COLORADO SUPREME COURT 2 East 1th Avenue, Denver, Colorado 80203 Telephone: (720) 625-5150	
Appeal from: COLORADO COURT OF APPEALS Case No. 2019CA000023 Hon. Judge Terry Fox, Hon. Anthony J. Navarro, and Hon. James Casebolt DISTRICT COURT, ADAMS COUNTY, COLORADO Case No. 2017CV030884 Hon. Judge Jaclyn Casey Brown	
Petitioner/Defendant: Lisa M. French, an individual, v. **Respondents/Plaintiffs:** Centura Health Corporation, a Colorado non-profit corporation, and Catholic Health Initiatives Colorado d/b/a St. Anthony North Health Campus, a Colorado non-profit corporation.	▲ COURT USE ONLY ▲
Attorneys for Self-Insurance Institute of America, Inc.: Scott T. Rodgers, #19943 John M. Tanner, #16233 Paul R. Janda, #48878 FAIRFIELD & WOODS, P.C. 1801 California Street, Suite 2600 Denver, Colorado 80202 Telephone: (303) 830-2400 Fax No.: (303) 830-1033 E-mail:srodgers@fwlaw.com; jtanner@fwlaw.com; pjanda@fwlaw.com	Case No.: 2020SC565
SELF INSURANCE INSTITUTE OF AMERICA, INC.'S AMICUS BRIEF IN SUPPORT OF LISA M. FRENCH'S OPENING BRIEF	

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with all requirements of C.A.R. 28, 32, 52, and 53 including all formatting requirements set forth in these rules. It contains 4745 words excluding the caption, certificate of compliance, table of contents, table of authorities, certificate of service, and signature block.

FAIRFIELD AND WOODS, P.C.

/s/ Paul R. Janda
Paul R. Janda

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The Self Insurance Institute of America, Inc. ("SIIA") is an association of self-insured entities and industry participants, including third-party administrators, captive managers, and excess carriers. *See* SIIA, About SIIA, https://www.siia.org/i4a/pages/index.cfm. A majority of workers and a significant percentage of patients covered by their employers' self-insurance plans. Kaiser Family Found., 2019 Employer Health Benefits Survey § 10 (Sept. 25, 2019).

The Patient Protection and Affordable Care Act (2010) ("ACA") requires that employers with at least 50 full-time employees provide health coverage. While self-insurance is a cost-effective option, employers are at a disadvantage compared to other payers because they lack access to the pricing information held by insurers or available to patients. White & Whaley, *infra*, at 1.[1] Furthermore, 87% of large employers say the costs of providing mandatory health-care benefits will become unsustainable, yet, they "have little ability to influence regulatory oversight." Gary Claxton, et al., *How Corporate Executives View Rising Health Care Costs and the Role of Government*, Kaiser Family Found. 6, 27 (Apr. 2021). Thus, employers are anxiously exploring options for providing coverage in compliance with the ACA.

[1] Employers—at least before the Opinion—have done better at controlling healthcare costs than other types of payers. Colorado Hospital Association & Colorado Health Institute, *infra*, at 5

Fallyn B. Cavalieri and Stanley L. Evans, *What's Your Trump Card for Obamacare?*, 60 No. 8 DRI For Def. 20 (Aug. 2018).

In resolving a simple contract dispute over surgery charges between Centura Health Corporation and Ms. French, who participated in an employer-provided health plan, the court of appeals created a new rule of law that threatens the viability of Ms. French's plan and one of the most desirable options available to employers—plans implementing Reference-Based Pricing. This new judge-made law, untethered from Colorado precedent and based on an unsupportable policy rationale, harms SIIA's interest in promoting a robust marketplace for self-insurance and its members' opportunities to provide cost-effective coverage. Thus, SIIA supports reversal of the court of appeals' decision.

