COLORADO SUPREME COURT 2 East 1th Avenue, Denver, Colorado 80203 Telephone: (720) 625-5150	DATE FILED: July 30, 2020 8:05 PM FILING ID: C8962754BC050 CASE NUMBER: 2020SC565
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@flaw.com	Case No.: 2020SC000565
SELF-INSURANCE INSTITUE OF AMERICA, INC.'S AMICUS BRIEF IN SUPPORT OF LISA M. FRENCH'S PETITION FOR WRIT OF CERTIORARI	

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 2761 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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I. AMICUS'S IDENTITY AND INTEREST IN THE CASE

The Self Insurance Institute of America ("SIIA") is a trade association of self-insured entities and others in the industry, such as 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 health care consumers, like Defendant/Petitioner Ms. French, benefit from their employers' self-insurance plans. Kaiser Family Found. & Health Research & Educ. Tr., *2019 Employer Health Benefits Survey, Section 10: Plan Funding*.

In resolving a simple contract dispute over surgery charges between Centura Health Corp. (the "Hospital") and Ms. French, who participated in an employer provided health plan, the Court of Appeals created a new rule of law that (as even the Hospital confirms) challenges the viability of that employer-provided plan and the business model of its administrator. Opening Brief, 2020 COA 85 at 40–41. This new judge-made law, untethered from Colorado precedent and based on an incomplete policy rationale, harms SIIA's interest in promoting a robust marketplace for self-insurance and its members' opportunities to provide or service cost-effective coverage. As a result, SIIA supports Ms. French's Petition for Writ of Certiorari.

II. STATEMENT OF THE CASE

SIIA agrees with and incorporates the facts and background as set forth in the Petition for Writ of Certiorari. This Court should review the Opinion and statement of policy because it addresses a fundamental policy of the State of Colorado.

III. REASONS IN SUPPORT OF CERTIORARI

Lisa French could have walked into a restaurant instead of the Hospital. Eating dinner, just like many planned back surgeries, is technically elective, but advisable sooner or later should she desire to experience the same length and quality of life she had long anticipated. Though the menu might define the price of various items from oysters to steaks as "MP" ("Market Price"), her server could provide an estimate. She could then decide to have that item at that price, make a different selection, or leave the restaurant and eat somewhere else.

While bills frequently exceed overly optimistic mental math, any diner would be shocked to find a tally more than two orders of magnitude higher than anticipated. But here, different tables get different prices. While most pay a negotiated rate that tracks the cost of the goods and services provided, one special table acts to subsidize whatever revenue problems stem from all other tables. Sitting there, even by accident, is akin to writing a blank check.

After initially assuring Ms. French she was not at that special table and after serving the entire meal, the restaurant realized it was mistaken and told Ms. French she had to pay 227 times the price they had estimated based on a pricing scheme so secret they refused to reveal it—even during discovery and trial. While a jury agreed Ms. French should owe no more than is reasonable, under the new rule created by the published Opinion, *Centura Health Corp. v. French*, 2020 COA 85 ("Opinion"), traditional rules of contract interpretation are inapplicable. Now free of the constraints of the common law on the grounds that such businesses are "complex," "Market Price" can mean exponentially different things for different patrons. So, the diners at the unlucky table—even if they were told by the restaurant that they were not at that table until after the check came—are on their own and defenseless against unconscionable rates.

1. Construed narrowly, as affecting only the interpretation of health care service agreements, this unprecedented rule will worsen the inequities Coloradans face and stifle market-based health care innovation.

Americans spend vastly more on health care per capita, both in terms of average cost of the product or service and of percentage of gross domestic product, than residents of any other industrialized nation. *See, e.g.*, Ctrs. For Medicare & Medicaid Servs., *National Health Expenditure Fact Sheet 2018* (providing an

overview of national health spending)[1]; Org. For Econ. Co-Operation & Dev., *Country Note: How Does Health Spending In The United States Compare?* 1–2 (2015).[2] By 2025, health care spending is expected to consume 20% of gross domestic product. Ctrs. for Medicare & Medicaid Servs., *Projections of National Health Expenditures Data Released*, 2016–2025 (Feb. 15, 2017).[3]

These high costs put many Americans in financial peril. *See, e.g.*, Timothy Jost, *Affordability: The Most Urgent Health Reform Issue for Ordinary Americans*, Health Aff. Blog (Feb. 29, 2016) (noting many living well-above the poverty line "do not have enough to even pay for the deductible of their coverage, much less the out-of-pocket limit")[4]; Cathy Schoen et al., *In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries*, 2008, 28 Health Aff. w1 (2008) ("U.S. patients were at particularly high risk of forgoing care because of

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[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

[2] https://www.oecd.org/unitedstates/Country-Note-UNITED STATES-OECD-Health-Statistics-2015.pdf.

