***Patchett v. Lee:* the end of the fight over the admissibility of medical write-offs?**

By: Blake N. Shelby

Personal injury cases present unique evidentiary challenges relating to the reasonable value of medical expenses incurred by the plaintiff. Indiana Evidence Rule 413 provides one method of proving the reasonable value of medical expenses. *Stanley v. Walker*, 906 N.E.2d 852, 856 (Ind. 2009). It reads: "[s]tatements of charges for medical, hospital or other health care expenses for diagnosis or treatment occasioned by an injury are admissible into evidence." *Id.* (citing Evid. R. 413). "Such statements shall constitute prima facie evidence that the charges are reasonable." *Id.* By its terms, Rule 413 allows actual past medical charges to serve as prima facie evidence that the charges are reasonable.

Oftentimes, medical billing is not a straightforward transaction involving only the medical provider and the patient. It involves various third-party entities including private health insurers, worker's compensation carriers, and government entities such as Medicare and Medicaid. These entities almost universally have contractual arrangements with medical providers in which they pay the providers a fraction of the amount billed by the provider. This creates situations where the reasonable value of the medical services is unclear. Is the amount billed by the medical provider the reasonable value of the services performed? Or is the amount actually accepted by the provider in full satisfaction of the services better evidence of the reasonable value of the services? Personal injury attorneys have fought over this issue for decades.

A. Initial application of the collateral source statute to medical bills paid by private health insurance companies.

Ever since the enactment of the collateral source statute, defense attorneys have grappled with the ability to admit evidence of the amounts paid by third-party providers in full satisfaction of the medical services. The collateral source statute provides:

> *In a personal injury or wrongful death action, the court shall allow the admission into evidence of:*
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> *(1) proof of collateral source payments other than:*
> *(A) payments of life insurance or other death benefits;*
> *(B) insurance benefits that the plaintiff or members of the plaintiff's family have paid for directly; or*
> *(C) payments made by:*
> *(i) the state or the United States; or*
> *(ii) any agency, instrumentality, or subdivision of the state or the United States;*
> *that have been made before trial to a plaintiff as compensation for the loss or injury for which the action is brought;*
> *(2) proof of the amount of money that the plaintiff is required to repay, including worker's compensation benefits, as a result of the collateral benefits received; and*
> *(3) proof of the cost to the plaintiff or to members of the plaintiff's family of collateral benefits received by the plaintiff or the plaintiff's family.*

Ind. Code Ann. § 34-44-1-2 (1998). Plaintiff's attorneys have repeatedly asserted that this statute prevents the admission of the lower amounts paid by private health insurance providers and government programs.

B. Reasonable value of medical services involving private health insurance write-offs.

This issue was addressed by the Indiana Supreme Court in 2009 in *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009). Stanley involved a run-of-the-mill automobile accident case. *Stanley*, 906 N.E.2d at 853. The plaintiff, Danny Walker, sustained injuries and received medical treatment from several medical providers. *Id.* He brought suit against the defendant, Brandon

Stanley, asserting that Stanley was negligent in causing the collision. *Id.* Stanley admitted liability and the case proceeded to a damages trial. *Id.* at 854.

During trial, Walker introduced redacted medical bills totaling $11,570 showing the amounts that the medical providers originally billed him. *Id.* Stanley then moved at the close of Walker's testimony to admit Walker's discounted medical bills totaling $6,820 into evidence. *Id.* Walker objected to the admission of the medical bills arguing that they violated Indiana's collateral source statute. *Id.* The Court sustained the objection finding that the discounts constituted "insurance benefits" paid for by the plaintiff. *Id.*

The jury returned a verdict in favor of Walker. *Id.* Stanley appealed asserting that the trial court erred when it refused introduction of Walker's discounted medical bills into evidence. *Id.* The court of appeals affirmed the trial court's ruling and the Indiana Supreme Court then granted transfer. *Id.*

The Supreme Court reversed the trial court and held that amounts paid by private health insurance providers in full satisfaction of medical services are admissible to determine the reasonable value the medical services that were performed. *Id.* at 859. The Court noted that an injured plaintiff is entitled to recover damages for medical expenses that were both necessary and reasonable. *Id.* at 855 (citing *Cook v. Whitsell-Sherman*, 796 N.E.2d 271, 277 (Ind. 2003)). It found that this measure of damages cannot be read as permitting only full recovery of medical expenses billed to the plaintiff nor can it be the amounts actually paid. *Id.* at 856. The Court reasoned that the focus is on the reasonable value, not the actual charge. *Id.* at 856-57. It found complexities of health care pricing structures make it difficult to determine whether the amount paid, the amount billed, or an amount between the two represents the reasonable value of medical services. *Id.* at 857. It states that "insurers generally pay about forty cents per dollar of

billed charges" and that "the relationship between the charges and costs is tenuous at best." *Id.* The Court then concluded that it was best to permit the jury to receive evidence of the amounts billed and the amounts paid so that it can determine the reasonable value of those expenses. *Id.* at 858.

