IN THE
SUPREME COURT OF INDIANA
Case No. _____

IN THE
INDIANA COURT OF APPEALS
Case No. 29A04-1501-CT-1

MARY K. PATCHETT,

Defendant-Appellant-Petitioner,

v.

ASHLEY N. LEE,

Plaintiff-Appellee-Respondent.

On Appeal from the Hamilton Superior Court
Cause No. 29D01-1305-CT-4116
The Honorable Steven R. Nation, Judge

BRIEF OF AMICUS CURIAE AMERICAN TORT REFORM ASSOCIATION

Bradley J. Buchheit
Attorney No. 27524-02
Tucker Hester Baker & Krebs, LLC
One Indiana Square, Suite 1600
Indianapolis, Indiana 46204
(317) 833-3030
bbuchheit@thbklaw.com

Counsel for Amicus Curiae American Tort Reform Association

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

OTHER

BRIEF STATEMENT OF THE INTEREST OF THE AMICUS CURIAE

Founded in 1986, the American Tort Reform Association ("ATRA") is a broad-based coalition of approximately 170 businesses, corporations, municipalities, associations, and professional firms that have pooled their resources to promote reform of the civil justice system with the goal of ensuring fairness, balance, and predictability in civil litigation. It is a nonpartisan, nonprofit organization with affiliated coalitions in over 40 states. For more than two decades, ATRA has filed amicus curiae briefs in cases before state and federal courts that have addressed important civil litigation issues.

The interpretation and application of the collateral source rule and related statutes has been an issue of special concern to ATRA.[1] In this case, ATRA is particularly concerned that the Court of Appeals' interpretation of Indiana's Collateral Source Statute in *Patchett v. Lee*, --- N.E.3d ----, 2015 WL 7352582 (Ind. Ct. App. Nov. 19, 2015), will improperly result in the phenomenon of "phantom damages"—i.e., monetary damages for the portion of an invoice from a medical provider that is discounted and therefore does not reflect a pecuniary loss to the plaintiff. To avoid that result, ATRA urges this Court to grant transfer and reverse, holding that the process this Court established in

[1] See, e.g., ATRA Issues, *Collateral Source Rule Reform*, http://www.atra.org/issues/collateral-source-rule-reform.

Stanley should be applicable in *all* cases, regardless of the type of insurance the plaintiff possesses.

SUMMARY OF THE ARGUMENT

ATRA submits this amicus brief to put the Court's decision in a national context. There is a growing recognition around the country that plaintiffs cannot recover phantom damages. These damages are inconsistent with the fundamental principles underlying tort law, states' collateral source statutes, and the common law collateral source rule. ATRA understands that briefs submitted by petitioner Mary Patchett and other amici will address the reasons the Court of Appeals' decision in this case conflicts with Indiana's substantive law, so this brief instead focuses on two procedural issues.

First, phantom damages will improperly arise in cases like this because the Court of Appeals' decision creates an evidentiary process that can only result in the jury being misled about the scope of the plaintiff's pecuniary loss. Following the Court of Appeals' decision, the plaintiff is permitted to introduce an original, non-discounted invoice, which all agree tells the jury nothing about the costs the plaintiff (or others on the plaintiff's behalf) incurred and very little about the reasonable value of the services. The defendant, however, is barred from introducing any evidence reflecting the actual pecuniary loss the plaintiff suffered. This result is fundamentally at odds with the purpose of the trial process—uncovering the truth.

Defendants can mitigate this harm by introducing other evidence of the reasonable value of medical services, but that unnecessarily and dramatically complicates the trial process. For example, defendants will now have to resort to calling hospital CFOs and other service providers to testify about the complexities of medical pricing. This will lengthen trials (which, in turn, increases the delay in obtaining a trial date), making the trial process more costly for trial courts and the parties, and imposing on the time and monetary resources of professionals who should be focused on providing medical services. Adhering instead to the process this Court established in *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009), would prudently avoid these problems.

Second, even if this Court agrees with the Court of Appeals that *Stanley* is inapplicable to cases involving government insurance, it does not follow that the plaintiff should recover phantom damages resulting from a one-sided evidentiary presentation. Other courts confronting the phantom damages problem have instead allowed for a post-verdict offset of the discount against the compensatory damages award. This Court could also allow the defendant to introduce evidence that the medical provider accepts discounted payments from other patients because those market negotiations remain probative of the reasonable value of medical services, especially since the plaintiff at issue will have received an even greater discount.

The Court of Appeals' decision in this case is a step in the wrong direction. This Court should grant transfer and reverse, returning the parties in personal injury lawsuits to equal footing.

