the notice of health care claim shall abate all further proceedings against the physician or health care provider receiving the notice until 60 days following receipt by the physician or health care provider of the required authorization.

(b) If the authorization required by this section is modified or revoked, the physician or health care provider to whom

the authorization has been given shall have the option to abate all further proceedings until 60 days following receipt of a replacement authorization that must comply with the form specified by this section.

(c) The medical authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

A. I, _____(name of patient or authorized representative), hereby authorize _____(name of physician or other health care provider to whom the notice of health care claim is directed) to obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes:

1. To facilitate the investigation and evaluation of the health care claim described in the accompanying Notice of Health Care Claim; or

2. Defense of any litigation arising out of the claim made the basis of the accompanying Notice of Health Care Claim.

B. The health information to be obtained, used, or disclosed extends to and includes the verbal as well as the written and is specifically described as follows:

1. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) in connection with the injuries alleged to have been sustained in connection with the

claim asserted in the accompanying Notice of Health Care Claim. (Here list the name and current address of all treating physicians or health care providers). This authorization shall extend to any additional physicians or health care providers that may in the future evaluate, examine, or treat _____ (patient) for injuries alleged in connection with the claim made the basis of the attached Notice of Health Care Claim;

2. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) during a period commencing five years prior to the incident made the basis of the accompanying Notice of Health Care Claim. (Here list the name and current address of such physicians or health care providers, if applicable.)

C. Excluded Health Information - the following constitutes a list of physicians or health care providers possessing health care information concerning _____ (patient) to which this authorization does not apply because I contend that such health care information is not relevant to the damages being claimed or to the physical, mental, or emotional condition of _____ (patient) arising out of the claim made the basis of the accompanying Notice of Health Care Claim. (Here state "none" or list the name of each physician or health care provider to whom this authorization does not extend and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure.)

D. The persons or class of persons to whom the health information of _____ (patient) will be disclosed or who will

make use of said information are:

1. Any and all physicians or health care providers providing care or treatment to _____ (patient);

2. Any liability insurance entity providing liability insurance coverage or defense to any physician or health care provider to whom Notice of Health Care Claim has been given with regard to the care and treatment of _____ (patient);

3. Any consulting or testifying experts employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

4. Any attorneys (including secretarial, clerical, or paralegal staff) employed by or on behalf of _____(name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of _____ (patient).

E. This authorization shall expire upon resolution of the claim asserted or at the conclusion of any litigation instituted in connection with the subject matter of the Notice of Health Care Claim accompanying this authorization, whichever occurs sooner.

F. I understand that, without exception, I have the right to revoke this authorization in writing. I further understand the consequence of any such revocation as set out in Section 74.052,

Civil Practice and Remedies Code.

G. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

H. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Signature of Patient/Representative

_____

Date

_____

Name of Patient/ Representative

_____

Description of Representative's Authority

_____

Sec. 74.053. PLEADINGS NOT TO STATE DAMAGE AMOUNT; SPECIAL EXCEPTION; EXCLUSION FROM SECTION. Pleadings in a suit based on a health care liability claim shall not specify an amount of money claimed as damages. The defendant may file a special exception to the pleadings on the ground the suit is not within the court's jurisdiction, in which event the plaintiff shall inform the court and defendant in writing of the total dollar amount claimed. This section does not prevent a party from mentioning the total dollar amount claimed in examining prospective jurors on voir dire or in argument to the court or jury.

[Sections 74.054-74.100 reserved for expansion]

SUBCHAPTER C. INFORMED CONSENT

Sec. 74.101. THEORY OF RECOVERY. In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.

Sec. 74.102. TEXAS MEDICAL DISCLOSURE PANEL. (a) The Texas Medical Disclosure Panel is created to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure.

(b) The disclosure panel established herein is administratively attached to the Texas Department of Health. The Texas Department of Health, at the request of the disclosure panel, shall provide administrative assistance to the panel; and the Texas Department of Health and the disclosure panel shall coordinate administrative responsibilities in order to avoid unnecessary duplication of facilities and services. The Texas Department of Health, at the request of the panel, shall submit the panel's budget request to the legislature. The panel shall be subject, except where inconsistent, to the rules and procedures of the Texas Department of Health; however, the duties and responsibilities of

the panel as set forth in this chapter shall be exercised solely by the disclosure panel, and the board or Texas Department of Health shall have no authority or responsibility with respect to same.

(c) The disclosure panel is composed of nine members, with three members licensed to practice law in this state and six members licensed to practice medicine in this state. Members of the disclosure panel shall be selected by the commissioner of health.

(d) At the expiration of the term of each member of the disclosure panel so appointed, the commissioner shall select a successor, and such successor shall serve for a term of six years, or until his successor is selected. Any member who is absent for three consecutive meetings without the consent of a majority of the disclosure panel present at each such meeting may be removed by the commissioner at the request of the disclosure panel submitted in writing and signed by the chairman. Upon the death, resignation, or removal of any member, the commissioner shall fill the vacancy by selection for the unexpired portion of the term.

(e) Members of the disclosure panel are not entitled to compensation for their services, but each panelist is entitled to reimbursement of any necessary expense incurred in the performance of his duties on the panel, including necessary travel expenses.

(f) Meetings of the panel shall be held at the call of the chairman or on petition of at least three members of the panel.

(g) At the first meeting of the panel each year after its members assume their positions, the panelists shall select one of the panel members to serve as chairman and one of the panel members to serve as vice chairman, and each such officer shall serve for a

term of one year. The chairman shall preside at meetings of the panel, and in his absence, the vice chairman shall preside.

(h) Employees of the Texas Department of Health shall serve as the staff for the panel.

Sec. 74.103. DUTIES OF DISCLOSURE PANEL. (a) To the extent feasible, the panel shall identify and make a thorough examination of all medical treatments and surgical procedures in which physicians and health care providers may be involved in order to determine which of those treatments and procedures do and do not require disclosure of the risks and hazards to the patient or person authorized to consent for the patient.

(b) The panel shall prepare separate lists of those medical treatments and surgical procedures that do and do not require disclosure and, for those treatments and procedures that do require disclosure, shall establish the degree of disclosure required and the form in which the disclosure will be made.

(c) Lists prepared under Subsection (b) together with written explanations of the degree and form of disclosure shall be published in the Texas Register.

(d) At least annually, or at such other period the panel may determine from time to time, the panel will identify and examine any new medical treatments and surgical procedures that have been developed since its last determinations, shall assign them to the proper list, and shall establish the degree of disclosure required and the form in which the disclosure will be made. The panel will also examine such treatments and procedures for the purpose of revising lists previously published. These determinations shall be

published in the Texas Register.

Sec. 74.104. DUTY OF PHYSICIAN OR HEALTH CARE PROVIDER. Before a patient or a person authorized to consent for a patient gives consent to any medical care or surgical procedure that appears on the disclosure panel's list requiring disclosure, the physician or health care provider shall disclose to the patient or person authorized to consent for the patient the risks and hazards involved in that kind of care or procedure. A physician or health care provider shall be considered to have complied with the requirements of this section if disclosure is made as provided in Section 74.105.

Sec. 74.105. MANNER OF DISCLOSURE. Consent to medical care that appears on the disclosure panel's list requiring disclosure shall be considered effective under this chapter if it is given in writing, signed by the patient or a person authorized to give the consent and by a competent witness, and if the written consent specifically states the risks and hazards that are involved in the medical care or surgical procedure in the form and to the degree required by the disclosure panel under Section 74.103.

Sec. 74.106. EFFECT OF DISCLOSURE. (a) In a suit against a physician or health care provider involving a health care liability claim that is based on the negligent failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider:

(1) both disclosure made as provided in Section 74.104 and failure to disclose based on inclusion of any medical care or

surgical procedure on the panel's list for which disclosure is not required shall be admissible in evidence and shall create a rebuttable presumption that the requirements of Sections 74.104 and 74.105 have been complied with and this presumption shall be included in the charge to the jury; and

(2) failure to disclose the risks and hazards involved in any medical care or surgical procedure required to be disclosed under Sections 74.104 and 74.105 shall be admissible in evidence and shall create a rebuttable presumption of a negligent failure to conform to the duty of disclosure set forth in Sections 74.104 and 74.105, and this presumption shall be included in the charge to the jury; but failure to disclose may be found not to be negligent if there was an emergency or if for some other reason it was not medically feasible to make a disclosure of the kind that would otherwise have been negligence.

(b) If medical care or surgical procedure is rendered with respect to which the disclosure panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law.

Sec. 74.107. INFORMED CONSENT FOR HYSTERECTOMIES. (a) The disclosure panel shall develop and prepare written materials to inform a patient or person authorized to consent for a patient of the risks and hazards of a hysterectomy.

(b) The materials shall be available in English, Spanish, and any other language the panel considers appropriate. The information must be presented in a manner understandable to a layperson.

(c) The materials must include:

(1) a notice that a decision made at any time to refuse to undergo a hysterectomy will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds or otherwise affect the patient's right to future care or treatment;

(2) the name of the person providing and explaining the materials;

(3) a statement that the patient or person authorized to consent for the patient understands that the hysterectomy is permanent and nonreversible and that the patient will not be able to become pregnant or bear children if she undergoes a hysterectomy;

(4) a statement that the patient has the right to seek a consultation from a second physician;

(5) a statement that the patient or person authorized to consent for the patient has been informed that a hysterectomy is a removal of the uterus through an incision in the lower abdomen or vagina and that additional surgery may be necessary to remove or repair other organs, including an ovary, tube, appendix, bladder, rectum, or vagina;

(6) a description of the risks and hazards involved in the performance of the procedure; and

(7) a written statement to be signed by the patient or person authorized to consent for the patient indicating that the materials have been provided and explained to the patient or person authorized to consent for the patient and that the patient or person authorized to consent for the patient understands the nature and

consequences of a hysterectomy.

(d) The physician or health care provider shall obtain informed consent under this section and Section 74.104 from the patient or person authorized to consent for the patient before performing a hysterectomy unless the hysterectomy is performed in a life-threatening situation in which the physician determines obtaining informed consent is not reasonably possible. If obtaining informed consent is not reasonably possible, the physician or health care provider shall include in the patient's medical records a written statement signed by the physician certifying the nature of the emergency.

(e) The disclosure panel may not prescribe materials under this section without first consulting with the Texas State Board of Medical Examiners.

[Sections 74.108-74.150 reserved for expansion]

SUBCHAPTER D. EMERGENCY CARE

Sec. 74.151. LIABILITY FOR EMERGENCY CARE. (a) A person who in good faith administers emergency care, including using an automated external defibrillator, [~~at the scene of an emergency but not in a hospital or other health care facility or means of medical transport~~] is not liable in civil damages for an act performed during the emergency unless the act is wilfully or wantonly negligent.

(b) This section does not apply to care administered:

(1) for or in expectation of remuneration, provided that being legally entitled to receive remuneration for the emergency care rendered shall not determine whether or not the care

was administered for or in anticipation of remuneration; or

(2) by a person who was at the scene of the emergency because he or a person he represents as an agent was soliciting business or seeking to perform a service for remuneration.

~~[(c) If the scene of an emergency is in a hospital or other health care facility or means of medical transport, a person who in good faith administers emergency care is not liable in civil damages for an act performed during the emergency unless the act is wilfully or wantonly negligent, provided that this subsection does not apply to care administered:~~

~~[(1) by a person who regularly administers care in a hospital emergency room unless such person is at the scene of the emergency for reasons wholly unrelated to the person's work in administering health care; or~~

~~[(2) by an admitting or attending physician of the patient or a treating physician associated by the admitting or attending physician of the patient in question.~~

~~[(d) For purposes of Subsections (b)(1) and (c)(1), a person who would ordinarily receive or be entitled to receive a salary, fee, or other remuneration for administering care under such circumstances to the patient in question shall be deemed to be acting for or in expectation of remuneration even if the person waives or elects not to charge or receive remuneration on the occasion in question.~~]

(e) This section does not apply to a person whose negligent act or omission was a producing cause of the emergency for which care is being administered.

Sec. 74.152 [~~74.002~~]. UNLICENSED MEDICAL PERSONNEL. Persons not licensed or certified in the healing arts who in good faith administer emergency care as emergency medical service personnel are not liable in civil damages for an act performed in administering the care unless the act is wilfully or wantonly negligent. This section applies without regard to whether the care is provided for or in expectation of remuneration.

Sec. 74.153. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of the evidence that the physician or health care provider, with wilful and wanton negligence, deviated from the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.

Sec. 74.154. JURY INSTRUCTIONS IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) In an action for damages that involves a claim of negligence arising from the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of

a patient in a hospital emergency department, the court shall instruct the jury to consider, together with all other relevant matters:

(1) whether the person providing care did or did not have the patient's medical history or was able or unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;

(2) the presence or lack of a preexisting physician-patient relationship or health care provider-patient relationship;

(3) the circumstances constituting the emergency; and

(4) the circumstances surrounding the delivery of the emergency medical care.

(b) The provisions of Subsection (a) do not apply to medical care or treatment:

(1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient;

(2) that is unrelated to the original medical emergency; or

(3) that is related to an emergency caused in whole or in part by the negligence of the defendant.

[Sections 74.155-74.200 reserved for expansion]

SUBCHAPTER E. RES IPSA LOQUITUR

Sec. 74.201. APPLICATION OF RES IPSA LOQUITUR. The common law doctrine of res ipsa loquitur shall only apply to health care liability claims against health care providers or physicians in those cases to which it has been applied by the appellate courts of

this state as of August 29, 1977.

[Sections 74.202-74.250 reserved for expansion]

SUBCHAPTER F. STATUTE OF LIMITATIONS

Sec. 74.251. STATUTE OF LIMITATIONS ON HEALTH CARE LIABILITY CLAIMS. (a) Notwithstanding any other law and subject to Subsection (b), no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that, minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided this section applies to all persons regardless of minority or other legal disability.

(b) A claimant must bring a health care liability claim not later than 10 years after the date of the act or omission that gives rise to the claim. This subsection is intended as a statute of repose so that all claims must be brought within 10 years or they are time barred.

[Sections 74.252-74.300 reserved for expansion]

SUBCHAPTER G. LIABILITY LIMITS

Sec. 74.301. LIMITATION ON NONECONOMIC DAMAGES. (a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the health care provider other than a health care institution, inclusive of all persons and entities for which

vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000.

(c) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.

Sec. 74.302. ALTERNATIVE LIMITATION ON NONECONOMIC DAMAGES. (a) In the event that Section 74.301 is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective:

(1) In an action on a health care liability claim where

final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(2) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000.

(3) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.

(b) Effective before September 1, 2005, Subsection (a) of

this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $200,000 for each health care liability claim and at least $600,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $500,000 for each health care liability claim and at least $1.5 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(c) Effective September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved

residency program;

(2) at least $300,000 for each health care liability claim and at least $900,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $750,000 for each health care liability claim and at least $2.25 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(d) Effective September 1, 2007, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $500,000 for each health care liability claim and at least $1 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $1 million for each health care liability claim and at least $3 million in aggregate for all health care

liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(e) Evidence of financial responsibility may be established at the time of judgment by providing proof of:

(1) the purchase of a contract of insurance or other plan of insurance authorized by this state or federal law or regulation;

(2) the purchase of coverage from a trust organized and operating under Article 21.49-4, Insurance Code;

(3) the purchase of coverage or another plan of insurance provided by or through a risk retention group or purchasing group authorized under applicable laws of this state or under the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as amended, or the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.), as amended, or any other contract or arrangement for transferring and distributing risk relating to legal liability for damages, including cost or defense, legal costs, fees, and other claims expenses; or

(4) the maintenance of financial reserves in or an irrevocable letter of credit from a federally insured financial institution that has its main office or a branch office in this state.

Sec. 74.303. LIMITATION ON DAMAGES. (a) In a wrongful death or survival action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages, including exemplary damages, shall be limited to an amount not to exceed

$500,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) When there is an increase or decrease in the consumer price index with respect to the amount of that index on August 29, 1977, the liability limit prescribed in Subsection (a) shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index, as published by the Bureau of Labor Statistics of the United States Department of Labor, that measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone (CPI-W: Seasonally Adjusted U.S. City Average - All Items), between August 29, 1977, and the time at which damages subject to such limits are awarded by final judgment or settlement.

(c) Subsection (a) does not apply to the amount of damages awarded on a health care liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the injury.

(d) The liability of any insurer under the common law theory of recovery commonly known in Texas as the "Stowers Doctrine" shall not exceed the liability of the insured.

(e) In any action on a health care liability claim that is tried by a jury in any court in this state, the following shall be included in the court's written instructions to the jurors:

(1) "Do not consider, discuss, nor speculate whether

or not liability, if any, on the part of any party is or is not subject to any limit under applicable law."

(2) "A finding of negligence may not be based solely on evidence of a bad result to the claimant in question, but a bad result may be considered by you, along with other evidence, in determining the issue of negligence. You are the sole judges of the weight, if any, to be given to this kind of evidence."

[Sections 74.304-74.350 reserved for expansion]

SUBCHAPTER H. PROCEDURAL PROVISIONS

Sec. 74.351. EXPERT REPORT. (a) In a health care liability claim, a claimant shall, not later than the 120th day after the date the claim was filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the report for each physician or health care provider against whom a liability claim is asserted. The date for serving the report may be extended by written agreement of the affected parties. Each defendant physician or health care provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the 21st day after the date it was served, failing which all objections are waived.

(b) If, as to a defendant physician or health care provider, an expert report has not been served within the period specified by Subsection (a), the court, on the motion of the affected physician or health care provider, shall, subject to Subsection (c), enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by

the physician or health care provider; and

(2) dismisses the claim with respect to the physician or health care provider, with prejudice to the refiling of the claim.

(c) If an expert report has not been served within the period specified by Subsection (a) because elements of the report are found deficient, the court may grant one 30-day extension to the claimant in order to cure the deficiency. If the claimant does not receive notice of the court's ruling granting the extension until after the 120-day deadline has passed, then the 30-day extension shall run from the date the plaintiff first received the notice.

[Subsections (d)-(h) reserved]

(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving an expert report by serving reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.

(j) Nothing in this section shall be construed to require the serving of an expert report regarding any issue other than an issue relating to liability or causation.

(k) Subject to Subsection (t), an expert report served under

this section:

(1) is not admissible in evidence by any party;

(2) shall not be used in a deposition, trial, or other proceeding; and

(3) shall not be referred to by any party during the course of the action for any purpose.

(l) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective good faith effort to comply with the definition of an expert report in Subsection (r)(6).

[Subsections (m)-(q) reserved]

(r) In this section:

(1) "Affected parties" means the claimant and the physician or health care provider who are directly affected by an act or agreement required or permitted by this section and does not include other parties to an action who are not directly affected by that particular act or agreement.

(2) "Claim" means a health care liability claim.

[(3) reserved]

(4) "Defendant" means a physician or health care provider against whom a health care liability claim is asserted. The term includes a third-party defendant, cross-defendant, or counterdefendant.

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted

standards of medical care, an expert qualified to testify under the requirements of Section 74.401;

(B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402;

(C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a dentist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence.

(6) "Expert report" means a written report by an expert that provides a fair summary of the expert's opinions as of the date of the report regarding applicable standards of care, the

manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed.

(s) Until a claimant has served the expert report and curriculum vitae as required by Subsection (a), all discovery in a health care liability claim is stayed except for the acquisition by the claimant of information, including medical or hospital records or other documents or tangible things, related to the patient's health care through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a), the restrictions imposed by Subsection (k) on use of the expert report by any party are waived.

(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than two depositions before the expert report is served as required by Subsection (a).

Sec. 74.352. DISCOVERY PROCEDURES. (a) In every health care liability claim the plaintiff shall within 45 days after the date of filing of the original petition serve on the defendant's attorney or, if no attorney has appeared for the defendant, on the

defendant full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the appropriate standard set of requests for production of documents and things promulgated by the Health Care Liability Discovery Panel.

(b) Every physician or health care provider who is a defendant in a health care liability claim shall within 45 days after the date on which an answer to the petition was due serve on the plaintiff's attorney or, if the plaintiff is not represented by an attorney, on the plaintiff full and complete answers to the appropriate standard set of interrogatories and complete responses to the standard set of requests for production of documents and things promulgated by the Health Care Liability Discovery Panel.

(c) Except on motion and for good cause shown, no objection may be asserted regarding any standard interrogatory or request for production of documents and things, but no response shall be required where a particular interrogatory or request is clearly inapplicable under the circumstances of the case.

(d) Failure to file full and complete answers and responses to standard interrogatories and requests for production of documents and things in accordance with Subsections (a) and (b) or the making of a groundless objection under Subsection (c) shall be grounds for sanctions by the court in accordance with the Texas Rules of Civil Procedure on motion of any party.

(e) The time limits imposed under Subsections (a) and (b) may be extended by the court on the motion of a responding party for good cause shown and shall be extended if agreed in writing between

the responding party and all opposing parties. In no event shall an extension be for a period of more than an additional 30 days.

(f) If a party is added by an amended pleading, intervention, or otherwise, the new party shall file full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the standard set of requests for production of documents and things no later than 45 days after the date of filing of the pleading by which the party first appeared in the action.

(g) If information or documents required to provide full and complete answers and responses as required by this section are not in the possession of the responding party or attorney when the answers or responses are filed, the party shall supplement the answers and responses in accordance with the Texas Rules of Civil Procedure.

(h) Nothing in this section shall preclude any party from taking additional non-duplicative discovery of any other party. The standard sets of interrogatories provided for in this section shall not constitute, as to each plaintiff and each physician or health care provider who is a defendant, the first of the two sets of interrogatories permitted under the Texas Rules of Civil Procedure.

[Sections 74.353-74.400 reserved for expansion]

SUBCHAPTER I. EXPERT WITNESSES

Sec. 74.401. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST PHYSICIAN. (a) In a suit involving a health care liability claim against a physician for injury to or death of a patient, a

person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of medical care only if the person is a physician who:

(1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose;

(2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care.

(b) For the purpose of this section, "practicing medicine" or "medical practice" includes, but is not limited to, training residents or students at an accredited school of medicine or osteopathy or serving as a consulting physician to other physicians who provide direct patient care, upon the request of such other physicians.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is board certified or has other substantial training or experience in an area of medical practice relevant to the claim; and

(2) is actively practicing medicine in rendering medical care services relevant to the claim.

(d) The court shall apply the criteria specified in

Subsections (a), (b), and (c) in determining whether an expert is qualified to offer expert testimony on the issue of whether the physician departed from accepted standards of medical care, but may depart from those criteria if, under the circumstances, the court determines that there is a good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

(f) This section does not prevent a physician who is a

defendant from qualifying as an expert.

(g) In this subchapter, "physician" means a person who is:

(1) licensed to practice medicine in one or more states in the United States; or

(2) a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association only if testifying as a defendant and that testimony relates to that defendant's standard of care, the alleged departure from that standard of care, or the causal relationship between the alleged departure from that standard of care and the injury, harm, or damages claimed.

Sec. 74.402. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST HEALTH CARE PROVIDER. (a) For purposes of this section, "practicing health care" includes:

(1) training health care providers in the same field as the defendant health care provider at an accredited educational institution; or

(2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.

(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person:

(1) is practicing health care in a field of practice that involves the same type of care or treatment as that delivered by the defendant health care provider, if the defendant health care

provider is an individual, at the time the testimony is given or was practicing that type of health care at the time the claim arose;

(2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is certified by a licensing agency of one or more states of the United States or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and

(2) is actively practicing health care in rendering health care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) in determining whether an expert is qualified to offer expert testimony on the issue of whether the defendant health care provider departed from accepted standards of health care but may depart from those criteria if, under the circumstances, the court determines that there is good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) This section does not prevent a health care provider who is a defendant, or an employee of the defendant health care provider, from qualifying as an expert.

(f) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

Sec. 74.403. QUALIFICATIONS OF EXPERT WITNESS ON CAUSATION IN HEALTH CARE LIABILITY CLAIM. (a) Except as provided by Subsections (b) and (c), in a suit involving a health care liability claim against a physician or health care provider, a person may qualify as an expert witness on the issue of the causal relationship

between the alleged departure from accepted standards of care and the injury, harm, or damages claimed only if the person is a physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a dentist or physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a podiatrist or physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(d) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this

subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

[Sections 74.404-74.450 reserved for expansion]

SUBCHAPTER J. ARBITRATION AGREEMENTS

Sec. 74.451. ARBITRATION AGREEMENTS. (a) No physician, professional association of physicians, or other health care provider shall request or require a patient or prospective patient to execute an agreement to arbitrate a health care liability claim unless the form of agreement delivered to the patient contains a written notice in 10-point boldface type clearly and conspicuously stating:

UNDER TEXAS LAW, THIS AGREEMENT IS INVALID AND OF NO LEGAL EFFECT UNLESS IT IS ALSO SIGNED BY AN ATTORNEY OF YOUR OWN CHOOSING. THIS AGREEMENT CONTAINS A WAIVER OF IMPORTANT LEGAL RIGHTS, INCLUDING YOUR RIGHT TO A JURY. YOU SHOULD NOT SIGN THIS AGREEMENT WITHOUT FIRST CONSULTING WITH AN ATTORNEY.

(b) A violation of this section by a physician or professional association of physicians constitutes a violation of Subtitle B, Title 3, Occupations Code, and shall be subject to the

enforcement provisions and sanctions contained in that subtitle.

(c) A violation of this section by a health care provider other than a physician shall constitute a false, misleading, or deceptive act or practice in the conduct of trade or commerce within the meaning of Section 17.46 of the Deceptive Trade Practices-Consumer Protection Act (Subchapter E, Chapter 17, Business & Commerce Code), and shall be subject to an enforcement action by the consumer protection division under that act and subject to the penalties and remedies contained in Section 17.47, Business & Commerce Code, notwithstanding Section 74.004 or any other law.

(d) Notwithstanding any other provision of this section, a person who is found to be in violation of this section for the first time shall be subject only to injunctive relief or other appropriate order requiring the person to cease and desist from such violation, and not to any other penalty or sanction.

[Sections 74.452-74.500 reserved for expansion]

SUBCHAPTER K. PAYMENT FOR FUTURE LOSSES

Sec. 74.501. DEFINITIONS. In this subchapter:

(1) "Future damages" means damages that are incurred after the date of judgment for:

(A) medical, health care, or custodial care services;

(B) physical pain and mental anguish, disfigurement, or physical impairment;

(C) loss of consortium, companionship, or society; or

(D) loss of earnings.

(2) "Future loss of earnings" means the following losses incurred after the date of the judgment:

(A) loss of income, wages, or earning capacity and other pecuniary losses; and

(B) loss of inheritance.

(3) "Periodic payments" means the payment of money or its equivalent to the recipient of future damages at defined intervals.

Sec. 74.502. SCOPE OF SUBCHAPTER. This subchapter applies only to an action on a health care liability claim against a physician or health care provider in which the present value of the award of future damages, as determined by the court, equals or exceeds $100,000.

Sec. 74.503. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court shall order that medical, health care, or custodial services awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump-sum payment.

(b) At the request of a defendant physician or health care provider or claimant, the court may order that future damages other than medical, health care, or custodial services awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump sum payment.

(c) The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for

the future damages.

(d) The court shall specify in its judgment ordering the payment of future damages by periodic payments the:

(1) recipient of the payments;

(2) dollar amount of the payments;

(3) interval between payments; and

(4) number of payments or the period of time over which payments must be made.

Sec. 74.504. RELEASE. The entry of an order for the payment of future damages by periodic payments constitutes a release of the health care liability claim filed by the claimant.

Sec. 74.505. FINANCIAL RESPONSIBILITY. (a) As a condition to authorizing periodic payments of future damages, the court shall require a defendant who is not adequately insured to provide evidence of financial responsibility in an amount adequate to assure full payment of damages awarded by the judgment.

(b) The judgment must provide for payments to be funded by:

(1) an annuity contract issued by a company licensed to do business as an insurance company, including an assignment within the meaning of Section 130, Internal Revenue Code of 1986, as amended;

(2) an obligation of the United States;

(3) applicable and collectible liability insurance from one or more qualified insurers; or

(4) any other satisfactory form of funding approved by the court.

(c) On termination of periodic payments of future damages,

the court shall order the return of the security, or as much as remains, to the defendant.

Sec. 74.506. DEATH OF RECIPIENT. (a) On the death of the recipient, money damages awarded for loss of future earnings continue to be paid to the estate of the recipient of the award without reduction.

(b) Periodic payments, other than future loss of earnings, terminate on the death of the recipient.

(c) If the recipient of periodic payments dies before all payments required by the judgment are paid, the court may modify the judgment to award and apportion the unpaid damages for future loss of earnings in an appropriate manner.

(d) Following the satisfaction or termination of any obligations specified in the judgment for periodic payments, any obligation of the defendant physician or health care provider to make further payments ends and any security given reverts to the defendant.

Sec. 74.507. AWARD OF ATTORNEY'S FEES. For purposes of computing the award of attorney's fees when the claimant is awarded a recovery that will be paid in periodic payments, the court shall:

(1) place a total value on the payments based on the claimant's projected life expectancy; and

(2) reduce the amount in Subdivision (1) to present value.

SECTION 10.02. Section 84.003(1), Civil Practice and Remedies Code, is amended to read as follows:

(1) "Charitable organization" means:

(A) any organization exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986 by being listed as an exempt organization in Section 501(c)(3) or 501(c)(4) of the code, if it is a nonprofit corporation, foundation, community chest, or fund organized and operated exclusively for charitable, religious, prevention of cruelty to children or animals, youth sports and youth recreational, neighborhood crime prevention or patrol, fire protection or prevention, emergency medical or hazardous material response services, or educational purposes, including [~~excluding~~] private primary or secondary schools if accredited by a member association of the Texas Private School Accreditation Commission but excluding fraternities, sororities, and secret societies, [~~alumni associations and related on-campus organizations,~~] or is organized and operated exclusively for the promotion of social welfare by being primarily engaged in promoting the common good and general welfare of the people in a community;

(B) any bona fide charitable, religious, prevention of cruelty to children or animals, youth sports and youth recreational, neighborhood crime prevention or patrol, or educational organization, excluding fraternities, sororities, and secret societies [~~alumni associations and related on-campus organizations~~], or other organization organized and operated exclusively for the promotion of social welfare by being primarily engaged in promoting the common good and general welfare of the people in a community, and that:

(i) is organized and operated exclusively

for one or more of the above purposes;

(ii) does not engage in activities which in themselves are not in furtherance of the purpose or purposes;

(iii) does not directly or indirectly participate or intervene in any political campaign on behalf of or in opposition to any candidate for public office;

(iv) dedicates its assets to achieving the stated purpose or purposes of the organization;

(v) does not allow any part of its net assets on dissolution of the organization to inure to the benefit of any group, shareholder, or individual; and

(vi) normally receives more than one-third of its support in any year from private or public gifts, grants, contributions, or membership fees;

(C) a homeowners association as defined by Section 528(c) of the Internal Revenue Code of 1986 or which is exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986 by being listed as an exempt organization in Section 501(c)(4) of the code; or

(D) a volunteer center, as that term is defined by Section 411.126, Government Code.

SECTION 10.03. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (6) to read as follows:

(6) "Hospital system" means a system of hospitals and other health care providers located in this state that are under the common governance or control of a corporate parent.

SECTION 10.04. Section 84.003, Civil Practice and Remedies

Code, is amended by adding Subdivision (7) to read as follows:

(7) "Person responsible for the patient" means:

(A) the patient's parent, managing conservator, or guardian;

(B) the patient's grandparent;

(C) the patient's adult brother or sister;

(D) another adult who has actual care, control, and possession of the patient and has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient;

(E) an educational institution in which the patient is enrolled that has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient; or

(F) any other person with legal responsibility for the care of the patient.

SECTION 10.05. Section 84.004, Civil Practice and Remedies Code, is amended by adding Subsection (f) to read as follows:

(f) Subsection (c) applies even if:

(1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or

(2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

SECTION 10.06. Chapter 84, Civil Practice and Remedies

Code, is amended by adding Section 84.0065 to read as follows:

Sec. 84.0065. ORGANIZATION LIABILITY OF HOSPITALS. (a) Except as provided by Section 84.007, in any civil action brought against a hospital or hospital system, or its employees, officers, directors, or volunteers, for damages based on an act or omission by the hospital or hospital system, or its employees, officers, directors, or volunteers, the liability of the hospital or hospital system is limited to money damages in a maximum amount of $500,000 for any act or omission resulting in death, damage, or injury to a patient if the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient signs a written statement that acknowledges:

(1) that the hospital is providing care that is not administered for or in expectation of compensation; and

(2) the limitations on the recovery of damages from the hospital in exchange for receiving the health care services.

(b) Subsection (a) applies even if:

(1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or

(2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

SECTION 10.07. Section 242.0372, Health and Safety Code, is amended by adding Subsection (f) to read as follows:

(f) An institution is not required to comply with this

section before September 1, 2005. This subsection expires September 2, 2005.

SECTION 10.08. Article 5.15-1, Insurance Code, is amended by adding Section 11 to read as follows:

Sec. 11. VENDOR'S ENDORSEMENT. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer, as that term is defined by Section 82.001, Civil Practice and Remedies Code. A physician or health care provider shall be considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy.

SECTION 10.09. The Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) is repealed.

SECTION 10.10. Unless otherwise removed as provided by law, a member of the Texas Medical Disclosure Panel serving on the effective date of this Act continues to serve for the term to which the member was appointed.

SECTION 10.11. (a) The Legislature of the State of Texas finds that:

(1) the number of health care liability claims (frequency) has increased since 1995 inordinately;

(2) the filing of legitimate health care liability claims in Texas is a contributing factor affecting medical professional liability rates;

(3) the amounts being paid out by insurers in judgments and settlements (severity) have likewise increased

inordinately in the same short period;

(4) the effect of the above has caused a serious public problem in availability of and affordability of adequate medical professional liability insurance;

(5) the situation has created a medical malpractice insurance crisis in Texas;

(6) this crisis has had a material adverse effect on the delivery of medical and health care in Texas, including significant reductions of availability of medical and health care services to the people of Texas and a likelihood of further reductions in the future;

(7) the crisis has had a substantial impact on the physicians and hospitals of Texas and the cost to physicians and hospitals for adequate medical malpractice insurance has dramatically risen, with cost impact on patients and the public;

(8) the direct cost of medical care to the patient and public of Texas has materially increased due to the rising cost of malpractice insurance protection for physicians and hospitals in Texas;

(9) the crisis has increased the cost of medical care both directly through fees and indirectly through additional services provided for protection against future suits or claims, and defensive medicine has resulted in increasing cost to patients, private insurers, and Texas and has contributed to the general inflation that has marked health care in recent years;

(10) satisfactory insurance coverage for adequate amounts of insurance in this area is often not available at any

price;

(11) the combined effect of the defects in the medical, insurance, and legal systems has caused a serious public problem both with respect to the availability of coverage and to the high rates being charged by insurers for medical professional liability insurance to some physicians, health care providers, and hospitals; and

(12) the adoption of certain modifications in the medical, insurance, and legal systems, the total effect of which is currently undetermined, will have a positive effect on the rates charged by insurers for medical professional liability insurance.

(b) Because of the conditions stated in Subsection (a) of this section, it is the purpose of this article to improve and modify the system by which health care liability claims are determined in order to:

(1) reduce excessive frequency and severity of health care liability claims through reasonable improvements and modifications in the Texas insurance, tort, and medical practice systems;

(2) decrease the cost of those claims and ensure that awards are rationally related to actual damages;

(3) do so in a manner that will not unduly restrict a claimant's rights any more than necessary to deal with the crisis;

(4) make available to physicians, hospitals, and other health care providers protection against potential liability through the insurance mechanism at reasonably affordable rates;

(5) make affordable medical and health care more

accessible and available to the citizens of Texas;

(6) make certain modifications in the medical, insurance, and legal systems in order to determine whether or not there will be an effect on rates charged by insurers for medical professional liability insurance; and

(7) make certain modifications to the liability laws as they relate to health care liability claims only and with an intention of the legislature to not extend or apply such modifications of liability laws to any other area of the Texas legal system or tort law.

ARTICLE 11. CLAIMS AGAINST EMPLOYEES OR VOLUNTEERS OF A GOVERNMENTAL UNIT

SECTION 11.01. Sections 108.002(a) and (b), Civil Practice and Remedies Code, are amended to read as follows:

(a) Except in an action arising under the constitution or laws of the United States, a public servant [~~, other than a provider of health care as that term is defined in Section 108.002(c),~~] is not personally liable for damages in excess of $100,000 arising from personal injury, death, or deprivation of a right, privilege, or immunity if:

(1) the damages are the result of an act or omission by the public servant in the course and scope of the public servant's office, employment, or contractual performance for or service on behalf of a state agency, institution, department, or local government; and

(2) for the amount not in excess of $100,000, the public servant is covered:

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HOUSE RESEARCH ORGANIZATION

daily floor report

Wednesday, March 19, 2003
78th Legislature, Number 36
The House convenes at 10 a.m.

HB 4 by Nixon, et al., medical malpractice and tort liability revisions, has been set on the calendar for second reading today. The analysis of CSHB 4 is in two parts: Part One — Medical Liability (Article 10 of CSHB 4), begins on page 1, and Part Two — Tort Liability, begins on page 24.

Peggy Hamric
Chairman
78(R) - 36

Roberto Gutierrez
Vice Chairman

SUBJECT: Medical malpractice and tort liability revisions

COMMITTEE: Civil Practices — committee substitute recommended

VOTE: 8 ayes — Nixon, Gattis, Capelo, Hartnett, King, Krusee, Rose, Woolley

1 nay — Y. Davis

[*CSHB 4 originally was two separate bills — HB 3 by Nixon, et al., dealing with medical liability, and HB 4 by Nixon, et al., dealing with tort liability. The committee substitute merged the two bills. Part One of this analysis covers the medical liability provisions in Article 10 of CSHB 4, originally HB 3, and Part Two covers the tort liability provisions.*]

Part One — Medical Liability

WITNESSES: *(On HB 3, original version:)*
For — Spencer Berthelsen, Antonio Falcon, M.D., and John Durand, M.D., Texas Medical Association; Michael Regier, Seton Healthcare Networks; Darlene Evans and Gavin Gadberry, Texas Health Care Association; Peggy Venable, Citizen for a Sound Economy; Jo Ann Howard, Texas Medical Liability Trust and American Physicians Insurance Exchange; Mike Hull, Texas Alliance for Patient Access; Thomas Permetti, CHRISTUS Health; Steve Wozmer, Corpus Christi Medical Center; Chris Spence, Texas Association of Homes and Services for the Aging; Joe Ewing, M.D., Primary Care Coalition; George Roberts, Lutheran Memorial Hospital; Robert Kottman, M.D., Bexar County Medical Society; Mary Dale Peterson; Vincente Juan, M.D.; Jerry Hunsaker.

Against — Reggie James, Consumers Union; David Bragg, AARP; Harvey Rosenfield, Foundation for Taxpayer and Consumer Rights; Paula Sweeney, Richard Mithoff, and Hartley Hampton, Texas Trial Lawyers Association; Tony Korioth, Texas Municipal League Intergovernmental Risk Pool; 13 individuals.

On — Donald Patrick, Texas State Board of Medical Examiners; C.H. Mah, Brian Ryder, Texas Department of Insurance; G.K. Sprinkle, Texas Ambulance Association

BACKGROUND:

The Medical Liability and Insurance Improvement Act of Texas (Art. 4590i, V.T.C.S.) governs medical liability and recovery. Under Sec. 4.01. (a) of the act and written notice of a possible health care liability claim must be sent to each health care provider involved at least 60 days before the filing of a suit. This notice is referred to as a "4590i" letter.

Sec. 11.02-04 of art. 4590i limits total civil liability in a medical malpractice claim to $500,000, unless invalidated, then the limit is $150,000 on noneconomic damages. Both of the limits are indexed to the Consumer Price Index (CPI). This limitation does not apply to the liability of an insurer under the "Stowers Doctrine," under which an insured can sue the insurer for failing to settle a claim that is within policy limits.

The Texas Supreme Court in 1990 ruled the caps unconstitutional except in cases of wrongful death. In *Lucas v. U.S.*, 757 S.W.2d 687, the high court found that limiting recovery for people injured by medical negligence for the purpose of reducing malpractice premium rates was unconstitutional, holding that the Texas Constitution, Art. 1, sec. 13, the Open Courts Doctrine, guarantees meaningful access to courts. The cap on damages in cases of wrongful death, which the court did not declare unconstitutional, is worth about $1.3 million today because of growth in the CPI.

A vendor's endorsement extends a manufacturer's commercial general liability policy to the vendor, protecting the vendor against claims asserted by third parties for injuries resulting from the manufacturer's product. For example, the vendor could be a physician, and the manufacturer could be a company that makes medical devices or implants.

Sec. 10.01 of Art. 4590i limits to two years the amount of time that may pass between the act of alleged malpractice and the commencement of a claim. Minors under the age of 12, however, have until age 14 to file.

Sec. 13.01 of Art. 4590i requires a claimant in a medical malpractice case within 90 days of filing the claim to file a cost bond of $5,000 per health care

provider or put the same amount in an escrow account. Alternatively, a claimant may file an expert report, a professional medical opinion on the case, in lieu of the financial bond. If neither the financial bond nor the expert report is filed within 90 days, the court must order a cost bond of $7,500 per defendant within 21 days. If the claimant fails to post the cost bond at that time, the claim is dismissed. To reinstate a claim, the claimant must post the $7,500 cost bond and court costs incurred by the defendant. A claimant who cannot afford the cost bond and does not have an attorney may file an affidavit in lieu of securities.

Within 180 days of filing a claim, the claimant must furnish an expert report, either the one used in filing or, if a cost bond was posted, an initial expert report, with the curriculum vitae of each expert to the defendant. The court may extend this deadline by 30 days and may grant a further grace period. If the expert report is not furnished, the claimant must voluntarily withdraw the claim and forfeit the cost bond to pay the defendant's attorney fees and court costs.

The expert report filed by a claimant is not admissible as evidence by the defendant and may not be referred to during the course of the action. The court will grant a motion challenging the adequacy of the report only if the author of the report is not qualified as an expert.

Sec. 16.02 (a) of Art. 4590i, prohibits collection of prejudgment interest if the claim is settled within 180 days after filing the claim.

DIGEST:

Article 10 of CSHB 4 would amend sections of the Medical Liability and Insurance Improvement Act of Texas (Art. 4590i, V.T.C.S.) as it applies to:

- the amount of liability for physicians and other health care providers;
- cases involving emergency or charity care;
- matters of litigation including expert reports, the structure of attorney fees, and filing deadlines;
- recovery matters; and
- the effect of any future legal challenge to the act.

The bill also would broaden the definition of health care provider and state legislative intent regarding the state of medical liability insurance, health care, and medical liability claims in Texas.

Limits on liability. Article 10 of CSHB 4 would amend the limits on liability in medical malpractice cases both in general and in specific instances.

The bill would amend sec. 11.02-04 of art. 4590i, V.T.C.S., the general, $500,000 indexed cap on liability in medical malpractice cases, to include punitive damages in the limit and apply it on a per-claimant basis. The bill would remove the alternative indexed limitation of $150,000 and replace it with a cap on noneconomic damages of $250,000 per claimant, regardless of the number of defendants. This cap would not be indexed. It also would repeal the section stating that the cap does not apply to the liability of an insurer under the "Stowers Doctrine."

Article 10 of CSHB 4 would create an alternative limit that would be effective if the previously described cap were invalidated. The alternative cap would apply to all damages, other than economic damages, and also would be set at $250,000. It would apply only to physicians and hospitals that carry certain levels of liability coverage, levels that would increase in three tiers over time.

Before September 1, 2005, the levels would be:

- $100,000 per claim and $300,000 aggregate for residents,
- $200,000 per claim and $600,000 aggregate for physicians, and
- $500,000 per claim and $1.5 million aggregate for hospitals.

Beginning September 1, 2005, the levels would be:

- $100,000 per claim and $300,000 aggregate for residents,
- $300,000 per claim and $900,000 aggregate for physicians, and
- $750,000 per claim and $2.25 million aggregate for hospitals.

Beginning September 1, 2007, the levels would be:

- $100,000 per claim and $300,000 aggregate for residents,
- $500,000 per claim and $1 million aggregate for physicians, and
- $1 million per claim and $3 million aggregate for hospitals.

Hospitals that provide charity care would have liability limited at $500,000, except in cases of intentional, willful or wanton negligence, conscious indifference, or reckless disregard for the safety of others. The limit on liability would be in exchange for uncompensated health care services.

The bill also would add a statute of repose, limiting the filing of a claim to 10 years after the act.

Article 10 of CSHB 4 would prohibit insurers from excluding or limiting coverage for a vendor's endorsement issued to a manufacturer and establish physicians as vendors in relation to a manufacturer's general liability policy.

Emergency or charity care. Article 10 of CSHB 4 would limit the liability of emergency care. It would require jury instructions to include circumstances surrounding the emergency and related medical care. The required qualifications for a testifying expert witness would apply to matters of causation in addition to standard of proof, and the bill would establish qualification requirements in cases involving a non-physician. In addition, the definition of "person responsible for the patient" would be broadened to include schools, siblings, and others for the purposes of liability limits in cases involving volunteers.

Pre-trial matters. Article 10 of CSHB 4 would prohibit taking a deposition of a health care provider for the purposes of a liability claim prior to filing. It would require filers of claims to submit only an expert report and no longer require a cost-bond. The bill would require a claimant to serve each party an expert report and the expert's curriculum vitae by the 180th day after filing the claim. If that failed to occur, the court would dismiss the claim with prejudice and order the claimant to pay the defendant's attorney fees and court costs.

Until the expert report was filed, all discovery would be stayed except for the patient's medical records. The expert report required for filing the claim could not be introduced into evidence or referred to by either party in the course of the action. Any other expert report could be introduced by either party. The bill would expand the qualification requirements for a testifying expert witness to include causation as well as standard of care. It also would establish qualifications for expert witnesses testifying in a claim against a non-physician.

Article 10 of CSHB 4 would limit the contingency fee that an attorney could contract or collect to 33.3 percent of the amount recovered. If the $250,000 cap on liability were invalidated, a different limit on contingency fees would take effect. This alternate limit would set the following schedule:

- 40 percent of the first $50,000 recovered,
- 33.3 percent of the next $50,000 recovered,
- 25 percent of the next $500,000 recovered, and
- 15 percent of any additional amount.

Recovery matters. Article 10 of CSHB 4 would limit the recovery of medical expenses to those actually paid by or on behalf of the claimant. It would permit claimants to collect prejudgment interest even if the claim were settled within 180 days after filing.

In cases when the claimant seeks recovery for economic losses, the bill would require the claimant to present evidence of economic loss in the form of a net after-tax loss and the jury to hear if any recovery would be subject to taxation.

Article 10 of CSHB 4 would add collateral source provisions to the Medical Liability and Insurance Improvement Act. Collateral source benefits would be defined as Social Security payments; workers' compensation; accident, health, or sickness insurance policies; disability insurance policies; and some other types of insurance, except for life insurance policies. The bill would allow the defendant in a medical liability claim to introduce collateral source benefits as evidence. Once collateral source was introduced, the plaintiff would be permitted to introduce evidence of payment for the insurance policy. The insurer paying the collateral benefits would be barred from recovering any payments from a claimant and would not hold any rights to the claimant's award, unless required by federal law.

During the course of an action, a defendant could pay for the continuation of a claimant's health or disability insurance, if the claimant were unable or unwilling to continue paying for it.

The bill would require the court to order periodic payments, rather than a lump sum payment, at the request of either the defendant or the plaintiff in cases when the award was $100,000 or more. The court would specify the

number, interval, and amount of the payments. The order for payment would constitute a release of the claim. As a condition of authorization for periodic payments, the defendant would be required to show financial responsibility, an insurance policy, bond, or other proof of ability to make full payment. If the recipient of periodic payments died, all payments except loss of earnings would cease and any remaining security would be returned to the defendant. Attorney fees would be paid in a lump sum by estimating the total value of the award and calculating its net present value.

Directions if challenged. The bill would direct any question of the constitutionality or other validity of its provisions to district court in Travis County, which could grant or deny a temporary or permanent injunction. Any appeal would be a direct, accelerated appeal to the Supreme Court. The bill would permit interested associations to sue if they had more than one member who would have standing to sue and seek a ruling on the constitutionality or validity the bill.

Effective date. The amendments that Article 10 of CSHB 4 would make to the Medical Liability and Insurance Improvement Act would apply to actions that occurred on or after January 1, 2004. The limits on attorney contingency fees also would apply only to contracts signed on or after January 1, 2004.

Article 10 of CSHB 4 would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2003. If it took effect September 1, 2003, then mailing of written notice of a claim by certified mail, return receipt requested on or after June 1, 2003, and before September 1, 2003, would constitute filing of a claim and it would be governed by current law. If the bill took immediate effect, then the same method of filing could be used if sent on or before the 60th day after the effective date.

SUPPORTERS SAY:

Texas has a medical malpractice crisis, and the changes included in Article 10 of CSHB 4 are the best way to help ensure patient access to care. Large jury awards have driven up the cost of medical malpractice insurance over the past few years. Faced with large increases in the cost of their malpractice insurance, physicians in some areas of the state have limited their practices, retired early, or left Texas. High-risk specialties, such as obstetrics and neurology, have been hardest hit, to the extent that many OB/GYNs no longer

deliver babies, while increasing numbers of neurologists no longer perform surgery. Article 10 of CSHB 4 would strike an appropriate balance between common sense reforms to the medical liability system and protecting the right of those who are harmed to recover damages to compensate them for the injury.

CSHB 4 would help ensure access to health care by limiting insurers' exposure to risk. This would lead to a reduction in medical malpractice rates, which would permit more physicians to practice in the state.

Other states have enacted similar reforms to address similar problems. In 1975, California enacted its Medical Injury Compensation Reform Act (MICRA), considered the nation's most comprehensive set of medical malpractice revision initiatives. It has had a significant impact on premium rates in California, where increases have occurred at about one-quarter the pace of the rest of the nation.

The only solution to the medical malpractice crisis is to limit the liability of insurers, who then could pass the savings on to physicians. The growth in malpractice claims has left insurers facing higher payouts from a shrinking pool of funds, which cannot be solved by passing the costs on to policyholders. Managed health care has forced physicians to operate within very thin margins and does not allow them to pass on the cost of higher premiums to their patients. Insurers' holdings primarily are in bonds, and their performance has not been hampered by the stock market. The shrinking pool of funds is due to payouts, not investment losses.

Also, increased regulation of physicians alone would not solve this problem. The regional disparities in malpractice claims have nothing to do with the doctors who practice there. Heavy advertising by lawyers in the Rio Grande Valley has driven the growth in malpractice claims there. Regional disparities in the pattern of malpractice claims are due to the sentiments of certain courts or venues, not the competence of the physicians practicing in those areas. This shows that the root of the problem rests with the tort system, not the Board of Medical Examiners. To strengthen the board, the Legislature also is considering SB 104 by Nelson and similar legislation to give the board greater regulatory authority and more resources.

Limits on liability. Limits on noneconomic damages are a cornerstone of the efforts to reduce medical malpractice rates because high verdicts in malpractice cases make it more expensive for insurers to write policies. A March 2000 report by Jury Verdict Research, a database of verdicts and settlements resulting from personal injury claims, found that jury awards in malpractice cases nationally rose by 43 percent from 1999 to 2000, to a median of $1 million, while the median settlement amount actually fell during the same period. The survey also found that plaintiffs lost more than half the cases that went to trial. Based on California's experience, a $250,000 cap on non-economic damages in Texas would result in a substantial reduction in liability premiums over a period of years.

Efforts to reduce medical malpractice insurance premiums and protect patient access would be useless without a cap on damages. California's long history of caps, as well as a report by the U.S. Office of Technology Assessment, support the conclusion that caps are an integral part of the solution. A higher cap on noneconomic damages would not have as much impact on liability premiums.

Limiting the amount of an award in a medical malpractice case would reduce premium rates. Juries often are sympathetic to plaintiffs and award them much more than a settlement would provide because that is what the jurors would want for themselves. Given that economic damages would not be capped, a limit on noneconomic damages would ensure that plaintiffs received the compensation they deserved, rather than winning a "lottery."

Unlimited noneconomic damages undermine the state's health-care system. Lawyers pursue medical malpractice cases in hopes of reaping large sums of money in emotional cases with unsophisticated jurors who do not understand the impact of multimillion-dollar settlements on the entire health-care system. When premiums rise too high, doctors stop practicing, thereby threatening access to medical care for all Texans. Capping damages would encourage insurers to do business in Texas by ensuring that they would not incur losses because of large damage awards. As more insurers joined the market, competition would reduce premiums.

A cap on noneconomic damages would not limit a patient's right to redress. It would not limit the amount a patient could be compensated for actual losses

and damages, past or future health care expenses, past loss of earnings, or future loss of earning capacity, and other economic damages. Noneconomic damages are intangible and include things like pain and suffering or punitive damages. These elements do not help the patient regain what was lost, instead they weigh down the medical system. Patients should get what they deserve in the form of economic losses because noneconomic damages do not make a patient whole — economic damages do.

Capping noneconomic damages would improve the health and welfare of nursing home residents. According to an industry trade group, about half of all nursing homes do not carry liability insurance because they cannot afford the premiums. Nursing homes will be required to carry insurance after September 1, 2003, but the high cost of the policies will squeeze the amount that is spent on residents' care. This bill would reduce premiums, freeing up money for direct care, and allowing nursing homes to buy adequate levels of liability insurance. In addition, insurers would become advocates for families of nursing home patients because liability policies often require certain levels of care at given policy rates.

Other types of liability that are similar to medical malpractice already have caps on damages. These include claims against charities and volunteers, some health plans, and manufacturers of vaccines. Physicians and hospitals should enjoy similar protection.