The Court also found that the collateral source statute does not bar evidence of discounted amounts in order to determine the reasonable value of medical services. *Id.* at 858. It noted that the purpose of the collateral source statute is to determine the actual amount of the prevailing party's pecuniary loss and to preclude that party from recovering more than once from all applicable sources for each item of loss sustained in a personal injury or wrongful death action. *Id.* at 855. The Court determined that this purpose was not violated so long as the adjustments or accepted charges for medical services are introduced without referencing insurance. *Id.*

C. Reasonable value of medical services involving government health benefit write-offs.

Following *Stanley*, plaintiffs began arguing that *Stanley* was limited to the admission of the amounts paid by private health insurance companies. They asserted that *Stanley* did not apply to payments made by government programs such as Medicare and Medicaid, which are expressly precluded by the collateral source statute. They also asserted that the policy behind *Stanley* was inapplicable because, unlike private health insurance, payments accepted from government programs were not bargained for in arms-length transactions.

1. ***Patchett v. Lee*** - Indiana Court of Appeals

The Indiana Court of Appeals addressed the issue in November 2015 in *Patchett v. Lee*, 46 N.E.3d 476 (Ind. Ct. App. 2015). *Patchett*, like *Stanley*, arose from an automobile accident. On July 5, 2012, Ashley N. Lee was operating her motor vehicle in Noblesville, Indiana, when

she was involved in a collision with Mary K. Patchett. *Patchett*, 46 N.E.2d at 478. Lee sustained injuries and brought suit against Patchett for personal injuries. *Id.* Lee was billed a total of $87,706.36 for the treatment of her injuries. *Id.* At the time of the accident, Lee was a member of Healthy Indiana Plan ("HIP"), which was "a program sponsored by the state of Indiana that provided a more affordable healthcare choice of otherwise uninsured individuals throughout Indiana." *Id.* HIP paid Lee's medical providers a total of $12,051.48 for Lee's medical care. *Id.*

Patchett admitted liability, and the case proceeded to trial on damages. *Id.* Lee filed a motion *in limine* regarding the HIP payments, seeking to prevent Patchett from "eliciting testimony concerning or introducing evidence regarding those payments." *Id.* Patchett objected to the motion. *Id.* The court ultimately issued an order finding that the collateral source rule prohibited defendants from introducing evidence of compensation received by plaintiffs from government sources. *Id.* Lee subsequently moved for an interlocutory appeal, which was granted by the trial court and accepted by the Indiana Court of Appeals. *Id.*

The Indiana Court of Appeals upheld the trial court's ruling and found that the HIP payments were made by the state of Indiana and are precluded by the collateral source statute. *Id.* at 489. It noted, just as the trial court, that the plain language of the collateral source statute precluded payments made by the government. *Id.* at 485. It also found that *Stanley* was inapplicable because it involved private health insurance providers that negotiated discounts with medical providers in arms-length transactions. *Id.* at 485-86. It found that government benefits, such as HIP, were different because they involve steeper discounts that were thrust upon the medical providers. *Id.* The court reasoned that the discounts were premised on political decisions as opposed to arms-length transactions. *Id.* at 486-87.

2. ***Patchett v. Lee* – Indiana Supreme Court.**

The Indiana Supreme Court accepted transfer of *Patchett*. On October 21, 2016, the Supreme Court reversed the decisions by the lower courts. *Patchett*, 60 N.E.3d 1025 (Ind. 2016). In doing so, the Court reaffirmed its holding and *Stanley*. *Id.* at 1029. It then expressly held that the principles set forth in *Stanley*, which permit the admission of both the amounts billed and those accepted by medical providers, apply with equal force to government benefits such as Medicare and Medicaid. *Id.* at 1030. The Court reasoned that this rationale allows the fact-finder to hear evidence of the reduced amounts a provider accepts as payment in full, even when the payer is a government health care program. *Id.* The Court indicated that that it is not important how the rates were negotiated and the court of appeals was incorrect to base its decision on the same. *Id.* What matters is that the participating provider agreed to accept the lower payments in full. *Id.* The Court noted that providers are not indentured to HIP (or other government programs) and are free to leave the programs at any time. *Id.* at 1031. Thus, it concluded that the reductions are relevant, probative evidence of the reasonable value of medical services provided. *Id.*

The Court further stated that its decision further solidified Indiana's desire to "chart a middle course by admitting billed charges and accepted amounts." *Id.* at 1032. It indicated that six states have precluded the admission of accepted amounts altogether since *Stanley* was decided. *Id.* Two other states held that only accepted amounts are admissible. *Id.* The Court opined that it disagrees with both approaches. *Id.* It reasoned that admitting the billed and accepted amounts is the better course since it allows the jury to determine the reasonable amount

of the medical services at issue. *Id.* The Court found this to be the fairest approach because it honors the Court's "deep, abiding faith in the jury system." *Id.*

D. The future of determining the reasonable value of medical services in personal injury cases.

Patchett should be the final chapter in the long saga relating to the admission of medical adjustments in personal injury cases. The Court reinforced its position that Indiana applies the "middle ground" approach in determining the reasonableness of medical services. It has affirmed this approach with respect to medical bills that are paid by private health insurance companies and government entities. The Court has now covered both ends of the spectrum (private and government payments). Therefore, amounts paid in full satisfaction of medical expenses by any other third-parties, such as worker's compensation insurance carriers and the like, should also be admissible at trial.

Mr. Blake is managing associate in the Indianapolis office of Frost Brown Todd. The author recognizes the excellent work of the authors of DTCI's amicus brief in Patchett, *Jon Pinnick, Angela Della Rocco, Michael Mullen, and Donald Kite, Sr. The opinions expressed in this article are those of the author.*