Introduction

Health-care costs impact the health and financial security of Coloradans. Since passage of the ACA, the uninsured patient volume at Colorado Hospitals has plummeted and commercial insurance payments have been near or beyond $1 billion more each year than the combined under-compensation from other payment types. Rather than passing the savings on to patients, Colorado hospitals multiplied profits. As Plaintiff/Appellee Centura Health Corporation's ("Hospital's") CEO recently acknowledged regarding the recent dramatic rise in Colorado hospital profits, "We've got a problem. We've got to make health care more affordable, more accessible and more transparent."

This "problem" exists in part because under traditional reimbursement models, hospitals bludgeon payers (including self-insured entities) into accepting rates that have no relation to the value of services provided using their "chargemaster," a secret list of tens-of-thousands of prices only experts can read set for the sole purpose of increasing profits and often varying by nearly an order of magnitude from provider-to-provider. While resulting in record profits for hospitals, this model harms patients, and the resulting high costs squeeze employers who are mandated to provide coverage to their employees.

To mitigate the problems of traditional models, many self-insured employers, like Defendant/Appellant Ms. French's, have implemented Reference-Based Pricing ("RBP"). Rather than being based on the arbitrary, inflated, and opaque chargemaster, RBP reimbursement rates are based on a reasonable reference, such as the Medicare rate or actual cost. This approach increases transparency, empowers patients, and lower costs while ensuring quality care and reasonable profits for hospitals. If the provider refuses to accept the reference-based rate, and instead, bills the patient for the difference—here, more than $200,000 more for a single stay—courts offer the only remedy against the imposition of the arbitrary, inflated, "life-crushing, overcharged medical bill."

While the trial court ably resolved this case, the court of appeals reversed with a new categorical rule that an agreement to pay "all charges" of the hospital incorporated the chargemaster rate. *Centura Health Corp. v. French*, 2020 COA 85 (the "Opinion"). This rule destroys market innovation like RBP under policy rationale that is insufficient and even incorrect. It should be reversed so Colorado courts can address agreements for health care provision as they would any other contractual dispute—based on the facts of the case. SIIA agrees with the Hospital's CEO that "we've got a problem." It asks to not be prohibited from continuing to be part of a solution.

Argument

The lower court listed four "reasons" for its determination that "all charges" means the chargemaster rate: (1) "hospitals cannot always accurately predict what services a patient will ultimately require;" (2) "chargemaster rates are predetermined;" (3) it "would [purportedly] be impractical for a court to attempt to resolve the complexity of the health care system by imposing a reasonableness requirement for an express, written contract with a sufficiently definite price term;" and (4) "Colorado law provides *some* public transparency for the Hospital's chargemaster rates." Opinion, ¶¶ 25–28 (emphasis in original).

These "reasons" misread the market and misapprehend the court's role. Before, nothing prevented hospitals from charging for all of the goods and services they provide, even if a new need arises during the course of treatment. Now, knowing they hold a blank check before treatment begins incentivizes providers to find new procedures to perform because patients' abilities to be conscious consumers are invariably compromised. Concerning the second and fourth "reasons," a core area of dispute here is whether the chargemaster rates are in any way "determined" or "transparent," given that they are nearly impossible to interpret, highly variable, and apply to almost no actual patients. Regarding the third "reason," the court appears

concerned with how hospitals are able to balance their books—a misplaced worry for the reasons described below. *Id*. ¶ 27.

1. Coloradans are struggling with health-care prices.

Hospital bills are "44 percent of total personal health care spending for the privately insured, and price increases are key drivers of recent spending growth …." Chapin White & Christopher Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely*, Rand Corporation 2 (2019). According to the Colorado Hospital Association, "Affordability and access to high quality health care are fixtures in Colorado's policy debates" that "affect[] nearly everyone" and influence "our health and our financial stability." Colorado Hospital Association & Colorado Health Institute, *Affordability in Colorado: Answers About Health Care Costs* 1 (2018). Coloradans "spend[] a lot on health care," have "seen premiums skyrocket," and have had costs shifted to out-of-pocket spending. *Id.* at 3, 5, 6. As the Colorado Business Group on Health summarized:

> … high health care costs are a significant problem in Denver. … the challenge of high health care costs "impacts employees' ability to sustain themselves and their families and affects business' competitive position in the current market." … over half of adults felt burdened in the prior year by health care costs they believed they could not afford Additionally, more than 39% of Denver adults struggled to pay their medical bills, incurring credit card debt or using up all or most of their savings.