The state should include a cap on damages in medical malpractice reform efforts even though a previous $500,000 cap on noneconomic damages was held unconstitutional by the Texas Supreme Court. In *Lucas v. U.S.*, 757 S.W.2d 687, the high court found that limiting recovery for people injured by medical negligence for the purpose of reducing malpractice premium rates was unconstitutional, except in cases of wrongful death. The basis for the court's decision is which Texas Constitution, Art. 1, sec. 13, called the Open Courts Doctrine, guarantees meaningful access to courts. In other cases, the court has held that the Legislature must offer a quid pro quo if it restricts access to the courts.

The cap proposed by Article 10 of CSHB 4 would not violate the Open Courts Doctrine because the limit on damages would be in exchange for access to

health care. In addition, the court has changed since the time of *Lucas* and might be more amenable to limits on damages.

An alternate to the first limit on liability in the bill would ensure that the state's reform efforts stand even if the first limit were held unconstitutional. The quid pro quo offered by the alternate cap would satisfy the constitutionality test as it has in the Charitable Immunity and Liability Act of 1987, upon which it is modeled. In addition, the caps-for-coverage trade would promote higher actual recovery for patients as it would ensure that physicians and hospitals carry sufficient liability insurance to cover an award.

Repealing of current law stating that a damage award cap does not apply to the liability of an insurer under the "Stowers Doctrine" would clarify the intent of the cap. With the current language, some plaintiff's attorneys argue that if a physician or hospital carries insurance that is greater than the cap, the insurer should settle for any amount within policy limits, even if that amount is above the cap.

Statute of repose. Article 10 of CSHB 4 would help reduce medical liability insurance premiums by increasing the predictability of the system. This statute of repose would limit the amount of time — from 14 years to 10 years — that an insurer might be called on to pay a claim involving a minor. According to insurers in Texas, most obstetric claims are filed within three years of the birth. It also would give physicians some relief in the length of a "trailer" policy, insurance to cover liability after retirement, that they must purchase.

Hospitals. Hospitals are charitable organizations because they are required to offer charity care in exchange for their tax-exempt status. In addition, any hospital with an emergency clinic must treat all patients, resulting in bad debt of about 25 percent. As a result, most hospitals are loathe to admit patients for non-emergency services or preventive care because the hospital must pay for liability insurance in addition to absorbing the cost of the care. This bill would afford to hospitals that offer charity care the same immunity that applies to other charitable organizations and would encourage hospitals to offer more free care.

The free services offered by many clinics are performed by volunteer physicians who are not always covered by clinics' liability policies. Just as

other volunteers have limited liability under the Charitable Immunity and Liability Act, so should volunteer physicians.

This bill would have no effect on the number of abortions performed in Texas. Medical malpractice rates for OB/GYNs reflect the risk associated with full-term births, not abortions. The only effect this bill would have on the unborn would be to ensure that there are enough OB/GYNs practicing without restrictions in Texas to have one present at birth.

Vendor's endorsement. In class action lawsuits involving prescription drugs or medical devices, a physician may be named as a defendant to prevent the case from being removed to federal court, even though the physician only prescribed the medication or device. The manufacturer of the drug or medical device is the more appropriate defendant in these cases, and CSHB 4 would indemnify the physician under the manufacturer's product liability insurance.

Emergency or charity care. Physicians are required to treat anyone who walks into an emergency room, yet their actions may be compared to those of a physician in an office environment in cases of alleged medical malpractice. Emergency care often is provided without medical history and under extreme time pressure. Because of these special circumstances, requiring jury instructions to include circumstances surrounding the emergency and related medical care is appropriate.

High school kids often receive free physicals from doctors volunteering their time. Because most of these kids are under 18, there are questions about who can sign the release form. This bill would fix the problem by extending that authority to the school.

Pre-trial matters.
Deposition. Rule 202 of Texas Rules of Civil Procedure permits claimants to petition the court for an order authorizing a deposition to investigate a potential claim or suit. In medical malpractice cases, a plaintiff's lawyer may depose one of the health care providers before filing a lawsuit without the knowledge of the other future defendants, thwarting a defendant's right to be present. This bill would prevent that abuse and ensure that all defendants were aware of the proceedings.

Expert report. The current cost bond system is ineffectual because there are so many loopholes. This bill would create one system that is straightforward and fair to people of all income levels because it would require no financial obligation. Requiring an expert report, or professional medical opinion on the case, when filing a lawsuit also focuses the suit on whether the defendant's actions were consistent with accepted standards of care, not on the finances of the plaintiff.

Claimants without legitimate cases should not be permitted to waste everyone's resources during the 180-day period until the expert report is filed. Even in cases that do not result in a lawsuit, claimants run up expenses on both sides with vast amounts of discovery. Article 10 of CSHB 4 would limit those expenses to legitimate claims, which could involve as much discovery as needed.

The required qualifications for an expert witness should apply to causation to give juries a better idea of what happened. Under current law, a testifying physician must be in active practice, know the accepted standards of medical care, and be qualified on the basis of training or experience to offer an expert opinion. For example, a neurologist only may testify to the standards of care for neurology. However, without including causation, a family physician could testify that an act by a neurologist caused the alleged damage. Juries should hear only the most qualified opinions from like specialists.

Attorney fees. Attorneys often receive more of the settlement than the claimant because of contingency arrangements. Injured parties should not be forced to exchange most of their award for access to the courts. A limit on attorney fees would help solve this problem.

A limit on attorney fees also would make attorneys more selective in accepting cases rather than taking "long-shot" cases in hopes of a big payout. This would help reduce premium rates because insurers would pay awards only on legitimate cases. Limiting the financial incentive to go to court would reduce the number of claims and equalize them across the state, thereby reducing premiums.

Recovery matters.

Medical expenses. Medical expenses should be limited to what was actually paid, not the normal charge for the service. Managed care companies have special contracts with physicians and hospitals, so they pay less. Similarly, Medicare reimburses at a rate below most private insurers. In both cases, successful claimants should be reimbursed the reduced amount originally paid for the services, (i.e., health care providers should not be charged for money they never received). This provision would not limit future medical expenses and would not preclude payment of Medicare costs.

Prejudgment interest. Interest should be paid for the amount of awarded damages outstanding, and not on monies already received. Under current law, a defendant is charged prejudgment interest on the entire amount of the award, which may include portions of the award already received by settlement with another party.

The interest rate should be pegged to 52-week treasury bills rather than the current peg that includes a 10 percent floor and a 20 percent ceiling. With interest rates in the 3 percent range recently, it is unfair to make defendants pay 10 percent. This change also would benefit the plaintiffs if rates should rise above 20 percent in the future.

Evidence of economic loss. Tax returns provide the best way to calculate loss of income and make a claimant whole. Personal injury awards are not taxable, so it is overly generous to compensate victims for money that would have gone to pay taxes when the award would not.

Collateral source. The concealment of collateral source compensation, such as insurance from workers' compensation, prevents a jury from making a true assessment of loss. Juries should know if the claimant would receive compensation from another source, otherwise it could overpay the claimant in an effort to make the claimant whole. Presenting collateral source information to a jury would help reduce medical malpractice insurance rates because the insurer would pay only what is not already covered. The court may order defendants to pay for the insurance policy to keep it in effect, so the claimant would not be forced to pay for anything.

Disclosure of collateral sources would not jeopardize the claimant, as the amounts paid to obtain the coverage could be introduced. Also, collateral sources are a more efficient mechanism by which a claimant can be compensated. A larger portion of a health care or disability insurance premium is expended on actual services than the portion of a liability premium amount spent to compensate claimants.

Subrogation, an insurance company's right to go after what it has paid on behalf of a plaintiff due to injuries or loss caused by the defendant, should be barred to protect claimants from lawsuits by insurers. Article 10 of CSHB 4 would ensure that claimants' awards could not be taken away by insurers.

Periodic payments. Claimants should not receive compensation for costs that never materialize. Periodic payments for awards over $100,000 would make the jury award system more fair. Economic damages are designed to compensate for expenses associated with harm to the patient, including medical bills, many of which cease when the patient dies. Even while the patient is alive periodic payments are fairer because the patient's future income is assured. With a lump-sum payment, a patient could lose the entire settlement through a bad investment decision.

This bill would help ease Texas' current crisis by allowing insurers to plan their payments better. Instead of paying an enormous sum at the end of a trial, an insurer could build future payments into its business plan and adjust rates accordingly. In this way, a few unusually high jury awards would not deplete an insurer.

Directions if challenged. Constitutionality of the noneconomic damages cap and other reforms in Article 10 of CSHB 4 should be established as quickly as possible to reap the benefits of reduced malpractice insurance premiums. Accelerated appeals and associations' standing to sue are important to put the constitutionality question to rest as quickly as possible. In California, the bulk of the premium rate reductions occurred only after the caps in MICRA were found constitutional.

Texas does not need a guaranteed premium rate reduction in statute to ensure that savings from these changes are passed on to physicians. The Texas Medical Liability Trust (TMLT), as the largest single medical malpractice

insurer, writes about 30 percent of all policies in the state. This not-for-profit trust must pass savings to policyholders and is likely to do so quickly, since it is owned and managed by physicians. The TMLT has indicated that it will reduce rates by as much as 12 percent if the constitutionality of caps on damages is upheld. If the TMLT lowered its rate, other insurers would follow suit to remain competitive.

OPPONENTS SAY:

The tort system is not a significant cause of the medical malpractice liability crisis. Texas should focus first on reforms that will directly lower medical malpractice rates, such as better regulation of doctors and insurance rate regulation.

The Texas State Board of Medical Examiners (BME) does not address problems with physicians adequately and cannot assure that all licensed physicians in Texas are fit to practice. According to BME data, the board received more than 6,000 malpractice complaints against physicians between January 2001 and May 2002, yet opened no investigations during that period. The board is underfunded and lacks legislative direction to go aggressively after bad doctors.

Legislators also should tighten regulation of the insurance industry. Insurers' intense competition for market share during the 1990s sank premium rates to artificial depths. Thin margins, coupled with stock market woes and low interest rates, have forced insurers to pass higher costs on to policyholders.

California's insurance premiums fell only after state voters approved Proposition 103, a 1988 insurance reform initiative that mandated lower rates and regulated insurance companies. A study of California's rate history shows that premiums grew along with the rest of the nation through the 1980s, even after the enactment of the damage award caps in MICRA.

Early analysis of 2002 Texas Department of Insurance (TDI) data suggests no correlation between how much insurers pay out and how much they charge in premiums. Instead, it suggests that noneconomic damage awards are not rising at all, but shrinking as a percentage of total damages. The agency currently is working on a full analysis, which is expected to support this hypothesis. At the very least, the Legislature should wait until TDI completes its analysis before making radical changes to medical malpractice tort.

Limits on liability. Limits on noneconomic damages would not reduce medical malpractice premium rates. Jury awards are not the main driver of premium rates. Some states that have capped noneconomic damages still have seen a rise in premiums, including West Virginia, which appears on the American Medical Association's medical liability insurance rate "crisis" list.

Insurers already have caps on damages. They do not have to pay out more than the policy limit. The caps proposed in CSHB 4 only would serve to reduce the amount a patient could recover from a physician who caused injury, not the insurer.

A cap on non-economic damages would limit unfairly a patient's right to redress. Economic damages account only for medical bills and wages, not intangible losses, such as becoming home-bound, being unable to care for one's children, suffering caused by major disfigurement, and other horrible results of medical malpractice. Economic damages alone do not make a patient whole.

Any cap on damages places an arbitrary value on human life, one that would diminish the value of the lives of women, children, the elderly, and the disabled. This bill would equate a person's life to the amount of money earned, which clearly would discriminate against individuals whose value exceeds their income. Even a cap in a case of a wealthy person with a high income places an arbitrary value on that person's life. Only juries are able to make those types of value distinctions — the Legislature should not.

A cap on damages could endanger older Texans in nursing homes. According to an October 2002 report by the U.S. House of Representatives more than 25 percent of nursing homes in Texas violated federal health standards that placed residents at serious risk. The only recourse for families of mistreated nursing-home patients is threat of a lawsuit. A cap on damages would make that threat meaningless and leave such patients and families powerless.

Other types of liability that already have caps should not apply to physicians and hospitals. Charities and volunteers offer services for free while physicians and hospitals get paid for services. The health plans with caps on liability are ERISA plans, which means they are governed by federal law,

while the liability of physicians and hospitals in Texas are governed by state law. The vaccines manufactured by the companies with liability limits directly protect the public's health while physicians and hospitals treat individual health concerns. Each of the groups now with a cap represents an exception to the general practice of medicine in Texas, while physicians and hospitals are the general practice of medicine and should have no special protection under a cap.

A $250,000 limit on noneconomic damages would violate the Open Courts Doctrine and is unconstitutional. The trade of damage caps for enhanced access to health care is insufficient to withstand a constitutional challenge because there is no guarantee that reducing access to courts in this way would increase access to health care. The alleged flight of physicians from certain areas of the state and certain specialties can be interpreted different ways, including population shifts within the state from rural to urban areas and physicians' dissatisfaction with working in a managed care environment.

An alternate limit on liability in the bill, which would require physicians and hospitals to carry certain levels of insurance in exchange for the protection of damage caps, also is insufficient to withstand a constitutional challenge. The caps-for-coverage trade is no trade at all: physicians already are required to carry certain levels of liability insurance to obtain hospital privileges. The public would be giving up access to courts for protection it already has.

A fairer quid pro quo for caps on damages would be increased compensation for more victims of medical malpractice. By some counts, as many as seven out of eight instances of medical malpractice do not result in a lawsuit and go without any compensation. Texas could implement some sort of "no fault" system, like that for auto insurance, under which losses are paid by the insurer without regard to fault. No fault insurance typically restricts a victim's ability to sue for losses that fall below a certain level. This could be combined with a "loser pay" system where plaintiffs pay the legal fees and court costs for non-meritorious cases. This would give more people access to compensation, a better trade for reduced access to courts.

Indigent patients should not be required to waive their right to recovery in exchange for health services. Hospitals do not give services away for free, except in emergencies as required by federal law. This bill would allow

emergency rooms to treat indigent patients at a lower standard of care without fear of liability because they would force patients to sign away their rights at the door.

Hospitals should not be protected under the Charitable Immunity and Liability Act, which immunizes volunteers and charitable organizations from liability to encourage individuals to give their time and talent without fear of being sued. Overall, hospitals receive compensation for their services, and liability is part of the cost of doing business.

If this immunity were extended to hospitals, the state should limit the immunity only to those that provide charitable care. Last session, the 77th Legislature considered HB 1340 by Brimer, which would have distinguished hospitals that administer charity care for the purposes of possibly extending the Charitable Immunity and Liability Act in the future. It would have limited eligible hospitals to those that provide charity care equal to 10 percent or more of net patient revenue and at least 50 percent of the charity care required by the county. That bill passed the House in the waning hours of the session, but died in the Senate.

Caps on noneconomic damages could increase the number of providers willing to perform abortions in Texas. Medical malpractice rates reflect the amount of financial exposure associated with a certain type of practice. Awards in abortion-related malpractice cases are almost always noneconomic damages, which would be capped under Article 10 of CSHB 4.

Emergency or charity care. The standard of proof and jury instructions in cases involving emergency care should not be any different from other cases. Because emergency room physicians may not know their patients' medical histories, they should be encouraged to run the tests needed to make a diagnosis. The problem of no prior relationship already is accounted for by the standard of care, which compares an emergency room physician's actions to those of another emergency room physician.

The bill should define an "emergency situation" if jury instructions are required. Any time a patient's condition deteriorates it could be termed an emergency, even when the change in condition was caused by malpractice.

A school, camp, or sibling of a child should not be permitted to waive liability. Parents may sign a waiver when they enroll their child, but that decision should be their choice. This bill would automatically waive liability without parents' permission.

Pre-trial matters.

Deposition. This bill would encourage frivolous lawsuits by forcing patients to file a lawsuit to find out if a wrong was done. Under current law, physicians are required to release patient records when they receive a "4590i letter," a claim that may lead to a lawsuit. Discrepancies in patient records and witnesses may be resolved with a deposition of the physician, and the letter may never result in a lawsuit. This bill would force claimants to file a lawsuit just to get the physician's side of the story. An increased number of lawsuits against a physicians also is likely to drive up that physician's medical malpractice insurance premium because those rates are set according to the number of claims against a doctor.

There are sufficient rules in place to limit the taking of depositions, so they should not be prohibited. Rule 202 of the Texas Rules of Civil Procedure permits claimants to petition the court for an order authorizing a deposition to investigate a potential claim or suit. This rule prevents claimants' lawyers from hassling people who are not involved and helps resolve misunderstandings before they become lawsuits.

Expert report. This bill would make it difficult for experts to adequately assess if an act of malpractice had been committed because all discovery would be stayed until after the expert report was filed. For example, the clinical record in nursing homes often is falsified, which prevents an expert from accurately assessing the alleged wrong.

The qualifications for an expert testifying to causation should be defined by the "same school" rule, meaning that peer physicians should be those who practice the same procedures, not necessarily the same specialty. This would give jurors a truer picture of how the procedure is actually performed, rather than an analysis by a specialist who may not perform the procedure often.

Attorney fees. The limit on attorney fees would diminish the public's ability to contract freely with a professional. The state does not limit how much a

doctor or an accountant can charge, so the contractual relationship between a client and an attorney should not be any different. Like those professions, attorneys belong to professional groups that establish ethical guidelines for fees.

The percentage fee reflects the risk a lawyer takes when accepting a case. Patients with difficult cases might be unable to secure representation if lawyers could not cover their risks. Limiting attorney fees would be unlikely to reduce the number of claims because disincentives already exist for lawyers to take "long-shot" cases. Under the contingency system, lawyers must invest significant amounts of money and time in trying cases and do not make such investments for illegitimate cases.

Also, limiting attorney fees has not been shown to prevent the rise of medical malpractice premiums. Three of the states now identified as in crisis — Florida, New Jersey, and New York — set caps on attorney fees.

In the interest of fairness, attorney fees should be better regulated. If they are limited on the claimant's side, they also should be limited on the defendant's side. However, the alleged problem of excessive attorney contingency fees could best be resolved through better oversight by the State Bar of Texas. Currently, claimants who feel their attorney's fees were too high can complain to the Bar, but little is actually done. The Bar should be more stringent in its regulatory role.

Statute of repose. The 10-year statute of repose would limit the right to recovery for children with neurological, endocrine, or reproductive conditions caused by malpractice in utero or at birth. These conditions often emerge only after puberty, which falls within the current statute of limitations, but would be missed by a 10-year cutoff.

Recovery matters.

Medical expenses. The intent of this bill's limits on medical expenses is unclear and should be better defined. It could be interpreted to mean that economic damages are capped as they relate to future medical expenses because they have not been incurred or paid by a claimant. It also could mean that elderly patients whose medical bills are reimbursed, not incurred or paid by Medicare on behalf of the elderly recipient, are not recoverable. Federal

law requires that Medicare recoup the amount it pays for health expenses attributable to a medical malpractice case, so this bill could leave elderly recipients owing Medicare without the inclusion of those expenses in an award.

Evidence of economic loss. The calculation of economic loss should be based on a calculation of net income, not tax returns. People with very good accountants would be punished, as would anyone whose earnings are under the table, such as a gardener or a nanny.

Collateral source. Juries often do not compensate plaintiffs fully for future medical bills or other financial burdens that the plaintiff is likely to encounter, so reducing the compensation further would harm plaintiffs. Responsible people who carry insurance should not be punished by having their awards reduced by that amount.

Prohibiting collateral source disclosure protects claimants from medical malpractice insurers who want to pay less because the claimant has coverage. It is unfair for a claimant's health or disability insurance to pay for an injury caused by a bad doctor. Shifting the risk of a physician's actions to another insurer is not an appropriate way to reduce malpractice insurance premiums.

Collateral source is a less efficient mechanism for compensating a claimant. Health care or disability insurance reimbursement requires an ongoing flow of paperwork for the claimant and the insurer, which adds administrative cost and hassle. Awards in a medical malpractice lawsuit are more streamlined.

Periodic payments. Periodic payments already are an option for courts in the form of structured payments. In fact, most settlements involving children use structured payments. The decision to use structured payments should remain with the court, however, and not be required. Making periodic payments mandatory would not reduce premiums because insurers still would be liable for the entire amount, and their rates would reflect that. Also, periodic payments would remove injured patients' certainty that their bills will be covered. If insurers are losing money now, as they claim, patients should not be at the mercy of insurers' future solvency. Money awarded today should be paid today to ensure that victims can receive the medical care and lost wages they will need in the future.

Directions if challenged. Associations should not have standing to sue because it is unfair to citizens. Instead of waiting until a case came along to decide the constitutionality of these changes, an association would be able to ask the court for a binding opinion without the specifics of a case. Other interested parties might not have the same privilege because the bill only affords standing to associations with more than one member who would have standing individually.

Definitions. The definition of health care provider should not include assisted living facilities. Those facilities are not permitted to administer medical care and are more similar to residences than nursing homes, which have 24-hour nursing care. Including assisted living facilities could limit their liability concerning residents' premises, such as walkway safety.

OTHER OPPONENTS SAY:

Any limit on liability should be indexed, as should the minimums for insurance policies under an alternate cap. These limits today will be worth nothing in 25 years and doctors would only be required to carry minimal levels of insurance by 2028 standards. As the caps and insurance minimums would be in statute, they could be increased over time, but it would make more sense and save future legislatures time and effort to index them in this bill.

Texas should require a guarantee from insurers that these reforms will result in lower premiums. In 1995, the 74th Legislature enacted HB 1988 by Duncan, establishing flexible rating for certain lines of insurance. That law contained a provision introduced by then-Rep. Mark Stiles requiring insurers to estimate the amount of money saved through the civil liability revisions also enacted that session and to apply that amount to a temporary rate reduction. CSHB 4 should require that reductions in tort costs be applied directly to reducing premium rates.

NOTES:

(See end of Part Two for NOTES for both parts of CSHB 4.)

Part Two — Tort Liability

WITNESSES:

(On HB 4, original version:)
For — Lee Blaylock; Bill Borden; George R. Carlton, Jr.; George Scott Christian, Texas Civil Justice League; Richard Evans, Texas Association of Business; Evan J. Griffiths, Westdale Asset Management; Ray Perryman, Richard J. Trabulsi, Jr., and Alan Waldrop, Texans for Lawsuit Reform; Shannon Ratliff; Mike Scott

Against — Steve Bresnen, Wade Caldwell, Kenneth T. Fibich, Charles S. Siegel, and Paula Sweeney, Texas Trial Lawyers Association; Billy Edwards; Jim Haire; Peter M. Kelly; Tony Korioth, Texas Municipal League Intergovernmental Risk Pool; Yvonne Moran

On — Brock Akers

BACKGROUND:

Class actions. The Civil Practice and Remedies Code (CPRC) and the Texas Rules of Civil Procedure (TRCP) generally govern civil litigation. No chapter of the CPRC specifically addresses class actions, but Rule 42 of the TRCP and supporting case law address the litigation aspects of class-action lawsuits.

A class action is a lawsuit in which a large group of plaintiffs allege injury in a similar manner by the same defendant(s). If a court certifies a group of plaintiffs as a class, the suit may proceed as a class action, with one person or several people serving as "class representative(s)" for the plaintiffs.

A party may file an interlocutory appeal on the issue of class certification. An interlocutory appeal is an accelerated appeal taken before the lawsuit is over. An interlocutory appeal taken on the issue of class certification entitles the party to appellate review of that issue before the case goes further.

Before an offer of settlement in a class action suit, including attorney's fees, can become effective, the court must approve the settlement. Attorney's fees are calculated pursuant to the contract between the clients and attorney(s) and often are structured as a contingent fee of between 20 and 40 percent of damages recovered. The court awards the amount of fees that it considers reasonable and necessary under the circumstances of the case. If a case is not

settled and goes to trial, the trier of fact determines the award to the class. The trier of fact may be the judge or the jury, depending on the case. Class attorneys are entitled to the percentage of the recovery for which they contracted with the class members, but the court may change this amount.

Settlement offers. Although no offer-of-settlement rule exists for all civil actions, some portions of Texas law provide for a system by which a party may offer a settlement to another party. For example, the Deceptive Trade Practices Act (DTPA, Business and Commerce Code, chapter 17) requires that consumers give notice of their complaints to potential defendants. After receiving such a notice, a defendant may offer a settlement to the plaintiff. A plaintiff that fails to accept a reasonable offer is limited in the amount of damages that can be recovered at trial.

Under the common-law Stowers Doctrine, an insurance company has a duty to accept reasonable settlement demands within policy limits. If the insurer fails to accept a reasonable demand and later is assessed with damages in excess of policy limits by the trier of fact, the company is liable for the amount in excess of policy limits.

The Federal Rules of Civil Procedure (FRCP) provide a federal equivalent to an offer of settlement, called an offer of judgment, in FRCP 68. A defendant may serve a plaintiff with an offer to allow judgment to be taken against the defendant for the amount of the offer. This offer may be made at any time up until 10 days before trial. The refusal of such an offer is not admissible in evidence before the jury. If the judgment finally obtained by the plaintiff is not more favorable to the plaintiff than the offer, the plaintiff must pay the costs, including attorney's fees, incurred after the offer.

Election of credit for settlements. CPRC, secs. 33.012 and 33.014 govern recovery amounts and the election of credit for settlements. A court must reduce the amount of damages to be recovered by the claimant on the basis of damages the claimant has received in settlement with other parties. The claimant's recovery can be reduced either by the sum of the dollar amounts of all settlements or by a formula reduction. The formula in sec. 33.012 reduces the recovery by 5 percent for the first $200,000 of damages, 10 percent of damages from $200,001 to $400,000, 15 percent of damages from $400,001 to $500,000, and 20 percent of damages greater than $500,000. A defendant

must elect a reduction method before the end of the trial. An election made by one defendant in writing binds all defendants in the case. If no election is made or if conflicting elections are made, all defendants are considered to have chosen the formula reduction.

Products liability. CPRC, chapter 82 and sec. 16.012 govern products liability. Sec. 82.001 defines a products liability action as an action against a seller or manufacturer for recovery of damages arising out of personal injury, death, or property damage allegedly caused by a defective product. Sec. 16.012 defines manufacturing equipment as equipment and machinery used in manufacturing, processing, or fabricating tangible personal property, excluding agricultural equipment or machinery.

Under sec. 16.012(b) and (c), a claimant must begin a products liability action against a seller or manufacturer of manufacturing equipment within 15 years after the date when the defendant sold the equipment. If the manufacturer or seller expressly represents that the equipment has a useful life of more than 15 years, a claimant must begin an action before the end of the number of years represented as the useful life of the equipment. This "statute of repose" does not apply to the lease of manufacturing equipment.

A manufacturer must indemnify a seller against loss from a products liability action, except for any loss caused by the seller's negligence, intentional misconduct, or other act or omission, such as negligently modifying or altering the product. If a seller alters a product in a way that makes it harmful, the seller is liable for damage caused by changing the product.

Chapter 82 protects a claimant from inherently unsafe products and design defects. An inherently unsafe product is one that is known to be unsafe by the ordinary consumer and is intended for personal consumption. A design defect is a defect that causes injury to a person or property and that could have been corrected by an already available safer alternative design.

A subsequent remedial measure is an action taken by a defendant to improve its product after an injury has occurred. In products liability law, evidence of a subsequent remedial measure generally is not admissible for showing proof of a defect in the product, but is admissible for purposes of impeachment and

showing the feasibility of the manufacturer's producing a safer product at the time of manufacture of the product in question.

Exemplary damages. CPRC, chapter 41 governs exemplary damages, often called punitive damages. Exemplary damages over and above compensatory damages are awarded as a penalty or to punish a wrongdoer for excessively bad conduct, whereas compensatory damages are intended only to compensate the injured party for the injury sustained. Economic damages are damages for pecuniary loss, such as medical expenses or lost wages. Noneconomic damages are damages not for pecuniary loss, such as for pain and suffering.

Chapter 41 caps exemplary damages for most causes of action, except for actions based on conduct described as a felony in portions of the Penal Code. The statute caps exemplary damages at the greater of $200,000 or twice the amount of economic damages plus an amount equal to noneconomic damages found by the jury, not to exceed $750,000.

Example: if a jury finds that a plaintiff should be awarded $50,000 in economic damages, $25,000 in noneconomic damages, and $500,000 in exemplary damages, the plaintiff is limited to $200,000 in punitive damages. To determine this amount, the court would double the economic damages ($100,000) and add the noneconomic damages for a sum of 125,000. Because the exemplary damages determined by the formula are less than $200,000 but the exemplary damages awarded by the jury are greater than that amount, exemplary damages are capped at $200,000. The plaintiff recovers $50,000 in economic damages, $25,000 in noneconomic damages, and $200,000 in exemplary damages, for a total of $275,000. If the exemplary damage award in this example were only $175,000, the plaintiff would recover the full $175,000 plus the other damages, because the exemplary damages would be below the lower cap of $200,000. If the plaintiff were awarded $1 million in economic damages, $2 million in noneconomic damages, and $3 million in exemplary damages, his exemplary damages would be capped at $2.75 million — double the economic damages ($2 million) plus $750,000 of noneconomic damages. The plaintiff is allowed only to add noneconomic damages awarded up to $750,000, but that limitation applies only to the determination of exemplary damages to be awarded, not to the amount of noneconomic damages to which the plaintiff is entitled. Because the amount

of exemplary damages under the formula is $2.75 million and the plaintiff was awarded more than that, the exemplary damage award is capped at that amount. The plaintiff can recover $1 million in economic damages, $2 million in noneconomic damages, and $2.75 million in exemplary damages, for a total of $5.75 million.

Juror qualification. Government Code, sec. 62.015 governs qualification of jurors. A juror may not serve on a particular case if he or she is a witness in the case; has an interest in the subject matter of the case; is related within three degrees of consanguinity (sibling, parent, grandparent, aunt, uncle, cousin) or affinity to a party in the case; has a bias or prejudice in favor of or against a party in the case; or has served as a juror in a former trial of the same case or in another case involving the same questions of fact.

Venue; forum non conveniens. CPRC, chapter 15 governs venue. To hear a case, a court must have proper venue over the proceeding. Generally, venue is proper in the county where the injury occurred or where one or more of the parties reside. Although each plaintiff must establish venue independently of any other plaintiff, if venue is proper over one defendant, it is proper over all defendants properly joined in the case. If a court decides that it does not have proper venue over a case or party, the court must transfer the case to a court that has proper venue.

Under the doctrine of forum non conveniens, governed by case law and CPRC, sec. 71.051, a court has the discretion to decline to hear a case when justice and the convenience of the parties would be served better if the action were brought in another forum. Forum non conveniens generally is used when a case comes from out of state or from another country, involving parties that reside and injuries that occurred outside of Texas.

Venue decisions in Texas courts are subject to interlocutory appeal only in certain circumstances. In federal courts, there is no right to immediate appeal from a venue decision.

Proportionate responsibility and designation of responsible parties. CPRC, chapter 33 and supporting case law govern proportionate responsibility and designation of responsible parties.

Under proportionate responsibility, an award to a party is reduced by the amount of responsibility apportioned to that party. Also, if a party is found to be more than 50 percent liable, that party is barred from recovery. Thus, if a plaintiff is found to be 30 percent liable and the defendant(s) 70 percent liable, the plaintiff's recovery is reduced by 30 percent, and the defendant(s) may not collect an award of damages.

Comparative responsibility laws were enacted to remedy a common-law rule under which contributory negligence was a complete bar to actions based on negligence. That is, plaintiffs could recover no damages if found to have any liability for their injuries. The comparative responsibility statute accounts for the liability of plaintiffs and reduces their recovery on the basis of that amount of liability, rather than completely barring them from recovery. However, it does not require a reduction of exemplary or punitive damages.

In 1989, the Legislature amended CPRC, sec. 33.002(b) to exclude the DTPA and worker's compensation benefits from application of this chapter. In 1995, the law was amended to exclude only those acting in a manner that could be a violation under the Penal Code, worker's compensation benefits, and a claim for exemplary damages.

Defendants may be jointly and severally liable for a plaintiff's injuries if they are found to bear more than 50 percent of the liability for a case. If defendants are found to be jointly and severally liable, each defendant is liable for the full amount of the judgment, not simply the proportion of responsibility assessed to that defendant. However, defendants have rights of contribution against each other, meaning that each defendant can recover from the other defendants for the amount in excess of his liability. For example, Defendant A is found jointly and severally liable for damages of $100,000 and is assigned 70 percent of the liability for those damages, and Defendant B is assigned 30 percent liability. Defendant A is liable for all $100,000 of damages but has a right of contribution from Defendant B for that defendant's $30,000 of damages.

A jury may apportion responsibility for an injury only among parties named in the case, although jurors may hear evidence about others who may have some responsibility. For example, a plaintiff may sue three defendants for damages but may settle with two of the defendants during the course of

litigation. At trial, the third defendant may not tell the jury about the plaintiff's settlement with the other two defendants but may argue that those defendants were responsible for the plaintiff's injuries. However, jurors may not apportion responsibility to the two defendants that settled.

Preserving rights of indemnity. Indemnity is an assurance by which a person is secured against anticipated loss by a third person. Suppose that A is involved in a car wreck with B, both are insured drivers, A is injured, and A sues B. In this case, B's insurance company indemnifies her from losses to A, because part of B's contract with the insurer requires the company to pay for any damage that B causes within policy limits.

CPRC, sec. 33.017 governs the preservation of rights of indemnity. Chapter 33 does not apply to rights of indemnity granted to a seller eligible for indemnity by Chapter 82, by the Texas Motor Vehicle Commission Code (Art. 4413(36), V.T.C.S), or by any other statute, nor rights granted by contract at common law.

Labor Code, sec. 417.001 governs third-party liability in labor-related actions. An employee or legal beneficiary may seek damages from a third party that is or may become liable for injury or death under the worker's compensation subtitle and may seek worker's compensation benefits as well. If benefits are claimed, the insurance carrier is subrogated to the injured employee's rights and may enforce the liability of the third party. That is, the insurer essentially assumes the role of the injured employee for purposes of regaining from the third party the costs of benefits paid to that employee.

Interest. Finance Code, chapter 304, subchapter B governs postjudgment interest and prejudgment interest on future damages.

A court may assess postjudgment interest on damages awarded to a plaintiff. An interest rate for this purpose that is not addressed in a contract under dispute is calculated on the basis of the auction rate for 52-week treasury bills issued by the Federal Reserve Board. Interest is 10 percent a year if the auction rate is less than 10 percent, or 20 percent per year if the auction rate is more than 20 percent. Postjudgment interest accrues from the date a judgment is rendered to the date the judgment is paid, and the interest compounds annually.

Prejudgment interest, assessed in wrongful death, personal injury, or property damage cases, is equal to the postjudgment interest rate applicable at the time of judgment. It does not compound but accrues from 180 days after the defendant receives written notice of the claim or the date the suit is filed and ends the day before the judgment is signed. If the defendant makes a written settlement offer to the claimant that is equal to or more than the amount of the judgment, prejudgment interest does not accrue during the period that the offer may be accepted. If the defendant makes a settlement offer that is less than the judgment amount, prejudgment interest does not accrue only on the amount of the settlement offer during the period when the offer may be accepted.

Appeal bonds. CPRC, sec. 35.006 governs the stay of execution of a judgment. If a party owing a judgment shows the court that it has taken an appeal from a foreign judgment and that that appeal is pending, that it will take an appeal from that foreign judgment, or that a stay of execution has been granted and the party has furnished security for satisfaction of that judgment, the court must stay the enforcement of the foreign judgment until the appeal is concluded, until time for appeal expires, or until the stay of execution no longer exists. A foreign judgment also may be stayed if the debtor shows the court a ground on which enforcement of a judgment of a Texas court would be stayed.

CPRC, chapter 52 governs security for judgments pending appeal. For a judgment to be stayed, the debtor must furnish a bond for the amount of the judgment or set aside the amount of the judgment in money. The trial court sets the amount of the bond or deposit, which generally equals the sum of the judgment, costs, and interest. A court may reduce that amount in a case that does not involve bond forfeiture, personal injury, or wrongful death, a claim covered by liability insurance, or a worker's compensation claim. The amount may be lowered only if the court finds that setting the amount equal to the sum of the judgment, interest, and costs would cause irreparable harm to the debtor and that setting the security at a lower amount would not substantially decrease the likelihood that a judgment creditor could recover the full amount assessed after the exhaustion of appellate remedies. An appellate court may review the amount of a bond or deposit for sufficiency or excessiveness.

Evidence relating to seat belts. Transportation Code, sec. 545.413 makes it a misdemeanor offense not to wear a safety belt if a person is at least 15 years old and is riding in the front of a passenger car while it is being driven, in a seat that has a safety belt. The use or nonuse of a seat belt under this section is not admissible in evidence in a civil trial except in certain cases brought under the Family Code.

Claims against employees or volunteers of a local government unit. CPRC, chapter 108 limits the liability of public servants, excluding an independent contractor, the contractor's agent or employee, or another person who performs a contract for a unit of government. Sec. 108.002 limits to $100,000 the personal liability of a public servant, other than a health-care provider, for actions in the course and scope of employment or service. This limitation applies to damages arising from personal injury, death, property damage, and deprivation of a right, privilege, or immunity.

Public school teachers. Education Code, sec. 22.051 governs liability of a school district's professional employees, defined to include a superintendent, principal, teacher, supervisor, social worker, counselor, nurse, teacher's aide, student teacher or intern, certified school bus driver, and any other person whose employment requires certification and the exercise of discretion. Such employees are immune from personal liability for any act that is incident to or within the scope of their duties and that involves the exercise of judgment or discretion, except when they use excessive force in the discipline of students or cause bodily injury to students through negligence. This provision does not apply to the operation, use, or maintenance of any motor vehicle.

DIGEST:

CSHB 4 (excluding Article 10 dealing with medical malpractice liability revisions, which was covered earlier) would make various changes in tort liability law.

Class actions. Article 1 of CSHB 4 would add Chapter 140 to the CPRC, governing the award of attorney's fees in class actions. Attorney's fees would have to be awarded from a common fund recovered for the class. The bill would cap attorney's fees at 25 percent of the amounts collected by the class members out of the common fund or at four times a base fee, whichever was lower. The court would have to determine the base fee by multiplying the number of hours the attorneys had worked by a rate the court deemed

appropriate in that area for that type of case. The court could increase or decrease the base fee on the basis of factors such as the novelty and difficulty of the case, the attorneys' experience, the amount of money in the action and the results obtained, and the level of expertise required to prosecute the action.

The bill would authorize immediate review by the Supreme Court, rather than by a court of appeals, of a decision of whether or not to certify the class.

CSHB 4 also would add Chapter 26 to the CPRC, governing class actions that involve the jurisdiction of a state agency. Parties to an action in which a state agency had exclusive jurisdiction to determine an issue in a dispute or to grant a remedy would have to exhaust all administrative remedies before going to state court. If the parties had not done so, a court would have to abate the action until administrative remedies were exhausted. If the court found that the administrative remedy conferred on the parties was an adequate substitute for the relief sought in court or was a substantial part of the relief sought by the claimant, the court would have to dismiss the action.

Settlement offers. Article 2 of CSHB 4 would add Chapter 42 to the CPRC, governing settlement and recovery of litigation costs. It would apply to all civil actions except class actions; actions brought under the Family Code; actions relating to residential and construction liability under Property Code, chapter 27; actions brought on behalf of a minor or of person of unsound mind; and actions to collect worker's compensation benefits. It would not apply to an action by or against a governmental unit unless the unit elected to seek recovery of litigation costs under this chapter or elected to waive immunity from liability for costs awarded under this chapter.

If a settlement offer was made under Chapter 42 and the plaintiff subsequently recovered at least 10 percent less than the offer at trial, the plaintiff could not recover attorney's fees from the time of the offer and would be liable to the defendants for the defense fees from the time of the offer, up to the amount of the judgment. The court would have to determine the amount of litigation costs. The judgment amount that would be subject to the settlement offer would not include the proceeds of an insurance policy paid to the claimant as the policy beneficiary, unless those proceeds were the subject of the suit.

A claimant would have up to 30 days to accept a settlement offer, or longer if stated in the offer. The settlement offer and acceptance would have to be in writing and served upon the other parties. The defendant could rescind the offer at any time before the claimant had accepted it. A rescinded offer would not count against the claimant at the time of judgment. A settlement offer would remain inadmissible in court.

In a case where the claimant had settled with one or more persons, the defendants could elect either to take a dollar-for-dollar reduction on their amount of liability on the judgment, based on the settling party's amount of responsibility, or to reduce the amount by a percentage equal to the settling party's liability (percentage test). If the defendants chose not to elect or if they differed on their elections, the percentage test would apply.

Products liability. Article 5 of CSHB 4 would revise statutes relating to products liability. For the purposes of CPRC, sec. 16.012, the bill would substitute its definition of "products liability action" for the definition found CPRC, sec. 82.001. The new definition would add that damages sought could be in the form of any legal or equitable relief, including suits for various types of personal injury actions seeking all types of relief. The bill also would replace the term "manufacturing equipment" in sec. 16.012 with the word "product."

For a claimant to have a statute of repose greater than 15 years, the seller or manufacturer would have to have made an express warranty in writing that the product had a useful safe life longer than 15 years. (The standard in current law is an express *representation*, which may occur verbally.)

CSHB 4 would make a nonmanufacturing seller immune from liability for harm caused to a claimant by a product unless the claimant proved that:

- the seller altered or modified the product and those changes caused the claimant's harm;
- the seller had control over the warnings or instruction for the product and an inadequate warning or instruction caused the claimant's harm;
- the seller made an incorrect express factual representation about the product that the claimant relied upon and thereby was harmed; or
- the seller knew of a defect to the product at the time of supply and the defect caused the claimant harm.

In an action alleging an injury caused by an inadequate warning or instruction with regard to a pharmaceutical product, the defendant would not be liable if the warnings or instructions that accompanied the medicine were those required by the U.S. Food and Drug Administration.

The bill would specify that evidence of subsequent improvements and remedial measures is not admissible in a products liability action, except for purposes of impeaching other evidence.

A defendant would not be liable for damages to a claimant caused by some aspect of labeling, formulation, or design of a product if the defendant proved by a preponderance of evidence that the product's labeling, formulation, or design complied with federal mandatory safety standards or regulations. However, if a plaintiff proved by clear and convincing evidence that the applicable federal standards were grossly inadequate to protect the public, the defendant would remain liable. A defendant would not be liable for damages if the defendant proved by a preponderance of the evidence that the product was subject to premarket licensing or approval by a government agency, that the manufacturer complied with all of the agency's standards, and that the agency later approved or licensed the product for sale. However, a defendant could be held liable if the claimant proved by clear and convincing evidence that the agency standards or procedures used for premarket licensing were grossly inadequate to protect the public or that the manufacturer had withheld from or misrepresented to the agency material and relevant evidence that was related to the performance of the product and the claimant's injury. These limitations would not apply to manufacturing flaws or defects.

Exemplary damages. CSHB 4 would change the determination of the cap on exemplary damages. A court would have to determine the cap on basis of the amount of damages awarded in the judgment, rather than the amount found by the jury; that is, the judge could adjust the jury award before determining the amount of exemplary damages. Also, the award of exemplary damages based on felony conduct would require an actual conviction of a felony, rather than proof that the conduct would constitute a felony.

Juror qualification. CSHB 4 would limit a party's ability to disqualify a petit juror for cause by specifying that a person's answer in voir dire that the person could not award a certain amount of damages based on a hypothetical

set of circumstances would not, in and of itself, establish bias or prejudice in favor or against a party in the action.

Venue; forum non conveniens. Article 3 of CSHB 4 would add Subchapter F to CPRC, chapter 15, establishing a method for transferring all multidistrict civil litigation filed in a district court to a different venue. It would add Subchapter H to Government Code, chapter 74, creating a judicial panel on multidistrict litigation.

The judicial panel could transfer related cases, those involving common issues of material fact, to any district court for consolidated or coordinated pretrial proceedings. Transfer could be initiated by the judicial panel or by a party in a case. The panel would have to order the transfer of related cases if the panel determined that the transfer was for the convenience of the parties and witnesses and was in the interest of justice and efficiency. An order granting transfer would be appealable by interlocutory appeal to the court of appeals, but an order denying transfer could not be appealed.

The judicial panel on multidistrict litigation would comprise seven justices, each from a different court of appeals, appointed by the chief justice of the Supreme Court. The panel would have to determine which multidistrict cases should be transferred and would have to preside over consolidation or coordination of those cases. The panel could assign a district judge to preside over the pretrial proceedings of the coordinated or consolidated cases. A case would have to be remanded to the district court from which it was transferred before the conclusion of pretrial proceedings, unless the case already had been terminated.

CSHB 4 would change the requirement that each plaintiff establish venue independently of any other plaintiff to require that each plaintiff establish venue independently of *every* other plaintiff. If a plaintiff could not establish venue, that plaintiff's part of the case would have to be dismissed or transferred to a county of proper venue. The bill would allow an interlocutory appeal of a trial court's determination that a plaintiff did or did not establish proper venue. It also would allow that appeal to be taken by any party affected by the venue determination.

CSHB 4 would not change the application of the common-law doctrine of forum non conveniens to cases that do not involve personal injury or wrongful death. It would broaden a court's ability to transfer a case out of Texas when the court found that Texas is not the proper venue and make such a transfer mandatory rather than discretionary. It also would reduce the parties' ability to have a case removed from the court to which it was transferred and sent back to a Texas court.

Proportionate responsibility. CSHB 4 would add actions brought under the DTPA, in which a defendant, settling person, or responsible third party is found partly responsible, to the application of CPRC, chapter 33. It also would allow the designation of responsible third parties. Such designation would allow juries to assess responsibility to all designated parties, not only those that are parties to a case.

A defendant who had engaged in a conspiracy to commit various felonies under the Penal Code would be jointly and severally liable for damages caused by that conduct only if the claimant proved that the defendant had acted with specific intent to do harm. Even if defendants were jointly and severally liable for damages to a claimant, they would be liable only for the percentage of damages found by the trier of fact equal to their percentage of responsibility.

CSHB 4 would limit the amount of an insurance carrier's subrogation interest to the amount of total benefits paid or assumed by the carrier to an employee or legal beneficiary, minus the amount by which the court reduces the judgment based on the percentage of liability assessed to the employer.

Interest. CSHB 4 would change the method of calculating postjudgment interest, basing it on the weekly average one-year treasury yield as published by the Federal Reserve System. It would lower the minimum amount of interest from 10 percent to 5 percent and would lower the maximum amount from 20 percent to 15 percent. The bill would prohibit assessment or recovery of prejudgment interest on an award of future damages.

Appeal bonds. CSHB 4 would add several circumstances in which a court could grant a stay of execution of judgment. It would allow a stay in cases where the time for taking an appeal had not expired or where a stay of execution had been requested or was expected to be requested. It would authorize a judgment creditor to furnish the security for a foreign judgment in the future.

The bill would reduce the amount of security required to obtain an appeal bond. It would cap the amount of security at 50 percent of the judgment debtor's net worth or $25 million, whichever was lower. If the debtor showed that it was likely to suffer substantial economic harm if required to post security in the required amount, the trial court would have to lower the bond amount to an amount that would not cause the debtor substantial economic harm. An appellate court could review the bond amount but could not increase the amount above the cap.

Evidence relating to seat belts. CSHB 4 would repeal Transportation Code, sec. 545.413(g), making the use or nonuse of seatbelts admissible in evidence in civil trials.

Claims against employees or volunteers of a local government unit. The bill would remove the exclusion of health-care providers from the limitations on personal liability. It would broaden the definition of a hospital district management contractor to statewide application by removing the qualification of having to provide services as part of a rural health-care network and in a district with a population below 50,000.

Public school teachers. CSHB 4 would remove "teacher" from the definition of "professional employee" under Education Code, sec. 22.051, and would specify that a teacher is not personally liable for acts that are incident to or within the scope of duties of the teacher's employment. This provision would not apply to a criminal offense, including sexual misconduct.

Assignment of judges. CSHB 4 would create a procedure for assigning judges to health-care liability cases. On motion of a party to such a case, the Supreme Court would have to assign a judge. All parties in the case would have an opportunity to file a written objection to the assignment.

Effective date. All portions of CSHB 4 except for Article 10 (medical malpractice liability) would take effect September 1, 2003.

SUPPORTERS SAY:

CSHB 4 would make comprehensive reforms in Texas' system of tort liability law to address the many problems the system now causes. In doing so, CSHB 4 would create a system that offers balance and fairness for all parties.

Texas is one of the most litigious states in the most litigious country in the world. The current lawsuit environment breeds litigiousness, which diminishes the peace of a civil society. Publicity about "jackpot" jury verdicts often does not relate those verdicts to job losses, reduced stock values, and the stifling effect on product improvements. Juries often appear to render such verdicts without first considering how much they will increase the costs of products and services to the average consumer.

Class actions. Class actions rarely go to trial, as defendants often are forced to settle the cases because the costs of pursuing the action and the risks involved are too great. Because it is less expensive to settle these cases, settlement often occurs shortly after a class is certified. Unfortunately, such settlements rarely benefit the class members more than they benefit the attorneys.

Interlocutory appeal. By authorizing interlocutory appeals for class certification, CSHB 4 would end abuses of class actions, rather than class actions themselves. Although imperfect, class actions are a good way to address small problems. Corporations often find it preferable to settle existing liabilities through a single suit rather than through many.

CSHB 4 would enable defendants to question the certification of a class and would remove the implied requirement that a defendant settle once a class is certified. Under current law, no appeal to the certification issue is possible until after trial, and because many cases do not go to trial, defendants unfairly are forced to settle once the class is certified, whether or not the certification is appropriate.

Although expedited appeals to the Supreme Court would be heard only slightly more quickly than regular appeals, using the normal appeals process would take much longer. Removing the court of appeals from the appellate

process would speed up litigation. Although it would take some time to establish this body of law, in the long run, it would make the process fairer, more efficient, and less expensive because the law would be uniform and certain across Texas. Defendants would be precluded from unnecessary appeals of class certification because they would know when their cases were proper under the law. This would save an immense amount of money for the judicial system as well as for parties and litigants.

Attorney's fees. Class attorneys often receive more recovery than the class members themselves receive because the interests of the class attorneys and the defense align when it comes to settlement. The defense wants to limit the amount that it has to pay out, while class attorneys want to maximize their fees. Unfortunately, this process often squeezes the interests of the class out of the fee formula. Although a class settlement must be approved by the court, securing a settlement favorable both sets of attorneys is not difficult.

CSHB 4 would ensure that class members recovered fully for their injuries. It would end the proliferation of "coupon settlements" that entitle class members to a discount off their next purchase while the class attorneys reap millions of dollars. The bill would create a mandatory procedure for calculating fees to be awarded to class counsel and would cap those fees at 25 percent of the class recovery. This cap would ensure that the class members could recover actual value for their injuries by forcing the class attorney to maximize the class recovery.

Administrative remedies. Asbestos litigation is clogging the courts. CSHB 4 would help valid claimants receive their recovery more quickly by requiring that claims within the jurisdiction of state agencies go to the appropriate agency for adjudication before going to court as class actions. Often agencies can offer the relief that the claimants have requested and can do so more quickly than the courts can. Requiring claimants to exhaust their administrative remedies before they go to court would ensure that claimants are compensated timely and fully for their injuries.

Settlement offers. The CSHB 4 provisions on offers of settlement are crafted after Rule 68 of the Federal Rules of Civil Procedure. However, unlike this bill, Rule 68 does not include the loss or gain of attorney's fees. Currently, every settlement has four corners: the plaintiff, plaintiff's attorney, defendant,

and defense attorney. Often, only one of these corners refuses to settle. CSHB 4 would create a system that provides an incentive for all corners to agree to a fair settlement at the earliest possible time.

Rule 68 often is not invoked because the amount that a party can gain — that is, only the litigation costs — is not worth the effort. CSHB 4 would give parties adequate incentive both to seek recovery of costs and fees and to settle early in the case to avoid the risk of losing costs and fees. These incentives would benefit both parties and would ensure relief for injured parties in a timely manner. Plaintiffs would risk losing their attorney's fees and costs from the time of the offer to the end of trial if they did not accept a reasonable offer. Plaintiffs would be liable for defense attorney's fees and costs for that same time period if they refused the offer. Defendants would be encouraged to make reasonable settlement offers early, because they would be entitled to receive reimbursement for their fees and costs from the plaintiffs if the offer was more favorable than the judgment for the plaintiffs. Plaintiffs would be encouraged to accept reasonable settlement offers early because if they did not, they would risk losing their fees and costs from the time the settlement offer was made to the end of trial. These incentives also would help to unclog the courts by reducing the number of cases that make it to trial.

The current system presumes that every defendant has the capacity to pay claims and that most plaintiffs do not have the resources to pay for their own legal representation. Some other states use what is called a two-sided system, in which plaintiffs can make counteroffers with the same protection as defendants have for making settlement offers. In practice, defendants under such systems often are forced to pay costs and fees, while plaintiffs are not required to do this because they do not have the resources. Although the systems are called two-sided, they are unilateral in practice.

CSHB 4 would provide a safeguard to prevent plaintiffs from being responsible for fees that they cannot pay. Plaintiffs would be responsible only for defense fees and costs up to the amount that the plaintiffs received in the judgment.

CSHB 4 is designed to deal with the average case, which generally has a nine-month discovery period. The vast majority of plaintiffs can determine

the value of their cases within 90 days. If a plaintiff with a complex case needed more time to determine its worth, the plaintiff could ask the court to extend the settlement time limit. This limit would encourage plaintiffs to gather information in a timely manner and would prevent cases from lingering in the system.

Election of credit for settlements. CSHB 4 would clarify defendants' choice of settlement credits by allowing them to choose between dollar-for-dollar and percentage credits.

Products liability. These provisions of the bill would diminish the practice of forum selection. Often a plaintiff sues an innocent retailer along with a liable manufacturer to give the plaintiff jurisdiction in Texas courts and to prevent the case from being removed to federal court, which generally is regarded as more defense-friendly. Some plaintiffs sue innocent retailers because the defendant may be willing to offer some money in settlement to avoid the nuisance of dealing with a lawsuit. This bill would protect people who are not at fault from being dragged into suits for the wrong reasons.