ARGUMENT

I. The Court of Appeals' evidentiary framework impedes the search for the truth and unnecessarily makes the trial process much less efficient

A trial is a process for discovering the truth. *McCullough v. Archbold Ladder Co.*, 605 N.E.2d 175, 179 (Ind. 1993). The Court of Appeals' decision interferes with that search because, when it comes to evidence regarding a plaintiff's compensatory damages for medical services, the factfinder is limited to evidence of the "sticker price"—a fiction in terms of the actual medical expenses incurred—and not provided evidence of the discounted amount accepted by the provider in full satisfaction of the invoice, which is, in reality, the extent of the plaintiff's pecuniary loss. Indeed, in *Stanley* this Court cited authority for the proposition that most hospital charges have "no relation to anything, and certainly not to cost." 906 N.E.2d at 857 (quotation marks and citation omitted).

There is an abundance of authority confirming almost nobody pays the sticker price for medical services.[2] As the California Supreme Court has rec-

[2] See, e.g., George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 Ky. L.J. 101, 104 (2006) (stating the term "regular," "full," or "list" price is misleading because less than five percent of

ognized, "[b]ecause so many patients, insured, uninsured, and recipients under government health care programs, pay discounted rates, hospital bills have been called insincere, in the sense that they would yield truly enormous profits if those prices were actually paid." *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1142 (Cal. 2011) (quotation marks and citation omitted).

The discounts are generally quite significant. In this case, the discount the plaintiff received was eighty-six percent of the original invoice amount, meaning eighty-six percent of the plaintiff's special damages claim may be for pecuniary losses she never suffered. *Patchett*, 2015 WL 7352582, at *1. In *Stanley*, this Court cited authority for the proposition that insurers generally receive a sixty-percent discount. 906 N.E.2d at 857 (citing Mark A. Hall & Carl E. Schneider, *Patients As Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 Mich. L. Rev. 643, 663 (2008)). The uninsured also may receive the same standard discounts that are offered to private insurers. See J.K. Wall, *Justices grill both sides in IU Health case*, Ind. Lawyer (May 23, 2012), http://www.theindianalawyer.com/justices-grill-both-sides-in-iu-

---

patients nationally pay those prices); *Stayton v. Delaware Health Corp.*, 117 A.3d 521, 530 (Del. 2015) (recognizing that "only a small fraction of persons receiving medical services actually pay original amounts billed for those services" (quotations and brackets omitted)); *Haygood v. De Escabedo*, 356 S.W.3d 390, 393 (Tex. 2011) ("We recently observed that few patients today ever pay a hospital's full charges. . . ." (quotation marks and brackets omitted)).

health-case/PARAMS/article/28857 (noting that IU Health gave a standard forty-percent discount off its chargemaster prices to uninsured patients).

The sticker prices also vary wildly from hospital to hospital. See *Howell*, 257 P.3d at 1142 (explaining that "[c]hargemaster prices for a given service can vary tremendously, sometimes by a factor of five or more, from hospital to hospital in California"); see also www.mycareINsight.org (compiling the average price for services at a particular hospital compared with the state average). For example, the California Supreme Court found that a patient might be charged seven times that of another patient for the same chest x-ray, with the sticker price varying from $200 to $1,500 depending on the hospital. *Howell*, 257 P.3d at 1142. This disparity between charges and costs has continued to grow over time. *Id.* at 1141.

There can be no serious doubt then that it is misleading to present the jury with evidence of the sticker price without also informing it of the amount that was actually accepted as payment in full. As the concurrence in *Stanley* cogently argued, "if we were to choose between the sticker price that most people do not pay and the discounted price that most people do pay, we should hold that the sticker price is to be excluded from evidence as the less realistic evidence of the reasonable value of these services that the real market for them reflects." 906 N.E.2d at 860 (Boehm, J., concurring).

If a trial court excludes evidence of the amount the provider accepted as payment in full while admitting evidence of a grossly inflated invoice amount, the only option the Court of Appeals' decision leaves defendants is litigating the "highly complex" issue of medical pricing by contesting the reasonable value of the medical services provided and whether the invoice amounts and charges reflect the reasonable value. *Howell*, 257 P.3d at 1142. To use the chest x-ray pricing example, the defendant may need to call the hospital CFO or other hospital representative as a witness to testify as to all the factors that went in to pricing the x-ray at $1,500, rather than the $200 charged by another provider. These factors may include "competing objectives of balancing budgets, remaining competitive, complying with health care and regulatory standards, and continuing to offer needed services to the community." *Id.* at 1141 (quotation marks omitted). The parties may then need to counter this testimony by calling the CFOs of competing medical providers.

