Summary of Texas HB 4.

Thanks largely to the vigorous advocacy efforts of the Texas Medical Association, just prior to the end of the Texas legislative session, the Texas legislature passed HB 4. HB 4 contains sweeping tort reforms, many of which exclusively address malpractice litigation against physicians. Of these reforms, perhaps the most important is the hard cap of $250,000 on noneconomic damages per claimant in any judgment against a physician or health care provider, regardless of any applicable theories of vicarious liability, the number of defendants involved, or the number of causes of action asserted as part of the claimant's case against the physician. What follows is a detailed summary of the significant reforms established by HB 4. Governor Perry signed off on the bill on June 11, 2003.

I. Caps on Noneconomic Damages.

A. The preferred system for capping noneconomic damages.

$250,000 cap for physicians and health care providers. If a judgment is rendered against a physician or health care provider, noneconomic damages are limited to a maximum of $250,000 per claimant, regardless of the number of defendants involved, the applicable theories of vicarious liability, or the number of causes of action asserted as part of the claim/lawsuit.

Expansive definition of “physician.” The term “physician” obviously includes those persons who are licensed to practice medicine in Texas. It is important to note, however, that the term also specifically includes the following business entities:

- a professional association organized under the Texas Professional Association Act;
- a partnership or limited liability partnership created by a group of physicians;
- a company created by physicians under the Texas Limited Liability Company Act; and
- a nonprofit health corporation certified by the Texas State Board of Medical Examiners. (This is a special non-profit entity whose board must be composed entirely of physicians but which may also have a lay member).

Because the term “physician” includes these corporate entities, these entities also benefit from the protections of the $250,000 hard cap available to individual physicians.

$250,000 cap on noneconomic damages in judgment against single health care institution. If a judgment in a health care liability claim lawsuit is rendered against a single health care institution, that single institution's noneconomic damages are limited to a maximum of $250,000 per claimant, regardless of the number of defendants or the causes of action that may comprise the health care liability claim.

Definition of “health care institution.” HB 4 defines a “Health Care Institution” to include an ambulatory surgical center, an assisted living
facility, an EMS provider, a home health agency, a hospice, a hospital, a hospital system, intermediate care facility for the mentally retarded, a nursing home, and an end stage renal disease facility.

$500,000 cap on noneconomic damages if judgment is rendered against two or more health care institutions. If a judgment is rendered against more than one health care institution, the total amount of noneconomic damages for each individual institution, shall not exceed $250,000 per claimant, irrespective of the number of defendants, causes of action, or vicarious liability theories involved. The total amount of noneconomic damages for health care institutions cannot exceed $500,000. Combining the liability limits for physicians, health care providers, and institutions, the maximum noneconomic damages that a claimant could recover in a health care liability claim is capped at $750,000.

B. Alternative System for Capping Noneconomic Damages. The drafters of HB 4 anticipated a constitutional challenge to the aforementioned caps on noneconomic damages. This is because, in 1988, the Texas Supreme Court in Lucas v. U.S., 757 S.W.2d 687, 691 (Tex. 1988) held that liability limits could only be constitutionally applied to wrongful death and survival actions. Because of this risk of constitutional invalidation, HB 4 establishes an alternate mechanism for limiting noneconomic damages, should the caps as structured under the prior, preferred scheme be declared unconstitutional, ala Lucas. (In another strategy to address the judicial challenge to the constitutionality of the new cap system, the Texas Legislature also passed HJR 3, a resolution calling for a constitutional amendment allowing the noneconomic damage caps. HJR 3 cannot amend the Texas Constitution unless the Texas public approves the resolution. HJR 3 is set for a public vote on September 13).

Different between the preferred scheme and the alternative scheme. The difference between the two damage-limit schemes is that the alternative system requires that the physician can demonstrate that he/she has the financial wherewithal, e.g., through malpractice insurance coverage, to ensure that the claimant will be compensated if the claimant obtains a judgment against the physician. Under the alternative scheme, the caps on noneconomic damages apply only if the physician, health care provider, or institution can provide evidence of this financial wherewithal, or evidence of “financial responsibility.” The amount of financial responsibility that the physician must demonstrate increases as time progresses.