CSHB 4 would protect retailers from liability for products manufactured by someone else. The bill would give immunity to a seller that had no part in making a product dangerous. Retailers often are small businesses that are in no better position to pay for the harm than is the plaintiff. The argument that this bill would cause retailers to ignore the safety of the products they sell is devoid of merit. A retailer known to sell shoddy products will lose its customer base.

Statute of repose. Establishing a 15-year statute of repose for product liability claims would allow manufacturers to determine how long they were susceptible to suits. Manufacturers could plan for expansion or improvement of their business without worrying about stale claims.

Government standards defense. CSHB 4 would relieve manufacturers of liability for claims arising from formulation, labeling, or design of products if they complied with mandatory governmental regulations associated with the sale or manufacture of a product. For this immunity to apply, the regulations would have to govern the product risk that allegedly caused harm. Thus, the defendant could use only a mandatory government standard that required

certain safety measures to be taken to prevent the problem that occurred if the defendant followed that standard.

Subsequent remedial measures. Limiting the use of evidence of subsequent remedial measures would encourage manufacturers to improve their products to make them better and safer.

Exemplary damages. By limiting the amount of exemplary damages that a claimant could receive, CSHB 4 would allow a claimant to send a message that the defendant did something wrong without putting the defendant out of business. Exemplary damages should be designed to prevent a defendant from repeating a harmful action, not to prevent a business from operating at all. Allowing the trial court to cap exemplary damages would ensure that the system has the proper checks and balances by allowing the judge to adjust the jury's verdict to conform with the law. Because juries often do not understand the complexities of corporate finance, they find it difficult to ascertain the proper amount of damages to assess against a corporate wrongdoer. The Legislature should assist judges by giving them a simple formula with which to determine damages.

The damage limit proposed in CSHB 4 would not apply to a case in which the defendant had been convicted of a felony. Current law removes the application of the cap if the defendant simply has been accused of conduct that is described as a felony. In some situations, plaintiff's attorneys are "pleading around the caps" by alleging conduct that would constitute a felony. The mere threat of such charges emerging at trial often makes the defendant settle the case, even if the plaintiff might not be able to prove the conduct. This bill would prevent juries from punishing defendants for crimes for which they have not been convicted.

Juror qualification. CSHB 4 would give judges explicit guidelines as to when they may or may not strike jurors for cause. Plaintiff's attorneys often prequalify jurors for large verdicts by striking jurors for cause even for a small amount of bias. The proposed limits on the use of strikes for cause would enable justice to be served better by allowing qualified jurors to serve.

Allowing jurors to be struck for their answers to a hypothetical question about the case would not be equivalent to refusing to allow a prosecutor to

ask if anyone on the panel could not send someone to jail. CSHB 4 would prevent a plaintiff from asking the panel a hypothetical question about one issue in the case, exemplary damages. It is not fair to allow one party to couch a specific question about the facts of its case in a hypothetical framework and then use the answer to strike a potential juror.

Venue; forum non conveniens. Texas courts are clogged with cases that should not belong there. In some cases, no parties are from Texas, the occurrences being litigated did not occur in Texas, and Texas has no meaningful relation to the cases or parties other than that the plaintiffs believe they can recover more money in a Texas court than elsewhere. CSHB 4 would make the Texas rule on forum non conveniens more consistent with the federal rule, giving Texas courts a more substantial basis to send cases back where they belong.

Allowing interlocutory appeals of all venue decisions would prevent cases from being heard in improper venues and being overturned later for that reason. This would speed up the administration of justice by allowing a party to receive appellate review on the issue immediately after it was decided, rather than going through the expense and delay of trial.

Multidistrict litigation. Currently, a large corporation can be sued by many plaintiffs in cases spread over hundreds of counties across the state. In such situations, the company cannot give each case the individual attention that it deserves. CSHB 4, modeled on the federal system, would allow consolidation of cases that share fact issues for the purposes of pretrial matters and would allow multi-plaintiff cases to be heard in a more efficient manner that would ensure justice for all parties. Allowing the same judge to hear cases that involve similar questions of fact would ensure that each case received the same ruling. This consolidation would reduce costs for the judicial system and for parties. The cases would have a consolidated discovery process, a consolidated effort on pretrial motions, and reduced attorney participation because the cases would be run by an attorney steering committee. In this system, each of the plaintiffs would be better able to get the amount that they deserve.

Proportionate responsibility and designation of responsible parties. CSHB 6 would allow all potentially responsible parties to be submitted to the

fact finder. The current system confuses jurors because they are told about all of the possibly responsible people but may assess liability only to those that are parties in the case. This encourages plaintiffs to seek to maximize their recovery by suing defendants with the "deepest pockets" rather than those that are most liable.

It makes no sense to allow jurors to hear about all of the responsible parties but not to let them decide the amount of responsibility that should be assessed to nonparties. Some innocent business owners are being held responsible for crimes committed by others. For example, an apartment owner was held liable for the murder of a resident. The jury was told about the murderer and about his conviction for murder, but he was not made a party to the case. The jury found the apartment owner liable for failure to protect the plaintiff from harm, even though the owner had nothing to do with the crime. Under CSHB 4, the jury could assess liability against the criminal and not hold the apartment owner responsible for a crime he did not commit.

Interest. Eliminating prejudgment interest on future damages would be fair because these damages are not incurred until after trial is over. The reasoning behind assessing prejudgment interest is that plaintiffs already have paid money for actual damages that could have been in their possession and control during the time they were waiting for defendants to pay. It does not make sense to charge a defendant interest on a debt that has yet to be incurred.

CSHB 4 would establish a judgment interest rate that more closely reflects market conditions. In recent months, interest rates have fallen sharply. Current law requires a minimum interest rate of 10 percent and a maximum of 20 percent. These rates are exorbitant in view of the interest that many investments are earning now. Reducing the rates would be fair to both parties.

Appeal bonds. Many defendants find it difficult to pursue appeals because they cannot afford the high costs of an appeal bond. In many cases, the cost of the bond makes the end of the suit at the time of judgment and not after a rightfully brought appeal. CSHB 4 would limit the bonding requirement to compensatory damages awarded and would cap the total amount of the bond. The proposed amount, the greater of 50 percent of the defendant's net worth or $25 million, has been found sufficient in other states and has not been

considered so high as to encourage defendants to default on their bonds or to deny plaintiffs the relief to which they are entitled.

There is no easy way to define "net worth," and it is important to give judges discretion to determine this on a case-by-case basis. If a plaintiff feels that a defendant is manipulating its assets to reduce the bond amount, the plaintiff can ask the judge to address this.

Evidence relating to seatbelts. CSHB 4 would ensure fairness at trial by allowing the use or nonuse of seatbelts to be admissible in evidence. Jurors must be able to hear appropriate evidence to assign fault appropriately. Excluding this evidence can result in assessing more responsibility and damages to defendants than they deserve. It is nonsensical to require people to wear seatbelts when in a moving vehicle and then to reward them at trial even if they have broken the law. CSHB 4 would give people an additional reason to wear their seatbelts, because if they were injured, they would bear some responsibility for failing to obey the law.

Claims against employees or volunteers of a local government unit. The lack of protection for workers in county hospitals makes these hospitals vulnerable to costly medical malpractice claims. CSHB 4 would make all public servants subject to a $100,000 limit on personal liability. This limitation would allow rightful claimants the relief they deserved while preventing hospitals from closing because of rising litigation costs.

Public school teachers. Teachers perform valuable services and deserve more protection from liability. CSHB 4 would eliminate current confusion over whether a teacher's act is discretionary or ministerial for purposes of determining liability and would enable teachers to do their jobs without worrying about being sued.

OPPONENTS SAY:

CSHB 4 would destroy the benefits that the legal system has developed for ordinary people over hundreds of years of common law. It would endanger the legal rights of millions of Texas citizens. Calling this a "reform" bill is misleading, as the system it would create would be more unfair than the current system. CSHB 4 effectively would slam the courthouse doors in the faces of plaintiffs with valid claims and would encourage defendants to continue wrongful business practices by removing the threat of suit.

So-called "jackpot" verdicts are a combination of compensation for injuries and a message to companies to stop hurting people. Companies sometimes refuse to listen to consumers' complaints unless they face severe consequences. If jurors are not allowed to send a message through damage awards, companies will have no incentive to keep deadly products off the market.

Class actions. Class actions provide a valuable avenue for relief, especially for small claims that are not sufficient to justify an individual expenditure of resources. By making it more difficult to maintain class actions, changing the appeals process, and requiring the exhaustion of administrative remedies before going to court, CSHB 4 would prevent thousands of people from being able to obtain the justice they deserve.

Interlocutory appeal. Providing an interlocutory appeal for class certification decisions would make defendants less likely to settle valid claims because they could delay the cases by seeking appeal at a stage where appeal is not necessary. Valid claims would take much longer to be resolved, and the people who need relief the most might die before they could receive it.

The current court system has checks and balances in place to prevent abuses. Trial judges are qualified to make class certification rulings and must follow set guidelines to certify a class. An existing body of case law clearly describes the elements of a valid class action. By certifying a class, the trial judge is stating that the claims alleged have merit. No other area of the law allows a party to appeal a trial court's determination that the claims alleged are not frivolous. An interlocutory appeal is intended to be reserved for extraordinary circumstances, not for class certification.

An expedited appeals process can be beneficial if applied fairly. However, interlocutory appeals on the class certification issue can become a tool for crafty litigants to abuse the process by delaying otherwise valid claims or having them dismissed because of minor procedural matters rather than on the facts.

Attorney's fees. Although problems may exist with attorney's fees in certain class settlements, CSHB 4 would not address the problems' source and solution. The problem arises when class attorneys have a conflict of interest

at the time of settlement. Often the interests of the class attorneys and defendant will align at the time of the settlement because the defendant wants to minimize its payout and the attorneys wants to maximize their fees. Often the defendants will agree to high attorney's fees in exchange for a settlement that reduces the overall payout. This agreement shortchanges class members and reduces the deterrent value of the suit.

The so-called lodestar method of fee determination proposed by CSHB 4 would do more to reduce the defendant's payout than to increase the class recovery. The solution to the current problem would be to mandate close oversight of settlements by judges and to implement standards and a process for determining attorney's fees that are fair to all parties.

Administrative remedies. In theory, state agencies could and should provide a fair and efficient avenue for pursuing redress of claims. However, many agencies are influenced unduly by the entities they regulate. Few agencies have the infrastructure and funding to adjudicate disputes in a timely manner, and the budget cuts now proposed are likely to make matters worse. For example, the Board of Medical Examiners traditionally has maintained a backlog of cases and cannot proceed on more than a few cases a year. Also, under this bill, it is possible that a party would have to go through every agency that has control over the issues in the case to exhaust the administrative remedies. Even then, the parties may not receive just compensation for their injuries because agencies rarely have the authority or inclination to award full damages and often cannot award attorney's fees.

Settlement offers. It is almost impossible to say what a case is worth 90 days after the case is filed. At that stage, litigants barely have had time to begin discovery and likely have not had a chance to depose any witnesses or parties. By requiring a plaintiff to accept a defendant's offer of settlement this early in the case, CSHB 4 would force plaintiffs to decide the value of their case before they have had a chance to gather enough facts. Defendants could undervalue their cases and make too low an offer, then have to incur the same litigation expenses they were trying to avoid.

CSHB 4 would cause a greater "litigation lottery" than now exists. It would force parties to guess the value of their cases early in the process at the risk of losing litigation costs. The process of determining the value of a person's

injuries would become a guessing game. The sharp penalties that would be assessed against the plaintiffs if they did not reach a certain mark would preclude many injured claimants from receiving the amount of recovery they deserved.

Election of credit for settlements. The easiest and fairest way to deal with settlement credits would be to allow only percentage credits. These enable plaintiffs to deal with defendants in settlements from a position of strength because the amount of the judgment would be reduced only by the amount of the settling defendant's assessed responsibility. With a dollar-for-dollar credit, plaintiffs would lose all of the recovery awarded at trial if the amount they settled for with a defendant was the same as or exceeded the amount of the judgment.

Products liability. Rather than protecting innocent sellers, CSHB 4 is aimed primarily at reducing justifiable forum selection. Plaintiffs typically sue all parties that they believe are liable for their injuries. Sanctions exist in current law for frivolous lawsuits. This bill only would preclude injured parties from recovering from tortfeasors and would not immunize sellers for their bad acts.

The vast majority of toys sold in this country are made abroad. The Consumer Product Safety Division neither has the time nor resources to ensure that these products meet federal safety standards that govern size of toy parts and the toxicity of paints and glues. They rely on the retailers to do this. This bill would remove the retailer's obligation to exercise judgment to ensure that the products they sell are safe.

Government standards defense. CSHB 4 would immunize manufacturers that make unsafe products. Protecting manufacturers that comply with governmental regulations would allow manufacturers to deny responsibility for injuries they cause. Governmental regulations are set as minimum standards, not according to what is or is not safe for the average consumer, and are not designed for setting liability limits. If companies are allowed to use this defense, it would completely remove any incentive they have to fix a problem that has injured people.

Subsequent remedial measures. Limiting the admissibility of subsequent remedial measures to impeachment purposes would prevent juries from

hearing all the evidence they need to determine liability and damages. It is important for jurors to know if a company has changed its product because the company knew that it was dangerous. Limiting this evidence would withhold material facts and would prevent juries from properly deciding cases. It would encourage companies to continue making products they know are unsafe without the deterrent of knowing that a jury might hear about it later.

Additionally, this protection would put an artificially short life span on products that frequently and reliably have lasted longer than the representations made by the manufacturer. There is nothing in this bill to prevent a manufacturer from purposely representing a shorter life than expected on a product and consumers would be harmed because they would be required to rely on these representations.

Exemplary damages. Exemplary damages are intended to punish wrongdoers for egregious harm so that they will not repeat the harmful acts. Limiting the amount of exemplary damages that a court could assess against a defendant would undermine a jury's ability to send the proper message to the wrongdoer. Jurors decide murder cases and other cases, and they can be trusted to determine how much to assess against a wrongdoer in exemplary damages. In the unlikely event that a jury grants a verdict that is too high, a judge can lower the damage award. Current law provides this protection, and there is no need for the changes proposed in CSHB 4.

A deterrent already exists to prevent plaintiffs from "pleading around the caps." Plaintiffs must both plead and prove acts that would constitute a felony before they can recover damages in excess of the caps. Regardless of what plaintiffs plead, they must have the proof to back up the pleadings to receive damages. This poses no threat to defendants because if plaintiffs fail to prove the actions, defendants are not liable for amounts in excess of the caps. CSHB 4 would reward criminals for "playing the system" by giving them protection from liability for which they are rightfully liable.

Juror qualification. By removing a party's ability to strike a juror for cause based on a statement of bias against damages, CSHB 4 would interfere with the jury process unnecessarily. In a system that is supposed to promote unbiased selection, it would be unfair to make a party use a preemptory strike

on a juror that should be struck for cause. Additionally, the law requires that jurors be struck for cause when they say that they are unwilling to follow the law, yet this bill would allow jurors that refuse to follow the law to be placed on a jury. This would be similar to requiring a prosecutor to use a preemptory strike against a juror who said that he did not want to send anyone to jail. Judges typically require a much higher standard of proof of bias to strike a juror for cause and generally do not base a causal strike on a juror's tendency to lean toward one party. It is important for both sides to be able to find out as much as possible about potential jurors before selecting them for the panel, to ensure trial by a jury of peers. Limiting one side's ability to do this would be unfair and against the interest of justice.

Venue; forum non conveniens. Pushing cases out of Texas that belong in the state's courts would deny claimants relief to which they are entitled. Plaintiffs already must plead and prove sufficient facts to show that venue is proper. The current venue rules give judges enough authority to remove cases that do not belong here. As the party who has been injured and needs compensation, the plaintiff is allowed to choose a forum that is both convenient and necessary to the parties. Denying plaintiffs this right would sway the balance in the favor of the defense and would trample the rights of injured plaintiffs.

Allowing an interlocutory appeal of venue decisions would cause unnecessary delay. Currently, a right to appeal a venue decision exists upon the completion of a case. To allow a party to appeal a decision in the middle of the process would invite gamesmanship and delaying tactics. For example, it could take four months for a party to receive a decision on the issue from the court of appeals and an additional four months if the Supreme Court decided to hear the case. During this eight-month delay, the parties would incur costs and tie up court time in a case that probably would have been concluded in that amount of time. This would be costly to both the parties and the judicial system and would reduce the system's efficiency.

Multidistrict litigation. Combining multi-plaintiff cases, as proposed by this bill, would not be in the interest of justice. Making the parties join together for purposes of pretrial procedure would ignore the uniqueness of each plaintiff's injuries. A single judge reviewing a block of hundreds of cases cannot give each case the individual attention it needs and deserves. Courts

are dealing with heavy dockets and are attempting to resolve pretrial matters more efficiently. Adding hundreds of cases to one judge's docket would tax the court and would be impractical in view of the overload that most courts already face. Combining cases also would require the parties to travel more, putting a greater burden on an already injured claimant.

CSHB 4 would allow defendants to "forum shop," which the bill's supporters say plaintiffs should not be allowed to do. Defendants could combine cases into the court of their choosing rather than into the court that was most proper.

CSHB 4 would deny plaintiffs the right to use their chosen attorneys for pretrial matters and would force them to use a panel of attorneys. No single plaintiff would be guaranteed that his attorney would be on the panel, and the panel might not include the most experienced or qualified attorneys. Also, the bill would provide no guidance as to how to choose the panel of attorneys. This could prove a Herculean task for a judge in a consolidated case, since there might be thousands of attorneys to choose from. Adding this task to a judge's already heavy docket would increase the frustration, inefficiency, and cost already burdening the parties and the system.

Proportionate responsibility and designation of responsible parties. Plaintiffs have the right to sue any and all parties that they believe are liable for their injuries, and they risk being forever barred from claims against necessary parties that they fail to sue. Requiring the designation of all potential defendants would be unfair to plaintiffs because it would override their right to sue whom they choose. Defendants could bring a string of possible defendants into the case in name only and encourage juries to assess damages to the imaginary defendants. Also, if a designated party is found to be jointly and severally liable for the plaintiff's injuries and the true defendants liable as well, but not jointly and severally, the true defendants could skip out on the amount of damages assessed against them because the designated parties would be liable for the whole amount. This would be unfair to the plaintiffs and would deny them their right to recourse for their injuries. CSHB 4 would increase juries' confusion because jurors would have to assess liability to a string of designated parties, none of whom they had seen or heard anything about, other than what the parties had said.

CSHB 4 would specify no means for a designated party to respond to an accusation. These parties would have no incentive to respond, because the statements made and verdict rendered at trial would have no bearing on further cases involving the designated parties. The jury would have to rely on a one-sided finger-pointing description of what occurred and would be denied the ability to hear the other side.

Interest. Prejudgment interest is assessed both to compensate a plaintiff for paying costs incurred before trial and as an incentive for a defendant to settle a valid suit before trial. By removing the claimant's ability to recover prejudgment interest, CSHB 4 would offer a defendant an incentive to wait as long as possible to go to trial and would remove the incentive for a timely settlement, because the defendant's damages would be the same no matter when he agreed to pay them.

Current law provides for fluctuation of interest rates by requiring that market rates apply. It also protects the parties from receiving too high or too low a rate by providing a floor and ceiling. A higher market rate encourages the defendant to settle a case in a more timely manner because it is more than the defendant's return on the money.

Appeal bonds. The purpose of an appeal bond is to ensure a plaintiff's recovery in the event that the defendant tries to skip out on the judgment. Capping the amount of the bond, as proposed in CSHB 4, would limit a party's ability to recover the full amount of damages if the defendant defaulted on the bond, because the cap often would be lower than the judgment amount.

Determining the cap would be difficult, expensive, and time-consuming for a court. It would have to assume the position of a corporate financial analyst and spend much time going through voluminous and complicated documents. Also, appeal could not be taken until the bond amount was assessed, creating further delay and costs to the parties.

Evidence relating to seatbelts. CSHB 4 would allow the use or nonuse of seatbelts to be admissible in evidence. This could allow defendants to reduce their liability on the basis of something wholly unrelated to the cause of an accident.

Claims against employees or volunteers of a local government unit. The bill would further strain already injured plaintiffs by limiting their ability to recover from certain health-care providers. Tortfeasors should be liable for all damages they cause. Reducing the liability of these providers would deprive claimants of their right to recover for their injuries.

Public school teachers. CSHB 4 would make school teachers immune from liability for acts that do not involve discretion and for acts involving the use or operation of a motor vehicle. For example, a teacher would not be liable if he or she were driving a bus full of children and had an accident that killed a child. Current law holds that a teacher's duty to report the sexual abuse of a student is not a discretionary act, and thus the teacher is not immune from liability under this section. CSHB 4 would immunize a teacher who failed to report such abuse. Expanding teachers' liability from immunity might make it easier for them to do their jobs, but it would do so at the expense of the health and safety of school children.

Assignment of judges. By allowing a party to move for the appointment of a judge on a health-care liability claim from a list promulgated by the Supreme Court, CSHB 4 would provide another avenue for forum shopping. Besides offering defendants the ability to delay the case, it would allow them to choose their judge.

OTHER OPPONENTS SAY:

HB 3 and HB 4 do not belong in the same bill. The fact that both bills relate to changes in tort liability statutes is not a sufficient reason to combine them. The public is better informed about medical malpractice than about tort law. The bills were combined so that tort-reform proposals could "piggyback" on medical malpractice. Both issues are important, and they carry distinct consequences for Texas. However, considering them together muddies the waters and makes it more difficult to debate these issues properly. Separating the bills would allow suitable review of all of the issues.

NOTES:

The committee substitute combines elements from two bills, HB 4 and HB 3, both by Nixon. CSHB 4 would remove the requirement that a court determine the reasonable attorney fees for a class action before determining a base fee; restore design defects immunity for toxic or environmental torts and for drugs or devices; and remove successor liability pertaining to civil suits of a foreign corporation. The substitute also would extend immunity to sellers of

pharmaceutical products when the buyer is given the FDA product insert; create an option to change judges to one from a list created by the Supreme Court for health care claims; and expand public school teachers' limitations from liability to all acts within the scope of their job, including the use of a motor vehicle.

The committee substitute includes the majority of HB 3 by Nixon in Article 10. The committee substitute would create a 10 percent buffer for the rejection of settlement offers. The committee substitute does not include changes to the statute of limitations that would remove any disability of minority and permit minors to file a claim, but includes a statute of repose. The committee substitute would award attorney fees in a lump sum even when the judgment was in periodic payments, while the bill as filed would have awarded some of the attorney fees under a periodic payment schedule. The committee substitute would identify physicians as vendors for the purpose of a vendor's endorsement. The bill as filed would have required the commissioner of insurance to conduct a study of the medical malpractice insurance market in Texas following enactment of the bill.

On March 13, the U.S. House passed H.R. 5, concerning medical liability, which would limit non-economic damages to $250,000, punitive damages to the greater of twice economic damages or $250,000, and attorneys' fees. It would prohibit a jury from awarding punitive damages when no monetary or economic award was granted. The bill would preempt state law where there are fewer liability protections for providers or health plans, but would not preempt state law in regard to caps as long as some type of cap exists.

CSHJR 3 by Nixon, which proposes a constitutional amendment to authorize the Legislature to limit medical liability damage awards, has been set on the calendar for March 20.

TEXAS HOUSE OF REPRESENTATIVES
VIDEO/AUDIO SERVICES

***** CERTIFICATION *****

As the designated custodian of the Committee on House Administration for electronic recordings of the House Committee and floor proceedings, I hereby certify that the attached is a duplication of the tapes of the following:

House Committee on Civil Practices	2-19-03	HB3	78th	Tapes 1, 2 & 4.
House Committee on Civil Practices	3-4 -03	HB4	78th	Tape 1.
House Floor Debate	6-1-03	HB4	78th	Tape 301.

Monica Vigil-McDonald

MONICA VIGIL-MCDONALD
DIRECTOR OF COMMUNICATIONS

STATE OF TEXAS)(

COUNTY OF TRAVIS)(

Before me, a Notary Public, on this day personally appeared Monica Vigil-McDonald, known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged that he executed it for the purposes and consideration therein expressed.

Given under my hand and seal of office, this the 30th day of JANUARY, 2006.

Abby Pettinos

NOTARY PUBLIC IN AND OF THE STATE OF TEXAS

ABBY PETTINOS
Notary Public, State of Texas
My Commission Expires
MAY 16, 2006

P.O. BOX 2910 * AUSTIN, TEXAS 78768-2910 * 512 463-0920

TEXAS HOUSE OF REPRESENTATIVES
VIDEO/AUDIO SERVICES

***** CERTIFICATION *****

As the designated custodian of the Committee on House Administration for House Committee records, I hereby certify that the attached is a true and correct photocopy of the following:

House Committee on Civil Practices 2-19-03 HB3 78th Minutes p. 1; Tape Log pp. 1- 3.

House Committee on Civil Practices 3-4 -03 HB4 78th Minutes p. 1; Tape Log p. 1 .

House Floor Debate 6-1-03 HB4 78th Tape Log pp. 1 & 7 .

Monica Vigil-McDonald

MONICA VIGIL- MCDONALD
DIRECTOR OF COMMUNICATIONS

STATE OF TEXAS)(

COUNTY OF TRAVIS)(

Before me, a Notary Public, on this day personally appeared Monica Vigil - McDonald, known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged that he executed it for the purposes and consideration therein expressed.

Given under my hand and seal of office, this the 30th day of JANUARY, 2006.

ABBY PETTINOS
Notary Public, State of Texas
My Commission Expires
MAY 18, 2008

Abby Pettinos

NOTARY PUBLIC IN AND OF THE STATE OF TEXAS

P.O. BOX 2910 * AUSTIN, TEXAS 78768-2910 * 512 463-0920

The House Committee on Civil Practices
78th Legislature
February 19, 2003
2:00 p.m. or upon adjournment
Capitol Extension, E2.026

CORRECTED MINUTES

On March 3, 2003, the House Committee on Civil Practices authorized the correction of the minutes for the meeting of the House Committee on Civil Practices held on February 19, 2003. The following are the corrected minutes for that meeting:

Pursuant to a notice posted on February 14, 2003, the House Committee on Civil Practices met in a public hearing and was called to order by the chair, Representative Nixon, at 2:26 p.m.

The roll was answered as follows:

Present: Representatives Nixon; Gattis; Davis, Yvonne; Hartnett; King; Krusee; Rose; Woolley (8).

Absent: Representative Capelo (1).

A quorum was present.

The chair laid out HB 3 and HJR 3 and explained the bills.

Testimony was taken. (See attached witness list.)

(Representative Capelo now present.)

The chair recognized Representative Eiland.

The chair closed on HB 3 and HJR 3.

HB 3 was left pending without objection.

HJR 3 was left pending without objection.

At 10:50 p.m., on the motion of Representative Gattis and without objection, the meeting was adjourned subject to the call of the chair.

Rep. Nixon, Chair

Teri Avery, Clerk

COMMITTEE TAPE LOG

COMMITTEE ON: Civil Practices DATE: 02.19.03

SUBCOMMITTEE: LOCATION: E2.026

TAPE #:	SIDE:	BILL #:	PERSON SPEAKING/ACTION:
1	A	HB 3	Rep Nixon laid out bill
1	A	HJR 3	Rep Nixon laid out bill
1	A	HB/HJR 3	Spencer Berthelsen testimony
1	A	HB/HJR 3	Michael Regier testimony
1	A	HB/HJR 3	Darlene Evans testimony
1	A	HB/HJR 3	Various questions & answers of panel
1	A/B	HB/HJR 3	David Bragg testimony
1	B	HB/HJR 3	Harvey Rosenfield testimony
1	B	HB/HJR 3	Reggie James testimony
1	B	HB/HJR 3	Peggy Venable testimony
1	B	HB/HJR 3	Various questions & answers of panel
2	A	HB/HJR 3	more questions & answers of panel
2	A	HB/HJR 3	Paula Sweeney testimony
2	A	HB/HJR 3	Richard Mithoff testimony
2	A	HB/HJR 3	Harthey Hampton testimony
2	A/B	HB/HJR 3	various questions & answers of panel
2	B	HB/HJR 3	Jo Ann Howard testimony
2	B	HB/HJR 3	Mike Hull testimony
3	A	HB/HJR 3	Mike Hull testimony
3	A	HB/HJR 3	various questions & answers of panel
3	B	HB/HJR 3	more questions & answers of panel
3	B	HB/HJR 3	Donald Patrick resource witness
3	B	HB/HJR 3	C. H. Mah resource witness

PLEASE 3-HOLE PUNCH THIS FORM AND RETURN IT WITH THE TAPES TO VIDEO/AUDIO SERVICES IN REAGAN 206

2/20/03

COMMITTEE TAPE LOG

COMMITTEE ON: Civil Practices DATE: 02.19.03

SUBCOMMITTEE: LOCATION: E2.026

TAPE #:	SIDE:	BILL #:	PERSON SPEAKING/ACTION:
3	B	HB/HSR 3	Brian Ryder Resource Witness
4	A	HB/HJR 3	Mah & Ryder resource witneses
4	A	HB/HJR 3	Antonio Falcon, MD testimony
4	A	HB/HJR 3	Mark Lanier testimony
4	A	HB/HJR 3	Thomas Permetti testimony
4	A/B	HB/HJR 3	Mary Dale Peterson testimony
4	B	HB/HJR 3	Vicente Juan MD testimony
4	B	HB/HJR 3	Jerry Hunsaker MD testimony
4	B	HB/HJR 3	Steve Woerner testimony
4	B	HB/HJR 3	John Durand MD testimony
4	B	HB/HJR 3	Craig Eiland testimony
4	B	HB/HJR 3	Laurie Grover testimony
4	B	HB/HJR 3	Tony Korioth testimony
4	B	HB/HJR 3	Chris Spence testimony
4	B	HB/HJR 3	Sheila Jetton testimony
5	A	HB/HJR 3	Sheila Jetton testimony
5	A	HB/HJR 3	Joe Ewing MD testimony
5	A	HB/HJR 3	Howard Fletcher testimony
5	A	HB/HJR 3	Gavin Gadberry testimony
5	A	HB/HJR 3	Kim Tutt testimony
5	A	HB/HJR 3	George Roberts testimony
5	A	HB/HJR 3	Aaron Young testimony
5	A/B	HB/HJR 3	Mary Roe Aleshire testimony

PLEASE 3-HOLE PUNCH THIS FORM AND RETURN IT WITH THE TAPES TO VIDEO/AUDIO SERVICES IN REAGAN 206

COMMITTEE TAPE LOG

COMMITTEE ON: Civil Practices

DATE: 02.19.03

SUBCOMMITTEE:

LOCATION: E2.026

TAPE #:	SIDE:	BILL #:	PERSON SPEAKING/ACTION:
5	B	HB/HJR 3	Robert Dye testimony
5	B	HB/HJR 3	Robert Kottman MD testimony
5	B	HB/HJR 3	G K Sprinkle testimony
5	B	HB/HJR 3	Cynthia Garza Weber testimony
5	B	HB/HJR 3	Larry Wright testimony
5	B	HB/HJR 3	Anita Zamora testimony
5	B	HB/HJR 3	Richard Gray testimony
6	A	HB/HJR 3	Laura Castleberry testimony
6	A	HB/HJR 3	Lester Gibson testimony

PLEASE 3-HOLE PUNCH THIS FORM AND RETURN IT WITH THE TAPES TO VIDEO/AUDIO SERVICES IN REAGAN 206

The House Committee on Civil Practices

78th Legislature
March 4, 2003
Upon final adjourn./recess
Capitol Extension, E2.014

Pursuant to a notice posted on February 28, 2003, the House Committee on Civil Practices met in a formal meeting and was called to order by the chair, Representative Nixon, at 12:30 p.m.

The roll was answered as follows:

Present: Representatives Nixon; Gattis; Capelo; Hartnett; King; Krusee; Rose; Woolley (8).

Absent: Representative Davis, Yvonne (1).

A quorum was present.

HB 4

The chair laid out HB 4 as pending business.

Representative Capelo offered a complete committee substitute.

The committee substitute was adopted without objection.

(Representative Davis, Yvonne now present.)

Representative King moved that HB 4, as substituted, be reported favorably to the full house with the recommendation that it do pass and be printed. The motion prevailed by the following record vote:

Ayes: Representatives Nixon; Gattis; Capelo; Hartnett; King; Krusee; Rose; Woolley (8).

Nays: Representative Davis, Yvonne (1).

Present, Not Voting: None (0).

Absent: None (0).

COMMITTEE TAPE LOG

COMMITTEE ON: Civic Practices

DATE: March 4/2003

SUBCOMMITTEE:

LOCATION: E2.014

TAPE #:	SIDE:	~~BILL #:~~	PERSON SPEAKING/ACTION:
1	A		

PLEASE 3-HOLE PUNCH THIS FORM AND RETURN IT WITH THE TAPES TO VIDEO/AUDIO SERVICES IN REAGAN 206

PAGE NO.:

3/6/03

Sunday, June 1, 2003

Tape	Side	Counter	Member	Bill/Res No.	Action
296	B	462	Speaker Craddick		Roll Call
		407	Rep. Christian		Invocation
		120	Rep. Delisi		Doctor of the Day
297	A	0	Rep. Menendez	HR1657	Adopted/Miller Memorial
		544			Message from Senate
		750			Announcements
		910	Rep. Quintanilla	HR1848, 1849,1853,1854	Adopted
		2217	Rep. Talton		Parliamentary Inquiry
		2372	Rep. Hope	SB1639	Conference Committee Report
	A/B	2435	Rep. Burnam	SB1639	Question
	B	2816			Point of Order / Time Expired
		2801	Rep. Burnam		Point of Order/over ruled
		2403	Rep. Burnam	SB1639	Point of Order/over ruled
		2266	Rep. Burnam	SB1639	Oppose
		2188	Rep. Cook, Robert "Robby"	SB1639	In Favor
		2065	Rep. Villarreal	SB1639	Question
		1905	Rep. Hope	SB1639	Close
		1886		SB1639	Conference Committee Report/Record Vote/adopted
		1809			Message from Senate
		1711	Rep. Telford	HB1566	Conference Committee Report/Adopted
		1627	Rep. Denny	HB1695	Conference Committee Report
		1490	Rep. Howard	HB1695	Question
		1416	Rep. Howard	HB1695	Reduce to writing and place in journal
		1389	Rep. Hochberg	HB1695	Oppose
		1260	Rep. Denny	HB1695	Close
		1237		HB1695	Conference Committee Report/Record Vote/adopted
		1133	Rep. Hupp	HJR68	Conference Committee Report/Record Vote/adopted
		984	Rep. Woolley	SB16	Conference Committee Report/Adopted
		880	Rep. Alonzo	SB103	Conference Committee Report/Record Vote/adopted
		740	Rep. Giddings	SB1010	Conference Committee Report/Adopted

		1642	Rep. Delisi	HR	Motion / Outside the Bounds
		1588	Rep. Gallego	HR	Question
		1478	Rep. Delisi	HB1370	Conference Committee Report
		1061	Rep. Escobar		Introduction
		126		HB1370	Motion / Withdrawn
301	A	335	Rep. Morrison	HB3015	Conference Committee Report
		654	Rep. Villarreal	HB3015	Question
		1142		HB3015	Record Vote / Adopted
		1287	Rep. Nixon	HB4	Conference Committee Report
		1505	Rep. Luna	HB4	Question
		1803	Rep. Luna	HB4	Reduce to writing and place in journal
		1821	Rep. Gattis	HB4	Question
		1848	Rep. Gattis	HB4	Reduce to writing and place in journal
		1870	Rep. Eiland	HB4	Question
		1973	Rep. Talton	HB4	Question
		2099	Rep. Smithee	In Chair	
		2115	Rep. Eiland		Reduce to writing and place in journal
		2131		HB4	Record Vote / Adopted
		2217			Message from Senate
		2446	Rep. Harper-Brown	HB2458	Conference Committee Report
		2472	Rep. Driver	In Chair	
		2504	Rep. Alonzo	HB2971	Question
		2641	Rep. Hartnett	HB2971	Question
		2664	Rep. Wise	HB2971	Question
		2718	Rep. Wise	HB2971	Reduce to writing and place in journal
		2733	Rep. Chavez	HB2971	Question
		2811	Rep. Thompson	HB2971	Question
	B	2906		HB2971	Point of Order / Time Expired
		2891		HB2971	Conference Committee Report / Record Voted / Adopted
		2819			Signing in Presence of the House
		2708	Rep. Morrison	SB976	Conference Committee Report/Adopted
		2525	Rep. Morrison	SB286	Conference Committee Report/Adopted
		2377	Rep. Swinford	SB1828	Motion Withdrawn
		2099	Rep. Hochberg		Parliamentary Inquiry
		2026	Reo. Moreno, Joe	HR1805-1847	Adopted
		1751	Rep. Branch	HR1875	Adopted
		1627	Rep. Eiland		Lost Button/Coat

By: Joe Nixon H.B. No. 3

A BILL TO BE ENTITLED

AN ACT

relating to health care.

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

SECTION 1. Section 1.03, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by amending Subdivisions (3), (4), and (8) and adding Subdivisions (10)-(14) to read as follows:

(3) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including [~~as~~] a registered nurse, hospital, dentist, podiatrist, pharmacist, assisted living facility, or nursing home. The term includes [~~, or~~] an officer, employee, independent contractor, or agent of a health care provider or physician [~~thereof~~] acting in the course and scope of the [~~his~~] employment or contractual relationship.

(4) "Health care liability claim" means a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care or health care, or safety or administrative practice or procedure which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.

(8) "Physician" means:

(A) an individual [~~a person~~] licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians;

(C) a partnership or limited liability partnership formed by a group of physicians; or

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code.

(10) "Claimant" means a person seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(11) "Economic damages" means compensatory damages for any pecuniary loss or damage. The term does not include noneconomic damages.

(12) "Emergency medical care" means bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(13) "Noneconomic damages" means any loss or damage, however characterized, for past, present, and future physical pain and suffering, mental anguish and suffering, loss of consortium, loss of companionship and society, disfigurement, physical impairment, and any other nonpecuniary loss or damage or element of loss or damage.

(14) "Nursing home" means a licensed public or private institution to which Chapter 242, Health and Safety Code, applies.

SECTION 2. Subchapter A, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 1.04 to read as follows:

Sec. 1.04. CONFLICT WITH OTHER LAW AND RULES OF CIVIL PROCEDURE. (a) In the event of a conflict between this Act and another law, including a rule of procedure or evidence or court rule, this section controls to the extent of the conflict.

(b) Notwithstanding Section 22.004, Government Code, and except as otherwise provided by this Act, the supreme court may not amend or adopt rules in conflict with this Act.

(c) The district courts and statutory county courts in a county may not adopt local rules in conflict with this Act.

SECTION 3. The Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. SETTLEMENT OFFERS

Sec. 3.01. SETTLEMENT OFFERS; ACCEPTANCE. (a) At any time

before the 30th day before the commencement of a trial of a health care liability claim, a defendant may serve on a plaintiff who is asserting or entitled to assert a claim a settlement offer for a stated consideration to be performed in accordance with the terms of an unconditional full release and settlement agreement executed by or on behalf of the plaintiff to whom the offer is made.

(b) The defendant shall prepare and serve the release and settlement agreement with the offer of settlement.

(c) A plaintiff who receives an offer of settlement from a defendant may accept the offer only if the plaintiff serves written notice on the defendant that the offer is accepted not later than the 10th day after the date the offer is received.

(d) If the plaintiff accepts the settlement offer, the defendant shall pay the full amount of the settlement offer to the plaintiff in exchange for the plaintiff's executed release not later than the 10th day after the date the plaintiff served notice on the defendant accepting the offer, unless the parties agree otherwise.

(e) The plaintiff accepting the settlement offer shall, not later than the seventh day after the date the plaintiff received payment and delivered the executed release, file a dismissal with prejudice.

Sec. 3.02. SETTLEMENT OFFERS; REJECTION. (a) A settlement offer by a defendant that is not accepted by a plaintiff within the time specified by Section 3.01 of this subchapter is considered rejected by the plaintiff and withdrawn by the defendant.

(b) Evidence of the settlement offer is admissible only in a

hearing before the court to determine court costs, expenses, and attorney's fees under this section.

(c) The court shall determine the amount of monetary damages that were awarded against a defendant who has made a settlement offer to a plaintiff who has rejected the offer. In determining the amount, the court shall exclude any prejudgment or postjudgment interest.

(d) If the amount of monetary damages determined under Subsection (c) of this section is equal to or less than the amount of any rejected offer of settlement by the plaintiff, the court shall order an offset against a judgment entered against the defendant up to the amount of the judgment:

(1) all court costs incurred after the date the offer was rejected; and

(2) reasonable and necessary expenses and attorney's fees incurred by the defendant after the date the defendant offered the settlement that was rejected.

(e) The court shall conduct a hearing to determine the amount to assess against the plaintiff under Subsection (d) of this section.

Sec. 3.03. MULTIPLE SETTLEMENT OFFERS. The defendant may make a settlement offer without regard to whether the plaintiff has rejected a previous offer.

SECTION 4. Section 4.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Subsection (f) to read as follows:

(f) Notwithstanding the provisions of Rule 202, Texas Rules

of Civil Procedure, a deposition may not be taken of a physician or health care provider for the purpose of investigating a health care liability claim before the filing of a lawsuit.

SECTION 5. The heading to Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

SUBCHAPTER G. EVIDENTIARY MATTERS [~~RES IPSA LOQUITUR~~]

SECTION 6. Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Sections 7.03 and 7.04 to read as follows:

Sec. 7.03. FEDERAL OR STATE INCOME TAXES. (a) In a health care liability claim, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, evidence of the past payment of federal or state income taxes by the injured party or decedent through which the alleged loss has occurred is admissible before the trier of fact for the purpose of determining the existence and amount, if any, of the alleged loss.

(b) In a health care liability claim, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, the court shall instruct the jury whether any recovery for compensatory damages sought by the claimant is subject to federal or state income taxes.

Sec. 7.04. JURY INSTRUCTIONS IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) In a health care liability claim that involves a

claim of negligence arising from the provision of emergency medical care, the court shall instruct the jury to consider, together with all other relevant matters:

(1) whether the person providing care did not have the patient's medical history or was unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;

(2) the lack of a preexisting physician-patient relationship;

(3) the circumstances constituting the emergency; and

(4) the circumstances surrounding the delivery of the emergency medical care.

(b) The provisions of Subsection (a) of this section do not apply to medical care or treatment:

(1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient; or

(2) that is unrelated to the original medical emergency.

SECTION 7. The heading to Subchapter I, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

SUBCHAPTER I. PAYMENT OF MEDICAL OR HEALTH CARE EXPENSES [~~ADVANCE PAYMENTS~~]

SECTION 8. Subchapter I, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 9.01 to read as follows:

Sec. 9.01. RECOVERY OF MEDICAL OR HEALTH CARE EXPENSES. Recovery of medical or health care expenses in a health care liability claim shall be limited to the amount actually paid or incurred by or on behalf of the claimant.

SECTION 9. Section 10.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 10.01. LIMITATION ON HEALTH CARE LIABILITY CLAIMS. (a) Notwithstanding any other law, no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that, minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided, this subchapter applies to all persons regardless of minority or other legal disability.

(b) Notwithstanding any other law regarding the disability of persons under the age of 18 years to file and prosecute causes of action, this section shall be construed as removing any disability of minority that would otherwise prevent a minor from filing and prosecuting a cause of action for a health care liability claim to the extent that the other law is inconsistent with this section.

SECTION 10. Section 11.02, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by amending Subsection (a) and adding Subsection (e) to read as follows:

(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages, including punitive damages, of the physician or health care provider shall be limited to an amount not to exceed $500,000 per claimant.

(e) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for noneconomic damages of the physician or health care provider shall be limited to an amount not to exceed $250,000 for each claimant.

SECTION 11. Section 11.03, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 11.03. ALTERNATIVE PARTIAL LIMIT ON CIVIL LIABILITY. (a) In the event that Section 11.02(e) [~~11.02(a)~~] of this subchapter is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective:

In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages and losses, other than economic damages of the physician or health care provider [~~for all past and future noneconomic losses recoverable by or on behalf of any injured person and/or the estate of such person, including without limitation as applicable past and future physical pain and suffering, mental anguish and suffering, consortium,~~

~~disfigurement, and any other nonpecuniary damage~~], shall be limited to an amount not to exceed $250,000 for each claimant [~~$150,000~~].

(b) Effective before September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $200,000 for each health care liability claim and at least $600,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $500,000 for each health care liability claim and at least $1.5 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(c) Effective September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability

claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $300,000 for each health care liability claim and at least $900,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $750,000 for each health care liability claim and at least $2.25 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(d) Effective September 1, 2007, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $500,000 for each health care liability claim and at least $1 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other

than a hospital; and

(3) at least $1 million for each health care liability claim and at least $3 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(e) Evidence of financial responsibility may be established at the time of judgment by providing proof of:

(1) the purchase of a contract of insurance or other plan of insurance authorized by this state; or

(2) the maintenance of financial reserves in a financial institution in this state that is chartered by the United States or this state or an irrevocable letter of credit from a financial institution in this state that is chartered by the United States or this state.

SECTION 12. Section 11.04, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 11.04. ADJUSTMENT OF LIABILITY LIMITS. When there is an increase or decrease in the consumer price index with respect to the amount of that index on the effective date of this subchapter, [~~each of~~] the liability limits prescribed in Section 11.02(a) [~~or in Section 11.03~~] of this subchapter[~~, as applicable,~~] shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index between the effective date of this subchapter and the time at which damages subject to such limits are awarded by final judgment or settlement.

SECTION 13. Subchapter L, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 12.02 to read as follows:

Sec. 12.02. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care, the person bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the person shows by clear and convincing evidence that the physician or health care provider did not use the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.

SECTION 14. The heading to Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 13.01. [~~COST BOND, DEPOSIT, AND~~] EXPERT REPORT.

SECTION 15. Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by amending Subsections (a), (b), (i), (j), (k), and (l) and by adding Subsections (s) and (t) to read as follows:

(a) In a health care liability claim, a claimant shall, not later than the 180th [~~90th~~] day after the date the claim is filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the[~~:~~

[~~(1) file a separate cost bond in the amount of $5,000 for each physician or health care provider named by the claimant in the action;~~

[~~(2) place cash in an escrow account in the amount of $5,000 for each physician or health care provider named in the action; or~~

[~~(3) file an expert~~] report for each physician or health care provider against whom a liability claim is asserted [~~with respect to whom a cost bond has not been filed and cash in lieu of the bond has not been deposited under Subdivision (1) or (2) of this subsection~~].

(b) If, as to a defendant physician or health care provider, an expert report[~~, cost bond, or cash in lieu of bond~~] has not been served [~~filed or deposited~~] within the period specified by Subsection (a) [~~or (h)~~] of this section, the court, on the motion of the affected physician or health care provider, shall enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider [~~requires the filing of a $7,500 cost bond with respect to the physician or health care provider not later than the 21st day after the date of the order~~]; and

(2) dismisses the claim [~~provides that if the claimant fails to comply with the order, the action shall be dismissed for want of prosecution~~] with respect to the physician or health care provider, with prejudice to the refiling of the claim [~~subject to~~

~~reinstatement in accordance with the applicable rules of civil procedure and Subsection (c) of this section~~].

(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving [~~filing~~] an expert report by serving [~~filing~~] reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.

(j) Nothing in this section shall be construed to require the serving [~~filing~~] of an expert report regarding any issue other than an issue relating to liability or causation.

(k) An [~~Notwithstanding any other law, an~~] expert report served [~~filed~~] under this section:

(1) is not admissible in evidence by any party [~~a defendant~~];

(2) shall not be used in a deposition, trial, or other proceeding; and

(3) shall not be referred to by any party [~~a defendant~~] during the course of the action for any purpose.

(l) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective [~~a~~] good faith

effort to comply with the definition of an expert report in Subsection (r)(6) of this section.

(s) Until a claimant has served the expert report and curriculum vitae, as required by Subsection (a) of this section, all discovery in a health care liability claim is stayed except for the acquisition of the patient's medical records, medical or psychological studies, or tissue samples through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a) of this section, the restrictions imposed by Subsection (k) of this section on use of the expert report by any party are waived.

SECTION 16. Section 13.01(r)(5), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 14.01(a) of this Act; [~~or~~]

(B) with respect to a person giving opinion

testimony regarding whether [~~about~~] a [~~nonphysician~~] health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 14.02 of this Act;

(C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a dentist who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence [~~who has knowledge of accepted standards of care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim~~].

SECTION 17. Sections 14.01(e) and (g), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), are amended to read as follows:

(e) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

(g) In this subchapter [~~section~~], "physician" means a person who is:

(1) licensed to practice medicine in one or more states in the United States; or

(2) a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association only if testifying as a defendant and that testimony relates to that defendant's standard of care, alleged departure

from that standard of care, or the causal relationship between the alleged departure from that standard of care and the injury, harm, or damages claimed.

SECTION 18. Subchapter N, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Sections 14.02 and 14.03 to read as follows:

Sec. 14.02. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST HEALTH CARE PROVIDER. (a) For purposes of this section, "practicing health care" includes:

(1) training health care providers in the same field as the defendant health care provider at an accredited educational institution; or

(2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.

(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person:

(1) is practicing health care in the same field of practice as the defendant health care provider at the time the testimony is given or was practicing that type of health care at the time the claim arose;

(2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is certified by a Texas licensing agency or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and

(2) is actively practicing health care in rendering health care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) of this section in determining whether an expert is qualified to offer expert testimony on the issue of whether the defendant health care provider departed from accepted standards of health care but may depart from those criteria if, under the circumstances, the court determines that there is good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) This section does not prevent a health care provider who is a defendant, or an employee of the defendant health care provider, from qualifying as an expert.

(f) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st

day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

Sec. 14.03. QUALIFICATIONS OF EXPERT WITNESS ON CAUSATION IN HEALTH CARE LIABILITY CLAIM. (a) Except as provided by Subsections (b) and (c) of this section, in a suit involving a health care liability claim against a physician or health care provider, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed only if the person is a physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a dentist and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a podiatrist and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(d) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if

possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

SECTION 19. Section 16.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 16.01. APPLICATION OF OTHER LAW. Notwithstanding Chapter 304, Finance Code [~~Articles 1E.101, 1E.102, and 1E.104-1E.108, Title 79, Revised Statutes~~], prejudgment interest in a judgment on a health care liability claim shall be awarded in accordance with this subchapter.

SECTION 20. Sections 16.02(b) and (c), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), are amended to read as follows:

(b) Subject to Sections 11.01 and 11.02 of this article [~~In a health care liability claim that is not settled within the period specified by Subsection (a) of this section~~], the judgment must include prejudgment interest on past damages awarded in the judgment [~~found by the trier of fact~~], but shall not include prejudgment interest on future damages [~~found by the trier of fact~~] awarded in the judgment.

(c) Prejudgment interest allowed under this subchapter shall be computed in accordance with Section 304.003(c)(1), Finance Code [~~Article 1E.103, Title 79, Revised Statutes~~], for a period

beginning on the date of injury and ending on the date before the date the judgment is signed.

SECTION 21. The Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) is amended by adding Subchapters Q, R, S, and T to read as follows:

SUBCHAPTER Q. COLLATERAL SOURCE BENEFITS

Sec. 17.01. DEFINITION. In this subchapter, "collateral source benefit" means a benefit paid or payable to or on behalf of a claimant under:

(1) the Social Security Act (42 U.S.C. Section 301 et seq.), and its subsequent amendments;

(2) a state or federal income replacement, disability, workers' compensation, or other law that provides partial or full income replacement; or

(3) any insurance policy, other than a life insurance policy, including:

(A) an accident, health, or sickness insurance policy; and

(B) a disability insurance policy.

Sec. 17.02. ADMISSIBILITY OF EVIDENCE OF COLLATERAL SOURCE BENEFITS. A defendant physician or health care provider may introduce evidence in a health care liability claim of any amount payable to the claimant as a collateral benefit. If a defendant physician or health care provider introduces evidence of a collateral source benefit, the claimant may introduce evidence of any amount the claimant has paid to secure the right to the benefit.

Sec. 17.03. MAINTENANCE OF COVERAGE DURING

CLAIM. (a) During the pendency of a health care liability claim, if the claimant has a policy of insurance that provides health benefits or income disability coverage and the claimant is unwilling or unable to pay the costs of renewing or continuing that policy of insurance in force, the defendant physician or health care provider may tender to the claimant the cost of maintaining the insurance coverage.

(b) On receipt of the tender, the claimant shall continue the policy in force.

Sec. 17.04. SUBROGATION. The payer of collateral benefits introduced under this subchapter may not recover any amount against the claimant and is not subrogated to any rights or claims of the claimant, unless authorized by a federal law.

SUBCHAPTER R. PAYMENT FOR FUTURE LOSSES

Sec. 18.01. DEFINITIONS. In this subchapter:

(1) "Future damages" means damages that are incurred after the date of judgment for:

(A) medical, health care, or custodial care services;

(B) physical pain and mental anguish, disfigurement, or physical impairment;

(C) loss of consortium, companionship, or society; or

(D) loss of earnings.

(2) "Future loss of earnings" means the following losses incurred after the date of the judgment:

(A) loss of income, wages, or earning capacity

and other pecuniary losses; and

(B) loss of inheritance.

(3) "Periodic payments" means the payment of money or its equivalent to the recipient of future damages at defined intervals.

Sec. 18.02. SCOPE OF SUBCHAPTER. This subchapter applies only to an action on a health care liability claim against a physician or healthcare provider in which the present value of the award of future damages, as determined by the court, equals or exceeds $100,000.

Sec. 18.03. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court shall order that future damages awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump-sum payment.

(b) The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages.