This would unduly impose on medical providers who are already overburdened, and create a trial within a trial regarding healthcare pricing—unnecessarily complicating the underlying matter.[3] As a matter of public pol-

[3] In its amicus brief, the Indiana Trial Lawyers Association argues that if Patchett's position is adopted, there will be a trial within a trial where plaintiff would need to explain "how and why particular Medicaid/Medicare reimbursement rates were decided upon." ITLA Br. 7 n.3. Yet, there is no suggestion that any such "trial within a trial" arose under the *Stanley* framework, whether in cases with private insurance or government insurance. On the other hand, as demonstrated above, departing from *Stanley* will give rise to complicated satellite litigation over the reasonableness

icy, it would be preferable to avoid routinely and unnecessarily dragging hospital CFOs and other medical providers into personal injury cases to discuss the pricing structure of health care providers, the reasonableness of the charges on the invoice, and the typical discounts that the providers anticipate will be given after the invoice is sent. The parties will also likely need to engage experts, particularly to compare the invoice to the prices that other providers would charge for the same service and to otherwise assess the degree to which the sticker price has been inflated. All this will lead to longer trials and additional motion practice. (Not to mention higher health care costs.) Considering the already-congested dockets of our courts, longer trials mean fewer trials.

And even with this additional evidence, the jury still will never hear the discount which the plaintiff received on the invoice, and will be left with the misleading impression that, while discounts are standard and sticker prices

---

of charges for medical care. Moreover, ITLA's argument loses sight of the fact that *compensatory* damages for medical services are awarded to make the plaintiff whole, and put the plaintiff "in a position substantially equivalent in a pecuniary way to that which [s]he would have occupied had no tort been committed." *Nichols v. Minnick*, 885 N.E.2d 1, 4 (Ind. 2008) (quoting Restatement (Second) of Torts § 903 cmt. a (1979)). If a plaintiff—by virtue of her government insurance—incurs less of a pecuniary loss, then there is no need to discuss why a particular rate was applicable, i.e., why her loss was a certain amount. The pecuniary loss remains the pecuniary loss. On the other hand, any recovery for the injury and suffering the plaintiff may have suffered remains recoverable as *general* damages.

are rarely paid, *this* plaintiff may be nevertheless be required to pay the invoice in full.

These considerations confirm that it is ill-advised to depart from the framework this Court established in *Stanley*. Unsurprisingly, other courts have adopted the *Stanley* approach of allowing the defendant to introduce evidence of the amount the medical provider accepts as payment in full. See *Howell*, 257 P.3d at 1146; *Martinez v. Milburn Enterprises, Inc.*, 233 P.3d 205, 223-29 (Kan. 2010) (discussing *Stanley* extensively and following its approach). But even if this Court were to agree with the Court of Appeals that evidence of the discounted payments should be excluded, it should still implement an evidentiary process that precludes phantom damages.[4]

II. Even if the Court agrees that evidence of payment from a government insurer should be excluded, it should allow for an offset of the phantom damages against the plaintiff's compensatory damages award, or otherwise allow the defendant to introduce evidence of the provider's willingness to discount charges for other patients

In *Stanley*, this Court considered three approaches to dealing with phantom damages: (1) barring evidence of the discount; (2) barring evidence of the

[4] As another court observed, phantom damages are particularly inappropriate in cases involving government insurance, as "[i]t would be unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person and then allow that person to recover damages for medical services from a tortfeasor and pocket the windfall." *Bates v. Hogg*, 921 P.2d 249, 253 (Kan. Ct. App. 1996), superseded by statute on other grounds, as stated in *Frans v. Gausman*, 6 P.3d 432, 440 (Kan. Ct. App. 2000) (internal quotation marks and citations omitted).

discount at trial but allowing for a post-verdict set-off against compensatory damages; and (3) the approach the Court chose, which was to allow the plaintiff to introduce the full invoice and to allow the defendant then to introduce evidence of the discount without referencing insurance. 906 N.E.2d at 855-56. Here, the Court of Appeals not only held that *Stanley* did not apply,[5] but by excluding the discounted amount, it made it so that the only evidence of payment the jury will ever see is an invoice containing charges far exceeding the expense the plaintiff actually incurred, which all agree is not reflective of the reasonable value of services. See *Stanley*, 906 N.E.2d at 857. If the Court decides to limit *Stanley* to cases with private insurance, it need not move the needle so far in the other direction for cases with government insurance.