Andrea Caballero & Alejandra Vargas-Johnson, *Denver-Area Market Assessment Report*, Catalyst for Payment Reform & Colo. Bus. Grp. on Health 9–10 (Sept. 2019) (citations omitted). Despite Coloradans' health-consciousness and correspondingly low levels of treatment, Colorado's rise in commercial insurance rates, deductibles, and out-of-pocket costs has been among the highest in the nation, causing nearly 20% of Coloradans to struggle to pay medical bills and even making it difficult for 10% to afford food. Colo. Dep't of Health Care Pol'y & Fin., *Colorado Hospital Cost Shift Analysis* 8–9, 42 (Jan. 2020) ("Cost Shift Report").

After many of the out-of-state cases cited by the court of appeals, the Colorado General Assembly passed the Colorado Health Care Affordability Act (2009) ("CHCAA") and the Colorado Healthcare Affordability and Sustainability Enterprise ("CHASE") Act (2017), and Congress passed the ACA. Now, Colorado hospitals could provide care to all without levying unreasonable charges on a select few, let alone without needing a new judicial shield to protect any unscrupulous practices. While shifting of uncompensated care costs to commercial or self-insurance payers historically escalated rates, the CHCAA, ACA, and the CHASE Act dramatically reduced the number of uninsured, the bad debt held by hospitals, and the need for charity care. Cost Shift Report at 3. Now, "[u]ncompensated care levels in Colorado are at historic lows." *Id*. at 4. Accordingly, commercial insurance

payments to Colorado hospitals have been near or beyond $1 billion more annually than the combined under-compensation from other payment types, with the difference expanding at an increasing rate. *Id*. at 16–25.

Rather than passing cost savings to patients, and contrary to their own forecast regarding the outcome of these legislative enactments,[2] **Colorado hospitals chose to increase profits "by more than 280% between 2009 and 2018."** *Id*. at 4 (emphasis added). Costs have increased for hospitals, but largely because of increased hospital consolidation[3] and acquisition of physician groups, which also increase profits. *See id*. at 48–55; *see gen.* Emily Gee & Ethan Gurwitz*, Provider Consolidation Drives Up Health Care Costs*, Ctr. For Am. Progress (Dec. 5, 2018); *see also* Caballero & Vargas-Johnson, *supra*, at 9–10. Furthermore, hospitals do not need to raise private rates to account for diminished Medicare reimbursement because when Medicare rates are reduced, private rates often fall. White & Whaley, *supra*, at 26. Thus, **"Colorado hospital margins are now higher than they have ever been."** Cost Shift Report, *supra*, at 35 (emphasis added). If hospitals limited

[2] *See* Cost Shift Report, *supra*, at 87 (CHA 2009 statement claiming "By increasing hospital reimbursement rates and covering the uninsured, we will reduce the rate of rising healthcare costs.").
[3] Figure 23 shows the Hospital's growth.

themselves to their not-insufficient 2009 profit margins, each commercially-insured Colorado family could save nearly $800 in annual premiums. *Id*. at 62.

As the Hospital's own CEO remarked after reviewing the Cost Shift Report, "We've got a problem. We've got to make health care more affordable, more accessible and more transparent. So with that, I agree that we've got to find solutions." John Daley, *Expensive Health Care? Blame The Hospitals, State Report Says*, Colo. Pub. Radio (Jan. 23, 2020) (quoting Peter Banko).