(c) The court shall specify in its judgment ordering the payment of future damages by periodic payments the:

(1) recipient of the payments;

(2) dollar amount of the payments;

(3) interval between payments; and

(4) number of payments or the period of time over which payments must be made.

Sec. 18.04. RELEASE. The entry of an order for the payment of future damages by periodic payments constitutes a release of the

health care liability claim filed by the claimant.

Sec. 18.05. FINANCIAL RESPONSIBILITY. (a) As a condition to authorizing periodic payments of future damages, the court shall require a defendant who is not adequately insured to provide evidence of financial responsibility in an amount adequate to assure full payment of damages awarded by the judgment.

(b) The judgment must provide for payments to be funded by:

(1) an annuity contract issued by a company licensed to do business as an insurance company;

(2) an obligation of the United States;

(3) applicable and collectible liability insurance from one or more qualified insurers; or

(4) any other satisfactory form of funding approved by the court.

(c) On termination of periodic payments of future damages, the court shall order the return of the security, or as much as remains, to the defendant.

Sec. 18.06. DEATH OF RECIPIENT. (a) On the death of the recipient, money damages awarded for loss of future earnings continue to be paid to the estate of the recipient of the award without reduction.

(b) Periodic payments, other than future loss of earnings, terminate on the death of the recipient.

(c) If the recipient of periodic payments dies before all payments required by the judgment are paid, the court may modify the judgment to award and apportion the unpaid damages for future loss of earnings in an appropriate manner.

(d) Following the satisfaction or termination of any obligations specified in the judgment for periodic payments, any obligation of the defendant physician or health care provider to make further payments ends and any security given reverts to the defendant.

Sec. 18.07. AWARD OF ATTORNEY'S FEES. (a) The court shall provide that, if attorney's fees are awarded to a claimant in a final judgment in which periodic payments are ordered, the defendant shall pay:

(1) a percentage of the attorney's fees as past damages, equal to the ratio of the past damages to the total present value of both past and future damages; and

(2) a percentage of the attorney's fees as future damages, equal to the ratio of the future damages to the total present value of both past and future damages.

(b) The defendant shall pay attorney's fees that are to be paid as future damages under Subsection (a)(1) of this section in periodic installments of the same duration and intervals as the periodic payments in accordance with an order entered by the court.

(c) A claimant who has agreed to compensate the claimant's attorney on a contingency-fee basis shall pay the agreed percentage calculated solely on the basis of that portion of the award not subject to periodic payments. The claimant shall pay the remaining unpaid portion of the attorney's fees in periodic installments of the same duration and intervals as the periodic payments in accordance with an order entered by the court.

SUBCHAPTER S. ATTORNEY'S FEES

Sec. 19.01. DEFINITION. In this subchapter, "recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical or health care services incurred by the claimant and the attorney's office overhead costs or charges are not deductible disbursements or costs.

Sec. 19.02. APPLICABILITY. The limitations in this subchapter apply without regard to whether:

(1) the recovery is by settlement, arbitration, or judgment; or

(2) the person for whom the recovery is sought is an adult, a minor, or an incapacitated person.

Sec. 19.03. PERIODIC PAYMENTS. If periodic payments are recovered by the claimant, the court shall place a total value on these payments based upon the claimant's projected life expectancy and then reduce this amount to present value for purposes of computing the award of attorney's fees.

Sec. 19.04. LIMITATION ON ATTORNEY CONTINGENCY FEE AGREEMENTS. (a) An attorney may not contract for or collect a contingency fee for representing any person seeking damages in connection with a health care liability claim in excess of 33-1/3 percent of the amount recovered.

(b) This section has no effect if Section 11.02(e) of this Act is stricken from this Act or is otherwise to any extent invalidated by a method other than through legislative means.

Sec. 19.05. ALTERNATIVE LIMIT ON ATTORNEY CONTINGENCY FEES. (a) If Section 11.02(e) of this Act is stricken from this

Act or is otherwise to any extent invalidated by a method other than through legislative means, this section is effective.

(b) An attorney may not contract for or collect a contingency fee for representing any person seeking damages in connection with a health care liability claim that exceeds the following limits:

(1) 40 percent of the first $50,000 recovered;

(2) 33.3 percent of the next $50,000 recovered;

(3) 25 percent of the next $500,000 recovered; and

(4) 15 percent of any additional amount recovered.

SUBCHAPTER T. DECLARATORY JUDGMENTS; INJUNCTIONS; APPEALS

Sec. 20.01. APPLICABILITY. This subchapter applies only to an amendment to this Act that is effective on or after January 1, 2003.

Sec. 20.02. DECLARATORY JUDGMENT. The constitutionality and other validity under the state or federal constitution of all or any part of an amendment to this Act may be determined in an action for declaratory judgment in a district court in Travis County under Chapter 37, Civil Practice and Remedies Code, if it is alleged that the amendment or a part of the amendment affects the rights, status, or legal relation of a party in a civil action with respect to any other party in the civil action.

Sec. 20.03. ACCELERATED APPEAL. (a) An appeal of a declaratory judgment or order, however characterized, of a district court, including an appeal of the judgment of an appellate court, holding or otherwise determining, under Section 20.02 of this Act, that all or any part of an amendment to this Act is constitutional

or unconstitutional, or otherwise valid or invalid, under the state or federal constitution is an accelerated appeal.

(b) If the judgment or order is interlocutory, an interlocutory appeal may be taken from the judgment or order and is an accelerated appeal.

Sec. 20.04. INJUNCTIONS. A district court in Travis County may grant or deny a temporary or otherwise interlocutory injunction or a permanent injunction on the grounds of the constitutionality or unconstitutionality, or other validity or invalidity, under the state or federal constitution of all or any part of an amendment to this Act.

Sec. 20.05. DIRECT APPEAL. (a) There is a direct appeal to the supreme court from an order, however characterized, of a trial court granting or denying a temporary or otherwise interlocutory injunction or a permanent injunction on the grounds of the constitutionality or unconstitutionality, or other validity or invalidity, under the state or federal constitution of all or any part of any amendment to this Act.

(b) The direct appeal is an accelerated appeal.

(c) This section exercises the authority granted by Section 3-b, Article V, Texas Constitution.

Sec. 20.06. STANDING OF AN ASSOCIATION OR ALLIANCE TO SUE. (a) An association or alliance has standing to sue for and obtain the relief described by Subsection (b) of this section if it is alleged that:

(1) the association or alliance has more than one member who has standing to sue in the member's own right;

(2) the interests the association or alliance seeks to protect are germane to a purpose of the association or alliance; and

(3) the claim asserted and declaratory relief requested by the association or alliance relate to all or a specified part of the amendment involved in the action being found constitutional or unconstitutional on its face, or otherwise found valid or invalid on its face, under the state or federal constitution.

(b) The association or alliance has standing:

(1) to sue for and obtain a declaratory judgment under Section 20.02 of this Act in an action filed and maintained by the association or alliance;

(2) to appeal or otherwise be a party to an appeal under Section 20.03 of this Act;

(3) to sue for and obtain an order under Section 20.04 of this Act granting or denying a temporary or otherwise interlocutory injunction or a permanent injunction in an action filed and maintained by the association or alliance; and

(4) to appeal or otherwise be a party to an appeal under Section 20.05 of this Act.

Sec. 20.07. RULES FOR APPEALS. An appeal under this subchapter, including an interlocutory, accelerated, or direct appeal, is governed, as applicable, by the Texas Rules of Appellate Procedure, including Rules 25.1(d)(6), 26.1(b), 28.1, 28.3, 32.1(g), 37.3(a)(1), 38.6(a) and (b), 40.1(b), and 49.4.

SECTION 22. Section 51.014(a), Civil Practice and Remedies Code, is amended to read as follows:

(a) A person may appeal from an interlocutory order of a district court, county court at law, or county court that:

(1) appoints a receiver or trustee;

(2) overrules a motion to vacate an order that appoints a receiver or trustee;

(3) certifies or refuses to certify a class in a suit brought under Rule 42 of the Texas Rules of Civil Procedure;

(4) grants or refuses a temporary injunction or grants or overrules a motion to dissolve a temporary injunction as provided by Chapter 65;

(5) denies a motion for summary judgment that is based on an assertion of immunity by an individual who is an officer or employee of the state or a political subdivision of the state;

(6) denies a motion for summary judgment that is based in whole or in part upon a claim against or defense by a member of the electronic or print media, acting in such capacity, or a person whose communication appears in or is published by the electronic or print media, arising under the free speech or free press clause of the First Amendment to the United States Constitution, or Article 1, Section 8, of the Texas Constitution, or Chapter 73;

(7) grants or denies the special appearance of a defendant under Rule 120a, Texas Rules of Civil Procedure, except in a suit brought under the Family Code; [~~or~~]

(8) grants or denies a plea to the jurisdiction by a governmental unit as that term is defined in Section 101.001;

(9) denies all or part of the relief sought by a motion under Section 13.01(b), Medical Liability and Insurance

Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes); or

(10) grants relief sought by a motion under Section 13.01(1), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

SECTION 23. Section 82.001, Civil Practice and Remedies Code, is amended by amending Subdivision (2) and adding Subdivision (5) to read as follows:

(2) "Products liability action" means any action against a manufacturer, [~~or~~] seller, or medical service provider for recovery of damages arising out of personal injury, death, or property damage allegedly caused by a defective product whether the action is based in strict tort liability, strict products liability, negligence, misrepresentation, breach of express or implied warranty, or any other theory or combination of theories.

(5) "Medical service provider" means:

(A) a person, partnership, corporation, or professional association composed of persons licensed or chartered by this state to practice medicine in this state;

(B) a licensed public or private institution under Chapters 241 or 577, Health and Safety Code; or

(C) a health care provider as defined by Section 1.03, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), that prescribes or dispenses a drug or device, as those terms are defined in the Federal Food, Drug, and Cosmetic Act (21 U.S.C. Section 321).

SECTION 24. Sections 82.002(a), (f), and (g), Civil

Practice and Remedies Code, are amended to read as follows:

(a) A manufacturer shall indemnify and hold harmless a seller or medical service provider against loss arising out of a products liability action, except for any loss caused by the seller's or medical service provider's negligence, intentional misconduct, or other act or omission, such as negligently modifying or altering the product, for which the seller is independently liable. A medical service provider shall not be considered negligent for prescribing or providing a drug or device according to the manufacturer's written or oral recommendations or according to any therapeutic manner generally accepted in the community.

(f) A seller or medical service provider eligible for indemnification under this section shall give reasonable notice to the manufacturer of a product claimed in a petition or complaint to be defective, unless the manufacturer has been served as a party or otherwise has actual notice of the action.

(g) A seller or medical service provider is entitled to recover from the manufacturer court costs and other reasonable expenses, reasonable attorney fees, and any reasonable damages incurred by the seller or medical service provider to enforce the seller's or medical service provider's right to indemnification under this section.

SECTION 25. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (6) to read as follows:

(6) "Person responsible for the patient" means:

(A) the patient's parent, managing conservator, or guardian;

(B) the patient's grandparent;

(C) the patient's adult brother or sister;

(D) another adult who has actual care, control, and possession of the patient and has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient;

(E) an educational institution in which the patient is enrolled that has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient; or

(F) any other person with legal responsibility for the care of the patient.

SECTION 26. Section 84.004(c), Civil Practice and Remedies Code, is amended to read as follows:

(c) Except as provided by Subsection (d) and Section 84.007, a volunteer health care provider [~~who is serving as a direct service volunteer of a charitable organization~~] is immune from civil liability for any act or omission resulting in death, damage, or injury to a patient if:

(1) [~~the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization;~~

[~~(2)~~] the volunteer commits the act or omission in the course of providing health care services to the patient;

(2) [~~(3)~~] the services provided are within the scope of the license of the volunteer; and

(3) [~~(4)~~] before the volunteer provides health care

services, the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient [~~patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient~~] signs a written statement that acknowledges:

(A) that the volunteer is providing care that is not administered for or in expectation of compensation; and

(B) the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

SECTION 27. Chapter 84, Civil Practice and Remedies Code, is amended by adding Section 84.0065 to read as follows:

Sec. 84.0065. ORGANIZATION LIABILITY OF HOSPITALS. Except as provided by Section 84.007, in any civil action brought against a hospital or hospital system, or its employees, officers, directors, or volunteers, for damages based on an act or omission by the hospital or hospital system, or its employees, officers, directors, or volunteers, the liability of the hospital or hospital system is limited to money damages in a maximum amount of $500,000 for any act or omission resulting in death, damage, or injury to a patient if the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient, signs a written statement that acknowledges:

(1) that the hospital is providing care that is not administered for or in expectation of compensation; and

(2) the limitations on the recovery of damages from the hospital in exchange for receiving the health care services.

SECTION 28. Section 88.002, Civil Practice and Remedies Code, is amended by adding Subsection (l) to read as follows:

(l) This chapter does not create liability on the part of physicians or health care providers for medical care or health care services performed or furnished or which should have been performed or furnished for, to, or on behalf of a patient.

SECTION 29. Article 5.15-1, Insurance Code, is amended by adding Section 11 to read as follows:

Sec. 11. VENDOR'S ENDORSEMENT. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer, as that term is defined by Section 82.001, Civil Practice and Remedies Code. A physician or health care provider shall be considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy.

SECTION 30. The following provisions are repealed:

(1) Section 11.02(c), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes);

(2) Sections 13.01(c), (d), (e), (f), (g), (h), (m), (n), (o), and (r)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes);

(3) Section 16.02(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes); and

(4) Section 242.0372, Health and Safety Code.

SECTION 31. (a) The Legislature of the State of Texas finds

that:

(1) the number of health care liability claims (frequency) has increased since 1995 inordinately;

(2) the filing of legitimate health care liability claims in Texas is a contributing factor affecting medical professional liability rates;

(3) the amounts being paid out by insurers in judgments and settlements (severity) have likewise increased inordinately in the same short period of time;

(4) the effect of the above has caused a serious public problem in availability of and affordability of adequate medical professional liability insurance;

(5) the situation has created a medical malpractice insurance crisis in Texas;

(6) this crisis has had a material adverse effect on the delivery of medical and health care in Texas, including significant reductions of availability of medical and health care services to the people of Texas and a likelihood of further reductions in the future;

(7) the crisis has had a substantial impact on the physicians and hospitals of Texas and the cost to physicians and hospitals for adequate medical malpractice insurance has dramatically risen in price, with cost impact on patients and the public;

(8) the direct cost of medical care to the patient and public of Texas has materially increased due to the rising cost of malpractice insurance protection for physicians and hospitals in

Texas;

(9) the crisis has increased the cost of medical care both directly through fees and indirectly through additional services provided for protection against future suits or claims, and defensive medicine has resulted in increasing cost to patients, private insurers, and Texas and has contributed to the general inflation that has marked health care in recent years;

(10) satisfactory insurance coverage for adequate amounts of insurance in this area is often not available at any price;

(11) the combined effect of the defects in the medical, insurance, and legal systems has caused a serious public problem both with respect to the availability of coverage and to the high rates being charged by insurers for medical professional liability insurance to some physicians, health care providers, and hospitals; and

(12) the adoption of certain modifications in the medical, insurance, and legal systems, the total effect of which is currently undetermined, may or may not have an effect on the rates charged by insurers for medical professional liability insurance.

(b) Because of the conditions stated in Subsection (a) of this section, it is the purpose of this Act to improve and modify the system by which health care liability claims are determined in order to:

(1) reduce excessive frequency and severity of health care liability claims through reasonable improvements and modifications in the Texas insurance, tort, and medical practice

systems;

(2) decrease the cost of those claims and ensure that awards are rationally related to actual damages;

(3) do so in a manner that will not unduly restrict a claimant's rights any more than necessary to deal with the crisis;

(4) make available to physicians, hospitals, and other health care providers protection against potential liability through the insurance mechanism at reasonably affordable rates;

(5) make affordable medical and health care more accessible and available to the citizens of Texas;

(6) make certain modifications in the medical, insurance, and legal systems in order to determine whether or not there will be an effect on rates charged by insurers for medical professional liability insurance; and

(7) make certain modifications to the liability laws as they relate to health care liability claims only and with an intention of the legislature to not extend or apply such modifications of liability laws to any other area of the Texas legal system or tort law.

SECTION 32. (a) The commissioner of insurance, with the full cooperation of the Health Professions Council, the Health and Human Services Commission, the Employees Retirement System of Texas, and the Teacher Retirement System of Texas, shall conduct a series of studies regarding the effect of this Act on the:

(1) price and availability of insurance for health care liability claims;

(2) number and cost of health liability claims;

(3) price and availability of health insurance;

(4) cost savings, if any, to the state budget; and

(5) willingness of health care providers to provide health care services.

(b) The commissioner of insurance may, at the commissioner's discretion, require the state entities listed in Subsection (a) of this section to enter into memoranda of understanding in order to facilitate the preparation of the study.

(c) The commissioner of insurance may contract with an outside consultant to assist with the study and to draft reports, as necessary.

(d) Not later than January 1, 2004, the commissioner of insurance shall begin collecting information necessary to conduct the study required under this section.

(e) Not later than December 1, 2006, the commissioner of insurance shall submit a report to the legislature regarding the results of the study conducted under this section. The commissioner of insurance shall submit subsequent reports to the legislature on an annual basis.

SECTION 33. (a) 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, 2003.

(b) Except as provided by this section, the changes in law made by this Act to the Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) apply

only to a cause of action that accrues on or after January 1, 2004. Except as provided by this section, a cause of action that accrues before January 1, 2004, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(c) Subchapter S, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as added by this Act, applies only to an attorney's fee agreement or contract that is entered into on or after January 1, 2004. An attorney's fee agreement or contract entered into before January 1, 2004, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 34. (a) This section applies only if this Act takes effect September 1, 2003.

(b) All changes in law made by this Act to the Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), other than Subchapter S, added by this Act, also apply to a health care liability claim that is included in an action or suit filed on or after September 1, 2003, and to that action or suit.

(c) If written notice of a health care liability claim is given by certified mail, return receipt requested, in compliance with Section 4.01(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), on or after June 1, 2003, and before September 1, 2003, the giving of that notice constitutes, for purposes of this section, the filing, as of

the date of depositing that notice in the mail, of an action or suit that includes that claim against each physician or health care provider to whom that notice is given.

SECTION 35. (a) This section applies only if this Act takes effect immediately.

(b) All changes in law made by this Act to the Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), other than Subchapter S, added by this Act, also apply to a health care liability claim that is included in an action or suit filed on or after the 60th day after the effective date of this Act, and to that action or suit.

(c) If written notice of a health care liability claim is given by certified mail, return receipt requested, in compliance with Section 4.01(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), on or after the effective date of this Act, and before the 60th day after the effective date of this Act, the giving of that notice constitutes, for purposes of this section, the filing, as of the date of depositing that notice in the mail, of an action or suit that includes that claim against each physician or health care provider to whom that notice is given.

RECOMMITTED

HOUSE
COMMITTEE REPORT

1st Printing

By: Nixon, Allen, Capelo, Woolley, Cook of Colorado, et al. H.B. No. 4

Substitute the following for H.B. No. 4:

By: King C.S.H.B. No. 4

A BILL TO BE ENTITLED

AN ACT

relating to reform of certain procedures and remedies in civil actions.

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

ARTICLE 1. CLASS ACTIONS

SECTION 1.01. Subtitle B, Title 2, Civil Practice and Remedies Code, is amended by adding Chapter 26 to read as follows:

CHAPTER 26. CLASS ACTIONS INVOLVING JURISDICTION OF STATE AGENCY

Sec. 26.001. DEFINITIONS. In this chapter:

(1) "Agency statute" means a statute of this state administered or enforced by a state agency.

(2) "Claimant" means a party seeking recovery of damages or other relief and includes a plaintiff, counterclaimant, cross-claimant, or third-party claimant.

(3) "Contested case" has the meaning assigned by Section 2001.003, Government Code.

(4) "Defendant" means a party from whom a claimant seeks recovery of damages or other relief.

(5) "Rule" has the meaning assigned by Section 2001.003, Government Code.

(6) "State agency" means a board, commission, department, office, or agency that:

(A) is in the executive branch of state

judgment is signed on or after the effective date of this article, without regard to whether the suit commenced before, on, or after that date.

ARTICLE 8. EVIDENCE RELATING TO SEAT BELTS

SECTION 8.01. Section 545.413(g), Transportation Code, is repealed.

SECTION 8.02. (a) Except as provided by Subsection (b) of this section, this article applies only to a suit commenced or pending on or after the effective date of this article.

(b) This article does not apply to a suit in which the trial on the merits commenced on or before the effective date of this article.

ARTICLE 9. RESERVED

ARTICLE 10. HEALTH CARE

SECTION 10.01. Section 1.03(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by amending Subdivisions (3), (4), and (8) and adding Subdivisions (10)-(22) to read as follows:

(3)(A) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including:

(i) [~~as~~] a registered nurse;

(ii) a [~~,~~] hospital;

(iii) a nonprofit hospital system;

(iv) a [~~,~~] dentist;

(v) a hospice;

(vi) a [~~,~~] podiatrist;

(vii) a [~~,~~] pharmacist;

(viii) an emergency medical services provider;

(ix) an assisted living facility;

(x) a home and community support services agency;

(xi) an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)), as amended; [~~,~~] or

(xii) a nursing home.

(B) The term includes:

(i) [~~, or~~] an officer, director, shareholder, member, partner, manager, owner, or affiliate of a health care provider or physician; and

(ii) an employee, independent contractor, or agent of a health care provider or physician [~~thereof~~] acting in the course and scope of the [~~his~~] employment or contractual relationship.

(4) "Health care liability claim" means a cause of action against a health care provider or physician arising out of or related to [~~for~~] treatment, lack of treatment, or other claimed departure from accepted standards of medical care, [~~or~~] health care, or safety or professional or administrative services practice or procedure which proximately results in injury to or death of a

claimant [~~the patient~~], whether the claimant's [~~patient's~~] claim or cause of action sounds in tort or contract.

(8) "Physician" means:

(A) an individual [~~a person~~] licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians;

(C) a partnership or limited liability partnership formed by a group of physicians;

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code; or

(E) a company formed by a group of physicians under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes).

(10) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified person, including any direct or indirect parent or subsidiary.

(11) "Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(12) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the

management and policies of the person, whether through ownership of equity or securities, by contract, or otherwise.

(13) "Economic damages" means compensatory damages for any pecuniary loss or damage. The term does not include noneconomic damages.

(14) "Emergency medical care" means bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(15) "Emergency medical services provider" means a licensed public or private provider to which Chapter 773, Health and Safety Code, applies.

(16) "Home and community support services agency" means a licensed public or provider agency to which Chapter 142, Health and Safety Code, applies.

(17) "Intermediate care facility for the mentally retarded" means a licensed public or private institution to which Chapter 252, Health and Safety Code, applies.

(18) "Noneconomic damages" means any loss or damage, however characterized, for past, present, and future physical pain

and suffering, mental anguish and suffering, loss of consortium, loss of companionship and society, disfigurement, physical impairment, and any other nonpecuniary loss or damage or element of loss or damage.

(19) "Nursing home" means a licensed public or private institution to which Chapter 242, Health and Safety Code, applies.

(20) "Professional or administrative services" means those duties or services that a physician or health care provider is required to provide as a condition of maintaining the physician's or health care provider's license, accreditation status, or certification to participate in state or federal health care programs.

(21) "Hospice" means a hospice facility or activity to which Chapter 142, Health and Safety Code, applies.

(22) "Hospital system" means a system of local nonprofit hospitals and nonprofit entities created by the hospital or its parent entity to further the charitable purposes of the hospital under the common governance of a single corporate parent that are located within a radius of not more than 125 linear miles from the corporate parent.

SECTION 10.02. Subchapter A, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 1.04 to read as follows:

Sec. 1.04. CONFLICT WITH OTHER LAW AND RULES OF CIVIL PROCEDURE. (a) In the event of a conflict between this Act and another law, including a rule of procedure or evidence or court

rule, this Act controls to the extent of the conflict.

(b) Notwithstanding Section 22.004, Government Code, and except as otherwise provided by this Act, the supreme court may not amend or adopt rules in conflict with this Act.

(c) The district courts and statutory county courts in a county may not adopt local rules in conflict with this Act.

SECTION 10.03. Section 4.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Subsection (f) to read as follows:

(f) Notwithstanding the provisions of Rule 202, Texas Rules of Civil Procedure, a deposition may not be taken of a physician or health care provider for the purpose of investigating a health care liability claim before the filing of a lawsuit.

SECTION 10.04. The heading to Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

SUBCHAPTER G. EVIDENTIARY MATTERS [~~RES IPSA LOQUITUR~~]

SECTION 10.05. Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Sections 7.03 and 7.04 to read as follows:

Sec. 7.03. FEDERAL OR STATE INCOME TAXES. (a) Notwithstanding any other law, in a health care liability claim, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, evidence to prove the loss must be presented in the

form of a net after-tax loss that either was or should have been paid by the injured party or decedent through which the alleged loss has occurred.

(b) In a health care liability claim, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, the court shall instruct the jury whether any recovery for compensatory damages sought by the claimant is subject to federal or state income taxes.

Sec. 7.04. JURY INSTRUCTIONS IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) In a health care liability claim that involves a claim of negligence arising from the provision of emergency medical care, the court shall instruct the jury to consider, together with all other relevant matters:

(1) whether the person providing care did not have the patient's medical history or was unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;

(2) the lack of a preexisting physician-patient relationship or health care provider-patient relationship;

(3) the circumstances constituting the emergency; and

(4) the circumstances surrounding the delivery of the emergency medical care.

(b) The provisions of Subsection (a) of this section do not apply to medical care or treatment:

(1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient;

or

(2) that is unrelated to the original medical emergency.

SECTION 10.06. The heading to Subchapter I, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

SUBCHAPTER I. PAYMENT OF MEDICAL OR HEALTH CARE EXPENSES [~~ADVANCE PAYMENTS~~]

SECTION 10.07. Subchapter I, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 9.01 to read as follows:

Sec. 9.01. RECOVERY OF MEDICAL OR HEALTH CARE EXPENSES. Recovery of medical or health care expenses in a health care liability claim shall be limited to the amount actually paid or incurred by or on behalf of the claimant.

SECTION 10.08. Section 10.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 10.01. LIMITATION ON HEALTH CARE LIABILITY CLAIMS. (a) Notwithstanding any other law and subject to Subsection (b) of this section, no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that, minors under the age of 12 years shall have until their 14th birthday in

which to file, or have filed on their behalf, the claim. Except as herein provided, this subchapter applies to all persons regardless of minority or other legal disability.

(b) A claimant must bring a health care liability claim not later than 10 years after the date of the act or omission that gives rise to the claim. This subsection is intended as a statute of repose so that all claims must be brought within 10 years or they are time barred.

SECTION 10.09. Section 11.02, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Subsections (e) and (f) to read as follows:

(e) The limitation on health care liability claims contained in Subsection (a) of this section includes punitive damages.

(f) The limitation on health care liability claims contained in Subsection (a) of this section shall be applied on a per-claimant basis.

SECTION 10.10. Section 11.03, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 11.03. LIMITATION ON NONECONOMIC DAMAGES [~~ALTERNATIVE PARTIAL LIMIT ON CIVIL LIABILITY~~]. [~~In the event that Section 11.02(a) of this subchapter is stricken from this subchapter or is otherwise invalidated by a method other than through legislative means, the following shall become effective:~~]

In an action on a health care liability claim where final

judgment is rendered against a physician or health care provider, the limit of civil liability for noneconomic damages of the physician or health care provider shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based [~~of the physician or health care provider for all past and future noneconomic losses recoverable by or on behalf of any injured person and/or the estate of such person, including without limitation as applicable past and future physical pain and suffering, mental anguish and suffering, consortium, disfigurement, and any other nonpecuniary damage, shall be limited to an amount not to exceed $150,000~~].

SECTION 10.11. Subchapter K, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 11.031 to read as follows:

Sec. 11.031. ALTERNATIVE LIMITATION ON NONECONOMIC DAMAGES. (a) In the event that Section 11.03 of this subchapter is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective:

In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages and losses, other than economic damages, shall be limited to an amount not to exceed

$250,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) Effective before September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $200,000 for each health care liability claim and at least $600,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $500,000 for each health care liability claim and at least $1.5 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(c) Effective September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter

applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $300,000 for each health care liability claim and at least $900,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $750,000 for each health care liability claim and at least $2.25 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(d) Effective September 1, 2007, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $500,000 for each health care liability claim and at least $1 million in aggregate for all health care

liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $1 million for each health care liability claim and at least $3 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(e) Evidence of financial responsibility may be established at the time of judgment by providing proof of:

(1) the purchase of a contract of insurance or other plan of insurance authorized by this state;

(2) the purchase of coverage from a trust organized and operating under Article 21.49-4, Insurance Code;

(3) the purchase of coverage or another plan of insurance provided by or through a risk retention group or purchasing group authorized under applicable laws of this state or under the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as amended, or the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.), as amended, or any other contract or arrangement for transferring and distributing risk relating to legal liability for damages, including cost or defense, legal costs, fees, and other claims expenses; or

(4) the maintenance of financial reserves in or an irrevocable letter of credit from a federally insured financial institution that has its main office or a branch office in this state.

SECTION 10.12. Section 11.04, Medical Liability and

Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 11.04. ADJUSTMENT OF LIABILITY LIMIT [~~LIMITS~~]. When there is an increase or decrease in the consumer price index with respect to the amount of that index on the effective date of this subchapter, [~~each of~~] the liability limit [~~limits~~] prescribed in Section 11.02(a) [~~or in Section 11.03~~] of this subchapter[~~, as applicable,~~] shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index between the effective date of this subchapter and the time at which damages subject to such limit [~~limits~~] are awarded by final judgment or settlement.

SECTION 10.13. Subchapter L, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 12.02 to read as follows:

Sec. 12.02. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care, the person bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the person shows by clear and convincing evidence that the physician or health care provider did not use the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health

care provider in the same or similar circumstances.

SECTION 10.14. The heading to Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 13.01. [~~COST BOND, DEPOSIT, AND~~] EXPERT REPORT.

SECTION 10.15. Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by amending Subsections (a), (b), (i), (j), (k), and (l) and adding Subsections (s) and (t) to read as follows:

(a) In a health care liability claim, a claimant shall, not later than the 180th [~~90th~~] day after the date the claim is filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the[~~:~~

[~~(1) file a separate cost bond in the amount of $5,000 for each physician or health care provider named by the claimant in the action;~~

[~~(2) place cash in an escrow account in the amount of $5,000 for each physician or health care provider named in the action; or~~

[~~(3) file an expert~~] report for each physician or health care provider against whom a liability claim is asserted [~~with respect to whom a cost bond has not been filed and cash in lieu of the bond has not been deposited under Subdivision (1) or (2) of this subsection~~].

(b) If, as to a defendant physician or health care provider, an expert report[~~, cost bond, or cash in lieu of bond~~] has not been

served [~~filed or deposited~~] within the period specified by Subsection (a) [~~or (h)~~] of this section, the court, on the motion of the affected physician or health care provider, shall enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider [~~requires the filing of a $7,500 cost bond with respect to the physician or health care provider not later than the 21st day after the date of the order~~]; and

(2) dismisses the claim [~~provides that if the claimant fails to comply with the order, the action shall be dismissed for want of prosecution~~] with respect to the physician or health care provider, with prejudice to the refiling of the claim [~~subject to reinstatement in accordance with the applicable rules of civil procedure and Subsection (c) of this section~~].

(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving [~~filing~~] an expert report by serving [~~filing~~] reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.

(j) Nothing in this section shall be construed to require the serving [~~filing~~] of an expert report regarding any issue other than an issue relating to liability or causation.

(k) An [~~Notwithstanding any other law, an~~] expert report served [~~filed~~] under this section:

(1) is not admissible in evidence by any party [~~a defendant~~];

(2) shall not be used in a deposition, trial, or other proceeding; and

(3) shall not be referred to by any party [~~a defendant~~] during the course of the action for any purpose.

(l) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective [~~a~~] good faith effort to comply with the definition of an expert report in Subsection (r)(6) of this section.

(s) Until a claimant has served the expert report and curriculum vitae, as required by Subsection (a) of this section, all discovery in a health care liability claim is stayed except for the acquisition of the patient's medical records, medical or psychological studies, or tissue samples through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a) of this section, the restrictions imposed by Subsection (k) of this section on use of the expert report by any party are waived.

SECTION 10.16. Section 13.01(r)(5), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 14.01(a) of this Act; [~~or~~]

(B) with respect to a person giving opinion testimony regarding whether [~~about~~] a [~~nonphysician~~] health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 14.02 of this Act;

(C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable

standard of care for a dentist, a dentist who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence [~~who has knowledge of accepted standards of care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim~~].

SECTION 10.17. Sections 14.01(e) and (g), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), are amended to read as follows:

(e) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if

possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

(g) In this subchapter [~~section~~], "physician" means a person who is:

(1) licensed to practice medicine in one or more states in the United States; or

(2) a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association only if testifying as a defendant and that testimony relates to that defendant's standard of care, the alleged departure from that standard of care, or the causal relationship between the alleged departure from that standard of care and the injury, harm, or damages claimed.

SECTION 10.18. Subchapter N, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Sections 14.02 and 14.03 to read as follows:

Sec. 14.02. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST HEALTH CARE PROVIDER. (a) For purposes of this section, "practicing health care" includes:

(1) training health care providers in the same field as the defendant health care provider at an accredited educational institution; or

(2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.

(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person:

(1) is practicing health care in the same field of practice as the defendant health care provider at the time the testimony is given or was practicing that type of health care at the time the claim arose;

(2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is certified by a Texas licensing agency or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and

(2) is actively practicing health care in rendering health care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) of this section in determining whether an expert is qualified to offer expert testimony on the issue of whether the defendant health care provider departed from accepted standards of health care but may depart from those criteria if, under the circumstances, the court determines that there is good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) This section does not prevent a health care provider who is a defendant, or an employee of the defendant health care provider, from qualifying as an expert.

(f) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the

hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

Sec. 14.03. QUALIFICATIONS OF EXPERT WITNESS ON CAUSATION IN HEALTH CARE LIABILITY CLAIM. (a) Except as provided by Subsections (b) and (c) of this section, in a suit involving a health care liability claim against a physician or health care provider, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed only if the person is a physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a dentist and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a podiatrist and is otherwise qualified to render opinions on that causal relationship under the Texas Rules

of Evidence.

(d) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

SECTION 10.19. Section 16.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 16.01. APPLICATION OF OTHER LAW. Notwithstanding Chapter 304, Finance Code [~~Articles 1E.101, 1E.102, and 1E.104-1E.108, Title 79, Revised Statutes~~], prejudgment interest in a judgment on a health care liability claim shall be awarded in

accordance with this subchapter.

SECTION 10.20. Sections 16.02(b) and (c), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), are amended to read as follows:

(b) Subject to Subchapter K of this Act [~~In a health care liability claim that is not settled within the period specified by Subsection (a) of this section~~], the judgment must include prejudgment interest on past damages awarded in the judgment [~~found by the trier of fact~~], but shall not include prejudgment interest on future damages awarded in the judgment [~~found by the trier of fact~~].

(c) Prejudgment interest allowed under this subchapter shall be computed in accordance with Section 304.003(c)(1), Finance Code [~~Article 1E.103, Title 79, Revised Statutes~~], for a period beginning on the date of injury and ending on the date before the date the judgment is signed.

SECTION 10.21. The Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) is amended by adding Subchapters Q, R, S, and T to read as follows:

SUBCHAPTER Q. COLLATERAL SOURCE BENEFITS

Sec. 17.01. DEFINITION. In this subchapter, "collateral source benefit" means a benefit paid or payable to or on behalf of a claimant under:

(1) the Social Security Act (42 U.S.C. Section 301 et seq.), and its subsequent amendments;

(2) a state or federal income replacement, disability, workers' compensation, or other law that provides partial or full

income replacement; or

(3) any insurance policy, other than a life insurance policy, including:

(A) an accident, health, or sickness insurance policy; and

(B) a disability insurance policy.

Sec. 17.02. ADMISSIBILITY OF EVIDENCE OF COLLATERAL SOURCE BENEFITS. A defendant physician or health care provider may introduce evidence in a health care liability claim of any amount payable to the claimant as a collateral benefit. If a defendant physician or health care provider introduces evidence of a collateral source benefit, the claimant may introduce evidence of any amount the claimant has paid to secure the right to the benefit.

Sec. 17.03. MAINTENANCE OF COVERAGE DURING CLAIM. (a) During the pendency of a health care liability claim, if the claimant has a policy of insurance that provides health benefits or income disability coverage and the claimant is unwilling or unable to pay the costs of renewing or continuing that policy of insurance in force, the defendant physician or health care provider may tender to the claimant the cost of maintaining the insurance coverage.

(b) On receipt of the tender, the claimant shall continue the policy in force.

Sec. 17.04. SUBROGATION. The payer of collateral benefits introduced under this subchapter may not recover any amount against the claimant and is not subrogated to any rights or claims of the claimant, unless authorized by a federal law.

SUBCHAPTER R. PAYMENT FOR FUTURE LOSSES

Sec. 18.01. DEFINITIONS. In this subchapter:

(1) "Future damages" means damages that are incurred after the date of judgment for:

(A) medical, health care, or custodial care services;

(B) physical pain and mental anguish, disfigurement, or physical impairment;

(C) loss of consortium, companionship, or society; or

(D) loss of earnings.

(2) "Future loss of earnings" means the following losses incurred after the date of the judgment:

(A) loss of income, wages, or earning capacity and other pecuniary losses; and

(B) loss of inheritance.

(3) "Periodic payments" means the payment of money or its equivalent to the recipient of future damages at defined intervals.

Sec. 18.02. SCOPE OF SUBCHAPTER. This subchapter applies only to an action on a health care liability claim against a physician or health care provider in which the present value of the award of future damages, as determined by the court, equals or exceeds $100,000.

Sec. 18.03. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court shall order that future damages awarded in a

health care liability claim be paid in whole or in part in periodic payments rather than by a lump-sum payment.

(b) The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages.

(c) The court shall specify in its judgment ordering the payment of future damages by periodic payments the:

(1) recipient of the payments;

(2) dollar amount of the payments;

(3) interval between payments; and

(4) number of payments or the period of time over which payments must be made.

Sec. 18.04. RELEASE. The entry of an order for the payment of future damages by periodic payments constitutes a release of the health care liability claim filed by the claimant.

Sec. 18.05. FINANCIAL RESPONSIBILITY. (a) As a condition to authorizing periodic payments of future damages, the court shall require a defendant who is not adequately insured to provide evidence of financial responsibility in an amount adequate to assure full payment of damages awarded by the judgment.

(b) The judgment must provide for payments to be funded by:

(1) an annuity contract issued by a company licensed to do business as an insurance company;

(2) an obligation of the United States;

(3) applicable and collectible liability insurance from one or more qualified insurers; or

(4) any other satisfactory form of funding approved by

the court.

(c) On termination of periodic payments of future damages, the court shall order the return of the security, or as much as remains, to the defendant.

Sec. 18.06. DEATH OF RECIPIENT. (a) On the death of the recipient, money damages awarded for loss of future earnings continue to be paid to the estate of the recipient of the award without reduction.

(b) Periodic payments, other than future loss of earnings, terminate on the death of the recipient.

(c) If the recipient of periodic payments dies before all payments required by the judgment are paid, the court may modify the judgment to award and apportion the unpaid damages for future loss of earnings in an appropriate manner.

(d) Following the satisfaction or termination of any obligations specified in the judgment for periodic payments, any obligation of the defendant physician or health care provider to make further payments ends and any security given reverts to the defendant.

Sec. 18.07. AWARD OF ATTORNEY'S FEES. For purposes of computing the award of attorney's fees when the claimant is awarded a recovery that will be paid in periodic payments, the court shall:

(1) place a total value on the payments based on the claimant's projected life expectancy; and

(2) reduce the amount in Subdivision (1) to present value.

SUBCHAPTER S. ATTORNEY'S FEES

Sec. 19.01. DEFINITION. In this subchapter, "recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical or health care services incurred by the claimant and the attorney's office overhead costs or charges are not deductible disbursements or costs.

Sec. 19.02. APPLICABILITY. The limitations in this subchapter apply without regard to whether:

(1) the recovery is by settlement, arbitration, or judgment; or

(2) the person for whom the recovery is sought is an adult, a minor, or an incapacitated person.

Sec. 19.03. PERIODIC PAYMENTS. If periodic payments are recovered by the claimant, the court shall place a total value on these payments based on the claimant's projected life expectancy and then reduce this amount to present value for purposes of computing the award of attorney's fees.

Sec. 19.04. LIMITATION ON ATTORNEY CONTINGENCY FEE AGREEMENTS. (a) An attorney may not contract for or collect a contingency fee for representing any person seeking damages in connection with a health care liability claim in excess of 33-1/3 percent of the amount recovered.

(b) This section has no effect if Section 11.03 of this Act is stricken from this Act or is otherwise to any extent invalidated by a method other than through legislative means.

Sec. 19.05. ALTERNATIVE LIMIT ON ATTORNEY CONTINGENCY FEES. (a) If Section 11.03 of this Act is stricken from this Act or is

otherwise to any extent invalidated by a method other than through legislative means, this section is effective.

(b) An attorney may not contract for or collect a contingency fee for representing any person seeking damages in connection with a health care liability claim that exceeds the following limits:

(1) 40 percent of the first $50,000 recovered;

(2) 33.3 percent of the next $50,000 recovered;

(3) 25 percent of the next $500,000 recovered; and

(4) 15 percent of any additional amount recovered.

SUBCHAPTER T. DECLARATORY JUDGMENTS; INJUNCTIONS; APPEALS

Sec. 20.01. APPLICABILITY. This subchapter applies only to an amendment to this Act that is effective on or after January 1, 2003.

Sec. 20.02. DECLARATORY JUDGMENT. The constitutionality and other validity under the state or federal constitution of all or any part of an amendment to this Act may be determined in an action for declaratory judgment in a district court in Travis County under Chapter 37, Civil Practice and Remedies Code, if it is alleged that the amendment or a part of the amendment affects the rights, status, or legal relation of a party in a civil action with respect to any other party in the civil action.

Sec. 20.03. ACCELERATED APPEAL. (a) An appeal of a declaratory judgment or order, however characterized, of a district court, including an appeal of the judgment of an appellate court, holding or otherwise determining, under Section 20.02 of this subchapter, that all or any part of an amendment to this Act is

constitutional or unconstitutional, or otherwise valid or invalid, under the state or federal constitution is an accelerated appeal.

(b) If the judgment or order is interlocutory, an interlocutory appeal may be taken from the judgment or order and is an accelerated appeal.

Sec. 20.04. INJUNCTIONS. A district court in Travis County may grant or deny a temporary or otherwise interlocutory injunction or a permanent injunction on the grounds of the constitutionality or unconstitutionality, or other validity or invalidity, under the state or federal constitution of all or any part of an amendment to this Act.

Sec. 20.05. DIRECT APPEAL. (a) There is a direct appeal to the supreme court from an order, however characterized, of a trial court granting or denying a temporary or otherwise interlocutory injunction or a permanent injunction on the grounds of the constitutionality or unconstitutionality, or other validity or invalidity, under the state or federal constitution of all or any part of any amendment to this Act.

(b) The direct appeal is an accelerated appeal.

(c) This section exercises the authority granted by Section 3-b, Article V, Texas Constitution.

Sec. 20.06. STANDING OF AN ASSOCIATION OR ALLIANCE TO SUE. (a) An association or alliance has standing to sue for and obtain the relief described by Subsection (b) of this section if it is alleged that:

(1) the association or alliance has more than one member who has standing to sue in the member's own right;

(2) the interests the association or alliance seeks to protect are germane to a purpose of the association or alliance; and

(3) the claim asserted and declaratory relief requested by the association or alliance relate to all or a specified part of the amendment involved in the action being found constitutional or unconstitutional on its face, or otherwise found valid or invalid on its face, under the state or federal constitution.

(b) The association or alliance has standing:

(1) to sue for and obtain a declaratory judgment under Section 20.02 of this subchapter in an action filed and maintained by the association or alliance;

(2) to appeal or otherwise be a party to an appeal under Section 20.03 of this subchapter;

(3) to sue for and obtain an order under Section 20.04 of this subchapter granting or denying a temporary or otherwise interlocutory injunction or a permanent injunction in an action filed and maintained by the association or alliance; and

(4) to appeal or otherwise be a party to an appeal under Section 20.05 of this subchapter.

Sec. 20.07. RULES FOR APPEALS. An appeal under this subchapter, including an interlocutory, accelerated, or direct appeal, is governed, as applicable, by the Texas Rules of Appellate Procedure, including Rules 25.1(d)(6), 26.1(b), 28.1, 28.3, 32.1(g), 37.3(a)(1), 38.6(a) and (b), 40.1(b), and 49.4.

SECTION 10.22. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (6) to read as follows:

(6) "Person responsible for the patient" means:

(A) the patient's parent, managing conservator, or guardian;

(B) the patient's grandparent;

(C) the patient's adult brother or sister;

(D) another adult who has actual care, control, and possession of the patient and has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient;

(E) an educational institution in which the patient is enrolled that has written authorization to consent for the patient from the parent, managing conservator, or guardian of the patient; or

(F) any other person with legal responsibility for the care of the patient.

SECTION 10.23. Section 84.004(c), Civil Practice and Remedies Code, is amended to read as follows:

(c) Except as provided by Subsection (d) and Section 84.007, a volunteer health care provider [~~who is serving as a direct service volunteer of a charitable organization~~] is immune from civil liability for any act or omission resulting in death, damage, or injury to a patient if:

(1) [~~the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization;~~

[~~(2)~~] the volunteer commits the act or omission in the course of providing health care services to the patient;

(2) [~~(3)~~] the services provided are within the scope of the license of the volunteer; and

(3) [~~(4)~~] before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient [~~patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of~~] signs a written statement that acknowledges:

(A) that the volunteer is providing care that is not administered for or in expectation of compensation; and

(B) the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

SECTION 10.24. Chapter 84, Civil Practice and Remedies Code, is amended by adding Section 84.0065 to read as follows:

Sec. 84.0065. ORGANIZATION LIABILITY OF HOSPITALS. Except as provided by Section 84.007, in any civil action brought against a hospital or hospital system, or its employees, officers, directors, or volunteers, for damages based on an act or omission by the hospital or hospital system, or its employees, officers, directors, or volunteers, the liability of the hospital or hospital system is limited to money damages in a maximum amount of $500,000 for any act or omission resulting in death, damage, or injury to a patient if the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient, signs a written statement that acknowledges:

(1) that the hospital is providing care that is not

administered for or in expectation of compensation; and

(2) the limitations on the recovery of damages from the hospital in exchange for receiving the health care services.

SECTION 10.25. Section 88.002, Civil Practice and Remedies Code, is amended by adding Subsection (l) to read as follows:

(l) This chapter does not create liability on the part of physicians or health care providers for medical care or health care services performed or furnished or that should have been performed or furnished for, to, or on behalf of a patient.

SECTION 10.26. Article 5.15-1, Insurance Code, is amended by adding Section 11 to read as follows:

Sec. 11. VENDOR'S ENDORSEMENT. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer, as that term is defined by Section 82.001, Civil Practice and Remedies Code. A physician or health care provider shall be considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy.

SECTION 10.27. The following provisions are repealed:

(1) Section 11.02(c), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes);

(2) Sections 13.01(c), (d), (e), (f), (g), (h), (m), (n), (o), and (r)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes);

(3) Section 16.02(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil

Statutes); and

(4) Section 242.0372, Health and Safety Code.

SECTION 10.28. (a) The Legislature of the State of Texas finds that:

(1) the number of health care liability claims (frequency) has increased since 1995 inordinately;

(2) the filing of legitimate health care liability claims in Texas is a contributing factor affecting medical professional liability rates;

(3) the amounts being paid out by insurers in judgments and settlements (severity) have likewise increased inordinately in the same short period of time;

(4) the effect of the above has caused a serious public problem in availability of and affordability of adequate medical professional liability insurance;

(5) the situation has created a medical malpractice insurance crisis in Texas;

(6) this crisis has had a material adverse effect on the delivery of medical and health care in Texas, including significant reductions of availability of medical and health care services to the people of Texas and a likelihood of further reductions in the future;

(7) the crisis has had a substantial impact on the physicians and hospitals of Texas and the cost to physicians and hospitals for adequate medical malpractice insurance has dramatically risen in price, with cost impact on patients and the public;

(8) the direct cost of medical care to the patient and public of Texas has materially increased due to the rising cost of malpractice insurance protection for physicians and hospitals in Texas;

(9) the crisis has increased the cost of medical care both directly through fees and indirectly through additional services provided for protection against future suits or claims, and defensive medicine has resulted in increasing cost to patients, private insurers, and Texas and has contributed to the general inflation that has marked health care in recent years;

(10) satisfactory insurance coverage for adequate amounts of insurance in this area is often not available at any price;

(11) the combined effect of the defects in the medical, insurance, and legal systems has caused a serious public problem both with respect to the availability of coverage and to the high rates being charged by insurers for medical professional liability insurance to some physicians, health care providers, and hospitals; and

(12) the adoption of certain modifications in the medical, insurance, and legal systems, the total effect of which is currently undetermined, will have a positive effect on the rates charged by insurers for medical professional liability insurance.

(b) Because of the conditions stated in Subsection (a) of this section, it is the purpose of this article to improve and modify the system by which health care liability claims are determined in order to:

(1) reduce excessive frequency and severity of health care liability claims through reasonable improvements and modifications in the Texas insurance, tort, and medical practice systems;

(2) decrease the cost of those claims and ensure that awards are rationally related to actual damages;

(3) do so in a manner that will not unduly restrict a claimant's rights any more than necessary to deal with the crisis;

(4) make available to physicians, hospitals, and other health care providers protection against potential liability through the insurance mechanism at reasonably affordable rates;

(5) make affordable medical and health care more accessible and available to the citizens of Texas;

(6) make certain modifications in the medical, insurance, and legal systems in order to determine whether or not there will be an effect on rates charged by insurers for medical professional liability insurance;

(7) make certain modifications to the liability laws as they relate to health care liability claims only and with an intention of the legislature to not extend or apply such modifications of liability laws to any other area of the Texas legal system or tort law;

(8) encourage offering services by physicians and hospitals, particularly those involving high risk, that will benefit, in particular, high-cost and low-income groups because lower malpractice insurance rates increase the willingness of physicians and hospitals to provide treatments that carry a

relatively high risk of failure but offer the only real prospect of success for seriously ill patients;

(9) encourage quality of care and discourage defensive medicine;

(10) decrease malpractice insurance premiums, which are a significant part of overall health care cost, and, as the cost savings are reflected in health insurance premiums, make health insurance benefit programs more affordable to businesses, particularly small businesses, and increase employee participation in health insurance programs offered by their employers;

(11) discourage unnecessary services and encourage fewer tests, procedures, and visits so that the direct financial cost to the patient will be reduced as well as time, travel, and other indirect costs;

(12) support health care insurance for employers and employees because malpractice insurance is a component of the overhead costs that providers must take into account in negotiating reimbursement rates with commercial insurers and employers that pay all or a portion of the premiums for their employees will save money and may make the difference in whether an employer can afford to maintain current health insurance benefits for its employees;

(13) reduce the time required for plaintiffs to obtain awards;

(14) reduce malpractice pressure and, as a result, increase the supply of physicians, especially obstetricians and other impacted specialists;

(15) contribute to the viability of community

hospitals by lowering malpractice insurance premiums;

(16) free funds in the operating budgets of self-insured hospitals, allowing the hospital to treat more patients;

(17) reduce or eliminate the incentive for physicians to go without insurance;

(18) lower costs for teaching and safety-net hospitals as well as nonprofit community clinics;

(19) decrease the costs for health care facilities that self-insure; and

(20) allow the Texas Medicaid program to save resources that can be used to provide additional health care goods and services.

SECTION 10.29. (a) Except as provided by Sections 10.30 and 10.31 of this article, the changes in law made by this article to the Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes) apply to a cause of action that accrues on or after January 1, 2004. Except as provided by this section and Sections 10.30 and 10.31 of this article, a cause of action that accrues before January 1, 2004, is governed by the law in effect immediately before the effective date of this article, and that law is continued in effect for that purpose.

(b) Subchapter S, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as added by this article, applies only to an attorney's fee agreement or contract that is entered into on or after January 1, 2004. An attorney's fee agreement or contract entered into

before January 1, 2004, is governed by the law in effect immediately before the effective date of this article, and that law is continued in effect for that purpose.

(c) This article does not make any change in law with respect to the adjustment under Section 11.04, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), of the liability limit prescribed in Section 11.02(a) of that Act, and that law is continued in effect only for that liability limit.

SECTION 10.30. (a) This section applies only if this article takes effect September 1, 2003.

(b) All changes in law made by this article to the Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), other than Subchapter S, added by this article, also apply to a health care liability claim that is included in an action or suit filed on or after September 1, 2003, and to that action or suit.

(c) If written notice of a health care liability claim is given by certified mail, return receipt requested, in compliance with Section 4.01(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), on or after June 1, 2003, and before September 1, 2003, the giving of that notice constitutes, for purposes of this section, the filing, as of the date of depositing that notice in the mail, of an action or suit that includes that claim against each physician or health care provider to whom that notice is given.

SECTION 10.31. (a) This section applies only if this

article takes effect immediately.

(b) All changes in law made by this article to the Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), other than Subchapter S, added by this article, also apply to a health care liability claim that is included in an action or suit filed on or after the 60th day after the effective date of this article, and to that action or suit.

(c) If written notice of a health care liability claim is given by certified mail, return receipt requested, in compliance with Section 4.01(a), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), on or after the effective date of this article, and before the 60th day after the effective date of this article, the giving of that notice constitutes, for purposes of this section, the filing, as of the date of depositing that notice in the mail, of an action or suit that includes that claim against each physician or health care provider to whom that notice is given.