Instead, if this Court agrees with the Court of Appeals' analysis of discounts involving government-insured plaintiffs, then it should hold that the defendant is entitled to a post-verdict offset of the phantom damages against

---

[5] The Court of Appeals' holding was based on the flawed premise that HIP payments do not reflect negotiated rates. *Patchett*, 2015 WL 7352582, at *8-10. But HIP was a fully-negotiated endeavor. The State's website posts the Term Sheet for HIP between the State and the Indiana Hospital Association, and the very first recital states: "The Parties have had discussions regarding a possible HIP expansion. These discussions, which have been constructive and collaborative in nature, have included the possible use of Indiana's hospital assessment fee to help fund the HIP expansion, as well as other matters relevant to coverage expansion." HIP Term Sheet at 1, *available at* http://www.in.gov/omb/files/IHA_HIP_HAF_Term_Sheet.pdf. The Court can take judicial notice of this government document. *Brenwick Associates, LLC v. Boone County Redevelopment Commission*, 870 N.E.2d 474, 478 (Ind. Ct. App. 2007), aff'd in part, vacated in part on other grounds by 889 N.E.2d 289 (Ind. 2008).

the compensatory damage award.[6] See *Kastick v. U-Haul Co. of Western Michigan*, 292 A.D.2d 797, 798 (N.Y. App. Div. 2002); *Slack v. Kelleher*, 104 P.3d 958, 967 (Idaho 2004); *Goble v. Frohman*, 901 So. 2d 830, 832-33 (Fla. 2005). This is consistent with the trial court's inherent power to reduce jury verdicts to ensure that a plaintiff does not receive more than a full recovery.[7] *Indiana Dep artment of Insurance v. Everhart*, 960 N.E.2d 129, 138 (Ind. 2012) (citing *Huffman v. Monroe County Community School Corp.*, 588 N.E.2d 1264, 1267 (Ind. 1992)). If a setoff can be used to ensure that a plaintiff does not recover a windfall for the same injury, it follows that a setoff can be used to ensure that a plaintiff does not recover (and a defendant does not pay) more for medical services than what was actually expended.

Moreover, setting off the phantom damages after trial will alleviate the concerns expressed in the *Stanley* dissent, 906 N.E.2d at 860-61, as well as by ITLA, ITLA Br. 3, regarding the jury's assessment of a plaintiff's general damages. In cases where the plaintiff receives government-funded or other subsidized healthcare, the jury would still only receive the amount of the invoice—and not the discounted amount accepted in satisfaction of the claim. This would allow the jury to consider the full amount of the invoice when de-

[6] The trial court would also need to consider the impact of these phantom damages on any associated punitive damages award.

[7] This is also consistent with Indiana's Collateral Source Statute. *See* Ind. Code § 34-44-1-3 ("Proof of payments under section 2 of this chapter . . . shall be considered by the court in reviewing awards that are alleged to be excessive.").

termining a plaintiff's general and punitive damages. But once the verdict is returned, the trial court would be compelled to reduce only the plaintiff's special damages for medical services, and only to the amount that was actually paid. Such a setoff would ensure that the plaintiff does not recover, and the defendant does not pay, costs for medical services that were never incurred.

Alternatively, if the Court rejects the application of *Stanley* to cases with government insurance, and if the Court does not permit a setoff, then the Court must still allow the defendant to introduce evidence of a medical provider's willingness to discount charges for other patients. See *Law v. Griffith*, 930 N.E.2d 126 (Mass. 2010). For example, even if the defendant in this case cannot introduce evidence of the eighty-six percent discount the plaintiff received (because the discount was received by virtue of plaintiff's insurance under HIP), the defendant is still permitted to introduce evidence that the provider is willing to give substantial discounts. The reality is that providers typically give discounts to private insurers, government insurers, and the uninsured, and that defendants will be forced to offer this evidence in a far-more cumbersome format through witness testimony.

Stanley held that evidence of the amount the provider is willing to accept as payment in full is probative of the reasonable value of the services, 906 N.E.2d at 856-58, and that evidence does not lose its probative value simply because the plaintiff has government insurance. Allowing all defendants to

introduce this evidence while omitting the identity of the third-party payor is consistent with this Court's objective of avoiding "creat[ing] separate categories of plaintiffs based on the method used to finance medical expenses." *Id.* at 858.