2. The court of appeals' new rule is contrary to policy, in part because it would effectively abolish Reference-Based Pricing.

a. Reference-Based Pricing sets hospital reimbursement rates relative to value and reasonable profit—like prices were determined before this era of exorbitant bills.

"For decades, the dominant model of paying health care providers has been network contracting, through which payors offer patient referrals in exchange for an ostensibly discounted price." Jackson Williams, *Reference Pricing in Health Care: An Inventory of Techniques, and Practical and Policy Implications*, 29 Annals Health L. & Life Sci. 211, 211 (2020). The four most common types of plans are health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), point-of-service ("POS"), and fee-for-service plans. *See* Michael A. Morrisey, *Health Insurance* 17–18 (2d ed. 2014). With HMOs, the payer and

provider is the same, restricting patients to in-network services. Employer's Guide to Self-Insuring Health Benefits, ¶ 250 *Multiple Option Plans*, 1993 WL 13550442 (Thompson Info. Serv. 2016) ("Employer's Guide"). In PPOs, a separate payer negotiates rates with "in-network" providers and various arrangements concerning out-of-network care. *Id*. POS plans are similar to HMOs in terms of a strict provider network, but often with provisions for out-of-network care. *Id*. Unlike the situation with providers, "there is some healthy competition among payers in Colorado," and "profit margins of Colorado payers have been a mixed bag in recent years." Caballero & Vargas-Johnson, *supra*, at 10–11.

The Medicare Modernization Act of 2003 instigated a dramatic shift to high deductible, so-called Consumer Driven Health Plans ("CDHPs"). John Aloysius Cogan, Jr., *The Failed Economics of Consumer-Driven Health Plans*, 54 U.C. Davis L. Rev. 1353, 1367 (2021). Now, nearly half of adults under the age of 65 use CDHPs. *Id*. The average annual deductible for employer-based CDHP's is approximately $2,500 for individuals and $5,000 for families, with some deductibles "exceeding $7,000 for single plans and $15,000 for family plans." *Id*. at 1368–69. The hope behind the policy was that consumers would be incentivized to shop around and drive increased transparency and reduced rates. *Id*. at 1359.

With these traditional models, payers often struggle to achieve a true discount because some hospitals leverage market share or monopolies and others refuse to enter networks. *E.g.*, *id*. at 1402–09; Williams, *supra*, at 211–12. Hospitals engage in "shenanigans to maintain high prices" including secret contract terms, cost savings coupons, and aggressive patent protections, including industry-driven efforts guised as citizen petitions to keep the FDA from considering generic drugs. Cogan, *supra*, at 1409–13. Furthermore, "Patients rely so much on their doctors that their purchasing choices are severely constricted, so constricted that it is hardly too much to say that doctors wield something like monopoly power over patients." Mark A. Hall and Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 Mich. L. Rev. 643, 652 (2008).

Reference-Based Pricing (sometimes called "RBB" for reference-based benefit) mitigates many of the traditional model's ills. "RBP is defined as any announced policy by a payor (or benefit administrator) to place a firm limit on payment for a service or product based upon some reference point." Williams, *supra*, 211. "A traditional RBP plan … avoids affiliation with any network, and instead establishes pre-determined parameters and criteria for determining the amount it will pay for benefits." Employer's Guide, *supra*, ¶ 250.

Ms. French's employer's self-insurance plan, as administered by ELAP Services ("ELAP"), is an RBP plan that uses two references: Medicare and actual cost. ELAP, *About ELAP*. https://www.elapservices.com/who-we-are/ (accessed June 2, 2021). Medicare reimbursement rates are arduously designed to be reasonable to providers. S*ee* White & Whaley, *supra*, at 6–7 and Erin C. Fuse Brown*, Irrational Hospital Pricing*, 14 Hous. J. Health L. & Pol'y 11, 20–21 (2014).[4] ELAP offers reimbursements of either 20% above the Medicare reimbursement amount or 12% over the provider's cost—whichever is greater. *IHC Health Servs. Inc. v. ELAP Servs., LLC*, No. 217CV01245JNPEJF, 2019 WL 4758032, at *1 (D. Utah Sept. 30, 2019).