ARTICLE 11. CLAIMS AGAINST EMPLOYEES OR VOLUNTEERS OF A UNIT OF LOCAL GOVERNMENT

SECTION 11.01. Sections 108.002(a) and (b), Civil Practice and Remedies Code, are amended to read as follows:

(a) Except in an action arising under the constitution or laws of the United States, a public servant [~~, other than a provider of health care as that term is defined in Section 108.002(c),~~] is not personally liable for damages in excess of $100,000 arising from personal injury, death, or deprivation of a right, privilege, or immunity if:

(Senator Ratliff in the Chair)

: --nursing home, we took care of him. When his daughter took over his finances, she stopped paying his insurance. She stopped paying his bills. She took all his money. She quit coming to see him. She would not help get him on Medicaid or help with his VA or anything. When we started trying to collect the money that they owed, several thousands of dollars, then she moved him to another facility. When he was at the other facility he lost a leg and we're the one's who got sued, and I don't know how that's gonna play out, but that's just things that we're having to deal with that's causing our insurance rates to go up. We can't afford them and we need some help. The insurance companies, the--there's not any that's insuring in Texas. If they are, you just can't afford it. But for th--for us to get some decent insurance rates we're gonna have to have some tort reform. We're gonna have to have something to stop the ridiculous lawsuits and put limits on, on that.

CHAIRMAN : Okay.

: Thank you very much.

FRASER : Thank you.

CHAIRMAN : Brian T-e-w, is that right? Would you state your name and who you represent if other than yourself, please.

TEW : Yes, Governor. My name is Brian Tew and I'm here representing myself. I'm a physician, and I've been licensed to practice medicine in the State of Texas for 24 years. I practice family practice in emergency medicine in Houston and in Sugar Land. I've been licensed to practice law now for 10 years in the State of Texas. I'm a card carrying Republican and I'm opposed to this tort reform bill as it exist today. My father was a surgeon in Beaumont for 35 years, now the eight members of my immediate family, all eight, are actively involved in either patient care or research. I have two brothers, I mean, one brother that's a physician, another sister that's a physician and a sister who's a neonatal ICU nurse. For the first eight and half years of my legal practice I defended physicians, nursing homes, paramedical personnel and different medical malpractice cases. I've also defended large corporations in a variety of toxic tort matters. I currently represent physicians in front of the Texas State Board of Medical Examiners and I represent physicians actively in front of medical staff--of different hospitals involving medical staff disputes. For the past two years I've also engaged in plaintiff's work including medical malpractice plaintiff's work. I still maintain a defense practice where I defend certain companies for, against cases of alleged brain injury and painful nerve syndromes, and I've tried cases in Texas and Arkansas and Florida. I have the unique perspective in this room of having been sued for medical malpractice as a physician, I've also defended physicians for medical malpractice. I've also sued physicians who I believe have committed medical malpractice. On behalf of my clients my fees have been paid by insurance companies. I've also accepted money from insurance companies on behalf of my clients. From the defense perspective I wanna give you some idea

of what my experience was like defending physicians. There were many times when I evalu--evaluated a case of a serious severe injury and was told by the insurance company to lower my evaluation, and that if I did not lower my evaluation that they would, quote, find a lawyer who believed in the case. This happened on several occasions, I eventually quit working for that particular company. In my own personal experience, defending nursing homes and physicians, I had the experience of insurance companies actively impeding my defense of those physicians and nursing homes because they refused to pay for the experts I felt like I needed, and they didn't wanna pay for research or the amount of time it took to spend on the case. I paid for experts out of my own pocket, as our canon of ethics says that I cannot allow an insurance company to tell me how to defend my client. I was once asked by a carrier to review a case of serious brain damage or alleged serious brain damage in which the plaintiff had been awarded millions of dollars. I went back to the insurance company, I said, the good news is the child had absolutely no brain injury at all. In fact, the kid had no injury. The bad news is, you lost millions of dollars. When they asked me if I would then work for their reduced rate, I said no, that's the reason you got into this problem. This case was overturned on appeal, and had the case been adequately worked up and adequately defended I believe the case would've turned out differently. I still defend some companies. The reason I do it, I have a contract with them that says they cannot interfere with the number of experts that I need or the amount of money that I need in order to defend the case properly, and I have that in writing with those companies. The outcome in all of those cases has been either a complete defense verdict or a verdict of less than we had offered (it) at mediation. From the plaintiff's perspective, as a plaintiff's lawyer, I've seen firsthand the insurance companies' refusal, absolute refusal to negotiate in good faith in cases involving severe and crippling injuries. I tried a case a year ago in which we had asked for a settlement within the policy limits from a chiropractor. When questions from the jury were submitted to the judge that indicated the jury was finding for the plaintiff, we went back to the adjuster and the lawyer and said, would you like to settle within your policy limits? The answer was no. The verdict resulted in an amount o--more than three times what the chiropractor had in insurance. There was recently an award in Nolan County, Texas where a plaintiff was awarded over four million dollars. If you looked at the, the pretrial demand it was within the policy limits of eight hundred and ninety thousand dollars and the TMLT offered eighty thousand dollars to settle the case. This is a case of an insurance company not properly evaluating the case and coming to the table ready to settle. I've currently got other cases with this exact same problem, people who are either killed or severely injured and the insurance company absolutely refuses to offer more than just a minimal amount of money. What, what concerns me about this is there's all this talk about the increased number of lawsuits, yet the Texas State Board of Medical Examiners' own data indicates that there are fewer lawsuits now than there were a couple of years ago against physicians. I believe that the result of this House Bill will be that there will be a decreased number of cases

that settle and there will be an increased number of trials. I believe that if you cap damages, noneconomic damages, at two hundred-fifty thousand dollars, the insurance companies will have absolutely no incentive to settle a case, and what they will then do is they will force their own lawyers to work for lower fees because they have no risk. The only thing that tr--triggers them, now, to settle a case is if we place risk in their pocket by plo--by making a demand within the policy limits. On almost everyone of these cases where we've heard about a huge verdict we have to remember that there was a mediation where probably a demand was made within the policy limits of the insurance. It was, subsequently, when it was taken to trial that this huge verdict was (rewarded). Also, House Bill 4 allows doctors to be named as responsible parties in lawsuits and to be found at fault without the opportunity to appear and defend, and without even knowing that they're a party. And I, I have had the experience where I've represented a doctor and the case was settled, that portion of the case was settled. Subsequently, the case is resolved and there's some--something in the paper about it and that doctor's name is mentioned, they, even though, were told that th--there might be some publicity about it, they're always furious. And I think you'll also, this, this idea that somehow this House Bill is gonna somehow improve the delivery of medical care in, in Texas, I think that those arguments are fallacious and I don't believe, as a physician with 24 years of experience, that that's gonna happen. I don't think this tort reform will result in better medical care for a single individual. Anyone who's reviewed a hospital bill of their own and who's been to a hospital knows firsthand why hospitals are cutting back on services, they're not being reimbursed for 'em. I wanna discuss the offer of settlement, and I'm gonna move quickly, Senator Ratliff. If a pla--plaintiff is horribly damaged and, and has huge--

CHAIRMAN : Doctor.

TEW : --economic damages--

CHAIRMAN : Doctor, we've closed testimony on Article, what is it, 2?

TEW : Okay.

CHAIRMAN : Article 2, but I'd be happy for you to submit it in writing.

TEW : T--that's fine, your Honor. On noneconomic damages, and I've submitted some paperwork to the, the Senators from Dr. Arthur Tarbox who's the Chief Psychologist for UT Hermann Trauma Center, and he's seen three to four thousand trauma and burn patients, and the, the specific point of his letter addresses how severe mental anguish, in fact, can be for patients and why he believes the caps are too small. I believe that capping mental anguish, fundamentally, or displays a fundamental misunderstanding of what mental anguish is, and the dignity that ca--should be attached to a persons psychologic suffering. I think the caps assume that each individual has the same capacity to recover from some life changing event. One of the things that we know is, that in mental anguish, patients who are less well-educated recover less well. (I mean), they don't recover as well as patients who are well-

educated. They don't have the social constructs to help themselves recover from these life changing events. Also, I'm concerned that with caps on damages of tort fees there's (sic) not gonna be responsible for all of the damages that they've caused, and if, if patients aren't adequately compensated for all of their damages then some of those damages are gonna be paid for, especially, b--in the lower socio--economic groups, by the State of Texas. Children don't suffer economic, I mean, don't respond to life changing traumatic events as well as adults. You can bend a young sampling, 20 years later that tree will be horribly bent and deformed and cannot be changed. Also, in children we can't, necessarily, know how much their mental anguish is gonna be when they're young. We don't know the exact outcome, and I think capping is the wrong thing to do. I also don't believe caps should apply to for-profit hospitals. I believe that caps discriminate against women. I think they discriminate against the poor and I think you've heard all that. Again, I've, I've submitted that article by Dr. Tarbox. There's also a letter from Dr. Tarbox, and there's also, in there, an evaluation, a disability evaluation involving an individual who was severely injured. And I have a couple of other areas I wanted to touch on. This, this jury instruction on Article 10, Section 7.04 that goes to the jury involving emergency care, and that, don't we already have law that instructs juries that, that the standard of care is what a doctor would do in like or similar circumstances, what a reasonable and prudent physician would do in like or similar circumstances? And, under Section 12.02, where you have the standard of proof in emergency medical care, would have to be clear and convincing evidence. I don't understand why we need that, because in a medical malpractice case one of the things that's pointed out to the jury is what was the situation that was occurring at the time. And, would a, a sim--a similar physician with similar training, in like or similar circumstances, would they act the same way? I personally worked in emergency rooms and in 1979 and 1980 there was a real problem with the, the type of doctors who where allowed to man emergency rooms. And I'm afraid if we, if we raised the bar so that the burden of proof against the physician in an emergency room or an emergency situation is higher, then we're going to go back to physicians who are poorly trained manning a, especially, the rural ER's. I don't believe that House Bill 4 is pro-physician. I d--I believe it's pro-insurance companies, and again, I believe fewer cases will settle because I don't think there's gonna be any incentive to, to settle a case, and more doctors are gonna spend more time in trial. Thank you.

CHAIRMAN : Okay. Thank you, Doctor. Richard Anderson. State your name and who you represent, please, Sir.

ANDERSON : Dr. Richard Anderson, Chairman of the Doctors Company, a physician-owned medical malpractice insurer that insures 1,700 Texas physicians, representing TAPA. Mr. Chairman, Senators, Members of the Committee, Ladies and Gentlemen, thank you for the opportunity to testify before you today. If I may, I'd like to refer you to an exhibit which I believe you have before you. I will go through this very briefly. What I'd like to do is review with you the creation of the California tort reforms MICRA, their public and

Solomons; Stick; Swinford; Talton; Taylor; Telford; Thompson; Truitt; Turner; Uresti; Van Arsdale; Villarreal; West; Wilson; Wise; Wohlgemuth; Wolens; Wong; Woolley; Zedler.

Present, not voting — Mr. Speaker(C).

Absent — Bailey.

MAJOR STATE CALENDAR
HOUSE BILLS
SECOND READING

The following bills were laid before the house and read second time:

CSHB 4 ON SECOND READING
(by Nixon, Allen, Capelo, et al.)

CSHB 4, A bill to be entitled An Act relating to reform of certain procedures and remedies in civil actions.

Amendment No. 1

Representative Nixon offered the following amendment to **CSHB 4**:

Floor Packet Page No. 1

Amend **CSHB 4** as follows:

(1) On page 2, line 3, strike "and".

(2) On page 2, line 4, between "jurisdiction" and the period, insert:

"; and

(D) has rulemaking authority involving the subject matter of the disputed claim".

(3) On page 8, strike lines 19 and 20 and substitute:

SECTION 1.03. Section 22.225, Government Code, is amended by amending Subsections (b) and (d) and adding Subsection (e) to read as follows:

(4) On page 9, between lines 18 and 19, insert:

(e) For purposes of Subsection (c), one court holds differently from another when there is inconsistency in their respective decisions that should be clarified to remove unnecessary uncertainty in the law and unfairness to litigants.

(5) On page 9, line 19, strike "Sections 51.014(a) and (b)" and substitute "Sections 51.014(a), (b), and (c)".

(6) On page 11, line 3, strike "Subsection (a)(3)" and substitute "Subsection (a)(3), (5), or (8)".

(7) On page 11, between lines 4 and 5, insert:

(c) A denial of a motion for summary judgment, special appearance, or plea to the jurisdiction described by Subsection (a)(5), (7), or (8) is not subject to the automatic stay [~~of the commencement of trial~~] under Subsection (b) unless the motion, special appearance, or plea to the jurisdiction is filed and requested for submission or hearing before the trial court not later than the later of:

(1) a date set by the trial court in a scheduling order entered under the Texas Rules of Civil Procedure; or

(2) the 180th day after the date the defendant files:

(A) the original answer;

(B) the first other responsive pleading to the plaintiff's petition; or

(C) if the plaintiff files an amended pleading that alleges a new cause of action against the defendant and the defendant is able to raise a defense to the new cause of action under Subsection (a)(5), (7), or (8), the responsive pleading that raises that defense.

(8) On page 11, strike lines 5 and 6 and substitute:

SECTION 1.05. Section 22.001, Government Code, is amended by adding Subsection (e) to read as follows:

(e) For purposes of Subsection (a)(2), one court holds differently from another when there is inconsistency in their respective decisions that should be clarified to remove unnecessary uncertainty in the law and unfairness to litigants.

SECTION 1.06. This article applies only to a suit commenced on or after the effective date of this article.

(9) On page 18, strike lines 25 and 26 and substitute:

SUBCHAPTER F. CONSOLIDATION OF MULTIDISTRICT LITIGATION FOR PRETRIAL PROCEEDINGS

(10) Beginning on page 32, strike from line 22 through page 33, line 13, and renumber the subsequent SECTIONS of ARTICLE 4 appropriately.

(11) On page 46, strike line 13 and substitute:

ARTICLE 9. BENEVOLENT GESTURES

SECTION 9.01. Section 18.061(c), Civil Practice and Remedies Code, is repealed.

SECTION 9.02. This article applies only to the admissibility of a communication in a proceeding that begins on or after the effective date of this article. The admissibility of a communication in a proceeding that began before the effective date of the article is governed by the law applicable to the admissibility of the communication immediately before the effective date of this article, and that law is continued in effect for that purpose.

(12) On page 46, line 25, strike "nonprofit".

(13) On page 47, strike lines 12 and 13 and substitute: Section 1396n(c)), as amended; [~~, or~~]

(xii) a nursing home; or

(xiii) a chiropractor.

(14) On page 47, lines 26 to 27, strike "practice or procedure".

(15) On page 50, strike lines 15 through 20 and substitute:

(22) "Hospital system" means a system of hospitals located in this state that are under the common governance or control of a corporate parent.

(16) On page 50, line 23, strike "Section 1.04" and substitute "Sections 1.04 and 1.05".

(17) On page 51, strike lines 2 through 6 and substitute:

(b) Notwithstanding Subsection (a) of this section, in the event of a conflict between this Act and Section 101.023, 102.003, or 108.002, Civil Practice and Remedies Code, those sections of the Civil Practice and Remedies Code control to the extent of the conflict.

(c) Notwithstanding Section 22.004, Government Code, and except as otherwise provided by this Act, the supreme court may not amend or adopt rules in conflict with this Act.

(d) The district courts and statutory county courts in a county may not adopt local rules in conflict with this Act.

Sec. 1.05. SOVEREIGN IMMUNITY NOT WAIVED. This Act does not waive sovereign immunity from suit or from liability.

(18) On page 55, line 7, strike "based" and substitute: based. This section does not apply to a health care liability claim based solely on intentional denial of medical treatment that a patient is otherwise qualified to receive, against the wishes of a patient, or, if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicted age, disability, degree of medical dependency, or quality of life unless the medical treatment is denied under Chapter 166, Health and Safety Code

(19) On page 58, between lines 26 and 27, insert:

(f) This section does not apply to a health care liability claim based solely on intentional denial of medical treatment that a patient is otherwise qualified to receive, against the wishes of a patient, or, if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicted age, disability, degree of medical dependency, or quality of life unless the medical treatment is denied under Chapter 166, Health and Safety Code.

(20) On page 60, line 9, strike "(s) and (t)" and substitute "(s), (t), and (u)".

(21) On page 60, strike line 12 and substitute:

later than the 90th day after the date the claim was [~~is~~] filed,

(22) On page 63, between lines 5 and 6, insert:

(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than one deposition before the expert report is served as required by Subsection (a) of this section.

(23) On page 70, line 18, strike "Q,".

(24) Beginning on page 70, strike from line 20 through page 71, line 27.

(25) On page 78, between lines 25 and 26, insert a new SECTION 10.22 to read as follows and renumber subsequent sections appropriately:

SECTION 10.22. Section 84.003, Civil Practice and Remedies Code, is amended by adding Subdivision (6) to read as follows:

(6) "Hospital system" means a system of hospitals located in this state that are under the common governance or control of a corporate parent.

(26) On page 80, between lines 13 and 14, insert a new SECTION 10.24 to read as follows and renumber subsequent SECTIONS appropriately:

SECTION 10.24. Section 84.004, Civil Practice and Remedies Code, is amended by adding Subsection (f) to read as follows:

(f) Subsection (c) applies even if:

(1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or

(2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

(27) On page 80, line 16, between the period and "Except", insert "(a)".

(28) On page 81, between lines 3 and 4, insert:

(b) Subsection (a) applies even if:

(1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or

(2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

(29) On page 88, strike lines 18 and 19 and substitute:

ARTICLE 11. CLAIMS AGAINST EMPLOYEES OR VOLUNTEERS OF A GOVERNMENTAL UNIT

(30) On page 92, strike lines 9 and 10 and substitute:

SECTION 13.02. Section 41.008(b), Civil Practice and Remedies Code, is amended to read as follows:

(31) Beginning on page 92, strike from lines 19 through page 93, line 17.

Amendment No. 2

Representative Nixon offered the following amendment to Amendment No. 1:

Amend Floor Amendment No. 1, **CSHB 4**, as follows:

Amend item (10), page 2, of Floor Amendment 1, to insert between "appropriately" and the period as follows:

, and beginning on page 35, strike from line 12 through line 23 and renumber the subsequent SECTIONS of ARTICLE 4 appropriately.

Amendment No. 2 was adopted without objection.

BILLS AND RESOLUTIONS SIGNED BY THE SPEAKER

Notice was given at this time that the speaker had signed bills and resolutions in the presence of the house (see the addendum to the daily journal, Signed by the Speaker, Senate List No. 9).

CSHB 4 - (consideration continued)

Amendment No. 3

Representative Dunnam offered the following amendment to Amendment No. 1:

Amend Amendment No. 1 by Nixon to **CSHB 4** beginning on page 2, by striking line 26 through page 3, line 6.

Representative Nixon moved to table Amendment No. 3.

A record vote was requested.

The motion to table prevailed by (Record 52): 81 Yeas, 64 Nays, 1 Present, not voting.

Yeas — Allen; Baxter; Berman; Bohac; Bonnen; Branch; Brown, B.; Brown, F.; Callegari; Campbell; Capelo; Casteel; Chisum; Christian; Cook, B.; Corte; Crabb; Davis, J.; Dawson; Delisi; Denny; Driver; Eissler; Elkins; Flores;

Pitts; Reyna; Riddle; Ritter; Rose; Seaman; Smith, T.; Smith, W.; Smithee; Solomons; Stick; Swinford; Taylor; Truitt; Van Arsdale; West; Wohlgemuth; Wong; Woolley; Zedler.

Nays — Alonzo; Bailey; Burnam; Canales; Castro; Chavez; Coleman; Davis, Y.; Deshotel; Dukes; Dunnam; Dutton; Edwards; Farrar; Gallego; Garza; Giddings; Guillen; Gutierrez; Hochberg; Hodge; Hopson; Jones, J.; Lewis; Luna; Mabry; Martinez Fischer; McClendon; Menendez; Moreno, J.; Moreno, P.; Naishtat; Noriega; Oliveira; Olivo; Peña; Pickett; Puente; Quintanilla; Raymond; Rodriguez; Solis; Talton; Telford; Thompson; Turner; Uresti; Villarreal; Wilson; Wise; Wolens.

Present, not voting — Mr. Speaker(C).

Absent — McReynolds.

Amendment No. 35

On behalf of Representative Eiland, Representative Uresti offered the following amendment to **CSHB 4**:

Floor Packet Page No. 82

Amend **CSHB 4** as follows:
On page 10, strike lines 19-25.

Representative Nixon moved to table Amendment No. 35.

A record vote was requested.

The motion to table prevailed by (Record 73): 81 Yeas, 66 Nays, 1 Present, not voting.

Yeas — Allen; Baxter; Berman; Bohac; Bonnen; Branch; Brown, B.; Brown, F.; Callegari; Campbell; Casteel; Christian; Cook, B.; Corte; Crabb; Crownover; Davis, J.; Dawson; Delisi; Denny; Driver; Eissler; Elkins; Farabee; Flynn; Gattis; Geren; Goolsby; Griggs; Grusendorf; Haggerty; Hamilton; Hamric; Hardcastle; Harper-Brown; Heflin; Hegar; Hilderbran; Hill; Hope; Howard; Hunter; Hupp; Isett; Jones, E.; Keel; Keffer, B.; Keffer, J.; King; Kolkhorst; Krusee; Kuempel; Laubenberg; Madden; Marchant; McCall; Mercer; Merritt; Miller; Morrison; Mowery; Nixon; Paxton; Phillips; Pitts; Riddle; Rose; Seaman; Smith, T.; Smith, W.; Solomons; Stick; Swinford; Taylor; Truitt; Van Arsdale; West; Wohlgemuth; Wong; Woolley; Zedler.

Nays — Alonzo; Bailey; Burnam; Canales; Capelo; Castro; Chavez; Chisum; Coleman; Cook, R.; Davis, Y.; Deshotel; Dukes; Dunnam; Dutton; Edwards; Eiland; Ellis; Farrar; Flores; Gallego; Garza; Giddings; Goodman; Guillen; Gutierrez; Hartnett; Hochberg; Hodge; Homer; Hopson; Hughes; Jones, D.; Jones, J.; Laney; Lewis; Luna; Mabry; Martinez Fischer; McClendon; McReynolds; Menendez; Moreno, J.; Moreno, P.; Naishtat; Noriega; Oliveira; Olivo; Peña; Pickett; Puente; Quintanilla; Raymond; Reyna; Ritter; Rodriguez; Smithee; Solis; Telford; Thompson; Turner; Uresti; Villarreal; Wilson; Wise; Wolens.

Present, not voting — Mr. Speaker(C).

Absent — Talton.

Naishtat; Noriega; Olivo; Peña; Pickett; Puente; Quintanilla; Raymond; Reyna; Rodriguez; Smithee; Solis; Telford; Thompson; Turner; Uresti; Villarreal; Wilson; Wolens.

Present, not voting — Mr. Speaker; Hamric(C); Jones, D.

Absent, Excused — Oliveira; Wise.

STATEMENT OF VOTE

I was shown voting yes on Record No. 121. I intended to vote no.

Hilderbran

Amendment No. 103

Representative Dunnam offered the following amendment to **CSHB 4**:

Floor Packet Page No. 243

Amend **CSHB 4** as follows:

On page 50, line 26, strike Subsection (a) and renumber the remaining subsections appropriately.

Amendment No. 103 was withdrawn.

Amendment No. 104

Representative Olivo offered the following amendment to **CSHB 4**:

Floor Packet Page No. 246

Amend **CSHB 4** as follows:

On page 51, strike lines 11-14 and substitute the following, starting on line 11:

(f)(1) Notwithstanding the provisions of Rule 202, Texas Rules of Civil Procedure, a deposition may not be taken of a physician or health care provider for the purpose of investigating a health care liability claim before the filing of lawsuit unless:

(a) Upon receipt of written notice as required under Section 4.01 of this Act, from a patient, patient's family or patient's representative, the physician or health care provider has failed, within the ten days specified in Section 4.01 of this Act, to provide complete, unaltered records; or

(b) Upon providing the records as required under Section 4.01 of this Act, the records are incomplete, inaccurate, illegible, show evidence of having been changed after the events which they purport to record, or fail to comply with any applicable rules, regulations, standards, policies or guidelines for proper completion of same; or

(c) Upon providing the records as required under Section 4.01 of this Act, it cannot be reasonably determined from the records provided what sequence of events occurred in the relevant treatment or events, or cannot be reasonably determined who was present, involved, participated in or observed the events in question.

(2) If the physician or health care provider fails to provide the records as required under Section 4.01 of this Act, the patient, the patient's family, or the patient's representative shall be entitled to Rule 202 depositions sufficient to provide the information needed for them to appropriately evaluate any potential health care liability claim and make decisions about inclusion or not of potential defendants.

Amendment No. 105

Representative Olivo offered the following amendment to Amendment No. 104:

Amend Amendment No. 104 by Olivo to **CSHB 4** (beginning on page 246, amendment packet) by striking the first line on page 2 of the amendment and substituting:

representative shall, notwithstanding Section 13.01(u) of this Act, be entitled to one deposition under Rule 202, Texas Rules of Civil Procedure, in addition to the deposition allowed under Section 13.01(u) of this Act, sufficient to provide the

Amendment No. 105 was adopted without objection.

Amendment No. 104, as amended, was adopted without objection.

Amendment No. 106

Representative Eiland offered the following amendment to **CSHB 4**:

Floor Packet Page No. 250

Amend **CSHB 4** as follows:

On page 51, strike lines 23-27 through page 52, strike lines 1-9.

On page 51, substitute the following, starting on line 23:

Sec. 7.03. FEDERAL OR STATE INCOME TAXES AND LITIGATION FEES AND EXPENSES. Notwithstanding any other law, in a health care liability claim, if a plaintiff seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, evidence of the income reported to a governmental entity in the form of a filed or amended tax return, social security earnings report, a W-2 or a 1099 form may be presented with competent expert testimony.

Amendment No. 106 was withdrawn.

Amendment No. 107

Representative Phillips offered the following amendment to **CSHB 4**:

Floor Packet Page No. 258

Amend **CSHB 4** as follows:

(1) On page 53, line 13, between "RECOVERY OF" and "MEDICAL", insert "PAST".

(2) On page 53, line 14, between "Recovery of" and "medical", insert "past".

Amendment No. 107 was withdrawn.

Amend **CSHB 4** on page 59, between lines 13 and 14, by inserting the following new SECTION, appropriately numbered, and renumbering subsequent SECTIONS of the bill accordingly:

SECTION 10._____. Subchapter K, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 11.08 to read as follows:

Sec. 11.08. APPLICATION TO CERTAIN CLAIMS. This subchapter does not apply in an action on a health care liability claim brought by a person who does not seek economic damages except for those health care related expenses that will be paid to a third party.

Representative Nixon moved to table Amendment No. 113.

A record vote was requested.

The motion to table prevailed by (Record 124): 84 Yeas, 60 Nays, 2 Present, not voting.

Yeas — Allen; Baxter; Berman; Bohac; Bonnen; Branch; Brown, B.; Callegari; Campbell; Capelo; Casteel; Chisum; Christian; Cook, B.; Corte; Crabb; Crownover; Davis, J.; Dawson; Delisi; Denny; Driver; Eissler; Elkins; Farabee; Flynn; Gattis; Geren; Goodman; Goolsby; Griggs; Grusendorf; Haggerty; Hamilton; Hardcastle; Harper-Brown; Heflin; Hegar; Hill; Hope; Howard; Hunter; Hupp; Isett; Jones, D.; Jones, E.; Keel; Keffer, B.; Keffer, J.; King; Kolkhorst; Krusee; Kuempel; Laubenberg; Madden; Marchant; McCall; Mercer; Merritt; Miller; Morrison; Mowery; Nixon; Paxton; Phillips; Pitts; Reyna; Riddle; Ritter; Rose; Seaman; Smith, T.; Smith, W.; Solomons; Stick; Swinford; Taylor; Truitt; Van Arsdale; West; Wohlgemuth; Wong; Woolley; Zedler.

Nays — Alonzo; Bailey; Brown, F.; Burnam; Canales; Castro; Chavez; Coleman; Cook, R.; Davis, Y.; Deshotel; Dukes; Dunnam; Dutton; Edwards; Eiland; Ellis; Farrar; Flores; Gallego; Garza; Guillen; Gutierrez; Hartnett; Hilderbran; Hochberg; Hodge; Homer; Hopson; Hughes; Jones, J.; Laney; Lewis; Luna; Mabry; Martinez Fischer; McClendon; McReynolds; Menendez; Moreno, J.; Moreno, P.; Naishtat; Noriega; Olivo; Peña; Pickett; Puente; Quintanilla; Raymond; Rodriguez; Smithee; Solis; Talton; Telford; Thompson; Turner; Uresti; Villarreal; Wilson; Wolens.

Present, not voting — Mr. Speaker; Hamric(C).

Absent, Excused — Oliveira; Wise.

Absent — Giddings.

Amendment No. 114

Representative Alonzo offered the following amendment to **CSHB 4**:

Floor Packet Page No. 297

Amend **CSHB 4** as follows:

On page 59, line 14, strike SECTION 10.13 and insert a new SECTION 10.13 to read as follows:

SECTION 10.13. Subchapter L, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 12.02 to read as follows:

Sec. 12.02. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care, the person bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the person shows by clear and convincing evidence that the physician or health care provider did not use the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances, provided that if the person bringing the suit has previously established a physician-patient relationship with the physician or health care provider or his partner or associate or on-call designated representative that proof shall be by a preponderance of the evidence.

Amendment No. 115

Representative Alonzo offered the following amendment to Amendment No. 114:

Amend Amendment No. 114 as follows:

On page 59, line 14, strike SECTION 10.13 and insert a new SECTION 10.13 to read as follows:

SECTION 10.13. Subchapter L, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), is amended by adding Section 12.02 to read as follows:

Sec. 12.02. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care, the person bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the person shows by clear and convincing evidence that the physician or health care provider did not use the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances, provided that if the person bringing the suit has previously established a physician-patient relationship with the physician ~~or health care provider or his partner or associate or on call designated representative~~ that proof shall be by a preponderance of the evidence.

Amendment No. 115 was adopted without objection.

Representative Nixon moved to table Amendment No. 114.

A record vote was requested.

The motion to table prevailed by (Record 125): 91 Yeas, 49 Nays, 2 Present, not voting.

Yeas — Allen; Baxter; Berman; Bohac; Bonnen; Branch; Brown, B.; Brown, F.; Callegari; Campbell; Capelo; Casteel; Chisum; Christian; Cook, B.; Cook, R.; Corte; Crabb; Crownover; Davis, J.; Delisi; Denny; Driver; Eissler; Elkins; Ellis; Farabee; Flynn; Gattis; Geren; Goodman; Goolsby; Griggs; Grusendorf; Haggerty; Hamilton; Hardcastle; Harper-Brown; Hartnett; Heflin; Hegar; Hilderbran; Hill; Homer; Hope; Howard; Hughes; Hunter; Hupp; Isett; Jones, E.; Keel; Keffer, B.; Keffer, J.; King; Kolkhorst; Krusee; Kuempel; Laubenberg; Madden; Marchant; McCall; Mercer; Merritt; Miller; Morrison; Mowery; Nixon; Paxton; Phillips; Pitts; Reyna; Riddle; Ritter; Rose; Seaman; Smith, T.; Smith, W.; Smithee; Solomons; Stick; Swinford; Talton; Taylor; Truitt; Van Arsdale; West; Wohlgemuth; Wong; Woolley; Zedler.

Nays — Alonzo; Burnam; Canales; Castro; Chavez; Coleman; Davis, Y.; Deshotel; Dukes; Dunnam; Dutton; Edwards; Eiland; Farrar; Flores; Gallego; Guillen; Gutierrez; Hochberg; Hodge; Hopson; Jones, J.; Laney; Lewis; Luna; Mabry; Martinez Fischer; McClendon; McReynolds; Menendez; Moreno, J.; Moreno, P.; Naishtat; Noriega; Olivo; Peña; Pickett; Puente; Quintanilla; Raymond; Rodriguez; Solis; Telford; Thompson; Turner; Uresti; Villarreal; Wilson; Wolens.

Present, not voting — Mr. Speaker; Hamric(C).

Absent, Excused — Oliveira; Wise.

Absent — Bailey; Dawson; Garza; Giddings; Jones, D.

Amendment No. 116

Representative Dutton offered the following amendment to **CSHB 4**:

Floor Packet Page No. 311

Amend **CSHB 4** as follows:

On page 72, line 1, strike Subchapter R and insert a new Subchapter R to read as follows:

SUBCHAPTER R. PAYMENT FOR FUTURE LOSSES

Sec. 18.01. Definitions. In this subchapter:

(1) "Future damages" means damages that are incurred after the date of judgment for:

(A) medical, health care, or custodial care services;

(B) physical pain and mental anguish, disfigurement, or physical impairment;

(C) loss of consortium, companionship, or society; or

(D) loss of earnings.

Sec. 18.02. SCOPE OF CHAPTER. This subchapter applies only to an action or a health care liability claim against a physician or health care provider in which the award of future damages exceeds $1,000,000.

Sec. 18.03. COURT ORDER FOR PERIODIC PAYMENTS. (a) On the motion of a party or on its own motion, the court may, in the exercise of its discretion, order that future damages awarded in a health care liability judgment

House Bill 4
Conference Committee Report
Section-by-Section Analysis

HOUSE VERSION	SENATE VERSION	CONFERENCE
ARTICLE 1. CLASS ACTIONS	ARTICLE 1. CLASS ACTIONS	
SECTION 1.01. Adds Chapter 26, Civil Practice and Remedies Code, Class Actions Involving Jurisdiction of State Agency, as follows:	SECTION 1.01. Adds Chapter 26, Civil Practice and Remedies Code, Class Actions, as follows:	Same as Senate version.
Sec. 26.001. Definitions. In this chapter: (1) "Agency statute" means a statute of this state administered or enforced by a state agency. (2) "Claimant" means a party seeking recovery of damages or other relief and includes a plaintiff, counterclaimant, cross-claimant, or third-party claimant. (3) "Contested case" has the meaning assigned by Section 2001.003, Government Code. (4) "Defendant" means a party from whom a claimant seeks recovery of damages or other relief. (5) "Rule" has the meaning assigned by Section 2001.003, Government Code. (6) "State agency" means a board, commission, department, office, or agency that: (A) is in the executive branch of state government; (B) is created by the constitution or a statute of this state; (C) has statewide jurisdiction; and (D) has rulemaking authority involving the subject matter of the disputed claim.	No equivalent provision. (*But see Sec. 26.051, State Agency with Exclusive or Primary jurisdiction, below.*)	Same as Senate version.
Sec. 26.002. Applicability. This chapter applies only to an action in which: (1) a claimant seeks recovery of damages or other relief on behalf of a class of claimants; and (2) a disputed claim in the action involves the interpretation, application, or violation of an agency statute or rule with respect to one or more defendants.	No equivalent provision. (*But see Sec. 26.051, State Agency with Exclusive or Primary jurisdiction, below.*)	Same as Senate version.

HOUSE VERSION	SENATE VERSION	CONFERENCE
No equivalent provision.	Subchapter B heading. Class Actions Involving Jurisdiction of State Agency.	Same as Senate version.
Sec. 26.003. Hearing. (a) On motion of a party, a court shall conduct a hearing to determine whether an action should be dismissed or abated under this chapter. (b) Notice of the hearing must be given to the named parties to the action on or before the 21st day before the date of the hearing.	Sec. 26.051. State Agency with Exclusive or Primary Jurisdiction. (a) Before hearing or deciding a motion to certify a class action, a trial court must hear and rule on all pending pleas to the jurisdiction asserting that an agency of this state has exclusive or primary jurisdiction of the action or a part of the action, or asserting that a party has failed to exhaust administrative remedies. The court's ruling must be reflected in a written order. (b) If a plea to the jurisdiction described by Subsection (a) is denied and a class is subsequently certified, a person may, as part of an appeal of the order certifying the class action, obtain appellate review of the order denying the plea to the jurisdiction. (c) This section does not alter or abrogate a person's right to appeal or pursue an original proceeding in an appellate court in regard to a trial court's order granting or denying a plea to the jurisdiction if the right exists under statutory or common law in effect at the time review is sought.	Same as Senate version.

HOUSE VERSION	SENATE VERSION	CONFERENCE
	signed on or after the effective date of this Act.	
ARTICLE 8. EVIDENCE RELATING TO SEAT BELTS	ARTICLE 8. EVIDENCE RELATING TO SEAT BELTS	Same as Senate version.
SECTION 8.01. Repeals Sec. 545.413(g), Transportation Code.	SECTION 8.01. Repeals Secs. 545.412(d) and 545.413(g), Transportation Code.	Same as Senate version.
ARTICLE 9. BENEVOLENT GESTURES.	No equivalent provision.	Same as Senate version.
No equivalent provision.	ARTICLE 9. RESERVED	Same as Senate version.
SECTION 9.01. Repeals Sec. 18.061(c), Civil Practice and Remedies Code.	No equivalent provision.	Same as Senate version.
SECTION 9.02. This article applies only to the admissibility of a communication in a proceeding that begins on or after the effective date of this article. The admissibility of a communication in a proceeding that began before the effective date of the article is governed by the law applicable to the admissibility of the communication immediately before the effective date of this article, and that law is continued in effect for that purpose.	No equivalent provision.	Same as Senate version.
ARTICLE 10. HEALTH CARE	ARTICLE 10. HEALTH CARE	*Conference version adopts new statutory citations to reflect Senate change that moved all of Article 4590i, Vernon's, to Chapter 74, Civil Practices & Remedies Code.*
SECTION 10.01. Amends Sec. 1.03(a), Subdivisions (3), (4), and (8), and adds Subdivisions (10)-(22), Medical Liability	SECTION 10.01. Amends Chapter 74, Civil Practice and Remedies Code, as follows:	Same as Senate version.

HOUSE VERSION	SENATE VERSION	CONFERENCE
and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).		
No equivalent provision.	Subchapter A. General Provisions.	Same as Senate version.
No equivalent provision.	Sec. 74.001. Definitions. (a) Defines a number of terms, as follows:	Same as Senate version.
(3)(A) Defines "health care provider" to mean any person, professional, association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including: a registered nurse; a hospital; a hospital system; a dentist; a hospice; a podiatrist; a pharmacist; an emergency medical services provider; an assisted living facility; a home and community support services agency; an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)), as amended; a nursing home; or a chiropractor. Specifies that the term includes an officer, director, shareholder, member, partner, manager, owner, or affiliate of a health care provider or physician; and an employee, independent contractor, or agent of a health care provider or physician acting in the course and scope of the employment or contractual relationship.	(12)(A) Similar to House version. The definition includes an optometrist and a "health care institution." "Health care institution" has its own definition, not in the House version, that includes the entities listed in the House definition of "health care provider" and some additional entities. (See the description of Subdivision (11), below.)	Same as Senate version.
(4) Defines "health care liability claim" to mean a cause of	(13) "health care liability claim" to mean a cause of action	Senate version with marked changes: (13) "Health care liability claim" means a cause of action

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action against a health care provider or physician *arising out of or related to* treatment, lack of treatment, or other claimed departure from accepted standards of medical care, health care, or safety *or professional or administrative services* which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.	against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, health care, or safety which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.	against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, or health care, or safety or professional or administrative services directly related to health care, which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.
(8) Defines "physician" to mean: (A) an individual licensed to practice medicine in this state; (B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians; (C) a partnership or limited liability partnership formed by a group of physicians; (D) a nonprofit health corporation certified under Sec. 162.001, Occupations Code; or (E) a company formed by a group of physicians under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes).	(23) Same as House version.	Same as Senate version.
(10) Defines "affiliate" to mean a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified person, including any direct or indirect parent or subsidiary.	(1) Same as House version.	Same as Senate version.
(11) Defines "claimant" to mean a person, including a decedent's estate, seeking or who has sought recovery of	(2) Same as House version.	Same as Senate version.

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damages in a health care liability claim. Provides that all persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.		
(12) Defines "control" to mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the person, whether through ownership of equity or securities, by contract, or otherwise.	(3) Same as House version.	Same as Senate version.
(13) Defines "economic damages" to mean compensatory damages for any pecuniary loss or damage. Provides that the term does not include noneconomic damages.	(6) Provides that "economic damages" has the meaning assigned by Sec. 41.001.	Same as Senate version.
(14) Defines "emergency medical care" to mean bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient's health in serious jeopardy; (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part.	(7) Same as House version, except provides that the term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency.	Same as Senate version.
(15) Defines "emergency medical services provider" to mean a licensed public or private provider to which Chapter 773, Health and Safety Code, applies.	(8) Same as House version.	Same as Senate version.

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(16) Defines "home and community support services agency" to mean a licensed public or provider agency to which Chapter 142, Health and Safety Code, applies.	(14) Same as House version.	Same as Senate version.
(17) Defines "intermediate care facility for the mentally retarded" to mean a licensed public or private institution to which Chapter 252, Health and Safety Code, applies.	(18) Same as House version.	Same as Senate version.
(18) Defines "noneconomic damages" to mean any loss or damage, however characterized, for past, present, and future physical pain and suffering, mental anguish and suffering, loss of consortium, loss of companionship and society, disfigurement, physical impairment, and any other nonpecuniary loss or damage or element of loss or damage.	(20) Provides that "noneconomic damages" has the meaning assigned by Sec. 41.001.	Same as Senate version.
(19) Defines "nursing home" to mean a licensed public or private institution to which Chapter 242, Health and Safety Code, applies.	(21) Same as House version.	Same as Senate version.
(20) Defines "professional or administrative services" to mean those duties or services that a physician or health care provider is required to provide as a condition of maintaining the physician's or health care provider's license, accreditation status, or certification to participate in state or federal health care programs.	(24) Same as House version.	Same as Senate version.
(21) Defines "hospice" to mean a hospice facility or activity to which Chapter 142, Health and Safety Code, applies.	(15) Same as House version.	Same as Senate version.

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(22) Defines "hospital system" to mean a system of hospitals located in this state that are under the common governance or control of a corporate parent.	(17) Same as House version.	Same as Senate version.
No equivalent provision.	(4) Defines "court" to mean any federal or state court.	Same as Senate version.
No equivalent provision.	(5) Defines "disclosure panel" to mean the Texas Medical Disclosure Panel.	Same as Senate version.
No equivalent provision.	(9) Provides that "gross negligence" has the meaning assigned by Sec. 41.001.	Same as Senate version.
No equivalent provision.	(10) Defines "health care" to mean any act or treatment performed or furnished, or that should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.	Same as Senate version.
No equivalent provision.	(11) Defines "health care institution" to include: (A) an ambulatory surgical center; (B) an assisted living facility licensed under Chapter 247, Health and Safety Code; (C) an emergency medical services provider; (D) a health services district created under Chapter 287, Health and Safety Code (FA11); (E) a home and community support services agency; (F) a hospice; (G) a hospital; (H) a hospital system; (I) an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section	Same as Senate version.

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	1396n), as amended; (J) a nursing home; or (K) an end stage renal disease facility licensed under Sec. 251.011, Health and Safety Code.	
No equivalent provision.	(16) Defines "hospital" to mean a licensed public or private institution as defined in Chapter 241, Health and Safety Code, or licensed under Chapter 577, Health and Safety Code.	Same as Senate version.
No equivalent provision.	(19) Defines "medical care" to mean any act defined as practicing medicine under Sec. 151.002, Occupations Code, performed or furnished, or which should have been performed, by one licensed to practice medicine in this state for, to, or on behalf of a patient during the patient's care, treatment, or confinement.	Same as Senate version.
No equivalent provision.	(22) Defines "pharmacist" to mean one licensed under Chapter 551, Occupations Code, who, for the purposes of this chapter, performs those activities limited to the dispensing of prescription medicines which result in health care liability claims and does not include any other cause of action that may exist at common law against them, including but not limited to causes of action for the sale of mishandled or defective products.	Same as Senate version.
No equivalent provision.	(25) Defines "representative" to mean the spouse, parent, guardian, trustee, authorized attorney, or other authorized legal agent of the patient or claimant.	Same as Senate version.
No equivalent provision.	(b) Provides that any legal term or word of art used in this	Same as Senate version.

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	chapter, not otherwise defined in this chapter, shall have such meaning as is consistent with the common law.	
SECTION 10.02. Amends Subchapter A, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as follows:	No equivalent provision.	Same as Senate version.
Sec. 1.04. Sets out provisions relating to conflict with other law and rules of civil procedures, as follows:	Sec. 74.002. Same as House version, except as follows:	Same as Senate version.
(a) Provides that in the event of a conflict between this *Act* and another law, including a rule of procedure or evidence or court rule, this *Act* controls to the extent of the conflict.	(a) Same as House version, except refers to *chapter* instead of *act*.	Same as Senate version.
(b) Provides that notwithstanding Subsection (a) of this section, in the event of a conflict between this *Act* and Sec. 101.023, 102.003, or 108.002, Civil Practice and Remedies Code, those sections of the Civil Practice and Remedies Code control to the extent of the conflict.	(b) Substantially the same as House version, except refers to *chapter* instead of *act*.	Same as Senate version.
(c) Prohibits the supreme court, notwithstanding Sec. 22.004, Government Code, and except as otherwise provided by this Act, from amending or adopting rules in conflict with this Act.	No equivalent provision.	Same as Senate version.
(d) Prohibits the district courts and statutory county courts in a county from adopting local rules in conflict with this *Act*.	(c) Same as House version, except refers to *chapter* instead of *act*.	Same as Senate version.
Sec. 1.05. Sovereign Immunity Not Waived. Provides that	Sec. 74.003. Same as House version, except refers to *chapter*	Same as Senate version.

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this *Act* does not waive sovereign immunity from suit or from liability.	instead of *act*.	
No equivalent provision.	Sec. 74.004. Exception from Certain Laws. (a) Notwithstanding any other law, Secs. 17.41-17.63, Business & Commerce Code, do not apply to physicians or health care providers with respect to claims for damages for personal injury or death resulting, or alleged to have resulted, from negligence on the part of any physician or health care provider. (b) This section does not apply to pharmacists.	Same as Senate version.
No equivalent provision.	[Sections 74.005-74.050 reserved for expansion]	Same as Senate version.
No equivalent provision.	Subchapter B. Notice and Pleadings.	Same as Senate version.
No equivalent provision.	Sec. 74.051. Notice. (a) Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the filing of a suit in any court of this state based upon a health care liability claim. The notice must be accompanied by the authorization form for release of protected health information as required under Sec. 74.052. (b) In such pleadings as are subsequently filed in any court, each party shall state that it has fully complied with the provisions of this section and Sec. 74.052 and shall provide such evidence thereof as the judge of the court may require to	Same as Senate version.

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	determine if the provisions of this chapter have been met. (c) Notice given as provided in this chapter shall toll the applicable statute of limitations to and including a period of 75 days following the giving of the notice, and this tolling shall apply to all parties and potential parties. (d) All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 45 days from the date of receipt of a written request for such records; provided, however, that the receipt of a medical authorization in the form required by Sec. 74.052 executed by the claimant herein shall be considered compliance by the claimant with this subsection. (e) For the purposes of this section, and notwithstanding Chapter 159, Occupations Code, or any other law, a request for the medical records of a deceased person or a person who is incompetent shall be deemed to be valid if accompanied by an authorization in the form required by Sec. 74.052 signed by a parent, spouse, or adult child of the deceased or incompetent person.	
No equivalent provision.	Sec. 74.052. Authorization Form For Release of Protected Health Information. (a) Notice of a health care claim under Sec. 74.051 must be accompanied by a medical authorization in the form specified by this section. Failure to provide this authorization along with the notice of health care claim shall abate all further proceedings against the physician or health care provider receiving the notice until 60 days following receipt by the physician or health care provider of the required authorization.	Same as Senate version.

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(b) If the authorization required by this section is modified or revoked, the physician or health care provider to whom the authorization has been given shall have the option to abate all further proceedings until 60 days following receipt of a replacement authorization that must comply with the form specified by this section.

(c) The medical authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

A. I, _____ (name of patient or authorized representative), hereby authorize _____ (name of physician or other health care provider to whom the notice of health care claim is directed) to obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes: 1. To facilitate the investigation and evaluation of the health care claim described in the accompanying Notice of Health Care Claim; or 2. Defense of any litigation arising out of the claim made the basis of the accompanying Notice of Health Care Claim.

B. The health information to be obtained, used, or disclosed extends to and includes the verbal as well as the written and is specifically described as follows: 1. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) in connection with the injuries alleged

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	to have been sustained in connection with the claim asserted in the accompanying Notice of Health Care Claim. (Here list the name and current address of all treating physicians or health care providers). This authorization shall extend to any additional physicians or health care providers that may in the future evaluate, examine, or treat _____ (patient) for injuries alleged in connection with the claim made the basis of the attached Notice of Health Care Claim; 2. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) during a period commencing five years prior to the incident made the basis of the accompanying Notice of Health Care Claim. (Here list the name and current address of such physicians or health care providers, if applicable.) C. Excluded Health Information -- the following constitutes a list of physicians or health care providers possessing health care information concerning _____ (patient) to which this authorization does not apply because I contend that such health care information is not relevant to the damages being claimed or to the physical, mental, or emotional condition of _____ (patient) arising out of the claim made the basis of the accompanying Notice of Health Care Claim. (Here state "none" or list the name of each physician or health care provider to whom this authorization does not extend and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure.) D. The persons or class of persons to whom the health information of _____ (patient) will be disclosed or who	

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	will make use of said information are: 1. Any and all physicians or health care providers providing care or treatment to _____ (patient); 2. Any liability insurance entity providing liability insurance coverage or defense to any physician or health care provider to whom Notice of Health Care Claim has been given with regard to the care and treatment of _____ (patient); 3. Any consulting or testifying experts employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization; 4. Any attorneys (including secretarial, clerical, or paralegal staff) employed by or on behalf of_____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization; 5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of _____ (patient). E. This authorization shall expire upon resolution of the claim asserted or at the conclusion of any litigation instituted in connection with the subject matter of the Notice of Health Care Claim accompanying this authorization, whichever occurs sooner. F. I understand that, without exception, I have the right to revoke this authorization in writing. I further understand the consequence of any such revocation as set out in Sec. 74.052, Civil Practice and Remedies Code.	

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	G. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits. H. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. Signature of Patient/Representative _____ Date _____ Name of Patient/ Representative _____ Description of Representative's Authority _____	
No equivalent provision.	Sec. 74.053. Pleadings Not to State Damage Amount; Special Exception; Exclusion From Section. Pleadings in a suit based on a health care liability claim shall not specify an amount of money claimed as damages. The defendant may file a special exception to the pleadings on the ground the suit is not within the court's jurisdiction, in which event the plaintiff shall inform the court and defendant in writing of the total dollar amount claimed. This section does not prevent a party from mentioning the total dollar amount claimed in examining prospective jurors on voir dire or in argument to the court or jury.	Same as Senate version.
No equivalent provision.	[Sections 74.054-74.100 reserved for expansion]	Same as Senate version.

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No equivalent provision.	Subchapter C. Informed Consent.	Same as Senate version.
No equivalent provision.	Sec. 74.101. Theory of Recovery. In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.	Same as Senate version.
No equivalent provision.	Sec. 74.102. Texas Medical Disclosure Panel. (a) The Texas Medical Disclosure Panel is created to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure. (b) The disclosure panel established herein is administratively attached to the Texas Department of Health. The Texas Department of Health, at the request of the disclosure panel, shall provide administrative assistance to the panel; and the Texas Department of Health and the disclosure panel shall coordinate administrative responsibilities in order to avoid unnecessary duplication of facilities and services. The Texas Department of Health, at the request of the panel, shall submit the panel's budget request to the legislature. The	Same as Senate version.

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	panel shall be subject, except where inconsistent, to the rules and procedures of the Texas Department of Health; however, the duties and responsibilities of the panel as set forth in this chapter shall be exercised solely by the disclosure panel, and the board or Texas Department of Health shall have no authority or responsibility with respect to same. (c) The disclosure panel is composed of nine members, with three members licensed to practice law in this state and six members licensed to practice medicine in this state. Members of the disclosure panel shall be selected by the commissioner of health. (d) At the expiration of the term of each member of the disclosure panel so appointed, the commissioner shall select a successor, and such successor shall serve for a term of six years, or until his successor is selected. Any member who is absent for three consecutive meetings without the consent of a majority of the disclosure panel present at each such meeting may be removed by the commissioner at the request of the disclosure panel submitted in writing and signed by the chairman. Upon the death, resignation, or removal of any member, the commissioner shall fill the vacancy by selection for the unexpired portion of the term. (e) Members of the disclosure panel are not entitled to compensation for their services, but each panelist is entitled to reimbursement of any necessary expense incurred in the performance of his duties on the panel, including necessary travel expenses. (f) Meetings of the panel shall be held at the call of the chairman or on petition of at least three members of the panel.	

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	(g) At the first meeting of the panel each year after its members assume their positions, the panelists shall select one of the panel members to serve as chairman and one of the panel members to serve as vice chairman, and each such officer shall serve for a term of one year. The chairman shall preside at meetings of the panel, and in his absence, the vice chairman shall preside. (h) Employees of the Texas Department of Health shall serve as the staff for the panel.	
No equivalent provision.	Sec. 74.103. Duties of Disclosure Panel. (a) To the extent feasible, the panel shall identify and make a thorough examination of all medical treatments and surgical procedures in which physicians and health care providers may be involved in order to determine which of those treatments and procedures do and do not require disclosure of the risks and hazards to the patient or person authorized to consent for the patient. (b) The panel shall prepare separate lists of those medical treatments and surgical procedures that do and do not require disclosure and, for those treatments and procedures that do require disclosure, shall establish the degree of disclosure required and the form in which the disclosure will be made. (c) Lists prepared under Subsection (b) together with written explanations of the degree and form of disclosure shall be published in the Texas Register. (d) At least annually, or at such other period the panel may determine from time to time, the panel will identify and examine any new medical treatments and surgical procedures	Same as Senate version.