Application of the Noneconomic Damages Cap Prior to September 1, 2005.

$250,000 cap for residents. Liability for noneconomic damages is still capped at $250,000 per claimant, regardless of the number of defendants or causes of action alleged as part of the claim, but only if the resident can show financial responsibility of at least $100,000 per occurrence and $300,000 for an annual aggregate.

$250,000 cap for physicians and health care providers. Noneconomic damages are still capped at $250,000 per claimant, but only if the physician/health care provider can furnish evidence of financial responsibility of at least $200,000 for each health care liability claim and at least $600,000 in aggregate in a health care policy year.
$250,000 cap for health care institutions. Noneconomic damages are still capped at $250,000 per claimant but only so long as the institution can provide evidence of financial responsibility of at least $500,000/$1,500,000.

Application of the Noneconomic Damages Cap from September 1, 2005, to September 1, 2007.

Residents. Residents still benefit from the $250,000 cap by providing evidence of financial responsibility for $100,000/$300,000.

Physicians/health care providers. The $250,000 cap on noneconomic damages still applies, but only if physician/health care provider can show financial responsibility of at least $300,000/$900,000.

Health Care Institutions. The $250,000 cap on noneconomic damages applies only if the health care institution can demonstrate financial responsibility of at least $750,000/$2,250,000.

Application of $250,000 Noneconomic Damages Cap from September 1, 2007.

Residents. Residents still benefit from the $250,000 cap by providing evidence of financial responsibility for $100,000/$300,000.

Physicians/health care providers. The $250,000 cap on noneconomic damages applies only if physician/health care provider can show financial responsibility of at least $500,000/$1,000,000.

Health Care Institutions. The $250,000 noneconomic damages cap applies only if the health care institution can demonstrate financial responsibility of at least $1,000,000/$3,000,000.

Evidence of Financial Responsibility. Evidence of financial responsibility can be provided by:

Purchase of malpractice coverage from an authorized malpractice insurance carrier;

Purchase of liability coverage from a trust;

Purchase of coverage through/or by a risk retention group or purchasing group authorized either under Texas law or federal liability risk law, or any other arrangement for transferring or distributing risk relating to legal liability for damages, including cost of defense, legal costs, fees, and other claims expenses; or

Maintenance of financial reserves per an irrevocable letter of credit from a federally insured financial institution that has an office in Texas.
II. Damages caps in wrongful death cases.

Cap of $500,000 total damages, adjusted in accordance with the consumer price index. HB 4 retains prior limitations on total damages in wrongful death cases. More specifically, if, in a wrongful death or survival action, a health care liability claim results in a judgment against a physician or health care provider, the physician’s or health care provider’s total liability, which includes all compensatory, non-economic and exemplary (punitive) damages, is capped at $500,000 for each claimant, regardless of the number of defendants involved or the number of individual causes of action asserted as part of the claim. There are, however, two qualifications regarding this cap:

The cap does not limit future medical, hospital, or custodial care that the wrongful death claimants may recover; and

The $500,000 has been indexed for inflation since it was first implemented in 1977. Due to this indexing, the $500,000 limit on these wrongful death damages has increased to approximately $1.4 million by 2002.

III. Alteration of “Stowers” doctrine.

Limitation of insurer liability under Stowers. The origin of the Stowers doctrine is Stowers v. American Indemnity Insurance, 15 S.W.2d 544 (Tex. 1929). According to Stowers, if a liability insurer rejects a plaintiff’s reasonable settlement offer within the insured defendant’s policy limits, the insurer is liable for any trial award that exceeds those policy limits. HB 4 amends the Stowers doctrine, limiting an insurer’s liability under that doctrine not to exceed the liability of its insured.