ELAP's plan is an expanded application of the "Medicare Plus" form of RBP, *see* Williams, *supra*, at 222, with an alternative reference that is more advantageous to the provider, offering a reasonable margin beyond the cost of the good or service. It is essentially how hospital pricing worked before the modern price explosion. *See* George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 Pepp. L. Rev. 745, 753 (2016) (describing when chargemaster rates were simply cost plus 10%). This form of RBP requires "additional infrastructure" including patient

[4] Because Medicare covers all ages, all services are rated, including those associated exclusively with younger patients. White & Whaley, *supra*, at 4.

advocates who attempt to arrange care within the reference price. Williams, *supra*, at 223. Thus, ELAP supports patients in any litigation instigated by providers who balance bill[5] after refusing to accept the reimbursement offered by ELAP. *IHC Health Servs. Inc*., 2019 WL 4758032, at *1.

By contrast to Medicare rates or actual cost, the chargemaster rate is "unilaterally set" by the hospital and "bears no relationship to the amount typically paid" for the product or service. *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003). "The CDM, or chargemaster, is a comprehensive listing of items a provider can bill to a patient, payer, or other provider." Timothy D. Martin, *The Impact of Healthcare Reform on Revenue-Cycle Management and Claim Coding*, 4 J. Health & Life Sci. L. 159, 173 (2011) (providing medical coding background and examples). "Fewer than 5%" of patients pay the chargemaster rate. Frank Griffin, *Fighting Overcharged Bills from Predatory Hospitals*, 51 Ariz. St. L.J. 1003, 1007 (2019).

[5] "Balance billing" is when providers "bill insureds directly for the difference between the amount paid to them by the insurer and the amount of their bill of charges." *Pac. Life & Annuity Co. v. Colorado Div. of Ins.*, 140 P.3d 181, 182 (Colo. App. 2006). It is also called "surprise billing," especially when out-of-network physicians practice at an in-network hospital. *See, e.g.*, Markian Hawryluk, *The Knee Surgeon Was In-Network. The Surgical Assistant Wasn't, and Billed $1,167*, Nat'l. Pub. Radio (July 22, 2020) (regarding a surprise bill assessed on a Colorado patient).

Chargemaster prices are set solely to maximize revenues. Ge Bai & Gerard F. Anderson, *US Hospitals Are Still Using Chargemaster Markups to Maximize Revenues*, 35 Health Aff. 1658, 1663 (2016) (rates are set to maximize reimbursements and dissuade insurers from leaving the network). They are contrived by an "arsenal of consultants and computer software ... used to determine optimal increases in charges" and are thus "bent, stretched, and distorted by numerous pressures and responses." Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 Health Aff. 45, 50–52 (2006).

Chargemaster rates are neither predictable nor transparent. Reading a chargemaster requires understanding each aspect of each procedure combined with a knowledge of medical coding sufficient to apply 30,000–40,000 separate line-item prices. *See gen*., Martin, *supra*, 174–75; TR 6/5/18, p. 462:24–463:1–8; TR 6/8/18, p. 1191:9–13. Chargemasters "are characterized by mind-boggling complexity, opacity, unfair and inefficient price discrimination, and wide variations." Fuse Brown, *supra*, at 14. In the Denver metropolitan area, the average price variance in 2017 was 837%. Caballero & Vargas-Johnson, *supra*, at 3. Hospitals—including the Hospital—increasingly "unbundle[]" to extract more line-item charges from each service. Rae Ellen Bichell, *A Hospital Charged More than $700 For Each Push of Medicine Through Her IV*, Nat'l Pub. Radio (June 28, 2021).