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	that have been developed since its last determinations, shall assign them to the proper list, and shall establish the degree of disclosure required and the form in which the disclosure will be made. The panel will also examine such treatments and procedures for the purpose of revising lists previously published. These determinations shall be published in the Texas Register.	
No equivalent provision.	Sec. 74.104. Duty of Physician or Health Care Provider. Before a patient or a person authorized to consent for a patient gives consent to any medical care or surgical procedure that appears on the disclosure panel's list requiring disclosure, the physician or health care provider shall disclose to the patient or person authorized to consent for the patient the risks and hazards involved in that kind of care or procedure. A physician or health care provider shall be considered to have complied with the requirements of this section if disclosure is made as provided in Sec. 74.105.	Same as Senate version.
No equivalent provision.	Sec. 74.105. Manner of Disclosure. Consent to medical care that appears on the disclosure panel's list requiring disclosure shall be considered effective under this chapter if it is given in writing, signed by the patient or a person authorized to give the consent and by a competent witness, and if the written consent specifically states the risks and hazards that are involved in the medical care or surgical procedure in the form and to the degree required by the disclosure panel under Sec. 74.103.	Same as Senate version.

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No equivalent provision.	Sec. 74.106. Effect of Disclosure. (a) In a suit against a physician or health care provider involving a health care liability claim that is based on the negligent failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider: (1) both disclosure made as provided in Sec. 74.104 and failure to disclose based on inclusion of any medical care or surgical procedure on the panel's list for which disclosure is not required shall be admissible in evidence and shall create a rebuttable presumption that the requirements of Secs. 74.104 and 74.105 have been complied with and this presumption shall be included in the charge to the jury; and (2) failure to disclose the risks and hazards involved in any medical care or surgical procedure required to be disclosed under Secs. 74.104 and 74.105 shall be admissible in evidence and shall create a rebuttable presumption of a negligent failure to conform to the duty of disclosure set forth in Secs. 74.104 and 74.105, and this presumption shall be included in the charge to the jury; but failure to disclose may be found not to be negligent if there was an emergency or if for some other reason it was not medically feasible to make a disclosure of the kind that would otherwise have been negligence. (b) If medical care or surgical procedure is rendered with respect to which the disclosure panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law.	Same as Senate version.

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No equivalent provision.	Sec. 74.107. Informed Consent for Hysterectomies. (a) The disclosure panel shall develop and prepare written materials to inform a patient or person authorized to consent for a patient of the risks and hazards of a hysterectomy. (b) The materials shall be available in English, Spanish, and any other language the panel considers appropriate. The information must be presented in a manner understandable to a layperson. (c) The materials must include: (1) a notice that a decision made at any time to refuse to undergo a hysterectomy will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds or otherwise affect the patient's right to future care or treatment; (2) the name of the person providing and explaining the materials; (3) a statement that the patient or person authorized to consent for the patient understands that the hysterectomy is permanent and nonreversible and that the patient will not be able to become pregnant or bear children if she undergoes a hysterectomy; (4) a statement that the patient has the right to seek a consultation from a second physician; (5) a statement that the patient or person authorized to consent for the patient has been informed that a hysterectomy is a removal of the uterus through an incision in the lower abdomen or vagina and that additional surgery may be necessary to remove or repair other organs, including an ovary, tube, appendix, bladder, rectum, or vagina; (6) a description of the risks and hazards involved in the performance of the procedure; and (7) a written statement to be signed by the patient or person authorized to consent for	Same as Senate version.

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	the patient indicating that the materials have been provided and explained to the patient or person authorized to consent for the patient and that the patient or person authorized to consent for the patient understands the nature and consequences of a hysterectomy. (d) The physician or health care provider shall obtain informed consent under this section and Section 74.104 from the patient or person authorized to consent for the patient before performing a hysterectomy unless the hysterectomy is performed in a life-threatening situation in which the physician determines obtaining informed consent is not reasonably possible. If obtaining informed consent is not reasonably possible, the physician or health care provider shall include in the patient's medical records a written statement signed by the physician certifying the nature of the emergency. (e) The disclosure panel may not prescribe materials under this section without first consulting with the Texas State Board of Medical Examiners.	
No equivalent provision.	[Sections 74.108-74.150 reserved for expansion]	Same as Senate version.
SECTION 10.03. Adds Sec. 4.01(f), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes). (f)(1) Notwithstanding the provisions of Rule 202, Texas Rules of Civil Procedure, a deposition may not be taken of a physician or health care provider for the purpose of investigating a health care liability claim before the filing of	No equivalent provision.	Same as Senate version.

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a lawsuit unless: (A) upon receipt of written notice as required under this section from a patient, patient's family, or patient's representative, the physician or health care provider has failed, within the 10 days specified in this section, to provide complete, unaltered records; (B) upon providing the records as required under this section, the records are incomplete, inaccurate, illegible, show evidence of having been changed after the events that they purport to record, or fail to comply with any applicable rules, regulations, standards, policies, or guidelines for proper completion of same; or (C) upon providing the records as required under this section, it cannot be reasonably determined from the records provided what sequence of events occurred in the relevant treatment or events, or cannot be reasonably determined who was present, involved, participated in, or observed the events in question. (2) If the physician or health care provider fails to provide the records as required under this section, the patient, the patient's family, or the patient's representative shall, notwithstanding Section 13.01(u) of this Act, be entitled to one deposition under Rule 202, Texas Rules of Civil Procedure, in addition to the deposition allowed under Section 13.01(u) of this Act, sufficient to provide the information needed for them to appropriately evaluate any potential health care liability claim and make decisions about inclusion or not of potential defendants.		
SECTION 10.04. Amends heading to Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Evidentiary Matters.	No equivalent provision.	Same as Senate version.

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SECTION 10.05. Amends Subchapter G, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as follows:	No equivalent provision.	Same as Senate version.
Sec. 7.03. Federal or State Income Taxes. (a) Notwithstanding any other law, *in a health care liability claim*, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, evidence to prove the loss must be presented in the form of a *net after-tax loss that either was or should have been paid by the injured party or decedent through which the alleged loss has occurred.* (b) *In a health care liability claim*, if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, the court shall instruct the jury whether any recovery for compensatory damages sought by the claimant is subject to federal or state income taxes.	SECTION 13.09. Adds Subchapter D, Chapter 18, Civil Practice and Remedies Code, Certain Losses, Sec. 18.091, Proof of Certain Losses; Jury Instruction. Same as House version, except not limited to only a health care liability claim, and requires evidence to prove the loss must be presented in the form of a net loss *after reduction for income tax payments or unpaid tax liability pursuant to any federal income tax law.*	Same as Senate version.
No equivalent provision.	Subchapter D. Emergency Care.	Same as Senate version.
No equivalent provision.	Sec. 74.151. Liability for Emergency Care. (a) A person who in good faith administers emergency care, including using an automated external defibrillator, is not liable in civil damages for an act performed during the emergency unless the act is wilfully or wantonly negligent. (b) This section does not apply to care administered: (1) for	Senate version, but strike Subsections (c) and (d): Sec. 74.151. Liability for Emergency Care. (a) A person who in good faith administers emergency care, including using an automated external defibrillator, is not liable in civil damages for an act performed during the emergency unless the act is wilfully or wantonly negligent. (b) This section does not apply to care administered: (1) for

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	or in expectation of remuneration, provided that being legally entitled to receive remuneration for the emergency care rendered shall not determine whether or not the care was administered for or in anticipation of remuneration; or (2) by a person who was at the scene of the emergency because he or a person he represents as an agent was soliciting business or seeking to perform a service for remuneration. (c) This section does not apply to a physician or other health care provider whose day-to-day responsibilities include the administration of care in a hospital emergency room for or in expectation of remuneration if the scene of an emergency is in a hospital or other health care facility or means of medical transport. (d) For purposes of Subsections (b)(1) and (c), a person who would ordinarily receive or be entitled to receive a salary, fee, or other remuneration for administering care under such circumstances to the patient in question shall be deemed to be acting for or in expectation of remuneration even if the person waives or elects not to charge or receive remuneration on the occasion in question.	or in expectation of remuneration, provided that being legally entitled to receive remuneration for the emergency care rendered shall not determine whether or not the care was administered for or in anticipation of remuneration; or (2) by a person who was at the scene of the emergency because he or a person he represents as an agent was soliciting business or seeking to perform a service for remuneration.
No equivalent provision.	Sec. 74.152. Unlicensed Medical Personnel. Persons not licensed or certified in the healing arts who in good faith administer emergency care as emergency medical service personnel are not liable in civil damages for an act performed in administering the care unless the act is wilfully or wantonly negligent. This section applies without regard to whether the care is provided for or in expectation of remuneration.	Same as Senate version.

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Sec. 7.04. Jury Instructions in Cases Involving Emergency Medical Care. (a) *In a health care liability claim* that involves a claim of negligence arising from the provision of emergency medical care, the court shall instruct the jury to consider, together with all other relevant matters: (1) whether the person providing care did not have the patient's medical history or was unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications; (2) the lack of a preexisting physician-patient relationship or health care provider-patient relationship; (3) the circumstances constituting the emergency; and (4) the circumstances surrounding the delivery of the emergency medical care. (b) The provisions of Subsection (a) of this section do not apply to medical care or treatment: (1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient; or (2) that is unrelated to the original medical emergency.	Sec. 74.154. Similar to House version. (a) *In an action for damages* that involves a claim of negligence arising from the provision of emergency medical care *in a hospital emergency room or department*, the court shall instruct the jury to consider, together with all other relevant matters: (1) whether the person providing care *did or* did not have the patient's medical history or was *able or* unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications; (2) *the presence or* the lack of a preexisting physician-patient relationship or health care provider-patient relationship; (3) the circumstances constituting the emergency; and (4) the circumstances surrounding the delivery of the emergency medical care. In Subsection (b), adds: (3) that is related to an emergency caused in whole or in part by the negligence of the defendant.	Senate version with the following marked changes: Sec. 74.154. JURY INSTRUCTIONS IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) In an action for damages that involves a claim of negligence arising from the provision of emergency medical care in a hospital emergency ~~room or~~ department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the court shall instruct the jury to consider, together with all other relevant matters:
No equivalent provision.	Adds Subchapter E. Res Ipsa Loquitur.	Same as Senate version.
No equivalent provision.	Sec. 74.210. Application for Res Ipsa Loquitur. The common law doctrine of res ipsa loquitur shall only apply to health care liability claims against health care providers or physicians in those cases to which it has been applied by the appellate courts of this state as of August 29, 1977.	Same as Senate version.
No equivalent provision.	[Sections 74.202-74.250 reserved for expansion]	Same as Senate version.

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SECTION 10.06. Amends heading to Subchapter I, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Payment of Medical or Health Care Expenses.	No equivalent provision.	Same as Senate version.
SECTION 10.07. Adds Sec. 9.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Recovery of Past Medical or Health Care Expenses. Recovery of past medical or health care expenses *in a health care liability claim* shall be limited to the amount actually paid or incurred by or on behalf of the claimant.	SECTION 13.08. Adds Sec. 41.0105, Civil Practice and Remedies Code, Evidence Relating to Amount of Economic Damages. (a) Limits the recovery of medical or health care expenses incurred in any action, not just in health care liability claims, to the amount actually paid or incurred by or on behalf of the claimant. This limitation is in addition to any other limitation under law. (b) A defendant may introduce evidence of any amount payable to the claimant as a collateral benefit arising from the event in the cause of action under: (1) the Social Security Act (42 U.S.C. Section 301 et seq.); or (2) a state or federal income disability or workers' compensation act. (c) If the defendant introduces evidence under Subsection (b), the plaintiff may introduce evidence of any legal obligation to reimburse any subrogated entity.	Senate version, but strike subsections (b) and (c).
No equivalent provision.	Adds Subchapter F. Statute of Limitations.	Same as Senate version.
SECTION 10.08. Amends Sec. 10.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Limitation on Health Care Liability Claims.	Sec. 74.251. Same as House version with minor wording changes. Sec. 74.251. STATUTE OF LIMITATIONS ON HEALTH CARE LIABILITY CLAIMS. (a) Notwithstanding any other law and subject to Subsection (b)[~~of this section~~], no health	Same as Senate version.

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	care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that, minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided this section applies to all persons regardless of minority or other legal disability. (b) A claimant must bring a health care liability claim not later than 10 years after the date of the act or omission that gives rise to the claim. This subsection is intended as a statute of repose so that all claims must be brought within 10 years or they are time barred.	
No equivalent provision.	[Sections 74.252-74.300 reserved for expansion]	Same as Senate version.
SECTION 10.09. Adds Secs. 11.02(e) and (f), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes). (e) The limitation on health care liability claims contained in Subsection (a) of this section includes punitive damages. (f) The limitation on health care liability claims contained in Subsection (a) of this section shall be applied on a per-claimant basis.	Sec. 74.303. Limitation on Damages. (a) In an action for wrongful death on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for damages of the physician or health care provider shall be limited to an amount not to exceed $500,000. (c) Subsection (a) does not apply to the amount of damages awarded on a health care liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the	Senate version with the following marked changes: Sec. 74.303. LIMITATION ON DAMAGES. (a) In a wrongful death or survival action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages ~~[of the physician or health care provider]~~, including exemplary damages, shall be limited to an amount not to exceed $500,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

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	injury. (d) The liability of any insurer under the common law theory of recovery commonly known in Texas as the "Stowers Doctrine" shall not exceed the liability of the insured. (e) In any action on a health care liability claim that is tried by a jury in any court in this state, the following shall be included in the court's written instructions to the jurors: (1) "Do not consider, discuss, nor speculate whether or not liability, if any, on the part of any party is or is not subject to any limit under applicable law." (2) "A finding of negligence may not be based solely on evidence of a bad result to the claimant in question, but a bad result may be considered by you, along with other evidence, in determining the issue of negligence. You are the sole judges of the weight, if any, to be given to this kind of evidence."	
No equivalent provision.	Subchapter G. Liability Limits.	Same as Senate version.
SECTION 10.10. Amends Sec. 11.03, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Limitation on Noneconomic Damages. In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for noneconomic damages of the physician or health care provider shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care	Sec. 74.301. Limitation on Noneconomic Damages. (a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages for each defendant physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an	Senate version with marked changes: Sec. 74.301. Limitation on Noneconomic Damages. (a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the health care provider other than a health care institution ~~for each defendant physician or health care provider other than a health care institution~~, inclusive of all persons and entities for which

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providers against whom the claim is asserted or the number of separate causes of action on which the claim is based. This section does not apply to a health care liability claim based solely on intentional denial of medical treatment that a patient is otherwise qualified to receive, against the wishes of a patient, or, if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicted age, disability, degree of medical dependency, or quality of life unless the medical treatment is denied under Chapter 166, Health and Safety Code.	amount not to exceed $250,000.	vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.
	(b) In an action on a health care liability claim where final judgment is rendered against a health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.	(b) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000[~~$500,000~~].
	(c) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all noneconomic damages shall be limited to an amount not to exceed $750,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.	(c) In an action on a health care liability claim where final judgment is rendered against [~~a physician or health care provider,~~] more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000[~~$750,000 for each claimant regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.~~] and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.

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SECTION 10.11. Adds Sec. 11.031, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Alternative Limitation on Noneconomic Damages. (a) In the event that Sec. 11.03 of this subchapter is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective: In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages and losses, other than economic damages, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.	Sec. 74.302. Alternative Limitation on Noneconomic Damages. (a) In the event that Sec. 74.301 is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective: (1) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages for each defendant physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000.	Sec.74.302. ALTERNATIVE LIMITATION ON NONECONOMIC DAMAGES. (a) In the event that Section 74.301 is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject to the provisions of this section, shall become effective: (1) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the health care provider other than a health care institution ~~for each defendant physician or health care provider other than a health care institution~~, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.
	(2) In an action on a health care liability claim where final judgment is rendered against a health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.	(2) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000[~~$500,000~~].
	(3) In an action on a health care liability claim where final	(3) In an action on a health care liability claim where final

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	judgment is rendered against a physician or health care provider, the limit of civil liability for all noneconomic damages shall be limited to an amount not to exceed $750,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.	judgment is rendered against [~~a physician or health care provider;~~] more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000[~~$750,000 for each claimant regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.~~] and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000.
(b) Effective before September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies: (1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program; (2) at least $200,000 for each health care liability claim and at least $600,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and	(b)-(d) Same as House version with minor wording changes.	House version.

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(3) at least $500,000 for each health care liability claim and at least $1.5 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.		
(c) Effective September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies: (1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program; (2) at least $300,000 for each health care liability claim and at least $900,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and (3) at least $750,000 for each health care liability claim and at least $2.25 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.		
(d) Effective September 1, 2007, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this		

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subchapter applies: (1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program; (2) at least $500,000 for each health care liability claim and at least $1 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and (3) at least $1 million for each health care liability claim and at least $3 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.		
(e) Subsection (e)(1) states that evidence of financial responsibility may be established at the time of judgment by providing proof of the purchase of a contract of insurance or other plan of insurance authorized by this state.	(e) Same as House version, except (1) provides for the purchase of a contract of insurance or other plan of insurance authorized by this state *or federal law or regulation.*	Same as Senate version.
(f) This section does not apply to a health care liability claim based solely on intentional denial of medical treatment that a patient is otherwise qualified to receive, against the wishes of a patient, or, if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicted age, disability, degree of medical dependency, or quality of life unless the medical treatment is denied under	No equivalent provision.	Same as Senate version.

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Chapter 166, Health and Safety Code.		
SECTION 10.12. Amends Sec. 11.04, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Adjustments of Liability Limit. When there is an increase or decrease in the consumer price index with respect to the amount of that index on the effective date of this subchapter, the liability limit prescribed in Section 11.02(a) of this subchapter shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index between the effective date of this subchapter and the time at which damages subject to such limit are awarded by final judgment or settlement.	Sec. 74.303. Limitation on Damages. (b) When there is an increase or decrease in the consumer price index with respect to the amount of that index on August 29, 1977, the liability limit prescribed in Subsection (a) shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index, as published by the Bureau of Labor Statistics of the United States Department of Labor, that measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone (CPI-W: Seasonally Adjusted U.S. City Average -- All Items), between August 29, 1977, and the time at which damages subject to such limits are awarded by final judgment or settlement.	Same as Senate version.
No equivalent provision.	[Sections 74.304-74.350 reserved for expansion]	Same as Senate version.
SECTION 10.13. Adds Sec. 12.02, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Standard of Proof in Cases Involving Emergency Medical Care. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of	Sec. 74.153. Similar to House version. Specifies *emergency medical care in a hospital emergency room or department*, and changes *clear and convincing evidence* to *preponderance of the evidence*.	Same as Senate version with the following marked changes: Sec. 74.153. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising

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emergency medical care, the person bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the person shows by *clear and convincing evidence* that the physician or health care provider did not use the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.		out of the provision of emergency medical care in a hospital emergency[~~room or~~] department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant[~~person~~] bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant[~~person~~] shows by a preponderance of the evidence that the physician or health care provider, with willful and wanton negligence, deviated from [~~did not use~~] the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances
SECTION 10.14. Amends heading to Sec. 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Expert Report.	No equivalent provision.	Same as Senate version.
No equivalent provision.	Subchapter H. Procedural Provisions.	Same as Senate version.
SECTION 10.15. Amends Secs. 13.01(a), (b), (i), (j), (k), and (l), and adds (s), (t), and (u), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as follows:	(See below.)	Same as Senate version.
(a) In a health care liability claim, a claimant shall, not later than the *90th* day after the date the claim was filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the report for	Sec. 74.351. Expert Report. (a) In a health care liability claim, a claimant shall, not later than the *150th* day after the date the claim was filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae	Senate version with marked changes: Sec. 74.351. EXPERT REPORT. (a) In a health care liability claim, a claimant shall, not later than the 120th [~~150th~~] day after the date the claim was filed, serve on each

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each physician.	of each expert listed in the report for each physician or health care provider against whom a liability claim is asserted. The date for serving the report may be extended by written agreement of the affected parties. *Each defendant physician or health care provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the 21st day after the date it was served, failing which all objections are waived.*	party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the report for each physician or health care provider against whom a liability claim is asserted. The date for serving the report may be extended by written agreement of the affected parties. Each defendant physician or health care provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the 21st day after the date it was served, failing which all objections are waived.
(b) If, as to a defendant physician or health care provider, an expert report has not been served within the period specified by Subsection (a) *of this section*, the court, on the motion of the affected physician or health care provider, shall enter an order that: (1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider; and (2) dismisses the claim with respect to the physician or health care provider, with prejudice to the refiling of the claim.	(b) Same as House version, except omits the phrase *of this section.*	Same as Senate version.
No equivalent provision.	(c) If an expert report has not been served within the period specified by Subsection (a) because elements of the report are found deficient, the court may grant a 30-day extension to the claimant in order to cure the deficiency. If the claimant does not receive notice of the court's ruling granting the extension until after the 150-day deadline has passed, then the 30-day extension shall run from the date the plaintiff first received	Same as Senate with changes marked: (c) If an expert report has not been served within the period specified by Subsection (a) because elements of the report are found deficient, the court may grant [~~a~~] one 30-day extension to the claimant in order to cure the deficiency. If the claimant does not receive notice of the court's ruling granting the extension until after the [~~150~~] 120-day deadline has passed, then the 30 day extension shall run from the date the plaintiff

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	the notice.	first received the notice.
No equivalent provision.	(d) If, on the motion of a claimant filed before the expiration of the 150-day period referred to in Subsection (a), the court finds that a claimant has been hindered in complying with Subsection (a) because a defendant physician or health care provider has failed to provide timely and complete discovery permitted under Subsection (s) or (u), the court shall extend the deadline until 30 days after complete discovery has been provided.	Same as House version.
	[Subsections (e) - (h) reserved]	
	(i) through (l) same as House version.	Same as Senate version.
(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving an expert report by serving reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.		
(j) Nothing in this section shall be construed to require the		

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serving of an expert report regarding any issue other than an issue relating to liability or causation.		
(k) An expert report served under this section: (1) is not admissible in evidence by any party; (2) shall not be used in a deposition, trial, or other proceeding; and (3) shall not be referred to by any party during the course of the action for any purpose.		
(l) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective good faith effort to comply with the definition of an expert report in Subsection (r)(6) of this section.		
	[Subsections (m) - (q) reserved]	
No equivalent provision.	*[Renumbered existing law only]* (r) In this section: (1) "Affected parties" means the claimant and the physician or health care provider who are directly affected by an act or agreement required or permitted by this section and does not include other parties to an action who are not directly affected by that particular act or agreement.	Same as Senate version.
	(2) "Claim" means a health care liability claim.	Same as Senate version.
	[(3) reserved]	
	(4) "Defendant" means a physician or health care provider against whom a health care liability claim is asserted. The	Same as Senate version.

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	term includes a third-party defendant, cross-defendant, or counterdefendant.	
SECTION 10.16. Amends Sec. 13.01(r)(5), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).		Same as Senate version.
(5) "Expert" means: (A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of *Section 14.01(a) of this Act*; (B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of *Section 14.02 of this Act*; (C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence; (D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a *dentist* who is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence; or (E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a *podiatrist* who	(5) "Expert" means: (A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of *Section 74.401*; (B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of *Section 74.402*; (C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence; (D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a *dentist or physician* who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence; or (E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a *podiatrist or physician* who	

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is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.	is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence.	
No equivalent provision.	(6) "Expert report" means a written report by an expert that provides a fair summary of the expert's opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed.	Same as Senate version.
(s) Until a claimant has served the expert report and curriculum vitae, as required by Subsection (a) *of this section*, all discovery in a health care liability claim is stayed except for the acquisition of the patient's medical records, medical or psychological studies, or tissue samples through: (1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure; (2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and (3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.	(s) Until a claimant has served the expert report and curriculum vitae as required by Subsection (a), ~~*of this section*~~ all discovery in a health care liability claim is stayed except for the acquisition by the claimant of information, *including medical or hospital records or other documents or tangible things, related to the patient's health care or a defendant's liability* through: (1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure; (2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and (3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.	Same as Senate with marked changes: (s) Until a claimant has served the expert report and curriculum vitae as required by Subsection (a), all discovery in a health care liability claim is stayed except for the acquisition by the claimant of information, *including medical or hospital records or other documents or tangible things, related to the patient's health care* ~~*or a defendant's liability*~~ through: (1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure; (2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and (3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.
(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a) *of this section*, the restrictions	(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a) ~~*of this section*~~, the restrictions	

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imposed by Subsection (k) of this section on use of the expert report by any party are waived.	imposed by Subsection (k) of this section on use of the expert report by any party are waived.	Same as Senate version.
(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than *one* deposition before the expert report is served as required by Subsection (a) of this section.	(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than *two* depositions before the expert report is served as required by Subsection (a) of this section. *The court may allow additional deposition discovery on a showing by a plaintiff that additional information is needed for the completion of an expert report that cannot otherwise practicably be obtained in a timely manner under this subsection and Subsection (s).*	Same as Senate version with marked changes: (u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than two deposition before the expert report is served as required by Subsection (a). ~~The court may allow additional deposition discovery on a showing by a plaintiff that additional information is needed for the completion of an expert report that cannot otherwise practicably be obtained in a timely manner under this subsection and Subsection (s).~~
SECTION 10.17. Amends Secs. 14.01(e) and (g), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes). (e) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the	Subchapter I. Expert Witnesses. Secs. 74.401(e) and (g). Same as House version.	Same as Senate version.

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party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications. (g) In this subchapter, "physician" means a person who is: (1) licensed to practice medicine in one or more states in the United States; or (2) a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association only if testifying as a defendant and that testimony relates to that defendant's standard of care, the alleged departure from that standard of care, or the causal relationship between the alleged departure from that standard of care and the injury, harm, or damages claimed.		
No equivalent provision.	*[Renumbered existing law only]* Sec. 74.352. Discovery Procedures. (a) In every health care liability claim the plaintiff shall within 45 days after the date of filing of the original petition serve on the defendant's attorney or, if no attorney has appeared for the defendant, on the defendant full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the appropriate standard set of requests for	Same as Senate version.

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	production of documents and things promulgated by the Health Care Liability Discovery Panel. (b) Every physician or health care provider who is a defendant in a health care liability claim shall within 45 days after the date on which an answer to the petition was due serve on the plaintiff's attorney or, if the plaintiff is not represented by an attorney, on the plaintiff full and complete answers to the appropriate standard set of interrogatories and complete responses to the standard set of requests for production of documents and things promulgated by the Health Care Liability Discovery Panel. (c) Except on motion and for good cause shown, no objection may be asserted regarding any standard interrogatory or request for production of documents and things, but no response shall be required where a particular interrogatory or request is clearly inapplicable under the circumstances of the case. (d) Failure to file full and complete answers and responses to standard interrogatories and requests for production of documents and things in accordance with Subsections (a) and (b) or the making of a groundless objection under Subsection (c) shall be grounds for sanctions by the court in accordance with the Texas Rules of Civil Procedure on motion of any party. (e) The time limits imposed under Subsections (a) and (b) may be extended by the court on the motion of a responding party for good cause shown and shall be extended if agreed in writing between the responding party and all opposing parties. In no event shall an extension be for a period of more	

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	than an additional 30 days. (f) If a party is added by an amended pleading, intervention, or otherwise, the new party shall file full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the standard set of requests for production of documents and things no later than 45 days after the date of filing of the pleading by which the party first appeared in the action. (g) If information or documents required to provide full and complete answers and responses as required by this section are not in the possession of the responding party or attorney when the answers or responses are filed, the party shall supplement the answers and responses in accordance with the Texas Rules of Civil Procedure. (h) Nothing in this section shall preclude any party from taking additional non-duplicative discovery of any other party. The standard sets of interrogatories provided for in this section shall not constitute, as to each plaintiff and each physician or health care provider who is a defendant, the first of the two sets of interrogatories permitted under the Texas Rules of Civil Procedure.	
No equivalent provision.	*[Renumbered existing law only]* Sec. 74.401. Qualifications of Expert Witness in Suit Against Physician. (a) In a suit involving a health care liability claim against a physician for injury to or death of a patient, a person may qualify as an expert witness on the issue of whether the	Same as Senate version.

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	physician departed from accepted standards of medical care only if the person is a physician who: (1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose; (2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care. (b) For the purpose of this section, "practicing medicine" or "medical practice" includes, but is not limited to, training residents or students at an accredited school of medicine or osteopathy or serving as a consulting physician to other physicians who provide direct patient care, upon the request of such other physicians. (c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness: (1) is board certified or has other substantial training or experience in an area of medical practice relevant to the claim; and (2) is actively practicing medicine in rendering medical care services relevant to the claim. (d) The court shall apply the criteria specified in Subsections (a), (b), and (c) in determining whether an expert is qualified to offer expert testimony on the issue of whether the physician departed from accepted standards of medical care, but may depart from those criteria if, under the circumstances, the court determines that there is a good reason to admit the expert's testimony. The court shall state on the record the	

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	reason for admitting the testimony if the court departs from the criteria. (f) This section does not prevent a physician who is a defendant from qualifying as an expert.	
SECTION 10.18. Amends Subchapter N, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), by adding the following sections:	(See below.)	Same as Senate version.
Sec. 14.02. Qualifications of Expert Witness in Suit Against Health Care Provider. (a) For purposes of this section, "practicing health care" includes: (1) training health care providers in the same field as the defendant health care provider at an accredited educational institution; or (2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.	Sec. 74.402. (a) Same as House version.	Same as Senate version.
(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person: (1) is practicing health care *in the same field of practice as the defendant health care provider* at the time the testimony is given or was practicing that type of health care at the time the claim arose; (2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or	(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person: (1) is practicing health care in *a field of practice that involves the same type of care or treatment as that delivered by the defendant health care provider, if the defendant health care provider is an individual*, at the time the testimony is given or was practicing that type of health care at the time the claim	Same as Senate version.

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treatment of the illness, injury, or condition involved in the claim; and (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.	arose; (2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.	
(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness: (1) is certified by a *Texas licensing agency* or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and (2) is actively practicing health care in rendering health care services relevant to the claim.	(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness: (1) is certified by a *licensing agency of one or more states of the United States* or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and (2) is actively practicing health care in rendering health care services relevant to the claim.	Same as Senate version.
(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) *of this section* in determining whether an expert is qualified to offer expert testimony on the issue of whether the defendant health care provider departed from accepted standards of health care but may depart from those criteria if, under the circumstances, the court determines that there is good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria. (e) This section does not prevent a health care provider who is a defendant, or an employee of the defendant health care	Subsections (d) through (f) Same as House version, except omits the phrase *of this section* in Subsection (d).	Same as Senate version.

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provider, from qualifying as an expert. (f) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.		
Sec. 14.03. Qualifications of Expert Witness on Causation in Health Care Liability Claim. (a) Except as provided by Subsections (b) and (c) *of this section*, in a suit involving a health care liability claim against a physician or health care provider, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or	Sec. 74.403. (a) Same as House version, except omits the phrase *of this section.*	Same as Senate version.

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damages claimed only if the person is a physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.		
(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a *dentist* and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.	(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a *dentist or physician* and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.	Same as Senate version.
(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a *podiatrist* and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.	(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a *podiatrist or physician* and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.	Same as Senate version.
(d) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was	(d) Same as House version.	Same as Senate version.

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not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.		
No equivalent provision.	Subchapter J. Arbitration Agreements.	Same as Senate version.
No equivalent provision.	Sec. 74.451. Arbitration Agreements. (a) No physician, professional association of physicians, or other health care provider shall request or require a patient or prospective patient to execute an agreement to arbitrate a health care liability claim unless the form of agreement delivered to the patient contains a written notice in 10-point boldface type clearly and conspicuously stating: UNDER TEXAS LAW, THIS AGREEMENT IS INVALID AND OF NO LEGAL EFFECT UNLESS IT IS ALSO SIGNED BY AN ATTORNEY OF YOUR OWN CHOOSING. THIS AGREEMENT CONTAINS A WAIVER OF IMPORTANT LEGAL RIGHTS, INCLUDING YOUR RIGHT TO A JURY. YOU SHOULD NOT SIGN THIS AGREEMENT WITHOUT FIRST CONSULTING WITH AN ATTORNEY.	Same as Senate version.

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	(b) A violation of this section by a physician or professional association of physicians constitutes a violation of Subtitle B, Title 3, Occupations Code, and shall be subject to the enforcement provisions and sanctions contained in that subtitle. (c) A violation of this section by a health care provider other than a physician shall constitute a false, misleading, or deceptive act or practice in the conduct of trade or commerce within the meaning of Sec. 17.46 of the Deceptive Trade Practices-Consumer Protection Act (Subchapter E, Chapter 17, Business & Commerce Code), and shall be subject to an enforcement action by the consumer protection division under that act and subject to the penalties and remedies contained in Sec. 17.47, Business & Commerce Code, notwithstanding Sec. 74.004 or any other law. (d) Notwithstanding any other provision of this section, a person who is found to be in violation of this section for the first time shall be subject only to injunctive relief or other appropriate order requiring the person to cease and desist from such violation, and not to any other penalty or sanction.	
No equivalent provision.	[Sections 74.452-74.500 reserved for expansion]	Same as Senate version.
SECTION 10.19. Amends Sec. 16.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), Application of Other Law. Notwithstanding Chapter 304, Finance Code, prejudgment interest in a judgment on a health care liability claim shall be awarded in accordance with this subchapter.	No equivalent provision.	Same as Senate version.

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HOUSE VERSION	SENATE VERSION	CONFERENCE
SECTION 10.20. Amends Secs. 16.02(b) and (c), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes). (b) Subject to Subchapter K of this Act, the judgment must include prejudgment interest on past damages awarded in the judgment, but shall not include prejudgment interest on future damages awarded in the judgment. (c) Prejudgment interest allowed under this subchapter shall be computed in accordance with Sec. 304.003(c)(1), Finance Code, for a period beginning on the date of injury and ending on the date before the date the judgment is signed.	No equivalent provision.	Same as Senate version.
SECTION 10.21. Adds Subchapters R, S, and T, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as follows:	No equivalent provision.	Same as Senate version.
Subchapter R. Payment for Future Losses.	Subchapter K. Payment for Future Losses.	Same as Senate version.
Sec. 18.01. Definitions.	Sec. 74.501. Same as House version.	Same as Senate version.
Sec. 18.02. Scope of Subchapter.	Sec. 74.502. Same as House version.	Same as Senate version.
Sec. 18.03. Court Order for Periodic Payments.	Sec. 74.503. Same as House version, with marked changes: Sec. 74.503. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court ~~[shall]~~ *may* order that future damages awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by	Senate version with marked changes: Sec. 74.503. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court ~~[may]~~ shall order that ~~[future damages]~~ medical, health care, or custodial services awarded in a health care liability claim be paid in

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HOUSE VERSION	SENATE VERSION	CONFERENCE
	a lump-sum payment. (b) The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages. (c) The court shall specify in its judgment ordering the payment of future damages by periodic payments the: (1) recipient of the payments; (2) dollar amount of the payments; (3) interval between payments; and (4) number of payments or the period of time over which payments must be made.	whole or in part in periodic payments rather than by a lump sum payment. (b) At the request of a defendant physician or health care provider or claimant, the court may order that future damages other than medical, health care, or custodial services awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump sum payment. (c)~~[b]~~ The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages. (d)~~[c]~~ The court shall specify in its judgment ordering the payment of future damages by periodic payments the: (1) recipient of the payments; (2) dollar amount of the payments; (3) interval between payments; and (4) number of payments or the period of time over which payments must be made.
Sec. 18.04. Release.	Sec. 74.504. Same as House version.	Same as Senate version.
Sec. 18.05. Financial Responsibility. In Subsection (b)(1), provides that the judgment must provide for payments to be funded by an annuity contract issued by a company licensed to do business as an insurance company.	Sec. 74.505. Same as House version, except Subsection (b)(1) provides that the judgment must provide for payments to be funded by an annuity contract issued by a company licensed to do business as an insurance company, *including an assignment within the meaning of Section 130, Internal Revenue Code of 1986, as amended.*	Same as Senate version.
Sec. 18.06. Death of Recipient.	Sec. 74.506. Same as House version.	Same as Senate version.

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HOUSE VERSION	SENATE VERSION	CONFERENCE
Sec. 18.07. Award of Attorney's Fees.	Sec. 74.507. Same as House version.	Same as Senate version.
Subchapter S. Attorney's Fees.	No equivalent provision.	Senate Version.
Sec. 19.01. Definition. In this subchapter, "recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical or health care services incurred by the claimant and the attorney's office overhead costs or charges are not deductible disbursements or costs.	No equivalent provision.	Same as Senate version.
Sec. 19.02. Applicability. The limitations in this subchapter apply without regard to whether: (1) the recovery is by settlement, arbitration, or judgment; or (2) the person for whom the recovery is sought is an adult, a minor, or an incapacitated person.	No equivalent provision.	Same as Senate version.
Sec. 19.03. Periodic Payments. If periodic payments are recovered by the claimant, the court shall place a total value on these payments based on the claimant's projected life	No equivalent provision.	Same as Senate version.

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of, irrespective of the fact that one or more of the sections, subsection, sentences, clauses, phrases and words are declared unconstitutional.

Sec. 3. The fact that the calendars of both Houses are likely to become crowded, and the further fact that there is now no adequate expeditious method of handling child neglect and desertion complaints and the further fact that the changes proposed herein need to become effective at the earliest possible time, creates an emergency and an imperative public necessity, that the Constitutional Rule requiring bills to be read on three several days in each House be suspended, and said Rule is hereby suspended; and this Act shall take effect and be in force from and after the date of its passage, and it is so enacted.

Passed the Senate, March 16, 1959, by a viva voce vote; May 11, 1959, Senate concurred in House amendment by a viva voce vote; passed the House, May 11, 1959, with amendment, by a viva voce vote.

Approved May 25, 1959.

Effective 90 days after May 12, 1959, date of adjournment.

1959 Previous acts repealed and this one takes their place

TEXAS HOSPITAL LICENSING LAW

CHAPTER 223 [77]

S. B. No. 121

An Act providing for the protection and promotion of the public health and welfare by providing for the development, establishement,[77a] and enforcement of certain standards in the construction, maintenance and operation of hospitals by the Licensing Agency; providing that no person or governmental unit shall establish, conduct, or maintain a hospital without a license; providing for the appointment of a Hospital Licensing Director; providing for the fixing of license fees; providing for licenses to be issued by the Licensing Agency; providing for the denying, cancelling, revoking, or suspending of licenses under certain conditions; providing the powers and duties of the Licensing Agency; providing for certain exceptions; providing for the appointment and duties of a Hospital Licensing Advisory Council; fixing a penalty; amending Section 2(a) of Article 4442c of Vernon's Annotated Civil Statutes in regard to the definition of "hospital"; repealing Article 4442 of Vernon's Annotated Civil Statutes, Acts 1921, page 146, Acts 1935, 44th Legislature, page 294, Chapter 108 § 1, and all laws in conflict herewith; containing a severance clause; and declaring an emergency.

Be it enacted by the Legislature of the State of Texas:

Section 1. This Act may be cited as the "Texas Hospital Licensing Law."

Sec. 2. For the purpose of this Act:

(a) The term "person" means any individual, firm, partnership, corporation, association or joint stock company, and includes any receiver, trustee, assignee, or other similar representative thereof.

(b) The term "hospital" means any institution, place, building, dwelling, or abode, whether organized for profit or non-profit, general or special, private, public, or governmental, offering or making available any medical and/or surgical services, facilities, or equipment for a period of time extending either over night or beyond twenty-four (24) hours, for two (2) or more nonrelated individuals, whereby such services, facilities, or equipment can, may, or are used for and in connection

77. Vernon's Ann.Civ.St. art. 4437f. 77a. So in enrolled bill.

field of hospital administration, be of good moral character, and a resident of the State of Texas for a period of not less than three (3) years.

Sec. 6. Any hospital which is in operation at the time of promulgation of any applicable rules or regulations or minimum standards under this Act shall be given a reasonable length of time within which to comply with such rules, regulations and standards, but in no event longer than six (6) months. Provided, however, that the Licensing Agency may extend the length of time within which to comply with such rules beyond six (6) months upon sufficient showing that it will require additional time to complete compliance with such rules, regulations, and standards.

Sec. 7. Applications for license shall be made to the Licensing Agency upon forms provided by it, and shall contain such information as the Licensing Agency may reasonably require. It shall be necessary that the Licensing Agency issuing licenses require that each hospital show evidence that there are one or more physicians on the medical staff of the hospital, and that these physicians are currently licensed by the Texas State Board of Medical Examiners.

The Licensing Agency may require that the application be approved by the local health officer, or other local official, for the compliance with city ordinances of building construction, fire prevention, and sanitation. Hospitals outside city limits shall comply with corresponding state laws.

Each application shall be accompanied by a license fee. In the event the application for a license is denied, such fee shall be refunded to the applicant.

All license fees collected shall be deposited with the State Treasury to the credit of the Licensing Agency and said license fees are hereby appropriated to said agency for its use in the administration and enforcement of this Act.

Each hospital so licensed shall pay a license fee, both initially and annually thereafter, of One Dollar ($1.00) per bed, provided, however, that a minimum license fee of Twenty-five Dollars ($25.00) will be required of those hospitals with less than twenty-five (25) beds, and a maximum license fee of Three Hundred Dollars ($300.00) will be required of those hospitals with more than three hundred (300) beds.

Sec. 8. Upon receipt of an application for license, and the license fee, the Licensing Agency shall issue a license if it finds that the applicant and the hospital comply with the provisions of this Act, and the rules, regulations, or standards promulgated hereunder. Each such license, unless sooner suspended, cancelled, or revoked, shall be renewable annually upon payment of the prescribed fee.

Sec. 9. The Licensing Agency shall have the authority to deny, cancel, revoke, or suspend a license in any case where it finds there has been a substantial failure to comply with the provisions of this Act or the rules, regulations, or standards promulgated under this Act, or for the aiding, abetting, or permitting the commission of any illegal act, or for conduct detrimental to the public health, morals, welfare and safety of the people of the State of Texas.

Proceedings under this Article shall be initiated by filing charges with the Licensing Agency, in writing and under oath. Said charges may be made by any person or persons. If upon investigation of such charge or charges it is found that such charge or charges appear to have merit, then the chairman of the Licensing Agency shall set a time and place for hearing, and shall cause a copy of the charges, together with a notice of the time and place fixed for hearing, to be served on the respondent or his counsel at least ten (10) days prior thereto. When personal service is impossible, or cannot be effected, the Licensing Agency shall cause to be published once a week for two (2) successive weeks a

notice of the hearing in a newspaper published in the county wherein the respondent was last known to be, and shall mail a copy of the charges and of such notice to the respondent at his last known address. When publication of the notice is necessary, the date of hearing shall not be less than ten (10) days after the date of the last publication of the notice. At said hearing the respondent shall have the right to appear, either personally or by counsel, or both, to produce witnesses or evidence in his behalf, to cross-examine witnesses, and to have subpoenas issued by the Licensing Agency. The Licensing Agency shall thereupon determine the charges upon their merits.

Any hospital whose license has been cancelled, revoked, or suspended by the Licensing Agency may, within twenty (20) days after the making and entering of such order, take an appeal to any of the District Courts in the county that the hospital is so located in, but the decision of the Licensing Agency shall not be enjoined or stayed except on application to such District Court after notice to the Licensing Agency.

The proceedings on appeal shall be a trial de novo as such term is commonly used and intended in an appeal from the Justice Court to a County Court, and which appeal shall be taken in any District Court of the county where the license has been issued.

Upon application, the Licensing Agency may reissue a license to a hospital whose license has been cancelled, revoked, or suspended when it feels that the reasons bringing about such cancellation, revocation, or suspension have been corrected. Any such applications for reissuance shall be made in such manner and form as the Licensing Agency may require.

The Licensing Agency shall not be bound by strict rules of evidence or procedure in the conduct of its proceedings but the determinations shall be founded on sufficient legal evidence to sustain it.

The Licensing Agency shall have the right to institute an action in its own name to enjoin the violation of any of the provisions of this Act. Said actions for an injunction shall be in addition to any other action, proceeding, or remedy authorized by law.

The venue for any suit seeking to enjoin the violation of any of the provisions of this Act shall lie in the county wherein such violation is alleged to have occurred.

The Licensing Agency shall be represented by the Attorney General and/or the County or District Attorneys of this state.

Before entering any order denying, cancelling, or suspending a license, the Licensing Agency shall hold a hearing in accordance with the procedures set out in this Section.

Sec. 10. Each license shall be issued only for the premises and persons or governmental units named in the application and shall not be transferable or assignable except with the written approval of the Licensing Agency. Licenses shall be posted in a conspicuous place on the licensed premises.

Sec. 11. Any officer, employee, or agent of the Licensing Agency may enter and inspect any hospital at any reasonable time to assure compliance with, or to prevent a violation of this Act.

Sec. 12. The Licensing Agency shall have the power to employ the services of stenographers, inspectors, and other necessary assistants in carrying out the provisions of this Act.

Sec. 13. The Governor shall appoint a Hospital Licensing Advisory Council consisting of nine (9) members as herein provided:

(a) Three (3) physicians who are duly licensed by the Texas State Board of Medical Examiners and who are engaged in the active prac-

CHAPTER 597

H.B. No. 1963

1985

An Act relating to minimum standards concerning licensed hospitals and the transfer of a patient from one hospital to another, to the denial, suspension, and revocation of hospital licenses, and to enforcement of the hospital licensing law.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Section 5, Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 5. *(a)* The Licensing Agency, with the advice of the Hospital Licensing Advisory Council, shall adopt [~~, amend, promulgate,~~] and enforce such rules [~~, regulations,~~] and minimum standards as may be designed to further the purposes of this Act. *Except as provided by Subsections (b) and (d) of this section,* [~~Provided, however, that~~] the rules [~~, regulations,~~] or minimum standards so adopted [~~, amended, promulgated,~~] or enforced shall be limited to *minimum requirements for staffing by physicians and nurses, hospital services relating to patient care, and* safety, fire prevention, and sanitary provisions of hospitals as defined in this Act. *Any* [~~Provided, however, that any~~] rules [~~, regulations,~~] or standards set shall [~~first~~] be *adopted* [~~approved~~] by the *Texas* [~~State~~] Board of Health *in accordance with the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes). The standards may not exceed the minimum standards for certification under Title XVIII of the Social Security Act* [~~, and after they have been so approved, shall be approved also by the Attorney General as to their legality, and then filed with the Secretary of State, and no such rule or regulation shall be effective until it has been filed with the Secretary of State~~].

(b) The Texas Board of Health shall adopt rules to implement the following minimum standards governing the transfer of patients. The rules must provide that patient transfers between hospitals should be accomplished in a medically appropriate manner from physician to physician as well as from hospital to hospital by providing for:

(1) notification to the receiving hospital prior to the transfer and confirmation by that hospital that the patient meets that hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to treat the patient;

(2) the use of medically appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer;

(3) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer;

(4) the transfer of all necessary records for continuing the care for the patient; and

(5) the date by which each hospital must adopt policies in accordance with the rules.

(c) Minimum standards prescribed by Board rules shall not contain provisions which require the consent of the patient or personal representative of the patient prior to transfer.

(d) Each hospital shall adopt binding policies relating to patient transfers that are consistent with the rules adopted by the Texas Board of Health. If possible, each hospital shall implement its transfer policies by adopting transfer agreements with other hospitals.

(e) The Commissioner of Health shall appoint, with the advice and consent of the *Texas* [~~State~~] Board of Health, a person to serve in the capacity of Hospital Licensing Director. The duties of *the* [~~such~~] Hospital Licensing Director shall be the administration of this Act and he shall be directly responsible to the Licensing Agency. Any person so appointed as Hospital Licensing Director must possess the following qualifications: He shall have had at least five (5) years experience and/or training in the field of hospital administration, be of good moral character, and a resident of the State of Texas for a period of not less than three (3) years.

SECTION 2. Section 7, Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 7. *(a)* Applications for *licenses* [~~license~~] shall be made to the Licensing Agency upon forms provided by it, and shall contain such information as the Licensing Agency may reasonably require. It shall be necessary that the Licensing Agency issuing licenses require that each hospital show evidence that:

(1) there are one or more physicians on the medical staff of the hospital;

(2) [~~, and that~~] these physicians are currently licensed by the Texas State Board of Medical Examiners; *and*

(3) the Governing Body of the hospital has adopted and implemented a patient transfer policy in accordance with Sections 5(b) and (d) of this Act.

(b) The Licensing Agency may require that the application be approved by the local health *authority* [~~officer~~], or other local official, for [~~the~~] compliance with city ordinances on building construction, fire prevention, and sanitation. Hospitals outside city limits shall comply with corresponding state laws.

(c) Each application shall be accompanied by a license fee *and a copy of the hospital's current patient transfer policy*. In the event the application for a license is denied, *the* [~~such~~] fee shall be refunded to the applicant.

(d) All license fees collected shall be deposited with the State Treasury to the credit of the Licensing Agency and said license fees are hereby appropriated to said agency for its use in the administration and enforcement of this Act.

(e) Each hospital [~~so~~] licensed shall pay a license fee, both initially and annually thereafter, of Two Dollars and Fifty Cents ($2.50) per bed; but in no event shall the total fee be less than One Hundred Dollars ($100.00) or more than Two Thousand Dollars ($2,000.00).

SECTION 3. Section 9, Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes), is revised to read as follows:

Sec. 9. (a) The Licensing Agency may deny, suspend, or revoke a hospital's license if the Licensing Agency finds that the hospital failed substantially to comply with this Act or a rule or standard adopted under this Act or aided, abetted, or permitted the commission of an illegal act.

(b) Except as inconsistent with this section, the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes) governs any action taken under this section.

(c) On application by the hospital, the Licensing Agency may reissue a license to a hospital whose license was suspended or revoked if the Licensing Agency determines that the hospital has corrected the conditions that led to the suspension or revocation. A hospital must apply for reissuance in the form and manner required by the Licensing Agency.

(d) Judicial review of a final decision by the Licensing Agency shall be by trial de novo in the same manner as cases appealed from the justice court to the county court, and the substantial evidence rule shall not apply.

SECTION 4. The Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes) is amended by adding Sections 9B and 9C to read as follows:

Sec. 9B. (a) If the Licensing Agency finds that a hospital is violating or has violated this Act or a rule or standard adopted under this Act, the Licensing Agency shall notify the hospital of its findings and provide the hospital the opportunity to correct the violations. After providing the hospital with notification and an opportunity to comply, the Licensing Agency may petition a district court in the county in which the violation occurred for assessment and recovery of civil penalties as provided under Subsection (d) of this section, for injunctive relief, or for both civil penalties and injunctive relief. If the Licensing Agency finds that the violation creates an immediate threat to the health and safety of the hospital patients, the Licensing Agency may petition the district court for a temporary restraining order to restrain continuing violations.

(b) The district court shall grant the injunctive relief the facts may warrant.

(c) At the request of the Commissioner of Health, the Attorney General or the appropriate district or county attorney shall initiate and conduct the suit.

(d) If a hospital does not timely adopt, implement, and enforce a patient transfer policy in accordance with Sections 5(b) and (d) of this Act, the facility is subject to a civil penalty of not more than $1,000 for each day of violation and for each act of violation. In determining the amount of the penalty, the district court shall consider the facility's history of previous violations, the seriousness of the violation, if the health and safety of the public was threatened by the violation, and the demonstrated good faith of the facility.

Sec. 9C. A person harmed by the failure of a hospital to timely adopt, implement, or enforce a patient transfer policy in accordance with Sections 5(b) and (d) of this Act may petition the district court of the county in which the person resides, or if the person is not a resident of the state, a district court of Travis County, for appropriate injunctive relief. Such person also may pursue remedies for civil damages existing under current common law.

SECTION 5. Section 4, Chapter 387, Acts of the 65th Legislature, Regular Session, 1977 (Article 4437h, Vernon's Texas Civil Statutes), is amended by adding Subsection (d) to read as follows:

(d) This section does not affect the authority of the Texas Department of Health to implement and enforce the provisions of the Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes) relating to the transfer of hospital patients or the means by which the department implements and enforces those provisions.

voting; passed by the Senate, with amendments, on May 25, 1989, by the following vote: Yeas 31, Nays 0.

Approved June 15, 1989.

Effective June 15, 1989.

CHAPTER 1027

H.B. No. 18

AN ACT

relating to health care, including powers and duties of the center for rural health initiatives, the collection of data concerning health professions, surveys of hospitals and physicians, breast cancer screening, hospital patient transfers, the establishment of advisory committees, the swing bed program to provide reimbursement for skilled nursing patients, rural health family practice residency programs, medical education, professional liability insurance for physicians and other health care professionals, state indemnification for the provision of charity care or services, the delegation of prescription drug orders, qualifications of expert witnesses and jury instructions in health care liability claims, and emergency medical services and trauma care systems; providing civil penalties.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. This Act may be cited as the Omnibus Health Care Rescue Act.

SECTION 2. Title 71, Revised Statutes, is amended by adding Article 4414b-1 to read as follows:

Art. 4414b-1. CENTER FOR RURAL HEALTH INITIATIVES

Sec. 1. DEFINITIONS. (a) "Center" means the Center for Rural Health Initiatives.

(b) "Executive committee" means the executive committee of the Center for Rural Health Initiatives.

Sec. 2. CENTER FOR RURAL HEALTH INITIATIVES. The Center for Rural Health Initiatives is established.

Sec. 3. PURPOSE. The center shall assume a leadership role in working or contracting with state and federal agencies, universities, private interest groups, communities, foundations, and offices of rural health to develop rural health initiatives and maximize use of existing resources without duplicating existing effort. The center shall provide a central information and referral source and serve as the primary state resource in coordinating, planning, and advocating for the continued access to rural health care services in Texas.