CONCLUSION

Phantom damages increase the stakes considerably. Beyond the fact that they often make up the majority of the plaintiff's special damages, the cost of these phantom damages are passed on to other insureds through higher premiums.[8]

This brings greater urgency to the growing trend of courts and commentators recognizing that a plaintiff's damages for medical expenses are limited to the pecuniary losses the plaintiff actually suffered. See, generally, Jamie L. Wershbale, *Tort Reform in America: Abrogating the Collateral Source Rule*

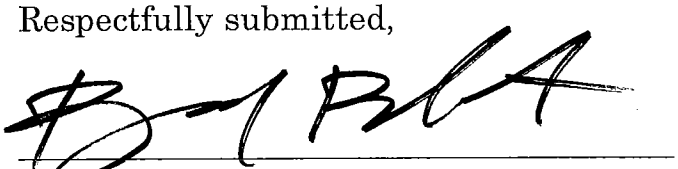
---

[8] See Linda J. Gobis, *Lambert v. Wrensch: Another Step Toward Abrogation of the Collateral Source Rule in Wisconsin*, 1988 Wis. L. Rev. 857, 885-86 (1988) ("Furthermore, a double recovery by the plaintiff leads to an unnecessary increase in insurance costs to the public in exchange for an unnecessary windfall to the plaintiffs. The party who pays the damages to a plaintiff already compensated by collateral benefits is often not a wrongdoing tortfeasor but rather the liability insurer. The additional costs under the collateral source rule not only increase the defendant's insurance premium but also increase the premium of the entire class of insureds whether they are careful or careless. Thus, it is not the wrongdoing defendant who is being penalized but rather the defendant's liability insurer.") (internal footnotes omitted); John L. Antracoli, *California's Collateral Source Rule and Plaintiff's Receipt of Uninsured Motorist Benefits*, 37 Hastings L.J. 667, 667 (1986) (noting that commentators "almost uniformly have criticized the [collateral source rule], primarily asserting that the Rule conflicts with the compensatory function of tort law and, consequently, contributes to increased insurance costs") (internal footnotes omitted); *Goble v. Frohman*, 848 So. 2d 406, 410 (Fla. Dist. Ct. App. 2003); *Stayton*, 117 A.3d at 526.

Across the States, 75 Def. Couns. J. 346, 350 (2008) (noting "a trend in a growing number of jurisdictions to limit a successful plaintiff's recovery to the actual amount of medical expenses paid.") (internal footnotes omitted); *Moorhead v. Crozer Chester Medical Center*, 765 A.2d 786, 789 (Pa. 2001) ("Pennsylvania case law allows a plaintiff to recover the reasonable value of medical services. . . . We find that the amount paid and accepted by Appellee as payment in full for the medical services is the amount Appellant is entitled to recover as compensatory damages."), abrogated on other grounds by *Northbrook Life Insurance Co. v. Commonwealth*, 949 A.2d 333 (Pa. 2008). That includes cases involving government insurance. *McAmis v. Wallace*, 980 F. Supp. 181, 185 (W.D. Va. 1997).

For these reasons, the Court should grant transfer and reverse, thereby precluding plaintiffs from recovering phantom damages.

Respectfully submitted,

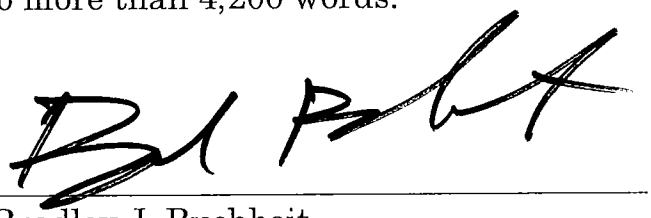


Bradley J. Buchheit
Attorney No. 27524-02
Tucker Hester Baker & Krebs, LLC
One Indiana Square, Suite 1600
Indianapolis, Indiana 46204
(317) 833-3030
bbuchheit@thbklaw.com

Counsel for Amicus Curiae
American Tort Reform Association

WORD COUNT CERTIFICATE

I certify that this brief contains no more than 4,200 words.



Bradley J. Buchheit

CERTIFICATE OF SERVICE

I certify that on February 19, 2016, I caused a copy of the foregoing to be served via first-class United States Mail, postage prepaid, and addressed to the following counsel of record:

Karl L. Mulvaney
Jessica Whelan
Bingham Greenebaum Doll LLP
2700 Market Tower
10 West Market Street
Indianapolis, IN 46204-4900

Daniel G. Foote
Tabor Law Firm, LLP
3610 River Crossing Parkway
Suite 250
Indianapolis, IN 46240-2150

Robert F. Ahlgrim, Jr.
State Farm Litigation Counsel
6640 Intech Blvd., Suite 210
P.O. Box 68995
Indianapolis, IN 46268-0995

Joseph N. Williams
Riley Williams & Piatt, LLC
301 Massachusetts Ave.
Indianapolis, IN 46204

Bradley J. Buchheit