"No patient can successfully use the CDM to calculate the price he or she will owe." George A. Nation III, *Contracting for Healthcare: Price Terms in Hospital Admission Agreements*, 124 Dick. L. Rev. 91, 150 n.210 (2019) ("Contracting"). The resulting rate is often a "life-crushing, overcharged medical bill that would make the Big Bad Wolf blush." Griffin, *supra*, 1004; *see also* John T. McLean & Vinay Datar, *Mastering the Chargemaster: Minimizing Price-Gouging and Exposing the Structural Flaws in the Healthcare "Market"*, 9 Pitt. J. Envtl Pub. Health L. 1, 3 (2014) (calling it a "Disneyland price structure"). This is the price that would be forced upon all out-of-network patients like Ms. French were the Opinion to stand. Employers seeking to use RBP would have no leverage to negotiate prices and hospitals would have no incentive or reason to do anything other than what they did here—sue the patient who received the surprise bill. That is not an ideal policy outcome.

b. Reference-Based Pricing has many advantages, and so long as it is not judicially barred in Colorado, works in practice.

Reference-Based Pricing solves many of the problems inherent in more traditional models. "RPB holds the promise of 'bending the cost curve' without the need to enact the global budgets or all-payor rate setting that have been necessary to contain health care costs in other countries, or to pursue complex antitrust litigation,"

Williams, *supra*, at 212; *see also* Cogan, *supra*, at 1420, and is explicitly endorsed by many scholars, *e.g.*, Nation, *Contracting*, *supra*, at 147; White & Whaley, *supra*, at 28. RBP diminishes the information and bargaining power asymmetry inherent in health-care decisions, balances hospitals' excess bargaining power, and "addresses the factor that most health care experts believe is responsible for America's high health care costs relative to similarly situated nations—excessive provider prices." *See* Williams, *supra*, at 212.

By giving cost and reasonableness information to patients, RBP mitigates the information asymmetry providers have traditionally abused and "puts a thumb on the scale" for more efficient options. Cogan, *supra*, at 1422. It realizes the theory behind deductibles by giving patients the knowledge to make informed choices. *Id*. It is especially empowering for patients with chronic conditions—who account for the majority of hospital bills—as it mitigates providers' leverage to drain their often very high deductibles and then extract excessive reimbursement based on the artificially-inflated chargemaster. *See id.* 1357, 1363. Patients can still get quality care because nearly half of hospitals are "high value," meaning that they provide among the highest quality services at low prices. *See* White & Whaley, *supra*, at 25.

This fits exactly with Colorado commentator's suggestions that purchasers "drive payment reform forward," "adopt direct-to-consumer financial incentives to

encourage patients to seek care from high-value health care providers," "be creative to entice providers to enter into two-sided risk arrangements," and seek increased price transparency. Caballero & Vargas-Johnson, *supra*, 18–21. The Colorado Hospital Association agrees that prices should be more transparent, competition between providers should be encouraged, and patients should be "engaged" and incentivized to have conversations with providers regarding what care is necessary. *See* Colorado Hospital Association & Colorado Health Institute, *supra*, at 7–9. Accordingly, Colorado "Employers identified … Reference Based [] Contracting" with a reference to Medicare pricing as one of the three "best opportunities for payment reform in the Denver Market." Caballero & Vargas-Johnson, *supra*, at 12–13.