Sec. 4. DUTIES. (a) The center shall:

(1) educate the public and recommend appropriate public policies regarding the continued viability of rural health care delivery in Texas;

(2) monitor and work with state and federal agencies to assess the impact of proposed rules and regulations on rural areas; provide impact statements of proposed rules and regulations as deemed appropriate by the center; streamline regulations to assist in the development of service diversification of health care facilities; and target state and federal programs to rural areas;

(3) promote and develop community involvement and community support in maintaining, rebuilding, or diversifying local health services;

(4) promote and develop diverse and innovative health care service models in rural areas;

(5) encourage the use of advanced communications technology to provide access to specialty expertise, clinical consultation, and continuing education;

(6) assist rural health care providers, communities, and individuals in applying for public and private grants and programs;

(7) encourage the development of regional emergency transportation networks;

(4) two hospital administrators who have been actively engaged in hospital administration in an urban area and who represent a public hospital and a private hospital;

(5) an emergency medical technician and a person serving as a volunteer to an emergency medical services provider; and

(6) two consumer members.

(f) The Commissioner of Health shall appoint, with the advice and consent of the Texas Board of Health, a person to serve in the capacity of Hospital Licensing Director. The duties of the Hospital Licensing Director shall be the administration of this Act and he shall be directly responsible to the Licensing Agency. Any person so appointed as Hospital Licensing Director must possess the following qualifications: He shall have had at least five (5) years experience and/or training in the field of hospital administration, be of good moral character, and a resident of the State of Texas for a period of not less than three (3) years.

SECTION 7. Section 7(a), Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes), is amended to read as follows:

(a) Applications for licenses shall be made to the Licensing Agency upon forms provided by it, and shall contain such information as the Licensing Agency may reasonably require. It shall be necessary that the Licensing Agency issuing licenses require that each hospital show evidence that:

(1) there are one or more physicians on the medical staff of the hospital;

(2) these physicians are currently licensed by the Texas State Board of Medical Examiners; and

(3) the Governing Body of the hospital has adopted and implemented a patient transfer policy in accordance with *Section* [~~Sections~~] 5(b) and *has implemented patient transfer agreements in accordance with Section 5(d) or complied with Section 5(e)* [~~(d)~~] of this Act.

SECTION 8. Section 9B(d), Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes), is amended to read as follows:

(d) If a hospital does not timely adopt, implement, and enforce a patient transfer policy in accordance with *Section* [~~Sections~~] 5(b) and *implement patient transfer agreements in accordance with Section 5(d) or complied with Section 5(e)* [~~(d)~~] of this Act, the facility is subject to a civil penalty of not more than $1,000 for each day of violation and for each act of violation. In determining the amount of the penalty, the district court shall consider the facility's history of previous violations, the seriousness of the violation, if the health and safety of the public was threatened by the violation, and the demonstrated good faith of the facility.

SECTION 9. Section 9C, Texas Hospital Licensing Law (Article 4437f, Vernon's Texas Civil Statutes), is amended to read as follows:

Sec. 9C. A person harmed by the failure of a hospital to timely adopt, implement, or enforce a patient transfer policy in accordance with *Section* [~~Sections~~] 5(b) and *patient transfer agreements in accordance with Section 5(d) or Section 5(e)* [~~(d)~~] of this Act, may petition the district court of the county in which the person resides, or if the person is not a resident of the state, a district court of Travis County, for appropriate injunctive relief. Such person also may pursue remedies for civil damages existing under current common law.

SECTION 10. Section 32.022, Human Resources Code, is amended to read as follows:

Sec. 32.022. MEDICAL *AND HOSPITAL* CARE ADVISORY *COMMITTEES* [~~COMMITTEE~~]. (a) The board, on the recommendation of the commissioner, shall appoint a medical care advisory committee to advise the board and the department in developing and maintaining the medical assistance program and in making immediate and long-range plans for reaching the program's goal of providing *access to* high quality, comprehensive medical and health care services to *medically indigent* [~~needy~~] persons in the state. *To ensure that qualified applicants receive services, the committee shall consider changes in the process the department uses to determine eligibility.*

CHAPTER 678

H.B. No. 2136

AN ACT

relating to the adoption of a nonsubstantive revision of the statutes relating to health and safety, including conforming amendments, repeals, and penalties.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. ADOPTION OF CODE. The Health and Safety Code is adopted to read as follows:

HEALTH AND SAFETY CODE

Contents

(3) the provision of appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care in the same or a similar locality would use for the transfer; and

(4) the transfer of all necessary records for continuing the care for the patient.

(c) The board may not adopt minimum standards that require the consent of the patient or the patient's personal representative before the patient is transferred. (V.A.C.S. Art. 4437f, Secs. 5(b) (part), (c).)

Sec. 241.028. ADOPTION OF PATIENT TRANSFER POLICIES. (a) A hospital shall adopt binding policies relating to patient transfers that are consistent with the rules adopted by the board.

(b) The board by rule shall set the date by which a hospital must adopt the patient transfer policies.

(c) A hospital shall, if possible, implement its transfer policies by adopting transfer agreements with other hospitals. (V.A.C.S. Art. 4437f, Secs. 5(b) (part), (d).)

[Sections 241.029–241.050 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 241.051. INSPECTIONS. An officer, employee, or agent of the department may enter and inspect a hospital at any reasonable time to assure compliance with or prevent a violation of this chapter. (V.A.C.S. Art. 4437f, Sec. 11.)

Sec. 241.052. COMPLIANCE WITH RULES AND STANDARDS. (a) A hospital that is in operation when an applicable rule or minimum standard is adopted under this chapter must be given a reasonable period within which to comply with the rule or standard.

(b) The period for compliance may not exceed six months, except that the department may extend the period beyond six months if the hospital sufficiently shows the department that it requires additional time to complete compliance with the rule or standard. (V.A.C.S. Art. 4437f, Sec. 6.)

Sec. 241.053. DENIAL, SUSPENSION, REVOCATION, OR REISSUANCE OF LICENSE. (a) The department may deny, suspend, or revoke a hospital's license if the department finds that the hospital:

(1) failed substantially to comply with this chapter or a rule or standard adopted under this chapter; or

(2) aided, abetted, or permitted the commission of an illegal act.

(b) A hospital whose license is suspended or revoked may apply to the department for the reissuance of a license. The department may reissue the license if the department determines that the hospital has corrected the conditions that led to the suspension or revocation.

(c) A hospital must apply for reissuance in the form and manner required by the department.

(d) Judicial review of a final decision by the department is by trial de novo in the same manner as a case appealed from the justice court to the county court. The substantial evidence rule does not apply. (V.A.C.S. Art. 4437f, Secs. 9(a), (c), (d).)

Sec. 241.054. VIOLATIONS; INJUNCTIONS. (a) The department shall:

(1) notify a hospital of a finding by the department that the hospital is violating or has violated this chapter or a rule or standard adopted under this chapter; and

(2) provide the hospital an opportunity to correct the violation.

(b) After the notice and opportunity to comply, the department may petition a district court in the county in which a violation occurs for assessment and recovery of the civil penalty provided by Section 241.055, for injunctive relief, or both.

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(c) The department may petition a district court for a temporary restraining order to restrain a continuing violation if the department finds that the violation creates an immediate threat to the health and safety of the patients of a hospital.

(d) The district court shall grant the injunctive relief warranted by the facts.

(e) The attorney general or the appropriate district or county attorney shall initiate and conduct the suit at the request of the commissioner of health. (V.A.C.S. Art. 4437f, Secs. 9B(a), (b), (c).)

Sec. 241.055. CIVIL PENALTY. (a) A hospital that does not timely adopt, implement, and enforce a patient transfer policy in accordance with Sections 241.027 and 241.028 is liable for a civil penalty of not more than $1,000 for each day of violation and for each act of violation.

(b) In determining the amount of the penalty, the district court shall consider:

(1) the hospital's previous violations;

(2) the seriousness of the violation;

(3) whether the health and safety of the public was threatened by the violation; and

(4) the demonstrated good faith of the hospital. (V.A.C.S. Art. 4437f, Sec. 9B(d).)

Sec. 241.056. SUIT BY PERSON HARMED BY FAILURE TO ADOPT, IMPLEMENT, OR ENFORCE PATIENT TRANSFER POLICY. (a) A person who is harmed by the failure of a hospital to timely adopt, implement, or enforce a patient transfer policy in accordance with Sections 241.027 and 241.028 may petition a district court for appropriate injunctive relief.

(b) Venue for a suit brought under this section is in the county in which the person resides or, if the person is not a resident of this state, in Travis County.

(c) The person may also pursue remedies for civil damages under common law. (V.A.C.S. Art. 4437f, Sec. 9C.)

Sec. 241.057. CRIMINAL PENALTY. (a) A person commits an offense if the person establishes, conducts, manages, or operates a hospital without a license.

(b) An offense under this section is a misdemeanor punishable by a fine of not more than $100 for the first offense and not more than $200 for each subsequent offense.

(c) Each day of a continuing violation constitutes a separate offense. (V.A.C.S. Art. 4437f, Sec. 16.)

[Sections 241.058–241.080 reserved for expansion]

SUBCHAPTER D. HOSPITAL LICENSING ADVISORY COUNCIL

Sec. 241.081. COMPOSITION. The Hospital Licensing Advisory Council is composed of the following nine members appointed by the governor:

(1) three members who are physicians and who are engaged in the active practice of medicine, one of whom is a member of the staff of a hospital with fewer than 50 beds;

(2) three members who are hospital administrators actively engaged in the field of hospital administration for at least two years, one of whom is an administrator of a hospital with fewer than 50 beds and one other of whom is an administrator of a hospital with fewer than 101 beds; and

(3) three members who represent the public. (V.A.C.S. Art. 4437f, Sec. 13 (part).)

Sec. 241.082. TERMS. (a) Members of the council serve for staggered six-year terms.

(b) A member whose term expires holds office until a successor is appointed.

(c) An appointment to fill a vacancy is for the unexpired term. (V.A.C.S. Art. 4437f, Sec. 13 (part).)

Sec. 241.083. COMPENSATION AND EXPENSES. A member of the council, while serving or acting in the member's official capacity on the council's official business, is entitled to receive:

suspended, and this rule is hereby suspended, and that this Act take effect and be in force from and after its passage, and it is so enacted.

Passed the Senate on February 25, 1991: Yeas 30, Nays 0; and that the Senate concurred in House amendment on March 21, 1991: Yeas 27, Nays 0; passed the House, with amendment, on March 19, 1991: Yeas 140, Nays 1.

Approved April 2, 1991.

Effective April 2, 1991.

Conforms 1989 amendment to new code, Nonsubstantive

CHAPTER 14

S.B. No. 404

AN ACT

relating to conforming the Health and Safety Code to certain Acts of the 71st Legislature, to nonsubstantively codifying in that code certain related health and safety laws, to making corrective changes in that code, and to making conforming changes to other laws involving health and safety matters.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. (a) This Act is enacted as part of the state's continuing statutory revision program under Chapter 323, Government Code. This Act is a revision of statutes, without substantive change, for purposes of Article III, Section 43, of the Texas Constitution and has the purposes of:

(1) conforming the Health and Safety Code to laws passed by the 71st Legislature that amended the laws codified by the Health and Safety Code or that enacted new provisions appropriate for codification in the Health and Safety Code;

(2) codifying in the Health and Safety Code certain laws that were not included in that code when it was enacted;

(3) making necessary corrective changes in the Health and Safety Code; and

(4) making necessary conforming amendments to other laws.

(b) Chapter 311, Government Code, applies to this Act as if this Act were a code governed by that chapter.

(c) The repeal of a law by this Act does not remove, void, or otherwise affect in any manner a validation under the repealed law. The validation is preserved and continues to have the same effect that it would have if the law were not repealed. This subsection does not diminish the saving provisions prescribed by Section 311.031, Government Code.

(d) A transition or saving provision of a law codified by this Act applies to the codified law to the same extent as it applies to the original law. The repeal of a transition or saving provision by this Act does not affect the application of the provision to the codified law. In this subsection, "transition provision" includes any temporary provision providing for a special situation during the transition period between the time of the existing law and the establishment or implementation of a new law.

SECTION 2. Subsection (d), Section 11.016, Health and Safety Code, is amended to conform to Section 1, Chapter 631 (S.B. 1362), Acts of the 71st Legislature, Regular Session, 1989, to read as follows:

(d) Except as otherwise provided by law and contingent on the availability of department funds for this purpose, a member of an advisory committee appointed by the board is entitled to receive, *with regard to travel expenses,* [:

~~[(1) $50 for each advisory committee meeting attended by the member; and~~

[~~(2)~~] the per diem and travel allowance authorized by the General Appropriations Act for state employees.

SECTION 3. Chapter 11, Health and Safety Code, is amended to conform to Section 1, Chapter 631 (S.B. 1362), Acts of the 71st Legislature, Regular Session, 1989, by adding Section 11.0161 to read as follows:

(4) two hospital administrators who have been in active hospital administration in an urban area, one representing a public hospital and one representing a private hospital;

(5) an emergency medical technician;

(6) a person serving as a volunteer to an emergency medical services provider; and

(7) two consumer members.

SECTION 86. Section 241.055, Health and Safety Code, is amended to conform to Section 8, Chapter 1027 (H.B. 18), Acts of the 71st Legislature, Regular Session, 1989, to read as follows:

Sec. 241.055. CIVIL PENALTY. (a) A hospital *shall:*

(1) [~~that does not~~] timely adopt, implement, and enforce a patient transfer policy in accordance with *Section* [~~Sections~~] 241.027*;* and

(2) implement patient transfer agreements in accordance with Section 241.028 *or comply with rules adopted under Section 241.029.*

(b) A hospital that violates Subsection (a) is liable for a civil penalty of not more than $1,000 for each day of violation and for each act of violation.

(c) [~~(b)~~] In determining the amount of the penalty, the district court shall consider:

(1) the hospital's previous violations;

(2) the seriousness of the violation;

(3) whether the health and safety of the public was threatened by the violation; and

(4) the demonstrated good faith of the hospital.

SECTION 87. Section 241.056, Health and Safety Code, is amended to conform to Section 9, Chapter 1027 (H.B. 18), Acts of the 71st Legislature, Regular Session, 1989, by amending the section heading and Subsection (a) to read as follows:

Sec. 241.056. SUIT BY PERSON HARMED [~~BY FAILURE TO ADOPT, IMPLEMENT, OR ENFORCE PATIENT TRANSFER POLICY~~]. (a) A person who is harmed by *a violation under Section 241.055* [~~the failure of a hospital to timely adopt, implement, or enforce a patient transfer policy in accordance with Sections 241.027 and 241.028~~] may petition a district court for appropriate injunctive relief.

SECTION 88. Subsection (a), Section 242.003, Health and Safety Code, is amended to conform to Section 9, Chapter 1085 (S.B. 487), Acts of the 71st Legislature, Regular Session, 1989, to read as follows:

(a) *Except as otherwise provided, this* [~~This~~] chapter does not apply to:

(1) a hotel or other similar place that furnishes only food, lodging, or both, to its guests;

(2) a hospital;

(3) an establishment conducted by or for the adherents of a well-recognized church or religious denomination for the purpose of providing facilities for the care or treatment of the sick who depend exclusively on prayer or spiritual means for healing, without the use of any drug or material remedy, if the establishment complies with safety, sanitary, and quarantine laws and rules;

(4) an establishment that furnishes, in addition to food, shelter, and laundry, only baths and massages;

(5) an institution operated by a person licensed by the Texas Board of Chiropractic Examiners;

(6) a facility that:

(A) primarily engages in training, habilitation, rehabilitation, or education of clients or residents;

(B) is operated under the jurisdiction of a state or federal agency, including the Texas Rehabilitation Commission, Texas Department of Mental Health and Mental

~~[(c) A nursing home or custodial care home or a portion of a home that is operating or approved for construction on or after September 1, 1987, must comply with the Life Safety Code provisions relating to new construction.~~

~~[(d) This section does not preclude an institution from conforming to a higher or additional fire safety standard or provision.]~~

SECTION 2. Section 242.094, Health and Safety Code, is amended by adding Subsection (e) to read as follows:

(e) Venue for an action brought under this section is in Travis County.

SECTION 3. This Act takes effect September 1, 1993.

SECTION 4. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

Passed the Senate on March 16, 1993, by a viva-voce vote; the Senate concurred in House amendment on May 23, 1993, by a viva-voce vote; passed the House, with amendment, on May 21, 1993, by a non-record vote.

Approved June 13, 1993.

Effective Sept. 1, 1993.

1993

CHAPTER 584

S.B. No. 86

AN ACT

relating to the licensing of hospitals by the Texas Department of Health including the provision and appropriation of fees and the assessment of civil penalties and administrative penalties.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Subsections (c) and (d), Section 241.022, Health and Safety Code, are amended to read as follows:

(c) The department shall require that each hospital show evidence that:

(1) at least one physician is on the medical staff of the hospital, including evidence that the physician is currently licensed; [~~and~~]

(2) the governing body of the hospital[:

[~~(A)~~] has adopted and implemented a patient transfer policy in accordance with Section 241.027; and

(3) if the governing body has chosen to implement patient transfer agreements, it [~~(B)~~] has implemented *the* [~~patient transfer~~] agreements in accordance with Section 241.028 [~~or has complied with rules adopted under Section 241.029~~].

(d) The application must be accompanied by:

(1) a copy of the hospital's current patient transfer policy; [~~and~~]

(2) a *nonrefundable* license fee;

(3) copies of the hospital's patient transfer agreements, unless the filing of copies has been waived by the hospital licensing director in accordance with the rules adopted under this chapter; and

(4) a copy of the most recent annual fire safety inspection report from the fire marshal in whose jurisdiction the hospital is located[~~, which shall be refunded to the applicant if the application is denied~~].

SECTION 2. Subchapter B, Chapter 241, Health and Safety Code, is amended by adding Section 241.0231 to read as follows:

(d) The order shall be effective on delivery to the hospital or at a later date specified in the order.

SECTION 11. Section 241.055, Health and Safety Code, is amended to read as follows:

Sec. 241.055. CIVIL PENALTY. (a) A hospital shall[~~; (1)~~] timely adopt, implement, and enforce a patient transfer policy in accordance with Section 241.027. *A hospital may*[~~; and (2)~~] implement patient transfer agreements in accordance with Section 241.028 [~~or comply with rules adopted under Section 241.029~~].

(b) A hospital that violates Subsection (a) is liable for a civil penalty of not more than $1,000 for each day of violation and for each act of violation.

(c) In determining the amount of the penalty, the district court shall consider:

(1) the hospital's previous violations;

(2) the seriousness of the violation;

(3) whether the health and safety of the public was threatened by the violation; and

(4) the demonstrated good faith of the hospital.

SECTION 12. Subsection (a), Section 241.056, Health and Safety Code, is amended to read as follows:

(a) A person who is harmed by a violation under Section *241.028 or* 241.055 may petition a district court for appropriate injunctive relief.

SECTION 13. Subchapter C, Chapter 241, Health and Safety Code, is amended by adding Section 241.058 to read as follows:

Sec. 241.058. MINOR VIOLATIONS. (a) This chapter does not require the commissioner of health or a designee of the commissioner to report a minor violation for prosecution or the institution of any other enforcement proceeding authorized under this chapter, if the commissioner or a designee of the commissioner determines that prosecution or enforcement is not in the best interests of the persons served or to be served by the hospital.

(b) For the purpose of this section, a "minor violation" means a violation of this chapter, the rules adopted under this chapter, a special license provision, an order or emergency order issued by the commissioner of health or the commissioner's designee, or another enforcement procedure permitted under this chapter by a hospital that does not constitute a threat to the health, safety, and rights of the hospital's patients or other persons.

SECTION 14. Subchapter C, Chapter 241, Health and Safety Code, is amended by adding Section 241.059 to read as follows:

Sec. 241.059. ADMINISTRATIVE PENALTY. (a) The commissioner of health may assess an administrative penalty against a hospital that violates this chapter, a rule adopted pursuant to this chapter, a special license provision, an order or emergency order issued by the commissioner or the commissioner's designee, or another enforcement procedure permitted under this chapter.

(b) In determining the amount of the penalty, the commissioner of health shall consider:

(1) the hospital's previous violations;

(2) the seriousness of the violation;

(3) any threat to the health, safety, or rights of the hospital's patients;

(4) the demonstrated good faith of the hospital; and

(5) such other matters as justice may require.

(c) The penalty may not exceed $1,000 for each violation. Each day of a continuing violation may be considered a separate violation.

(d) When it is determined that a violation has occurred the commissioner of health shall issue a report that states the facts on which the determination is based and the commissioner's recommendation on the imposition of a penalty, including a recommendation on the amount of the penalty.

(e) Within 14 days after the date the report is issued, the commissioner of health shall give written notice of the report to the person, delivered by certified mail. The notice must include a brief summary of the alleged violation and a statement of the amount of the

Legislative History of Section 241.056, Texas Health & Safety Code*

Issue: What is the discussion of this "Anti-Dumping Statute?"

Summary: Prior to the Regular Session in 1985, the Indigent Health Care Task Force worked on and recommended a proposed package of legislation, much of which was enacted, along with a related constitutional provision.

The legislative history of the constitutional amendment indicates that the House intended for it to allow the legislature to be able to propose legislation to limit the responsibility of the Hospital District towards needy persons. The discussion in the Senate appears to indicate that the Senate author was not attempting to limit the scope of a 1954 constitutional mandate to serve the needy.

The new constitutional amendment was linked, in general, with the entire indigent health care package. The House discussion indicated that there was a need for the amendment, because it was unclear whether the legislature had the authority to define what was health care for the needy. According to the discussion, only the courts had been able to define it up to that point. In the Senate, there was clearly confusion as to the purpose or need for the new constitutional amendment. Sen. Traeger quizzed Sen. Farabee about its purpose, but the conclusion between them appeared to be that it would not harm the indigent health care package, and neither Senator was sure that the amendment was needed for any other purpose.

The "enabling legislation" related to the constitutional amendment, HB 1963, had a long legislative history because of a dispute over who should have civil penalties assessed against them, the hospital board or the administrators or neither group. This subject was the bulk of the discussion on this bill.

There is no attempt in this brief summary section to synthesize the discussion as to who is liable for harm under Section 9C, Texas Hospital Licensing Law (Art. 4437f, Vernon's Texas Civil Statutes). The discussion of this issue is transcribed in the background below.

Background: The origin of Section 241.056, Tex. Health & Safety Code, is a 1959 bill, which was amended in 1985 and placed in the Texas Health & Safety Code in a nonsubstantive revision of statutes in 1989.

1959

In 1959 the first state hospital licensing law was passed, and a state agency was designated as a licensing agency to regulate hospitals. [*General Laws of Texas*, 56th Legislature, Regular Session, ch. 223.]

1975

In 1975, the first legislation was considered to require that hospitals provide emergency care to all persons, without regard to their ability to prove that they could pay for it. This bill was discussed in some detail. [*General Laws of Texas*, 64th Legislature, Regular Session, ch. 495.]

1983

In 1983, the 1975 Act was amended to provide that there should be no discrimination based on other criteria, including race or national origin. This legislation not only prescribed punishments, but defined "emergency" and made the physician responsible for determining the emergency status of the patient. There was a great deal of discussion of the scope and meaning of this bill in the legislative history. [*General Laws of Texas*, 68th Legislature, Regular Session, ch. 388.]

1985: HJR 89

In 1985, the "Indigent Health Care" bill, House Bill 1963 (HB 1963), and a related constitutional amendment, HJR 89, were passed as a part of a package of bills on indigent care. HB 1963 was sponsored by Rep. Oliver and Sen. Brooks, and the constitutional amendment, HJR 89, was sponsored by Rep. Schoolcraft and Sen. Farabee. [HJR 89, As Introduced.]

House Action

HJR 89 was intended to add a new Section 9A to Article IX of the Texas Constitution. It was first heard in the House Public Health Committee but, unfortunately, it was heard in a "formal" meeting which

was not tape-recorded. It was reported out of committee with no recorded discussion on May 16, 1985.

A committee report was prepared which included the text of the bill, a bill analysis and a fiscal note. [HJR 89, House Committee Report.]

The House Research Organization, a department of the House, prepared a report on the resolution as it reached the House floor. [House Research Organization, Daily Floor Report, 5/21/85, pp. 16-17.]

On the floor, Rep. Schoolcraft explained the proposed amendment. [House Floor Debate, 5/21/85, Tape 89, Side B.]

> SCHOOLCRAFT: This constitutional amendment deals with hospital districts and currently under the constitution once these districts are created, the only guidance put on them is that they'll provide medical and hospital care to the needy. There's no limitation, there's nothing and there's, the legislature nor the hospital districts have any authority to define who would be eligible for their services and what had to be provided. That's strictly left up to the courts.
>
> So what this amendment would do would be to give us the same authority that we have over, for counties and so forth, that is to limit their liabilities or to establish some sort of guidelines.
>
> A good example of why this would be needed was a dispute that occurred between one hospital district on whether or not they had to provide care for illegal aliens. Nobody could rule on it so it went through the federal court systems. So this is anticipation of continued problems, to give us the ability to address that.
>
> There was questions [sic] asked about whether or not it would give the Senate authority to put a tax on here for the hospital districts at 50 cents per $100 of valuation and the answer to that is no, they wouldn't do that because we already have a tax in the constitution at 75 cents per $100 valuation. [Ibid.]

The amendment was adopted with no further discussion, and since more than two thirds of the members supported it, there was no need for a third reading of the bill. [Ibid.]

Senate Action

HJR 89 was sent to the Senate State Affairs Committee and a hearing was held on May 27, 1985. [Senate State Affairs Committee, 5/27/85, Tape 2, Side A, about two thirds into side.]

Sens. Farabee and Kothmann were the sponsors of the bill. Sen. Farabee first read the amendment to the committee, then discussion took place.

> FARABEE: This would be a proposed constitutional amendment that would – and I'll read it to you, it's relatively short.
>
> I'm advised that this is a part of the indigent health care package and although it's later coming over, that was a part of that package and gives the latitude to make sure that districts are a part of the overall obligation we all have to meet our obligations to indigent or whatever, but it would require passage of a law before you could do anything, but there's some question apparently now, the way the constitution deals with it. Gives the legislature authority. It does not make any requirements.
>
> BLAKE: And that has to be a constitutional amendment?
>
> : There's something, because we had all those hospital districts years ago were created, constitutionally created hospital authority. There may be some reason why this has to be.
>
> FARABEE: I bet that is it. I'm not --.
>
> BLAKE: I didn't know we had to create them with the constitution.

: Well, I, we had to repeal one a few years ago, an old one had been on there for ninety something years.

: I think we finally amended the constitution to say we could create it by statute.

BLAKE: Oh, that's right. To keep us from having a constitutional --. [Inaudible.] [Ibid.]

There was no further discussion of the resolution before it was adopted. [Ibid.]

On the Senate floor on May 27, 1985, Sen. Farabee took questions about the need for the constitutional amendment. [Senate Floor Debate, 5/27/85, Tape 2, Side A, about one third into side.]

FARABEE: Presently, Article IX of the Texas constitution mandates that hospital districts assume full responsibility for providing medical hospital care for its needy inhabitants. That is such a specific provision that it raises questions as to whether a legislative act could establish the specific eligibility and service responsibilities for the hospital districts and this makes it clear that the legislature would have that authority to establish the standards for that hospital district responsibility.

TRAEGER: Sen. Farabee, in the bill it says that the Constitutional requirement to assume full responsibility for needy inhabitants pre-empts legislative authority to establish specific eligibility and service responsibilities for hospital districts. Now, how does this --, this can't pre-empt that constitutional authority. What does the bill do actually that currently can't be done or is not being done?

FARABEE: Well, I think the joint resolution makes it clear that it would be, the legislature by law may determine the health care services that a hospital district is required to provide, because I think that the present, as I understand this, the present constitutional provision is so global that it's unclear whether we could pass an act to try to establish that.

I think some people argue that this is not needed. Others do. Rep. Schoolcraft felt that it was important as did Rep. Oliveira, who is also a co-sponsor on the House side. So this simply states in 9A that the legislature by law may determine the health care services of a hospital that a district is required to provide, and that is my understanding of the need for it.

TRAEGER: Senator, can't we do that now?

FARABEE: I think there's some feeling that we can, but it was my understanding that as a part of your indigent health care negotiations that was a willingness to consider this on the last day of the legislature if other things seemed to come to pass and --.

TRAEGER: And no way in your mind would this impact on that legislation?

FARABEE: No, I see no reason why it should. It clarifies within the constitution, and also the same people that reviewed and worked with that package also reviewed this and indicated that it was all right if it came up in the latter days of the session.

TRAEGER: You know the old hospital provision in the State constitution is terribly outmoded, you know, we used to have to pass a constitutional amendment every time we wanted to close a hospital or close a hospital district, or a hospital that was within or run by a hospital district. And then a few years ago we passed a broad sweeping one which enables us to do that legislatively, and I was trying to determine with, since we are able to do --, I just, -- really, the purpose for this bill. There's some purpose that somebody had that's not apparent.

FARABEE: Well, the testimony at the committee level indicated there were some older hospital districts that still had a problem possibly.

TRAEGER: I'm sorry, I couldn't under --.

FARABEE: That still had a problem that necessitated this.

TRAEGER: Could you give me an example?

FARABEE: They didn't give an example at the hearing, to tell you the truth. And I thought it was something to do with San Antonio, in the sense that Sen. Kothmann --.

TRAEGER: Sen. Kothmann just told me that a local hospital district in San Antonio wants and needs it and I just wondered why, I guess, that's, uh, maybe it's not polite to ask why about bills today, but --.

FARABEE: That's always a valid question.

TRAEGER: Well, let's look at it from the other side. [Tape 1, Side A ends; Tape 1, Side B begins.]

FARABEE: I can't see that it would hurt anything, and I know that the people who have reviewed it have the same concerns that you have and I think that there's some question that you raised of whether it's needed, but then again, the Article 9 does, is fairly global in their responsibility and it doesn't apparently give, in the opinion of some people, the latitude to make a determination of what the eligibility requirements are. And that's the analysis.

TRAEGER: But this spells out specifically in the statute?

FARABEE: That's right, and that's set out in the bill analysis.

TRAEGER: Okay, I can't see where it's gonna do any harm so I have no objection to the bill. I just wanted a clarification. [Ibid.]

The resolution was then reported out with no further discussion. [Ibid. See HJR 89, Senate Committee Report.]

On May 27, 1985, the full Senate considered HJR 89. Sen. Farabee explained the resolution. [Senate Floor Debate, 5/27/85; this tape was not reviewed.]

The Senate passed HJR 89 by the necessary two thirds vote. [Ibid. See *Senate Journal*, 5/27/85, p. 2335.]

For HJR 89 as enacted, see the resolution. [*General Laws of Texas*, 69th Legislature, Regular Session, HJR 89, p. 3371.]

1985: HB 1963

House Bill 1963 (HB 1963) is one of four bills in a package of Indigent Health Care legislation considered in 1985. As introduced, HB 1963 did not contained an amendment adding Art. 4437f, Secs. 9A and 9C, Tex. Rev. Civ. Stats. [HB 1963, As Introduced.]

House Action

HB 1963 was first considered in a lengthy public hearing of the House Public Health Committee on April 9, 1985. Rep. Oliver, the bill sponsor, explained the package of indigent health care bills. [House Public Health Committee, 4/9/85, Tape 1, Side A, near beginning of side.]

> OLIVER: House Bill 1963 relates to hospital transfers and provides a means by which the Department of health can establish rules and regulations for inter-hospital transfers of emergency patients. [Ibid.]

Rep. Oliver then explained HB 1023, 1844, 1843, and HB 602 and HB 671 very briefly.

> OLIVER: This is probably one of the most significant public health committee meetings you'll have this session. The legislation that we will cover today will change the way that the state of Texas takes care of its poor with regard to health care and will make a big difference in the future as to the liability of the State and the counties with regard to that care. It will be our task in the coming days to address the imperative need for

> prudent changes in public policy toward a health care industry that is struggling to survive in the face of radical new strains imposed by the transformation toward the for-profit system of hospital enterprise.
>
> We cannot, nor do we desire to stand in the way of that change because in the long run it stands to do us a lot of good. But we must invoke our right and fulfill our duties as responsible policymakers to insure that change does not occur at the cost of depriving the poorest members of our society of any meaningful access to health care.
>
> Those of us on the Indigent Health Care Task Force have responded to the cry of the counties, the poor and our legislative leadership with a complex, comprehensive proposal to protect the future of the hospital industry from runaway development, and to insure that the indigent population of Texas does not suffer needlessly from the curable disease of poverty.
>
> What you will see today is sometimes almost too complex to simplify. We have brought with us an army of resource witnesses to insure that you have immediate access to the data and explanations that you will need in order to make your decision. At times what you'll see is graphic and horrifying. It may strain your faith in this society that we have today to see some of the pain and suffering that people have to go through.
>
> A couple of weeks ago I sent you a package and asked you to weigh our presentation before forming any opinion as to the benefits or the non-benefits of this legislation. Today we're here to present you with the facts and I hope you'll take time and listen carefully to the facts that will be presented by the authors and by the witnesses. [Ibid.]

The first witness was Helen Farabee, the Chair of the Indigent Health Task Force.

> FARABEE: The issue of health care for indigents has been with us for some time. Basically, the indigents are the uninsured and, most importantly, it's the very

uninsured poorest of the poor. After the last regular session of the legislature, the Lieutenant Governor, Governor, and Speaker met together and determined that the complexity of the issues facing the state relative to indigent health care needed to be addressed in a comprehensive way by the Task Force.

The issue at that time, to be very candid with you, was less an issue of what's humane and decent as it was an issue of who is responsible for the indigent, what services are they responsible for, how shall we administer care to indigents and how shall we finance care to indigents. At the time that the Task Force was created, I think it's fair to say that we were spending more money on lawsuits between towns and their hospital districts, between individuals and their home towns, and arguments between the state, the county and the federal government on who's to be responsible for paying the cost of health care for the poorest of the poor.

I'm pleased to say that the package that you will look at today begins to address answers to those questions, along with other issues that we found to be a very integral part of the problem. The Task Force has 71 members. We held 11 public hearings across the state. We did over 24 site visits. We did a comprehensive survey of county information and a comprehensive survey of hospitals across the state of Texas.

We met and deliberated many, many hours and we found, in addition to some solutions that we will propose to the issue of county responsibility, state responsibility, federal responsibility, that the health issues or the services needed in the state in order of priority were maternal and child health, primary care, preventative services, catastrophic and finally emergency and mental health.

The program that you will hear about that encompasses four bills that you'll hear today will deal with a number of those issues. First of all, 1843 by Oliver and Lee will, ... will address the issue of the county's relationship to indigent health care. It's a very conservative solution that

> has the potential to have the legislature address that issue and keep the issue out of the court in terms of who shall determine who is responsible for the indigent and what determines an indigent. [Ibid.]

Rep. Oliver mentioned the subject matter of HB 1023 and HB 1844.

> HB 1023 by Madla addresses the issue of maternal and child health ... [Ibid.]

> HB 1844. . . is an integral part of the package in that it begins to put into place a preventive and primary care that has the potential to take away some of the inappropriate uses of the emergency room of our hospital and to introduce some up-front early intervention care ... [Ibid.]

The description of these bills was very brief. Rep. Oliver also described HB 1963 briefly.

> And finally, HB 1963 . . . has the potential to make more humane the movement of patients from one emergency room to another if that's appropriate and to organize the transfer procedure between hospitals. [Ibid.]

Ms. Farabee generally discussed the package, giving some data on the cost of indigent care. [Ibid.]

The next witnesses spoke on HB 1023 and the package as a whole. [Ibid. Tape 2, Side A ended. The committee recessed just after the beginning of Side B.]

When the committee reconvened, the next witness was Richard Durbin, representing the Texas Hospital Association, who spoke about the revenues needed to support a hospital district such as the one in Harris County. He then turned to the subject of HB 1963.

> DURBIN: The hospital transfer bill, we've had a problem as many hospitals have had in the past, of what's referred to as dumping. We have now identified what dumping is. About a year ago we put out a policy adopted by the Medical Society of Harris County and the

> other hospitals and I'm proud to say that problem has voluntarily been relieved. [Ibid.]

He mentioned that he supported House Bill 602 rather than HB 1843. He then changed the subject back to the transfer bill.

> DURBIN: The hospital transfer bill can be done, I think, on a voluntary basis. We've done it in Harris County and we find a great deal of support and less animosity from other hospitals. I'm hearing pleading for legislation or lack of legislation that encourages better health, protects the system so people have the freedom of choice to use private non-profit and public hospitals according to their need, ability to pay and some freedom on their own part to select. [Ibid.]

He was asked a question on out-of-county hospitals' payment to county hospitals, and then he discussed Medicare. [Ibid., Tape 2, Side B, about a tenth into side.]

The next witness was James Belk of Hale County, speaking against HB 602, HB 671 and for HB 1843; his testimony was inaudible. [Ibid.]

The next witness was Dean Davis of the Texas Hospital Association, discussing financing mechanism problems. He said that his group had spent a substantial amount of time on the package of bills. [Ibid., Tape 2, Side B, about a fifth into the side.]

> DEAN: Mr. Chairman, if I may, let me indicate that we have had a considerable amount of effort put into this particular issue. I think the committee ought to know that, uh, that Rep. Al Edwards, in my certain knowledge, three years ago – three sessions ago – six years ago, tried to help the hospitals of this state address the issue at that time, somewhat confined to the ability of the state to try to equalize the burden that our larger hospitals were facing in the care of indigent care from counties around those major hospitals and those major counties. His bill last session passed the House and was not able to pass the Senate, and was restricted to an effort to try to equalizes the unfortunate, unequal burden that many of our larger hospitals have faced.

In the interim, as certainly you have heard today, the Task Force has identified not only the problem that Mr. Edwards attempted to zero in on, but has, has further done the excellent job and performed the valuable task of identifying many of those areas that have contributed mightily to the one billion dollars that Texas hospitals do annually in uncompensated care.

So we have kind of a special place for Rep. Edwards in our thinking, a very special place for this Task Force in addressing the greater issue of identifying the more intricate problems of causation that we have faced and, consequently, the Texas Hospital Association has appeared and its witnesses will appear in full support of the philosophy that is represented by the four bills that Mr. Oliver has in his package.

We are, as you might suspect, my particular task is someone technical in nature and that is to go over those bills that we are familiar with that have committee substitutes that are in somewhat of the form that will – if the subcommittee will, will view, and we do have suggestions on all four. I won't take up the committee's time this afternoon to, to discuss those. I think the appropriate way to do that is with your subcommittee.

I will say that, technically, because you have laid out the original of the transfer bill and we have not seen the committee substitute on that bill, I need to let the committee know that we have a major concern about that bill because of its wide-ranging scope. Uh, but not in philosophy. And let me tell you those parts, philosophically, that we have no problem with, as I understand from Rep. Oliver's staff., there is a substitute being worked on at this particular point. And let me tell you those areas that, that we affirmatively would be privileged to support.

The transfer problem is, is one that needs to be addressed, and the philosophy of those that I represent is basically that the safety of the patient, the expediting of the transfer, the, the proper documentation of the transfer are those things that we would have no problem with. As

long as the Department of Health that is given the authority under Rep. Oliver's bill has the rulemaking authority to adopt rules and regulations that are oriented to the safety of the patient and the completion of the transfer under proper circumstances, you will not find us adverse to that provision. Likewise, we have no problem with the concept that hospital boards should implement and take the opportunity to, to formulize the transfer policy of each individual hospital. We have no problem with that.

The basic problems we've had were with what we think are somewhat inappropriate sanctions in light of the way the bill was drafted originally. But conceptually, we have no problem with an effort to try to work with the subcommittee to develop a transfer policy for the state of Texas as between its physicians on various hospital staffs and between the various hospitals to ensure that that patient transfer is done safely and appropriately.

Mr. Chairman, I, I would close by making one additional comment. And, and in keeping with the chairman's admonishment early in the day, we are not prepared, though we ask for the opportunity, to discuss either with this committee or with this subcommittee, the issue of the financing of these tremendously important pieces of legislation. We are concerned about the financing because of what has, at this point, been a little more than, that speculation, that, uh, those that I represent would be asked to do something in addition to the somewhat one billion dollars annually that they're currently doing. We have tremendous problems with that. We do not intend, nor are we prepared, and we will abide by the chairman's admonishment not to go into the issue of the financing of these particular bills, but by the same token, it would be unfair and inappropriate if we did not indicate to the committee that this is an issue that in our judgment needs to be publicly heard. We would encourage the subcommittee or this committee sitting as committee of the whole, or whatever mechanism you wanted to utilize, to at another time pursue the financing of this, this tremendously important bills. We would like the privilege of trying to demonstrate to you that hospitals of

> Texas are doing sufficiently, and they do not and do not choose to stand moot to be asked to do something in addition. We will be delighted to try to make that position clear and articulate to your subcommittee or this committee at a later time, but I think it would be inappropriate if we did not indicate to the chair and to the committee that that is the major concern that we have with this package.
>
> Indeed, the governor and the speaker and the lieutenant governor were kind enough to present – to, to nominate people from our organization to serve on this Task Force, and they have worked as diligently as your colleagues have worked and are as proud of the product. The financing mechanism is an issue that needs to be debated and we ask only for the opportunity to present what we think is our, our position at a time that would be appropriate to the chair and to its subcommittee. [Ibid.]

The next witness was Leonard Riggs, a Dallas emergency physician, representing the Texas Medical Association. He spoke in favor of HB 1963. [Ibid., Tape 2, Side B.]

> RIGGS: We're very pleased with the direction that this bill is taking and, as has been indicated by others present here, there are some continuing changes that are applying today. We appreciate Rep. Oliver and the hard work that THA and TMA have all put into developing this bill.
>
> These comments that I have with us and I think our staff will pass out to you later really indicate our comments to the Task Force on Indigent Health Care that go right down the line with committee recommendations that have been put into this bill.
>
> Now, this is gonna be, we're talking about a very important social issue, I think, and I think the transfer bill is just one small portion of it, one symptom of the overall issue, whether we're talking about small versus large hospitals, rural versus big cities, it is not one of those deals where somebody else is into the canoe that's sinking. I think the overall issue is that we're all in this same boat.

> The elements of the bill that we think are important are already included there with prior notifications, the medical, proper medical stabilization of the patient, before they are sent on, the appropriate personnel and equipment being dedicated toward these tasks, sending the records and x-rays and all that business with them and then at the same time, making certain that hospitals have in advance true policies and procedures and so forth that address themselves to these issues. So we're very happy with the way all this is going, and stand here in support of it. [Ibid.]

There was a committee recess as the House went back into session, after which the hearing resumed. [Ibid., Tape 2, Side B, ending about two fifths into the side. The hearing began at about three fifths into the side.]

Dallas Mayor Pro Tem Annette Strauss testified next. She said that the city council had endorsed HB 1023 and HB 1843. She explained some initiatives that were taking place in Dallas. She discussed the infant mortality rate in Dallas and Texas and clinics for children and pregnant adolescents. [Ibid.]

A film was shown to the committee, the subject of which was not audibly explained to the committee or audience. At the end of the film, Dr. Ron Anderson, President of Parkland Memorial Hospital, testified for the Texas Association of Public Hospitals. He explained the segment of the film which showed a county eligible charity patient who was transferred to Parkland with the proper transfer provisions. He said that the 60 Minutes segment showed that a white 58 year old unemployed many would be a ward of the state with a major injury. He said that the other patient was in the same position in terms of financial need. He listed several public hospitals which were in Texas and said that Medicaid payments in Texas were the 48th in the nation. [Ibid., ending nearly at the end of Tape 2, Side B.]

Dr. Anderson described the bad debt the hospital had from patients from surrounding counties. He said his hospital took many transfers from surrounding hospitals for which there was no legal mandate to have to take them. He said that there was a tripling in transfers since increased unemployment, the recession, the cut in federal funds for family planning, and other changes which they do not have the ability to

manage. He discussed the activity level of Parkland at 102 percent, with length of stay decreased by two days in the previous two years, and said that Parkland was at an impass for taking care of the poor. He discussed the one billion dollars of free indigent care. [Ibid. Tape 2, Side B ended, Tape 3, Side A began.]

Dr. Anderson gave statistics about the bad debt in public hospitals and specifically his hospital. He said that it was not true that if all hospital debt for the indigent were taken into consideration, all hospitals were about equal in their burden. He gave further statistics about what was different in public hospitals compared to other hospitals.

He said that there needed to be attention to preventive care. He said that the balance was reached by the Task Force in attempting to share the burden, emphasizing preventive care and access and quality of care. He said they "do not allow implicit rationing and they protect the patients and the patients' rights."

> ANDERSON: I would like to briefly, since we started off with the transfer issue, emphasize that transfer in and of itself is not bad, but if you look at our transfer policy, which I've handed you, you'll see that what Rep. Oliver has recommended is very much what we are or should be doing in the hospital industry, if you will. Adequate appraisal and advice or initial treatment shall be rendered to any ill or injured patients who present themselves at the hospital. This is according to the Joint Commission on Accreditation of Hospital Standards. Also, the transferring hospital must institute essential lifesaving measures and provide emergency procedures that will minimize the aggravation or condition under transportation, during transportation. Further, Joint Commission requires that reasonable records of immediate medical problems must be accompany the patient.
>
> And then if you will, for a moment, let me read from the Patient Bill of Rights. No patient may be transferred to another facility unless he has received complete explanation of the desirability and the need for the transfer, the other facility has accepted the patient for transfer, and the patient has agreed to transfer. If the

patient does not agree to transfer, the patient has a right to a consultant's opinion on the desirability of transfer.

Finally, from the Joint Commission on Accreditation of Hospital Standards for Emergency Services, unless extenuating circumstances are documented in the patient's record, no patient shall be arbitrarily transferred to another hospital if the hospital where he has initially been seen has the means for providing adequate care.

We're not asking for anything that is out of line. I think that these bills will improve patient care, but I do think that we have to find a way over time to approach all of the recommendations of the Task Force. We are not dealing with the issue of regionalization, tertiary care. We are protecting counties from a bankruptcy situation at the present time. We're not doing the same safeguard for the hospital districts. All that being as it is, and we're not satisfied that everything has been done, I can tell you this is a first step, a very important first step and we are so much farther than we were two years ago when I was in Lieutenant Governor Hobby's Office and talking with, with the Speaker later and others about setting up this Task Force, that it will be a real mistake to go back and to give up any of these pieces of the pie, if you will, because it's a first step, it's a foundation. We need to build on these in future years as we can afford to, but I really feel that if we don't fund these pieces of legislation, the cost will be real for not funding those. There is a real cost for not making the decisions here, and that is a decision, particularly in the case of peri-natal health care. It's the number one priority for the Texas Health and Human Services Coordinating Council, the Texas Department of Health, the, uh, the Public Hospital Association, even if it doesn't necessarily relate to us as much, and it comes back down to the fundamental issue, if we can't afford everything and somebody has to come out of life boat, it should not be the women and children of Texas, the next generation. So if we're going to invest, we should at least invest at that level and those preventive aspects, even if it leaves us short in the public hospitals of Texas. [Ibid.]

Rep. Oliver asked questions.

OLIVER: Dr. Anderson, earlier today, Dick Durbin mentioned that hospital transfer policies could be handled on a voluntary basis, or should be. Have you attempted a voluntary system for controlling transfers to your hospital?

ANDERSON: The voluntary system was not a system, it was chaos. We have a 77 to 78 percent compliance now with the Parkland policy, which is voluntary. We basically have a peer review program with the Dallas County Medical Society. We have a town and gown operation at Parkland, where many of the doctors who come out there are from the private sector. They review cases that are sent to them when we think there are problems and we handle it through peer review. It is voluntary and we get 78 percent compliance with the physicians. Many physicians have the kind of the pressure as the first doctor said he had pressure, but it's not just a doctor problem, but it's not just the doctor problem. It's a doctor and a hospital administration problem. So I think that we can, through hospital by-laws, I think we can handle it there. We don't need a new bureaucracy. I don't want to see the health department ride the ambulance system. I don't think that's necessary. I think that once it's in the by-laws of hospitals as part of their condition of licensure, that would be adequate and wouldn't require a great deal of bureaucracy and oversight. I think most people want to comply with this if they can.

OLIVER: So you think that if the, this legislation would further reduce that other 22 percent of noncompliance.

ANDERSON: Yes, sir, I do. I think that, uh, the patient would have some recourse and I think we would probably, uh, would see much of the inappropriate transfer of patients without proper notification cease because of liability issues that would result in not participating in it. I, I think it's a very important step in protecting the patients' well-being. I'm sorry to say that there are very few people who do this, but those very few

> do it repeatedly and the majority of physicians in our community and the majority of the hospitals in our community work with me on this issue now, and that's something that did not come in the 60 Minute segment. So over the last year, we've had terrific participation, working with us on a voluntary basis. I think this legislation would make other places do what we have done and get involved in the peer review process when it did fail. [Ibid.]

Joel Allison, representing the Texas Association of Public Hospitals, testified in favor of the package. He thanked all the members who had worked on the four bills.

> ALLISON: Our hospital district is mandated to provide care to the residents of Amarillo, yet we are serving as a tertiary care center for the neo-natal intensive care for the twenty six counties and through the emergency room. So we are meeting, again, beyond that mandated obligation.
>
> On $55 million revenues, we experience in the Panhandle a $9 million bad debt, a third of that coming from out of county transfers, so we are vitally interested in this legislation. We also want to publicly express appreciation for the work of the Governor's Task Force on Indigent Care that's chaired so capably by Ms. Helen Farabee. We feel that this legislation is essential. It is time that we had this type of legislation in order that we can continue to provide the level of services that are needed by the residents of Texas, not worrying about the cost of the care to the individual, but rather that they have access to an adequate level of care. [Ibid.]

Tom Bacus, a Wichita County judge representing the Texas Association of Counties, was for the package of bills. He said that a 1983 package of bills was potentially devastating to Texas counties. He said that they did not realistically assess the need for financing health care, nor did they deal with delivery of services or burden of taxes. He thought it was piecemeal and was inadequate to deal with the needs of the indigent. He described the shortages of funds for public health in his district.

Mr. Bacus said that so much time and so many people in different professions had donated their energies to the work of the Task Force. He said that he was opposed to some of the bills: HB 602 and HB 671. He said that HB 796 was proposed two years ago and the implications for Texas counties was $500,000 to $1 billion for the counties. He said the consequence of passing that bill would have been obvious. [Ibid.]

> BACUS: The bills that you have before you today are much more realistic assessments of the overall capability with the counties, of hospitals, of everyone involved. They represent a partnership effort. And believe me, there's not anybody that's participated in this Task Force that is totally happy with any and all aspects of it, but the fact is, I think everyone realizes that the strength of this is the amount of compromise that we've been able to reach and amount of agreement that we've been able to come to. Just as Dr. Anderson indicated to you, you have to start somewhere. Not everybody's gonna be totally happy with every aspect of it, but at least it's a good starting point and it's something that we can stand and hold fast to and know that we can have a delivery system that will work. [Ibid.]

He praised the staff work that was done for the Task Force and said that the preparation allowed the counties to go along with the compromises. He said that the fiscal stability of Texas counties was a real concern and most of them did not have a county hospital district. When counties with districts had to raise money, they were responsible for the money raised, while other counties did not have to share this financial responsibility. This was the problem with the past laws.

> BACUS: That's the reason that a part of our, our concept of what needed to be done and what's been adopted by the Task Force is a fact that 8 -- the 8 percent roll back doesn't apply to funds that are used to finance indigent medical care. Now there's a real practical reason for that. I think you know what it is, but we all assume that we're looking for a very stable financing base with which to fund care for the poor of our state. It makes no sense to, to use a financing resource that is immediately going to be attacked and eroded and taken away. Now, if we're

> talking about contributing new dollars to a program, and new dollars that may come out of taxes that are already in existence, that the public in general feels may be a little bit high, then you've got to find some way to insulate that. Otherwise you have no funding resource. And that's the reason we felt that in order to be stable, have a stable funding source, that this exemption had to be there.
>
> Now, remember that the majority of the counties are sharing this 8 percent with the other constitutional tasks that they already have. The state itself, out of its budget, finances less than, I believe it's three tenths of a percent of the judiciary out of its budget, the total of the budget. The majority of the judiciary funding is done at the local level through the counties. We support the local court systems and all the support functions, the prosecutors and so forth. Those offices are sharing out of the same money funds. And we can't take – and rob from Peter to pay Paul, so eventually you're going to have to shut down one office to operate the other. I don't think any of us want that to happen.
>
> I feel like that the Task Force recommendations have taken a very good look at counties. I think that the counties themselves have been very honest and forthright in their analysis of their abilities. [Ibid.]

He commented that the counties established their own task force and made their recommendations to the state task force, at which many of the recommendations were adopted. He listed the opportunities the legislature had to provide for health care at the local and state levels. [Ibid.]

An amendment was laid out related to HB 1843. Rep. Oliver explained the amendment, which provided a financing mechanism of one percent of all hospitals' net receipts. He also defined gross and net receipts as used in this amendment. This tax was discussed in some detail. [Ibid. Tape 3, Side A, about one third into side; this discussion did not end until Tape 3, Side A, about halfway into the side.]

Jamie H. Clements, representing Scott and White Medical Center, testified for HB 1843. He said he was on the Task Force and was still in

favor of the bill and the amendment by Rep. Oliver. He was in favor of a large tax on cigarettes, but would support a county hospital tax. [Ibid.]

Barry M. Massey, also of Scott and White, testified as the Chief Financial Officer. The tape of his testimony was cut off soon after he began. [Ibid., ending at Tape 3, Side A, about four fifths into side. Tape 3, end of Side A and all of Side B was blank. The testimony continued on Tape 4, Side A, beginning of side.]

Kay Vacha, Texas AARP Legislative Committee, testified for HB 1843. [Ibid. This testimony was not reviewed since it was only on HB 1843.]

Ernesto (Buddy) Flores, President and CEO of Mercy Hospital of Laredo, testified for the Task Force package, including HB 1843, HB 1023, 1844 and 1963. He also supported Rep. Oliver's one percent levy of a tax on net hospital revenues. He went through his previous year's revenues, including a write off of about 9 percent for charity care, 9 percent for bad debts, and 18 percent to contractual allowances, discounts and Medicare and Medicaid. He said there was no public hospital, and his hospital served Jim Hogg and Zapata. He said that the funds which were allocated by the city and by the county did not always get paid, and this was a stark reason why the County Responsibility Bill was needed. He briefly discussed a few points in the other bills. [Ibid.]