IV. Mandatory Jury Instructions. In any health care liability claim tried before a jury, the jury must be instructed that it is not to consider any damage limitations that might be applicable in the case. The instructions must also inform the jury that it cannot make a negligence determination solely based on a bad outcome suffered by a plaintiff.

V. Expert Report Reform. The following expert report reform provisions apply only to health care liability claims filed against a physician or health care provider.

Service within 120 days or dismissal. Not later than 120 days after filing a health care liability claim, the claimant must serve an expert report, including the expert’s C.V., on each party to the lawsuit. If plaintiff fails to serve the expert report within the 120 days, the court must, on motion by the defendant physician, award the physician his/her attorneys’ fees incurred in defending the case and dismiss the claim with prejudice.

Privilege for expert report. Unless a claimant uses the expert report for purposes other than to meet the 120 day service requirement, no party to the health care liability claim can: (a) introduce the report into evidence; (b) use the report in any deposition or proceeding in the lawsuit, or (c) refer to the report during the course of the lawsuit.

Definition of “expert report.” An expert report is a written document that summarizes the expert opinion regarding the applicable standard of care, how the
physician failed to meet that standard, and the casual relationship between that failure and the harm suffered by the claimant.

VI. Expert Witness Requirements in Health Care Liability Claims against Physicians. HB 4 has expert witness requirements that specifically apply only when the health care liability claim has been asserted against a physician. Under the new requirements of HB 4, an expert witness must be a physician who:

Is either practicing medicine at the time he/she renders his/her testimony, or was practicing medicine at the time in which the claim arose;

“practicing medicine” includes training residents or students at an accredited school or medicine or osteopathy, or serving as a consulting physician to other physicians who provide direct patient care.

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

Is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care. In determining whether a witness is qualified on the basis of training or experience, the court must consider, unless it can show good cause otherwise, whether, the expert witness:

is board certified or has other substantial training in an area of medical practice relevant to the health care liability claim; and

is actively practicing medicine.

Definition of “physician” for purposes of serving as an expert witness. In a health care liability claim lawsuit against a physician, an expert witness in the case must be a “physician.” Under the expert witness requirements of HB 4, a “physician” is defined as either:

a person who is licensed to practice medicine in the U.S.; or

a graduate of a medical school accredited by the LCME or the AOA, but only if (a) that person is testifying as a defendant; and (b) that person’s/defendant's testimony relates to the physician's/defendant’s standard of care.

VII. Periodic Payment for Future Losses/Payment Based on Accrual.

Threshold for mandatory periodic payments. If the present value of an award for future damages equals or exceeds $100,000, then a health care provider or a physician may request that a court order periodic payment of those damages. The term “future damages” that are included in calculating the $100,000 threshold include the cost of medical, health care, or custodial services, and noneconomic damages such as awards for paid and suffering and loss of consortium. “Future damages” also includes loss of earnings.
Mandatory payments upon request of physician or health care provider. Upon a request from a physician or health care provider, the court must order that medical, health care, or custodial services be paid out in periodic payments. The court’s ordering periodic payments of damages other than those of medical, health, and custodial services is optional.

Future medical expenses are paid only when those expenses accrue.

VIII. Award of Exemplary Damages. Prior law with respect to the award of exemplary damages stated that a claimant could not obtain exemplary damages unless the claimant proved entitlement to such damages by “clear and convincing” evidence. HB 4 adds the requirement that a claimant cannot be awarded exemplary damages unless the jury is unanimous with regard not only to liability for those damages, but also for the amount thereof.

IX. Proportionate Liability Reform. Defendants that are a party to a suit are held responsible only for the portion of fault attributable to them.

X. Settlement Offers. In addition to implementing specific medical liability reforms, HB 4 also amends the Texas Civil Practice and Remedies Code (“the Code”) by adding a Chapter 42 concerning settlements. Chapter 42 creates procedures which litigants may elect to govern their settlement negotiations. These new settlement procedures are described in detail below.