Reference-Based Pricing is also proven to work. "Studies have found that [RBP] increased use of low-price facilities, reduced the use of high-price facilities, reduced prices at high-price facilities, and reduced average prices." Cogan, *supra*, 1421. It has helped control pharmaceutical prices in other countries. Srishti Miglani, *Reference Pricing: A Small and Mighty Solution to Bend the Health Care Cost Curve*, 22 Conn. Ins. L.J. 47, 58 (2016). ELAP's RBP plan has attained extraordinary results for more than twelve years. ELAP, *Reference-based Pricing*, https://www.elapservices.com/rbp-explained/ (click "See How RBP works")

(accessed June 5, 2021). More than 500 employers using ELAP's RBP model have achieved health care cost reductions of, on average, 25–30%. *Id*. They have been immune from rising premiums, saving households thousands of dollars annually. *Id*.; ELAP, *A Decade of Success With Reference-Based Pricing* 4 (download at https://www.elapservices.com/whitepaper/managing-healthcare-costs-a-transformative-solution/).

Others have had similar success. *See, e.g.*, *Why All the Buzz Around Reference Based Pricing?*, Mercer LLC, https://info.mercer.com/rs/521-DEV-513/images/Reference_Based_Pricing_Webcast_Deck.pdf (accessed June 7, 2021) (describing case studies related to products offered by ELAP's competitors). The California Public Employees' Retirement System benefited from a reference-based system targeting certain procedures. Susan Adler Channick, *The ACA, Provider Mergers and Hospital Pricing: Experimenting with Smart, Lower-Cost Health Insurance Options*, 6 Wm. & Mary Pol'y Rev. 95, 123 (2015). RBP "not only saved money for both the state of California and its employees, but also had a competitive effect on pricing among higher-priced providers." *Id*. at 124. Large employers Kroger and Safeway had positive results with similar programs. Miglani, *supra*, at 60–66. Montana implemented RBP with its state employee health plan and saved $50 million in the first three years "without pushing costs onto employees." Steve

Schramm & Zachary Aters, *Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan* 3–4, 8 Nat'l Acad. St. Health Pol'y (Apr. 6, 2021).

In Ms. French's case, the jury essentially agreed with ELAP's approach to determining the reasonable value of the services provided. The Hospital billed Ms. French $303,709.48 of which French paid $1,000.00 before surgery in reliance on Hospital's $1,336.90 estimate. TR 6/6/18, pp. 775:1–778:1. Ms. French's plan paid $73,957.35 consistent with its obligations. CF, p. 10. The jury fundamentally affirmed this result and determined that the RBP benefit differed from the reasonable value of the services by only $766.74. CF, pp. 4980–86.

3. Colorado courts can resolve hospital pricing disputes without new categorical rules.

"Hospitals are … reacting in unconstructive ways to reference-based pricing." *See* Adam Russo, *Attitude Shift: The Glacial Pace of Hospital Billing Transparency*, 23 No. 9 Employer's Guide Self-Insuring Health Benefits Newsl. 1 (May 9, 2016). Furthermore, because there is no contract between payer and provider, Medicare-plus RBP only works where there are tools—including litigation—to support patients and balance the industry forces that have historically escalated prices. *See* Cogan, *supra*, at 1423. But, hospitals are in no position to cry foul

because they too resort to courts. *See, e.g.*, Wendi C. Thomas, *The Nonprofit Hospital That Makes Millions, Owns a Collection Agency and Relentlessly Sues the Poor*, PROPUBLICA (June 27, 2019).

The critical role of health care does not warrant special breaks for providers. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 552–58 (2012) (dismissing the government's arguments that health care is unique and analogizing to wheat and furniture production). Even under since-discarded exceptionalism doctrines, courts sought to preserve patient access in addition to differing to providers' judgment. *Health Care Law and Ethics* 527, 536–40 (8th ed. 2013) (discussing health-care exceptionalism). And, the current market suggests patients, rather than providers, are in the more precarious position. *Supra* Part 1.