Richard Bettis, a Vice President with the Texas Hospital Association, testified that the association supported the four bills, but wanted to respond to the tax proposal by Rep. Oliver. He discussed some of the testimony which he said appeared to be based no conclusions drawn from Hospital Association data. He discussed what he considered to be discrepancies in the conclusions made from the point of his association. He and Rep. Oliver discussed the use of funding from several sources in relation to who is paying it. There was a lengthy discussion of data indicating which sources pay for indigent care through charity sources and bad debt. They discussed the criteria used to determine indigency. [Ibid.]

A woman asked if she could ask a question and the chair responded, "What the hell, go ahead!" She asked about the pool of funds from the 1 percent tax. She asked how this would alleviate the cost to the individual patient. The witness said he supported a tax bill or a product such as cigarettes to be taxed. The chair offered the possibility of a tax on insurance premiums. Someone else asked for more information on

the "pooling" option. The Hospital Association representative said his group was in favor of expanding the existing Medicaid program, which allowed for the federal matching funds, or increasing the county participation level. [Ibid., Tape 4, Side A ended; Tape 4, Side B began.]

A list of witnesses who were present, but who were not recognized, apparently because time ran out, is in the committee minutes.

The bills were sent to a subcommittee by the chair and Reps. Oliver, Wright, Harris, Lee and Short were appointed to the subcommittee. [Ibid., ending at Tape 4, Side B, about one third into side.]

On April 30, 1985, the Subcommittee on Indigent Health Care was called to order. Unfortunately, the tape recorder does not appear to have worked for Tape 1, Side A; Tape 1, Side B began with testimony on a bill which was laid out after HB 1963 and three other House bills were considered in committee. Apparently, these first four bills were heard and discussed on the tape side which is blank.]

According to the minutes of the subcommittee hearing, HB 1963 was reported out of committee. [Ibid.]

On May 7, 1985, HB 1963 was considered by the full House Public Health Committee in a formal meeting. [House Committee on Public Health; there was no tape for this meeting.]

Several bills in the Task Force package were laid out and considered by the full committee. A Committee Substitute for HB 1963 by Rep. Cooper was laid out. Rep. Wright moved adoption of Amendment Number 1 to the Cooper substitute bill, which failed of adoption. [Ibid.]

Rep. Wright moved adoption of Amendment Number 1 to the Subcommittee Report. With no objection, the amendment was adopted and the Subcommittee Report, as amended, was reported out of committee. [Ibid.]

The committee prepared a report on HB 1963. [See HB 1963, House Committee Report.]

The House Research Organization prepared a report on HB 1963 as it reached the House floor. [House Research Organization, Daily Floor Report, 5/16/85, pp. 12-16.]

On May 16, 1985, HB 1963 was laid out on second reading before the House. Rep. Oliver explained the bill in one sentence. [House Floor Debate, 5/16/85, Tape 89, Side B, about a third into side.]

> OLIVER: This bill would prohibit medically inappropriate transfers from hospitals. [Ibid.]

There were several amendments proposed on the bill. The first was by Rep. McKinney and Rep. Oliver explained it.

> OLIVER: This amendment by Dr. McKinney would ensure that the transfers were conducted under medically prudent -- in a medically prudent manner related to the standard in that particular locality. I move adoption. [Ibid.]

The amendment was adopted. [Ibid.]

The next amendment was by Rep. Harris.

> HARRIS: Although we are in sympathy with the intent of this bill, you might say this amendment is a minority report of some members of the Public Health Committee of this House. Our concerns are several-fold, but the two I might spotlight for you are the portion on page 2 having to do with the receiving hospital. It is our intent that the receiving hospital should, besides being notified, should confirm that the patient does meet the hospital's admissions criteria that relates to appropriate bed, physician and other services necessary to treat the patient. It's one thing to demand that a patient be transferred properly. It's another thing not to demand that that hospital be prepared to receive, that that hospital receive that patient.
>
> I might direct you to another portion and that is to the back portion of the bill, page 4, -- no, take that back, yeah, page 5, I believe of the bill you have in regard to civil penalties of governing boards. In the, in this amended bill as we have, and also in the bill that you have, there are definite provisions for the licensing agency to remove, revoke or suspend that license, and

that is the method by which we have governed hospitals throughout the years in Texas.

Hospitals adhere to those standards. They respect the right to maintain their licenses, and for some reason in this particular bill which you have now, 1963, suddenly we are requesting civil penalties of the governing boards. Now, let's discuss who's on the governing boards of your hospitals of your districts. They are not generally physicians, they are not generally hospital administrators. They're usually the solid, caring citizens of your community who donate their time and services to help govern your local hospitals. It seems to us that it's very unfair to make those people liable for civil penalties in situations of improper transfer standards set up by that hospital. It seems very obvious that the licensing agency, if they determine that there is not a proper, there are not proper standards set up, would suspend or temporarily revoke the license of that hospital until it does comply with the licensing guidelines. I would ask you to please support this substitute bill. It's much more practical. I think it does the same thing and accomplishes the purposes that we all want to accomplish to take care of our indigents.

OLIVER: The story about inappropriate, medically inappropriate hospital transfers is a graphic and telling tale. I don't know how many of you had an opportunity to see the 60 Minutes show that highlighted medically inappropriate hospital transfers in the Dallas Fort Worth area. But the stories were graphic. Even more graphic were the conversations between people at the transferring hospital and persons at the receiving hospital, statements such as, that's what I pay my damn taxes for. What do you mean you can't take this patient. I want him out of my hospital. Those are not the statements of people who are carrying out the mission of hospitals. We have to provide an incentive to hospital administrators that says that they have to do a certain minimum amount of care when a person is in the emergency room. That they can't call up the taxi cab and put that person in the cab with an IV in their arm, that they can't send them forty miles across town in Dallas County to another hospital. They

can't transfer them when they've got third degree burns all over their body. They can't make them sit in their waiting room for 8 hours and then transfer them.

You know, every law that we pass, every criminal law we pass, we put penalties on it. We put those penalties on those laws to try to stop people from breaking the laws. The purpose of civil penalties is to stop people from breaking the laws that we think are so important that we pass. I say to you today that we have a well-thought out and well worked hospital transfer bill. The Task Force spent 18 months working on this problem. The Task Force staff, myself, my staff, the Texas Medical Association and other health care providers have worked feverishly over the last few months trying to hone this bill down so it had met the needs of everyone that was involved. And even that great group, the Texas Hospital Association was involved in those negotiations, however some parts of it didn't fall just the way they wanted to so they backed out of the whole thing, and that was after telling us that, I think we've got an agreement in principle. So what we have here is a transfer bill that reflects a lot of work. I don't think we can go with a wholesale substitution of that bill on the House floor and relegate all the work that's been done to the back shelves of the Texas legislature. Members, I respectfully move to table Dr. Harris' amendment.

HARRIS: Mr. Speaker, members, I applaud the Task Force's work in not only this area, but in all areas that we have been dealing with today, but I submit to you that sometimes things do fall through the cracks. I am certainly not in favor of the problems that we have today in regard to transfers. As a matter of fact, if I were I'd be asking for defeat of 1963. But I do think this. Before a person is transferred from one hospital to another, the hospital that's receiving that patient should be able to say, yes, we have the facilities, yes, we have the doctor, yes, we are ready to take that patient. What it says now, on page 2 is, you make a phone call, you say we're sending the patient in and the patient has to be received. That's not right.

> What we also say is that in all these many years that we have been licensing agencies and telling those agencies to comply with the rules or they lose their licenses, we're now going to say in this one small piece of legislation, that's not enough. We're not only going to do that, we're going to take you and your governing board of interested citizens to court. Now I don't know about you, but if this bill passes, I'd be very tempted not to be asked to serve on a governing board of a hospital, if I were asked in my community. It's just a little bit too violent to solve a simple problem, and I would ask that you please stay with me and vote not to table. [Ibid.]

The motion to table failed. The next discussion was on passage of the Harris amendment itself. [Tape 89, Side B ended; Tape 90, Side A began.

> OLIVER: -- while the transfer of bills was part of the Indigent Health Care Task Force, because it does place an undue burden on public hospitals because of people showing up at the emergency rooms after having been transferred from private facilities, you might think of a person, that it doesn't happen that a person is sent to a John Peter Smith or a Parkland Hospital or a Scott and White in a taxi cab with a bandage around their bleeding wound, but it does happen. Little children suffering from meningitis do get bounced from for-profit hospitals' emergency rooms and transferred to public hospitals. The reason that this is part of the indigent health care package is because of that impact on public hospitals, the surprise transfers. But I'll tell you what. This piece of legislation relates to anyone of you that shows up in a hospital emergency room without your Blue Cross card or whatever other kind of insurance identification you might have, that shows up in a hospital emergency room without your check book, that shows up in a hospital emergency room without any means of providing a deposit to insure that you can stay in that hospital. This is a people bill. It relates to all of us. Now, you might think that there's no need to put any penalties on a hospital that breaks its own rules, essentially. And maybe I should explain to you that what the bill says is that the Department of Health shall establish minimum

standards for medically appropriate transfers. The hospital board is responsible for setting up rules and regulations to conform with those standards. The hospital board itself sets up the rules under which it's supposed to conform to the standards. If the hospital fails to conform to its own standards after they've been set up, then the hospital will be subject to penalties, subject to fines. If they repeatedly violate the circumstances of the bill, they may lose their license. And I say to you right now that if I were going to a hospital and I knew nothing about that hospital other than the fact that it had the sign hospital on its building, I would like to know that that hospital is meeting some standards, other than the fact that they've got hospital up there. I would like to know that I'm going to get appropriate care and so these penalties and sanctions are important. Rest assured that if they're not there, there'll be another 60 Minutes story of the type that was done, and it will be done on Texas hospitals and one of us may be one of the headliners of the story.

LEE: Mr. Oliver, in the course of this year that we spent on the Indigent Health Task Force listening to a great deal of public testimony as well as the Texas Hospital Association being a party to this negotiation and writing of this bill, did not they agree to your bill sir?

OLIVER: They did at one point in time. As a matter of fact, if you will look back at the minutes of the hearing, there is no opposition to this bill in committee hearing or in subcommittee hearing at any time.

LEE: Mr. Oliver, you know, in all due respect to our colleague, we've rewritten a bill that it took us a year or approximately 52 meetings to make some agreement on. We've rewritten it right here on this House floor by an amendment.

OLIVER: Right.

HARRIS: I certainly agree with my colleague, Jesse, that if anyone of us winds up in a hospital without our Blue Cross card or whatever we have that we want to be

treated fairly. We want to be transferred properly. We want to be cared for. I submit to you first of all that if I'm being sent to a hospital, I want it to be a hospital in which it is guaranteed that that hospital is ready to accept me. Unfortunately, the bill you have does not do that. I also respectfully disagree with him in this respect. And I think we've talked about this already. That when we license people, and when we license agencies, it is the job of the state to check those agencies continually and make sure they are complying with the standards, the standards which they're required in both bills to set up and maintain. We are not lowering the standards. We are simply saying that the proper agency to enforce those standards will enforce those standards in the way we know best and that's by either revoking or suspending a license, and I submit to you that that is a far, far greater penalty than a civil penalty at any time.

OLIVER: Dr. Harris, you're saying that the civil penalty is your problem with this particular bill?

HARRIS: That's certainly a good part of it, yes sir, I think I've --.

OLIVER: The civil penalty creates a problem. The thousand dollars a day for failing to comply, is that correct?

HARRIS: That penalty is applied not to the hospital, not to the administrator, but to the governing body, according to the bill.

OLIVER: Who's responsible for the operation of the hospital?

HARRIS: There's no question, the governing body is. On the day to day administration, it's the administrator of that hospital.

OLIVER: Would you change your amendment to say that the hospital administrator would be subject to a thousand dollar a day fine for failure to comply with his own rules?

HARRIS: My personal opinion is there's no greater penalty than revocation of a license. You can't operate without a license, Jesse.

OLIVER: Alright. Let's see, what was your first point there. You said that the hospitals, you wanted to make sure that the hospital was ready to receive you if you were being transferred. And that our bill doesn't provide that.

HARRIS: Yes, sir.

OLIVER: Well, clearly it doesn't state that one of the requirements under there that the hospital has to say okay send them over because the transferring hospital is generally a public hospital and they have no say in that transfer, because if you're going to send somebody to a public hospital, they have to take them under the constitutional requirement.

HARRIS: Well, I think that you and I both know that part of the problem that was testified to is the neonatal care situation. And one of those in particular was the Harris County District which many times, the neonatal care situation is overloaded, and at one time recently made the TV because they had to go to Scott and White.

OLIVER: Okay, Dr. Harris, with regard to the transfers. Now if, I would be agreeable to an amendment that said that a hospital would be able to handle that transfer if you would have proposed such an amendment.

HARRIS: I have it in this bill.

OLIVER: I think that I would be, also, acceptable to an amendment that would place the civil penalty on the hospital administrator, if you don't want the board, you say that's a voluntary board, you don't want them to be responsible for it. I think that what we need to do though is to amend the committee substitute to House Bill 1963 and not come up with a blanket substitution that changes the whole general application of the bill. Now if you

want to address those two or three specific items, we can address them in some specific amendments. But I think that what you're doing is just changing the entire gist of this piece of legislation.

HARRIS: I think what you're talking about here is a difference in philosophies, and my philosophy is that the revocation of license is the strongest penalty you can put on any agency. You feel like you must have civil penalties. I'm sorry, but that's where we disagree.

COLBERT: Mr. Harris, the problem that I have with what you're proposing is that sometimes you can make sure that nothing gets done by making what you have as your choices so strong that no one would want to impose it. What happens if you revoke that license?

HARRIS: That hospital ceases to operate until it gets its transfer policy in order, it's simple as that, Paul.

COLBERT: Okay, that hospital ceases to operate, so number one, you have a situation where nobody is receiving care even in an instance where people are currently receiving care, is that not correct?

HARRIS: If they can't maintain their own transfer policy, then I think they've got a real problem, personally, and I'm not too sure if the rest of their care would be adequate.

COLBERT: Oh, so what you're saying in effect is you would want to create a situation where people who are in no way shape or form at fault would suddenly have medical care denied to them or create the alternative that no penalty would be imposed cause the only penalty that is available is one that is that strong. Is that not a problem?

HARRIS: No sir, it's not a problem. What is a problem is this. Any hospital that would endanger its license by not maintaining its own transfer rules that have been filed with the state and that will conform to the state plan, that hospital has a real problem, and I submit to you that that

> is the strongest penalty we can enforce, and as a result of that you're not going to see these people abuse the transfer privileges.
>
> GRANOFF: Doctor, very simply, you have a whole substitute with lots of things in it, many of which you haven't mentioned yet, but let me, let me just ask you one thing. In the main bill, we have fines, civil fines, and we have revocation and suspension of license also. Isn't that right?
>
> HARRIS: And those fines will go against the board of governors, yes Al, that's right.
>
> GRANOFF: Okay, well, if you've heard the author say that if you wanted it to be the administrator, if you offered that he'd accept that, so that shouldn't be a problem.
>
> HARRIS: We offered it earlier, and the suggestion was he'd rather not do that, but besides that --. [Ibid.]

The time ran out on the speaker, and there was a record vote on the amendment, which failed 58 to 74. The bill was then passed by a non-record vote. [Ibid. See *House Journal*, 5/16/85, pp. 2350-2366.]

On the House floor on Third Reading, the indigent health care bills were all passed on May 17. The last bill of the package was HB 1963. Rep. Oliver again presented the bill. [House Floor Debate, 5/17/85, Tape 95, Side A.]

> OLIVER: This is the hospital transfer bill from yesterday on Second Reading. I move final --. We have one amendment. [Ibid.]

The amendment by Rep. Harris was laid out and Rep. Oliver explained it.

> OLIVER: This is an amendment that takes care of one of the concerns that Dr. Harris had on yesterday. Provides for confirmation by the receiving hospital that the patient is acceptable to them. [Ibid.]

The amendment was adopted and the bill was then passed. [Ibid., *House Journal*, 5/17/85, p. 2645.]

Senate Action

When HB 1963 arrived in the Senate Health and Human Resources Committee, it was first heard on May 20, along with three other bills on health care. The first witnesses on the bill spoke on all four bills generally. The witnesses were Dr. John Asbury, Sam Hontz, Michael Hudson and C. Dean Davis. [Senate Health & Human Resources Committee, 5/20/85, Tape 1, Side A, about one third into side.]

Mr. Davis spoke more specifically about HB 1963.

> DAVIS: We are in support of all four of the bills, three of them as written and the transfer bill that I'll visit with you just a moment about. We have one particular problem with that we'd like to urge clarifying. We will commend the Task Force for the tremendous job that it has done. It has been a difficult task for these issues to be addressed in this session. We are delighted that the package of bills has reached the stage that it looks like their implementation may in fact occur.
>
> With respect to 1963, we have a particular concern and that concern is that section of the bill that specifically directs penalties toward board members of hospitals imposing fines and providing for the kind of causes of action for damages against hospital board members for the non-implementation of a transfer policy.
>
> The transfer policy that is contained in 1963 is the, conceptually, one that is important for, to be sure that patients that are transferred from one hospital to another are transferred safely. We have no problem at all with the concept that that needs to have an enforcement provision in it, and indeed portions of the bill have the capability of a hospital having its license revoked, suspended, or cancelled with the provisions of the Act. A rather severe penalty, I think you would find.

We have no problem with that penalty being in the statute, but we feel that any additional penalties as are likewise contained in the statute are purely and simply overkill. We would urge the committee to eliminate those kinds of penalties that are directed toward our boards of trustees because we are most concerned that the manner in which they're written, the fines a thousand dollars a day, every day, a separate offense are only the kinds of things that dissuade people from serving on hospital boards, community hospitals throughout the state, and we think it is in fact an overkill of the situation.

BROOKS: I'd like to pass to you an amendment that the chair is going to offer and ask you to comment on it. It deals specifically with the question you have raised about revocation of the license, and the appropriateness of any sanctions we put in the law pertaining to a violation or an abuse of a transfer, whatever you choose to call it.

DAVIS: Mr. Chairman, this is a proposed committee amendment that does in fact put into place the kind of sanction that we feel is appropriate for those hospitals that do not substantially comply with this transfer requirement. It is stringent in that it would allow for the licensing agency which would be the Health Department to deny, suspend or revoke the hospital's license if indeed the hospital did not substantially comply with the provisions of the Act. We have no problem with that approach at all, Mr. Chairman. Likewise, the rest of the amendment details the manner in which the APA is to be applied and we have no problem with that particular provision either.

BROOKS: There is another amendment that's been suggested and that [inaudible] strike. I'd simply suggest that we eliminate that Section 4 that had the penalties levied against the Board members themselves.

DAVIS: Yes, sir.

BROOKS: I think that would be like saying that because someone in the bank had violated the law, the banking rules, that you'd go against the directors who probably

had no, certainly did not set a policy for the viola that law, and had no knowledge of it taking place.

DAVIS: It seems to us that it is the hospital that ha responsibility for those transfers and the Board has the responsibility for implementing that policy. If the hospital does not do so, sanctions against its license appear to be the proper way of doing that rather than jeopardizing board service by penalties or causes of action against individual board members.

BARRIENTOS: Mr. Davis, let me ask a couple of questions. Back up on the first amendment.

DAVIS: Yes, sir.

BARRIENTOS: Could you go step by step with me what exists now in the law, what the bill provides, and then what the amendment provides?

DAVIS: First of all, with respect to the requirement for a hospital to have a transfer policy, there is no requirement to set into place the mechanism and the requirements by which a patient may be safely transferred from one hospital to another, and those things that are contained in the bill are excellent in our judgment, well needed, clearly defining what it is that hospitals' responsibilities are, both the transferring hospital and the receiving hospital and allows the board of health to adopt rules and regulations that would implement that, and we think that's a good idea.

The amendment that Sen. Brooks inquired of me about and the concern that we have with the bill as it exists is that Section 4 of the bill which talks about the kinds of things that involve fines and personal, or penalties against board members of hospitals, as opposed to the penalties against the hospital itself which we have no problem with. We feel that the penalties that are provided against individual board members for the implementation of policy is an overkill in circumstances like this. And this is what we have objection to.

BARRIENTOS: Okay, back up for a minute.

DAVIS: Alright.

BARRIENTOS: Now, well, first of all let me ask you this. Why was this particular area that we're discussing, why was it placed in this bill?

BROOKS: In the House? Cause it wasn't introduced that way.

DAVIS: My recollection is that it wasn't introduced that way, and why it was placed in the bill in the House, Sen. Barrientos, I'm not sure I can tell you.

BARRIENTOS: To be perfectly frank with you, I just heard a little rumor earlier today that some hospitals, private I think, were vacating some beds of some more indigent patients into public hospitals so that they could fill those beds with good paying folks who happen to get sick. Do you know of that situation?

DAVIS: I really, no, I really don't know of that situation being the reason for this amendment being in there. This particular penalty section being in the Act. The thing that this particular section would address would be the establishment of a policy, not necessarily a particular procedure. For instance, in the event the Health Department under the requirements that the bill would impose, would require that those, that the persons were transferred from one hospital to another on the basis of a particular criterion (sic) were violated, then the hospital would have the, would run the risk of losing the license of the hospital to exist, which in our judgment is enough sanction to do it. It would be difficult for me to understand or see how it was that individual trustees or a board of trustees and sanctions against them would be, would help to insure against the kind of thing that you just alluded to. I'm not, in other words what I'm saying is, if indeed that practice is one to be condemned, I think the substantial failure to comply with the Act occurred and the sanctions are there to remedy it, without the sanctions that are in that Section 4 of the bill.

BROOKS: Let me ask you a question, if I may, Mr. Davis, while my staff people are here who are helping with these amendments, and will ultimately incorporate any amendments we adopt in the substitute. Instead of striking the section altogether, is there any merit, would you feel that there'd be some merit of holding a penalty against an officer who deliberately gave directions counter to the law, a violation of the law. I'm not talking so much about the directors who as all of us know, really just meet as a governing board and set the general policy. They don't actually make the transfer decisions, I don't think in any case in any hospital in Texas, but what if we had a potential sanction apply against an individual who actually did issue an order in violation of this act, a transfer in --[Tape 1, Side A ends; Side B begins.]

DAVIS: Well, of course the penalties would be different. Point out to me if you will, what portion, what section of that, is it in 9B or 9C?

BROOKS: C. Oh, Section 4. Staff says it's B, 9B. Injunctive relief, maybe, the injunctive relief is what they're talking about.

BARRIENTOS: Well, the way it was, way it was.

DAVIS: Well, it would be --. It's my judgment that even without that particular provision of injunctive relief, that is a cause of action that's available to the Health Department to enjoin violations of the act if they wanted to choose it. Now, we would have no particular problem if you wanted to leave that area where injunctive relief was sought in the event of some particular kind of violation.

BROOKS: Well, to accomplish that, I know you're familiar with this is why I'm asking the technical questions. To accomplish what we've just said here, would we strike 9C instead of the whole section, and leave 9A, or was it 9B, intact?

DAVIS: We have some concerns with 9B because I believe it goes more than just the injunctive relief. It would seem to me that maybe if what you wanted to do would --.

BROOKS: Could we rewrite for injunctive relief and not get beyond the perimeters that all of us I think are --.

DAVIS: I think that one or two sentences allow for injunctive relief to be an additional sanction by the Health Department we would have no objection to. It's the spilling out of what appears to be new and different kinds of causes of action against these people personally that we have major concern about.

BROOKS: I understand. That's what I have concern about, too. I don't want someone who is really not an active ongoing hands-on administrator and has no real opportunity to contribute to this administrator other than just in general policy terms to be held liable for a specific act that is done by the administrator.

DAVIS: And we would have no problem if the injunctive relief were given as an additional sanction against the facility, and I think that's the key thing.

BROOKS: Against the facility. Would you be willing to help us, uh, help the staff, work with the staff here to try to get that kind --.

DAVIS: Be happy to.

TRUAN: Let me ask a question here. Are all of these officials, don't they have some kind of protection in their official capacity by their bonding or being bonded or --.

DAVIS: Not from liability, Senator.

TRUAN: Well, I can appreciate the concern of suing someone individually aside and apart from their role as an administrator, but I always assumed that if they were acting in their official capacity that the hospital or the board would bond them so that in case anybody sues the

hospital, sues the administrator as the administrator, not as a private individual, that that was always the case. I don't see what the problem would be under this bill.

DAVIS: Well, Senator, first of all I think you're, we are, the bonding situation is more of a fidelity kind of an issue, and the liability situation is totally different. We're concerned about the liability situation from the standpoint of creating additional liability on hospitals legislatively such as this. And it is the extensive language in this particular section that gives us the concern. If what the agency wants us to do is to enjoin a violation or to enforce sanctions against the violation of the other part of the act which we think reads fine, we don't have any objection to it. But it's the language in here appears to create additional legal exposure over and above that which the other portions of the bill create we have some problem with. And we think that, and we don't have any problem with the injunctive part, as Sen. Brooks has indicated, but certainly what we feel is that the sanctions should be against the institution and not against particular individuals that either would for, or are on boards of the institution, but the institution itself is responsible for its policy, and it ought to have the sanctions imposed against it.

TRUAN: Well, I always thought if somebody was the president or the administrator of the hospital, if they did something wrong that they could be sued in their official capacity.

DAVIS: And they can and they still can.

TRUAN: And so that doesn't change, and you're asking for that, but you're --. It's not that you're asking for that, you are not taking issue with that but you're taking issue with changes being brought against the institution?

DAVIS: No, we don't mind if the institution is called irresponsive to what this act requires it to do, but we have concern that the way this section is written, that it's more than the institution, it's the individuals in the institution.

And so we think the sanctions ought to be directed toward the institution.

TRUAN: Is that the only amendment that you have for this whole bill?

DAVIS: Yes, sir.

TRUAN: You don't think that this is something that could wait to be amended at the next session, being the last week of the session and the danger of returning the bill to the House and having to suspend the rules and so forth.

DAVIS: Senator, I really don't believe the amendment is that extensive.

TRUAN: It's not your intention to try to prevent the rules from suspending in the House if this goes back with that amendment.

DAVIS: Certainly not.

TRUAN: That's my concern, Senator. You know this is the worst week of the session.

URIBE: What happens in a situation where a hospital adopts a policy on transfers, we would require it by this law, and then in spite of the fact that a policy has been adopted, somehow there appears to be consistent violations of its own policy. It seems to me that corporations, corporate bodies, governmental bodies all act through individuals. Don't you think it would be beneficial to have some sort of legal stick to bang them over the head and say now boys we, or girls, you've adopted the policy. You're great on paper but your record isn't all that good.

DAVIS: Senator, of course we do, and this is why we're suggesting to Sen. Brooks with respect to the amendment that he laid out that says this: the licensing agency may deny, and this is the Health Department, may deny, suspend or revoke the hospital's license if the licensing

> agency finds that the hospital failed substantially to comply with this act. And you know, that is the area where we think that sanction --.
>
> URIBE: Isn't that a pretty extreme remedy? You know, you're going from nothing to taking away a license. That's an awfully extreme remedy when something such as a fine against an individual or an injunction against an individual that serves on the board and who in fact develops the de facto policy.
>
> DAVIS: And I have indicated to Sen. Brooks that if that, if the injunctive relief is sought against the institution, I don't have any problems with that. That would be a lesser sanction than denial, cancellation or revocation of the hospital's license. And could be zeroed in on and directed toward whatever the concern was.
>
> URIBE: It just seems to me, Dean, that wherever you have a corporation official acting ultra vires (?) beyond the scope of his authority and legal authority that sometimes it is necessary to have a legal hammer with which to hit that person to make him understand and appreciate that in spite of the fact they've adopted a policy to comply with law, they've got to do a little bit more and that is actually follow the policy on the day to day operation. [Ibid.]

Sen. Barrientos asked to see a copy of the amendment, and then the next witness, Helen Farabee, the Chair of the Indigent Health Care Task Force, spoke in favor of all four bills. She commented further on the transfer bill.

> FARABEE: I think one of the things that greatly concerned us is the fact that we wanted some sanctions, as you pointed out Senator, that were short of something that was very extreme such as licensure revocation which hurts all patients and is not our intent. The bill was carefully put together to try and encourage a more rational carefully worked out policy by the hospitals that deal with each other and with the policy boards working with the medical staff. We don't, the Task Force, pretend we have the expertise to do that. We think it's a first step

in making a more organized system and working relationship between hospitals, because we know that there are many transfers that are very appropriate and we want them to be done in the best manner with the patient in mind.

We feel that there need to be fines and there needs to be injunctive relief. I would say that it has never been the intent of anyone drafting that bill to have individual liability for any particular, any individual board member. And if there is some minor change in language that could make that very clear that we're talking about a corporate entity, not individuals, that is not a problem with us, but we do feel that it is necessary to have sanctions such as fines and injunctive relief and some standards for enforcement short of what I think is a very severe action and one that rarely occurs and that is revocation of licensure over this sort of thing.

URIBE: Let me interrupt to see if I'm not understanding you. It's your testimony that it was not the intent of the committee to provide for specific sanctions against individuals, persons that represent the corporate body?

FARABEE: I believe that's correct.

URIBE: Okay, because the language --.

FARABEE: The corporate entity that we're concerned about having sanctions against, not individuals.

URIBE: The language on page 6, in Section 9B, Subsection (d) reads, in determining the amount of the penalty, the district court shall consider the person's history of previous violations, the seriousness of the violation, if the health and safety of the public was threatened by the violation and the demonstrated good faith of the person.

FARABEE: Should that be facility in both instances? I think that would suffice if that would relieve anxiety. If they're trying to strike all of the other remedies, I think that severely changes the bill. It would create the

> problem that we referred to in terms of the time frame, but I think the word facilities, it's certainly not an attempt to get at individuals or individual board members. We're concerned about these facilities developing their own standards, working through them and living by them, and we think this is a first step in going in that direction, and that it's solid legislation in terms of the best interests of the patient.
>
> As you know, we have on the books the requirement that hospitals do provide emergency care and we feel that there have been too many reports of people being moved before they're appropriately stabilized, before they have the appropriate consent of the receiving hospitals.
>
> We have worked with the Texas Hospital Association very closely on this bill and made numerous changes in addition to this one at their request. If this is the one remaining anxiety and they're willing to leave the other sanctions such as fines and injunctive relief, then I think that that could be worked out. If they want to strike all of that then I would have to say the Task Force would have to oppose that. [Ibid.]

The next witness was Jose Camacho, representing the Texas Association of Community Health Centers. He spoke in favor of all the bills, and particularly commented on HB 1963.

> CAMACHO: I think Sen. Truan made a very good point about this being the last week of the session and any changes right now would be extremely difficult to concur with. Of course, you all are in the legislative process. I don't mean to, well I just mean to agree with Sen. Truan and his very good point.
>
> I agree with Section 9B(d) as it is written presently and would hope that that would remain in there. I think it's a very good stick like you said, Sen. Uribe, to get compliance on a hospital that has a very bad track record. I think we saw an example of it recently. When the Commissioner of Health was held personally liable for implementing an order at $1,000 a day fine and it was implemented immediately, where there had been foot

> dragging on that order prior to that. So I support that section just as it is presently written, but if Mrs. Farabee of course would not go against it, then we would support her also, but we'd like to see it remain just as is now. I think you had a very good point that you raised. [Ibid.]

The committee took a recess in order for certain amendments to be drawn up. After the recess, Sen. Brooks explained an amendment.

> BROOKS: It is my understanding that Committee Amendment Number 1 has been redrawn along the lines of the injunctive relief that we had all agreed on in Section 4, and Committee Amendment Number 2 has already been explained and is still in the same form in which I sent it up earlier, having to do with Section 3 about revocation of a license for non-compliance with the requirements against transfer under certain circumstances. It is further the Chair's understanding that a third amendment is being drawn having to do with changing the sanctions on facilities to make it consistent with the other sections of the bill that deals with the facilities. So as soon as that typed amendment is here, we'll act on all three of them. Sen. Barrientos, we do have the, the two amendments that we talked are now completed and ready, the third one has arrived. [Ibid.]

There was a discussion between Sen. Brooks and his aide, and Sen. Brooks decided that the third amendment was not applicable, so it was dropped. [Ibid.]

Several other witnesses were registered on the bills, but did not speak: Alfred Gilchrest of TMA; James Pearly (sp?), Task Force Staff; Juan Crory (sp?), Task Force on Cancer; Brian Sperry, resource person; Joe Ratcliff, representing a group in favor of HB 1943 and HB 1944; Jim Allison, in favor of HB 1843. [Ibid.]

The discussion on HB 1963 continued.

> BROOKS: Amendment Number 1 would not strike Section 4 as we'd originally talked about, but would pinpoint it for injunctive relief to give the licensing agency the ability to get in and may petition the District Court for a temporary restraining order to get injunctive

relief as the facts may warrant. And it says at the request of the Commissioner of Health, the Attorney General or the appropriate district attorney or county attorney shall initiate and conduct the suit, so the Commissioner of Health would be able to use any of those sources for seeking the injunctive relief, the Attorney General's Office, the county attorney or the district attorney.

[An inaudible comment was made.]

WASHINGTON: Mr. Chairman, this deletes Section 4 starting at the bottom of page 5?

BROOKS: Well, yes, sir, technically it substitutes.

WASHINGTON: Okay, right.

BROOKS: It doesn't strike it in its entirety. It simply substitutes. It puts the injunctive relief in as opposed to the $1,000 a day against an individual who may not even be remotely, you know a board member who might not even be remotely connected with the institution.

TRUAN: What is the alternative?

BROOKS: The alternative, you have the amendment in front of you. What is in the bill as it came over from the House was $1,000 a day penalty against an individual and that individual could be a hospital board --. It says governing body, so that it could be a hospital board member who would really have no direct contact with the actual incident, so --.

WASHINGTON: I apologize for being lost but I'm going back and forth between two committees. Is there a substitute laid out to the House Bill 1963?

BROOKS: No sir, no sir, it is House Bill 1963 that is in our bill book. The only thing being considered at the present time is the, on page 6, rewritten Section 4.

WASHINGTON: The reason I asked is because there is injunctive relief on line 8 of page 6.

BROOKS: Let's see, I think that refers to a different -.

WASHINGTON: Section 9B. That's the same section.

BROOKS: Oh, okay. You're right, we enlarged on that injunctive relief section.

WASHINGTON: Okay, so under the bill as written, agency could petition the district court for assessment of penalties plus injunctive relief or both.

BROOKS: Yes.

WASHINGTON: And under the amendment they could petition for injunctive relief but not penalties.

BROOKS: Right. Not individual.

WASHINGTON: I don't mean penalties.

BROOKS: Not individual fines.

WASHINGTON: Okay.

BROOKS: And then the one on Section 3 of course was one that I don't think there was any problem with. That was the one that has to do with the suspension or revocation of hospital license if they don't comply with this act. And I think that one --.

WASHINGTON: Is this a different amendment?

BROOKS: Yes, they're two different sections. Section 4 is the one that we had to rewrite. We have not done any rewriting on this Section 3 amendment.

TRUAN: Well, Senator, the people that are involved in promoting this legislation that you have been working with I'm sure have expressed great concern over this amendment to me, and I wonder if perhaps, if we might, if it's necessary, my apologies because like you, I've been also at some other hearings, if they feel that this

amendment is going to do harm to the bill, first of all I'm sure you wouldn't be offering the amendment if that were the case.

BROOKS: It is the only common sense, reasonable approach to the issue. You cannot put, you cannot levy a fine against an individual who's not remotely connected with the decision to transfer. If you get right down to it, I think if you really followed it to the final analysis, the physician that actually ordered the transfer would be responsible for the transfer even though the physician was ordering that transfer only in response to hospital policy.

TRUAN: My concern is whether we are diluting the impact by putting too much of the liability on the institution, on the hospital in this case, and the people that are acting in their official capacity ought to be held responsible. And my concern is that if it comes to the question of having to close a hospital in its entirety, it's going to be extremely hard to enforce the statute and that's why I'm concerned about your amendment.

URIBE: Mr. Chairman, my concern is over the situation where the hospital has in fact adopted a policy officially and yet the hospital, in effect, continues to violate its own policy.

BROOKS: Well, then you have two methods of response. You have not only the injunctive relief about the violation, through the commissioner, but you then also have the potential revocation of a license of that facility.

URIBE: It seems to me that the potential revocation is such an extreme remedy that it's one that is not likely to be utilized because it would create a great deal of upheaval in the hospital and subject a lot of innocent people, perhaps, in the hospital who would also be injured by a decision to revoke the license. With respect to the injunctive relief, I think that that assumes a prospective remedy for future acts but it doesn't, it's not, I think, a punitive enough measure to --.

BROOKS: It's the only one that makes any sense unless you want to levy against the facility itself and I don't think, well, I have some real reservations about trying to levy fines against facilities. I had that same problem with other legislation we've had in our committee. But I think the injunctive relief is a very appropriate way to enforce compliance. And then the revocation of the license is the ultimate, of course, it's the ultimate, would seldom if ever be used, but it is never the less the real strength of the law. That, if someone flaunts the law they could get revocation or suspension.

WASHINGTON: Did we have a $10,000 a day penalty on that Sunset Act and that --.

BROOKS: Yes, sir, but that had to do with endangering lives. Of course, an inappropriate transfer also has the potential of endangering lives, I understand.

TRUAN: The amendment that calls for both civil penalties and injunction relief, not the amendment, but the section that's in the bill that passed the House is obviously much stronger.

BROOKS: It's obviously also completely unenforceable or lacks common sense. If you just target a fine against an individual that has no part in the incident executing the act itself that caused an inappropriate transfer, like a hospital governing board member. Well, the governing board member can say we have a policy for transfers, so why should that governing board person have to pay a $1,000 a day fine that that board member really had not direct control --.

TRUAN: Well, I am more concerned about the --.

BROOKS: If you want to put on an amendment, that suits me fine. Let's go ahead and act on the ones that we don't -- [Ibid., Tape 1, Side B ends; Tape 2, Side A begins.]

The committee then voted out the other indigent health care bills, but left HB 1963 pending. [Ibid.]

There was further discussion of the Brooks amendment related to changing the wording from "individual" to "facility." Sen. Uribe and Sen. Parmer proposed an amendment, but Sen. Brooks objected to its affect on another part of the bill. There was confusion about the potential inconsistency in wording between several amendments.

> URIBE: It would change the word "person" to "facility" wherever the word person appears in Section 4, and that would be in lines 25 to 27 and this would --.
>
> TRUAN: Would you discuss it very slowly and I'll be right back? [Laughter.]
>
> URIBE: Okay. [Laughter.]
>
> BROOKS: A man under pressure. [Laughter.]
>
> URIBE: Mr. Chairman, we had some testimony this afternoon that when the, the, uh, Task Force that studied this particular problem developed it's report, that it had been their intention that it not be the persons that serve on the governing body but the facility itself be liable for civil penalties and it seems to me that while this is not as strong a position as I would advocate, that it might be a good middle ground for the, for the committee to, to adopt. We would impose a civil penalty on the governing body rather than the individual's. The persons that serve on the governing body may have no actual notice of any violation with respect to enforcement of, of the transfer policy.
>
> WASHINGTON: A question?
>
> CHAIR: [Inaudible.]
>
> WASHINGTON: Mr. Chairman, may I ask him a question about his amendment? You would amend Sen. Brooks's amendment only with respect to --.
>
> CHAIR: Texas.

URIBE: Actually, it's a complete substitute, but it would only amend, uh, section – subsection (d), where the word "person" appears we would substitute the word "facility," so that it would be the facility, the governing body of the facility as a bonded politic, as a group that would be liable for civil sanctions, as opposed to the individual members, the boards, the board members.

WASHINGTON: So this would mean that the injunctive relief would be granted as to --.

URIBE: The governing body.

WASHINGTON: And you remove the civil penalties.

URIBE: For the individual, but the civil penalties would still be applicable to the facility and the governing body, but not an – any individual member.

WASHINGTON: So it's your intent to meet the objection, legitimate objection, I think, raised by Sen. Brooks, with respect to $1000 per day civil penalty by having it imposed upon the facility rather than the individual.

URIBE: That's correct. That would be the ultimate affect.

WASHINGTON: Would you raise it to $10,000?

URIBE: Would I raise it to $10,000?

WASHIINGTON: I said did you?

URIBE: No, I did not, I did not. [Laughter.]

WASHINGTON: The reason I asked that is because I recall in the bill that Sen. Edwards had the other day --.

URIBE: That's right.

WASHINGTON: -- there was a position in Sunset that all those penalties be made uniform, I believe -- $25,000, wasn't it?

EDWARDS: It moved down. Originally, 25,000, recommendation of the Sunset Commission, but the water bill reduced that to 10,000 and the nursing home Department of Health bill at the present time is 10,000.

PARMER: Mr. Chairman?

URIBE: Sen. Parmer?

PARMER: I spoke with the House author, Mr. Oliver and he indicated to me and to Sen. Uribe that it was in fact their intent that the per day time be applied to the facility and not to the individual and that, that the word person, the, the change of the word "persons" to "facility" would more clearly reflect the intent of the House author.

BROOKS: Uh, let me ask you a question, though, Sen. Uribe or Sen. Parmer, one. That, then, taken in tandem with the other amendment having to do with the verification procedure would work, I think, would, you, you'd really have a strong, a stronger bill, probably. So then, is it your position that we could adopt it? It does not conflict in any way with the – the Number 2? We'd adopt yours, uh, as one, and, and, uh, mine as two? The licensing and certification?

URIBE: Well, when I sent it up, I, I really had not considered what the effect of your Committee Amendment Number 2 would have on it.

BROOKS: What's the different section?

URIBE: But it's, it's a completely different section, uh, and I'm not really certain as to what provisions you eliminate in the original draft with your Committee Amendment Number 2.

BROOKS: The, there, there's several kinds of inst --, institutions, and what you're trying to do, you're trying to get 'em in a different section for each institution. So you, you have, then you'd have in Section 3, you could have the – the revocation potential for noncompliance, and then in the, in the section that you propose to amend, uh, you would have both the injunctive relief and the civil penalty.

URIBE: Are you saying, Mr. Chairman, that, that if we adopt the Uribe/Parmer amendment that if we do not amend the language on, on page 5, Section 9A, that we are – you're duplicating the language --.

: No.

BROOKS: No, no.

URIBE: -- and duplicating the pages?

BROOKS: I'm just saying they're not in conflict if, if we adopt my amendment about certification.

URIBE: There would not be a conflict.

BROOKS: Actually, you have three, three things. And you have the revocation, you have the civil fine, against the civil --. And then you have the injunctive relief.

URIBE: The injunctive relief. That's correct.

BROOKS: Is that alright?

PARMER: Well, I don't want you to misunderstand, Mr. Chairman, I, I personally, I prefer the approach that Sen. Uribe and I have sent up, but as it appears to me in the Amendment Number 2, which I guess we're not on at this point, that amendment would specifically remove the ability to, uh, suspend or revoke a license for violations that relate to patient transfers. I think, to me, that's a separate issue. I, I wouldn't link the two together.

BROOKS: Well, the whole bill is about the patient transfer. That's the whole idea of the bill. Inappropriate transfer was the issue that we tried to deal with in the Task Force. I don't – frankly, I think that if you do it that way, I don't have any objection to your amendment. We'll just run with this and adopt your amendment. Adopt my amendment on the other one. Then we'll ask unanimous consent for it to be folded it into a substitute on the floor.

URIBE: If that's the will of the committee, but I'm not sure that --.

BROOKS: Let's have an up or down on these amendments.

PARMER: Mr. Chairman, I, I personally would think that each one of the two amendments, uh --.

BROOKS: Well, they'll be voted on separately.

URIBE: They're not inconsistent, but I --. They do apply to different sections, so perhaps it would be the better approach to go ahead and vote on, on the substitute amendment unless it's acceptable to the author of the Committee Amendment Number 1.

BROOKS: It's not acceptable to the author of the original amendment if you're going to still going to tinker with the other section. The oth--, because the two are --. The whole thing has to be looked at as, as inappropriate transfer, trying to address inappropriate transfer. If, if you'd kept two and one together, your substitute is certainly acceptable.

URIBE: Why don't we just go ahead and vote on my substitute amendment, then.

BROOKS: In that case, where would be --. Just withdraw Amendment Number 1, just make it, uh, make this Amendment Number 1. It doesn't make any difference 'cause actually we're gonna fold 'em into the

substitute. Senator, you need to take the chair just for the moment to --, for your, for your, your amendment.

URIBE: Do I have it --.

BROOKS: Uh, Sen. Uribe and Sen. Parmer send up Committee Amendment Number 1, which changes the term "person" to "facility" in, in both places appropriate in Section 4. Leaves in place both the civil against the facility and the injunctive relief, uh, which, uh, our new one was, uh, was anticipating to provide.

WASHINGTON: It's going to be denominated Committee Amendment Number 1, Mr. Chairman?

BROOKS: Yes, sir, it'll become Committee Amendment Number 1. Is there objection to its adoption? Chair hears none, Committee Amendment Number 1 is adopted.

Now, Sen. Uribe, if you'd take the chair, then I'll send up Committee Amendment Number 2.

URIBE: Okay. Chair lays out Committee Amendment Number 2 and recognizes its sponsor, Sen. Brooks.

BROOKS: This is, uh, I think, is, uh, in perfect harmony is with the, uh, changes we've made on the other, we're trying to address inappropriate transfer and, and the things was, all the inflammatory cases we've seen on 60 minutes and what we're experiencing, the cost increases for -- in uncompensated care, we're experiencing at all of our public supported hospitals, both state and local public supported hospitals. I think the two work – this amendment in tandem with the other works very well, and I move its adoption.

CHAIR: Is there objection to adoption of Committee Amendment Number 2 by Brooks?

: Okay.

CHAIR: There is objection. Uh, Sen. Brooks sends up Committee Amendment Number 2 and moves adoption. Call the roll.

CLERK: Barrientos?

BARRIENTOS: No.

CLERK: Brooks?

BROOKS: Aye.

CLERK: Edwards?

EDWARDS: No.

CLERK: Parmer?

PARMER: No.

CLERK: Sharp? Truan?

TRUAN: No.

CLERK: Uribe? Washington?

WASHINGTON: No.

CHAIR: There being one aye, six – one aye, six nays, Committee Amendment Number 2 fails to be adopted. [Ibid.]

The Uribe/Parmer amendment was adopted, but the Brooks amendment was not adopted. Sen. Brooks said that he would work further on the amendments and the bill was not reported out at that time. [Ibid.]

On May 22, Sen. Brooks announced that one amendment was adopted at the last meeting, and that persons who were interested in the bill had met and signed off on everything related to the indigent health package except one issue. [Senate Health & Human Resources Committee, 5/22/85, Tape 1, Side A, about one half into side.]

> BROOKS: The controverted issue that still has not been settled was the one about the addition of a new, of an additional cause of action in addition to the general negligence common law and malpractice law we have now under which a hospital could be sued for inappropriate transfer.
>
> I'm not attempting to deal with that issue. We're leaving it just like it was in the bill originally when the bill came to us. I'm still hoping that --, we're still working with the people hoping that we might find some middle ground that both sides could agree on, but we don't have that yet and I'm not gonna try to force one in.
>
> We're just going to go ahead with the permission of the committee, we're just going to go ahead and send the bill out with, in the substitute form with all of the agreed changes in there and still the controverted one, just leave it in there and we'll take it in the floor, hopefully it, maybe we can get a sign off. [Ibid.]

Ms. Farabee and Mr. Dean both said that the bill had been worked on, and that there were some improvements in the bill. The substitute version of the bill was then passed. [Ibid.]

A committee report was prepared which included the text of the bill, a bill analysis, and a fiscal note. [HB 1963, Senate Committee Report.]

On the Senate floor on May 24, Sen. Brooks explained HB 1963. [Senate Floor Debate, 5/24/85, 10:30 a.m., Tape 1, Side A, near end of side.]

> BROOKS: This bill is the one that -- also recommended by our Task Force on Indigent Health Care. We have likewise worked on it long and hard in both houses. We have in this bill incorporated the language that pertains to transfers from hospitals to hospitals or from, technically, from physician to physician at another hospital.
>
> It is one that we hope will address the issue that you've seen dramatized on 60 Minutes. And, and you've heard, I know, a great deal of discussion in the media and in,

certainly, in the urban areas, particularly the Dallas area about inappropriate transfers when patients are under present law supposed to be stabilized before they're transferred to another facility. We have some suspicion that perhaps in some cases, at least, those patients are really not stabilized before transfer and may indeed be endangered by an inappropriate transfer.

I must say that we have had very good cooperation from all parties trying to reach a good middle ground for the kinds of transfer restrictions, the kinds of language that would even provide, it provides some levels of penalties for inappropriate transfer or for causing harm to a patient.

The bill that will be on the floor that was reported from committee in substitute form has been agreed on in all aspects. We have the Hospital Association, other professional provider organizations represented, our Task Force on Indigent Health Care represented. We also, of course, had the staff of the Lieutenant Governor's office and of our committee and of my office working very closely together.

There will be one floor amendment which is also an agreed amendment. At the time we brought the bill out of committee, there was still one point in controversy and that was whether present law suit for civil damages under negligence, present common law negligence, was clearly enumerated or whether the bill in the form it came over from the House created another cause of action that would be negligence per se where you wouldn't even have to prove negligence. That has been now resolved.

We were not able to do it in committee, but we met with the Hospital Association counsel and with others after the bill was reported from committee. I now have a floor amendment that makes it very clear that the cause of action will be the regular negligence, the present negligence statutes that we also hear referred to from time to time as malpractice, where the malpractice suits would come from in the case a patient was harmed, injured or caused to die or suffer additional harm by being inappropriately transferred.

TRUAN: Senator? Will the Senator yield for a question?

BROOKS: Yes, sir, I yield.

TRUAN: What you have referenced to, Senator, is what we have been working in, in our committee, our Health and Human Resources Committee.

BROOKS: Yes, sir.

TRUAN: And that concern that had been expressed by the advocates of this legislation and you're, you're telling this body as, as we had discussed, as – [Tape 2, Side A ended; Side B began.] -- that this amendment is the one that has been agreed to by all parties concerned, those advocating this legislation, as well as people that have signed off representing the Hospital Association and so forth?

BROOKS: Yes, sir. We have, basically, in 9C of the bill we will have a floor amendment that will leave intact the present language having to do with appropriate injunctive relief. And we also add the additional language that says that such person, a person who has been harmed also may pursue remedies for civil damages existing under current common law. And we make it very plain that of course that refers directly to the negligence statutes, the common law statutes, the common law cause of action on negligence or what is frequently -- becomes a malpractice act.

TRUAN: Thank you, Senator.

BROOKS: And we have a sign off by all parties and I feel that it is a very, a very good solution to the controversy. I think now we will be able to have everybody pulling together in the same direction. I think this is a very good, a very good bill now in its completed form. [Ibid.]

On the amendment, specifically, Sen. Brooks explained further.

> BROOKS: Mr. President, members, this is the amendment I talked about. It is the agreed amendment. We have everyone signed off on it. It simply makes it clear that there can either be the injunctive relief remedy or remedy for civil damages under the common law. [Ibid., end of side.]

The amendment was adopted and the bill was passed on second and third readings with no further discussion. [Ibid. *Senate Journal*, 5/24/85, pp. 1471-1472.]

The *Senate Journal* contained the text of the floor amendment:

> Sec. 9C. A person harmed by the failure of a hospital to timely adopt, implement, or enforce a patient transfer policy in accordance with Sections 5(b) and (d) of this Act, may petition the district court of the county in which the person resides, or if the person is not a resident of the state, a district court of Travis County, for appropriate injunctive relief. Such person also may pursue remedies for civil damages exiting under current common law. [*House Journal*, 5/24/85, p. 1471.]

A "Legislative Intent Statement" was included in the journal:

> The Floor Amendment No. 1 to **C.S.H.B. 1963** that has been adopted for Section 9C is an agreement of all of the parties involved with the issue, namely the Texas Hospital Association and the Task Force on Indigetn Care. The section will allow a person harmed by the failure of a hospital to adopt or enforce an effective patient transfer policy, to have these remedies available: (1) appropriate injunctive relief, and (2) the pursuit of existing remedies for civil damages under current common law.
>
> It is most important for the Senate to understand that it is not intended by any of those who have been involved in the resolution of this issue that any new cause of action based upon an allegation of negligence per se is intended by this section to be available for use against a hospital. That is to say that the remedy [sic] available for civil

> damages are those civil remedies that currently exist under common law and that neither this section nor this statute intends to impose any new standard of care, or become the basis for a negligence per se cause of action. Those remedies that currently exist are those remedies that will be available to an aggrieved or injured person. [Ibid., p. 1472.]

House Bill 1963 was sent back to the House, which considered the Senate amendments. [House Floor Debate, 5/26/85, Tape 124, Side A, about three fourths into side.]

> OLIVER: I move that we concur in Senate amendments to House Bill 1963. This was a transfer bill. [Ibid.]

Rep. Toomey asked him to explain what changes were made by the Senate to this bill.

> OLIVER: One provision in the bill provided for civil penalties against the hospital board for violating its by-laws with regard to hospitals' transfers. That provision was changed to permit the penalties to be assessed against the institution itself, rather than its board.
>
> Additionally, the, uh, there was a change made which would, uh, be – the bill as it was originally sent over to the Senate set up a statutory recovery for civil damages. That was changed to accord common law recovery, to make sure that it was common law rather than a statutory recovery in the bill.
>
> TOOMEY: Are those all the major changes made by the Senate that you recall?
>
> OLIVER: Those were the only changes that were made in that bill, to my knowledge. [Ibid.]

The House concurred in the Senate amendments. [Ibid. *House Journal*, 5/26/85, pp. 3539-3542.]

For HB 1963 as enacted, see the general law. [*General Laws of Texas*, 71st Legislature, Regular Session, ch. 597.]