Content of settlement offer. According to HB 4, A Chapter 42 settlement offer must be written; state that it is being made under Chapter 42 of the Code; state the terms of settlement; state the deadline within the offer must be accepted; and be served on all parties to whom the offer is made.

Process must be initiated by defendant. A defendant may only initiate the new Chapter 42 settlement process. Once a defendant makes an offer under Chapter 42, the claimant may then make counter offers utilizing the Chapter 42 process.

Awarding litigation costs under the Chapter 42 settlement scheme. The Chapter 42 settlement scheme contains fee shifting provisions intended to encourage settlements of disputes. Specifically, if a party makes a settlement offer under Chapter 42 that is rejected by the other party, that rejecting party must bear the offering party’s litigation costs if the rejecting party receives a judgment at trial that is “significantly less favorable” than the terms of the settlement offer.

Meaning of “significantly less favorable.” Under HB 4, a judgment is significantly less favorable than a rejected settlement offer if:

the claimant rejected the defendant’s settlement offer and the claimant’s award at trial is less than 80% of the value of the rejected offer; or

the defendant rejected the claimant’s settlement offer and the award at trial is more than 120% of the offer the rejected settlement offer.
Meaning of “litigation costs.” Litigation costs are the money that is spent or monetary obligations incurred that are directly related to the case in which a settlement offer is made. The term “litigation costs” thus includes court costs, e.g., filing fees, etc., reasonable fees for not more than two expert witnesses, and reasonable attorney’s fees.

Limitation on recovery of litigation costs. Not all of the “litigation costs” incurred by a litigant are recoverable. Time and formula limit the amount of recovery.

Time limit. The offering party can recovery only those litigation costs that were incurred after the rejection of the offering party’s settlement offer.

Limit by formula. There is also a formula that limits the amount of litigation fees that the offeror of a rejected settlement offer can receive. The litigation costs that the offeror can recovery cannot exceed the sum of 50% of the noneconomic damages, 100% of the noneconomic damages, and 100% of the exemplary (i.e., punitive”) damages that were awarded to the claimant, MINUS any amount for applicable statutory or contractual liens.

Promulgation of implementing rules. The Texas Supreme Court must promulgate rules implementing this portion of HB 4. These rules must be in effect on January 1, 2004.

XI. Statute of Limitations. HB 4 made the following sweeping changes to the statute of limitations that are applicable to health care liability claims.

Statute of limitations for patients age 12 years and over. For any health care liability claim involving injuries to a patient aged 12 and over, the claim must be brought within two years of either the occurrence of the alleged negligence or within two years from the date on which the medical care that is the subject of the health care liability claim was completed. Failure to bring the health care liability claim within this limitations period will forever time - bar the filing of the claim, unless the claimant can successfully argue that the two-year limitations period can be tolled by the discovery rule, intentional concealment, etc.

Statute of limitations for patients younger than 12 years of age. If the health care liability claim involves a patient who is under the age of 12 years at the time of the injury, the patient, or those who would file a health care liability on behalf of the patient, have until the patient reaches the age of 14 to file the health care liability claim.

HB 4’s statute of limitation’s provisions relating to minors is a huge change from prior case law. According to previous Texas case law, if a patient suffered an injury due to the alleged negligence of a physician while that patient was a minor, the statute of limitations for filing a health care liability claim against the physician did not expire until the patient reached the age of 20, i.e., two years beyond the age of 18—the age of majority in Texas. For example, if a patient suffered an injury at the age of 13, the statute of limitations for that patient’s filing a claim would not expire until the patient reached the age of 20. Similarly, if the
patient were injured at birth, the statute would still not expire on the patient’s claim until the patient turned 20. Now under HB 4, the claim involving the injured thirteen-year-old would have to be brought within two years, and the claim for the child injured at birth would have to be filed no later than the child’s fourteenth birthday.