Neither complexity nor profit preservation entitle the health-care industry to a special rule. Courts need not consider effect on profits when crafting an award. Ever-increasing profits, freedom from competition, and shields from judicial scrutiny are not rights. And even if profits were probative, the complexity of issues cannot defeat a party's right to a trial. In health care, especially, complexity should caution against application of a categorical rule because "there is no extended period of business as usual," Cost Shift Report, *supra*, at 12, and the traditional model is largely an unanticipated artifact of a wage cap policy meant only to conserve

resources during a war 80 years ago, *see, e.g.*, Christopher Wiltowski, *Billions Unrealized: Modifying Tax Expenditures on Employer-Sponsored Insurance Plans*, 30 Annals Health L. Advance Directive 305, 307 (2021). Furthermore, nothing about this business mitigates the potential for the rule to creep into other difficult contract questions or other industries seeking their own special rules. *See All Seasons Restoration, Inc. v. Forde,* No. 7:19-CV-00247-BR, 2021 WL 784644, at *3 (E.D.N.C. Mar. 1, 2021) (attempting to apply rule to contract for "inherently indefinite" disaster recovery services).

Most fundamentally, it makes no sense to suggest that courts lack the capacity to assess the complexity of health-care pricing while simultaneously basing the judge-made rule on the argument that Ms. French should have known to what she was agreeing when she signed the admission forms agreeing to pay "all costs" that did not even mention the chargemaster.

These cases can be resolved with "rudimentary contract law." Barak D. Richman, et al., *Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care*, 23 Am. J. Managed Care 4, 102 (Apr. 2017). Courts routinely resolve complex questions regarding the value of goods and services, intellectual property, or entire businesses. Judges often assess the reasonableness of attorney fees in large matters—and frequently find that certain

line items or book rates are unjustified even where a party explicitly agreed to pay them. Juries regularly gauge the value of medical services received, in addition to future medical costs, non-economic loss, and permanent impairment. *See, e.g.*, *Wal-Mart Stores, Inc. v. Crossgrove*, 2012 CO 31, ¶ 25, 276 P.3d 562, 568. As the pattern jury instructions provide, "Difficulty or uncertainty in determining the precise amount of any damages does not prevent you from deciding an amount. [Jurors] should use [their] best judgment based on the evidence." Colo. Jury Instr., Civil 5:6. The same rule should apply here.

Conclusion

Health-care costs are broadly impactful and result from a wide range of underlying issues, but courts do not need to make policy or force patients to suffer unnecessarily until Congress acts. There are many reasons from broad analyses of the health-care market in general to ELAP's demonstrable record of success mitigating problems faced by local hospital patients why Reference-Based Pricing should be encouraged rather than functionally prohibited. RBP "put[s] a thumb on the scale" and incentivizes consumers to make efficient choices. It is helping employers and patients now and functioned properly in this case in particular. Neither the narrow facts of this case nor all possible circumstances where chargemaster rates are asserted requires courts to smash the scale and remove one of

the only checks on hospital pricing. Market-based innovators should be allowed to function within only the constraints of traditional contract law—not subjected to a new judicial rule designed to freeze patients into unsustainable rates that are rising in a wild pursuit for profits and absent any regard for the value of the services provided. SIIA asks that this Court reverse the court of appeals so disputes between hospitals and patients can continue to be resolved case-by-case with the same law that governs any other consumer transaction.

Respectfully submitted this 28th day of June, 2021.

FAIRFIELD & WOODS, P.C.

s/ Paul R. Janda
Paul R. Janda, #48878
Scott T. Rodgers, #19943
John M. Tanner, #16233
1801 California Street, Suite 2600
Denver, Colorado 80202
Telephone: (303) 830-2400
Fax No.: (303) 830-1033
E-mail: srodgers@fwlaw.com;
jtanner@fwlaw.com;
pjanda@fwlaw.com

Attorney for Amicus Curiae
Self-Insurance Institute of America, Inc.

CERTIFICATE OF SERVICE

I hereby certify on this 28th day of June 2021 I electronically filed a true and correct copy of this Amicus Curiae Brief via Colorado Courts E-Filing, which will serve as notification of such filing to all persons registered in this case.

s/ *Melia Danielson*
Melia Danielson