**Statute of repose.** HB 4 anticipates that there may be circumstances in which the court may toll the state of limitations, e.g., under theories such as the discovery rule or fraudulent concealment. HB 4 therefore provides a statute of repose that requires a claimant to bring a health care liability claim within ten years of the act or omission that gave rise to the claim, or the claim will forever be time-barred regardless of tolling.

### XII. Amendments to the Good Samaritan Statute.

**Liability protections for emergency care no longer excluded from emergency room setting.** HB 4 states that a person who in good faith provides emergency care is not liable for civil damages unless the act is “willfully or wantonly negligent.”

**Expansion of the Good Samaritan law’s immunity by repealing exceptions based on regular administration of emergency care and attending/admitting physician Status.** Paring down the exceptions to the Good Samaritan’s liability protections to acts that are “willfully or wantonly negligent” is a very significant change from prior law. Prior Good Samaritan law did not provide immunity if the emergency care was provided in a hospital, health care facility, or in medical transportation by a person who either: (a) regularly administered emergency room care, unless the person was at the scene of the emergency for wholly unrelated reasons; or (b) the emergency care was provided by an attending or admitting physician of the patient, or a treating physician associated with the admitting or attending physician. HB 4 greatly expands the scope of the Good Samaritan law’s immunity protections by eliminating the exclusions (a) and (b) above.

**Expansion of the Good Samaritan law’s immunity protections by clarifying meaning of “for or in expectation of remuneration.”**

**Prior law.** Prior law stated that the Good Samaritan’s civil immunities did not apply if the emergency care was provided “for or in the expectation of remuneration.” Changes made by HB 4 clarify that being legally entitled to receive remuneration for the emergency care rendered does not determine whether or not the care was in fact provided “for or in expectation of remuneration.” This clarification was added in order to legislatively overrule the holding of a Texas circuit court case *Ramirez v. McIntyre*, 59 S.W.3d 821 (Tex. App.—Austin 2001, pet. granted).

**Facts of Ramirez.** In this unfortunate case, the defendant, Dr. McIntyre, an OB/GYN, was present on a delivery ward when a patient, Ms. Ramirez, began to experience trouble as the head of her baby crowned during delivery. Ms. Ramirez’s own OB/GYN was not in Ms. Ramirez’s room when the trouble began so an emergency page was announced throughout the floor. Dr. McIntyre responded, even though Ms. Ramirez was not his patient, and he was not on call that day. During the course of
providing emergency treatment, the baby sustained injuries. Mr. and Mrs. Ramirez sued Dr. McIntyre. Dr. McIntyre argued that he was entitled to dismissal from the suit as a matter of law under the Good Samaritan statute’s immunities, because he never would have billed the patient because it would have been unethical for him to have done so. The appeals court ruled, however, that Dr. McIntyre was not entitled to dismissal from the case, because his statements could not establish that he was not otherwise entitled to remuneration for his services. HB 4 clarifies that being entitled to remuneration for emergency care does not by itself mean that the care was provided “for or in expectation of remuneration.” Since the passage of HB 4, the Texas Supreme Court also reversed the holding of the lower circuit court’s decision in Ramirez, thereby unifying case law with the new provisions of HB 4.

Burden of proof in Good Samaritan cases involving care provided in an emergency room. In a health care liability claim relating to emergency care provided in a hospital emergency or obstetrical department, or in a surgical suite immediately following the evaluation or treatment of a patient in the emergency department, in order to prevail on a health care liability claim, the claimant now must prove that the physician, with willful and wanton negligence, deviated from the degree of care reasonable expected of an ordinarily prudent physician in similar circumstances.

Mandated jury instructions in Good Samaritan cases involving care provided in an emergency room. In a health care liability claim involving the provision of emergency medical care provided in a hospital emergency or obstetrical department, or in a surgical suite immediately following the evaluation or treatment of a patient in the emergency department, the judge in the case must provide the jury with specific instructions, including: (a) whether the person providing the care had access to the patient’s medical history; and (b) the presence/lack of any pre-existing physician-patient relationship between the physician and the patient.