[3] https://www.cms.gov/newsroom/press-releases/2016-2025-projections-national-health-expenditures-data-released.

[4] http://healthaffairs.org/blog/2016/02/29/affordability-the-most-urgent-health-reform-issue-for-ordinary-americans/.

costs ….)[5]; Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 Yale J. Health Pol'y L. & Ethics 239, 287–291 (2010) (exploring the relationship between medical bills and bankruptcy and methodological flaws by critics of the connection).

Even if Americans could afford these inflated rates and were unconcerned about comparative value, the current situation is economically precarious, because as many as one-in-three dollars spent on health care constitutes waste. Isaac D. Buck, *The Cost of High Prices: Embedding an Ethic of Expense into the Standard of Care*, 58 B.C. L. Rev. 102, 107 (2017). Worse, increases in health care spending are "crowding out other productive investments such as infrastructure and education." John Commins, *Healthcare Spending at 20% of GDP? That's an Economy-Wide Problem*, HealthLeaders (Sept. 19, 2018).[6]

The reasons for the high cost of health care are wide-ranging and heavily debated.[7] *See, e.g.*, John Aloysius Cogan Jr., *Health Insurance Rate Review*, 88

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[5] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.1.w1.

[6] https://www.healthleadersmedia.com/finance/healthcare-spending-20-gdp-thats-economy-wide-problem.

[7] As the Colorado Community Health Initiative ("CCHI") Amicus Brief Supporting Petition for Certiorari ("Amicus Brief") describes in greater length, the arbitrary and often secret nature of the chargemaster renders it ineffectual as any sort of cost

Temp. L. Rev. 411, 429 (2016) ("The asymmetries of information associated with health care services, including the difficulty of identifying prices, the moral hazard associated with insurance, and the market power of providers vis-a-vis insurers together form a potent recipe for market failure and excessive provider prices"); Martin Gaynor & Robert Town, *Synthesis Report Update, The Impact of Hospital Consolidation - Update 2* (2012), Robert Wood Johnson Found.[8]; Isaac D. Buck, *Caring Too Much: Misapplying the False Claims Act to Target Overtreatment*, 74 Ohio St. L.J. 463, 473–79 (2013); Christopher Weaver et al., *How Medicare Rewards Copious Nursing-Home Therapy*, Wall St. J., Aug. 16, 2015. Both patients and providers suffer the effects of moral hazard, because both have incentives to initially ignore (or in the case of providers, actively frustrate) cost considerations. Russell Korobkin, *Comparative Effectiveness Research as Choice*

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containment. Amicus Brief at 6–8. Under the new rule of law announced by the Court of Appeals, there are no controls on any line item price of the potentially 50,000 separate entries. Furthermore, providers exercise unrestricted discretion regarding what charges to wring from a particular service. "Hospitals have complete discretion over the process of setting charges, which lacks any discernable methodology and has been described variously as 'ad hoc,' 'bewildering,' 'arbitrary,' and 'cockamamie.'" Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 Hous. J. Health L. & Pol'y 11, 17–18 (2014) (citations omitted).

[8] http://www.rwjf. org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis, 112 Mich. L. Rev. 523, 541 (2014).

But significantly here, traditional health care insurance is one of the main drivers of increasing health care costs. *See, e.g.*, Thomas E. Getzen, *Health Economics: Fundamentals and Flow of Funds* 6–8 (1997) (reliance on third parties may be heightened by the high proportion of money paid by third parties and the wide variability of payments)[9]; Charles E. Phelps, *Health Economics* 2–10 (1992) (discussing unique aspects of health care economics, such as uncertainty, externalities affecting outcomes, and asymmetric knowledge); 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, 10 (2014) (noting, *e.g.*, how insurance companies "have only a limited concern to control price").

Unlike traditional insurance, Ms. French's employer's self-insurance plan,[10] as administered by ELAP Services ("ELAP"), pays providers based on the actual

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[9] Mr. Getzen testified as an expert witness on behalf of Ms. French.

[10] A self-insured plan pays for employees' benefits directly from funds held by the employer and does not contract with a separate insurance company to provide health insurance. *See* John Macdonald, *Health Plan Differences: Fully-Insured vs. Self-Insured*, Employee Benefit Research Institute (Feb. 11, 2009), *available*

cost to deliver the service in what it calls "reference-based pricing." ELAP, *Our Solution*, https://www.elapservices.com/who-we-are/ (last visited July 23, 2020). Unlike with a preferred provider organization ("PPO"), all patients are always out-of-network. *Id*. In its twelve years of operation, ELAP has successfully helped more than 500 employers achieve health care cost reductions of, on average, 25–30%. ELAP, *Reference-based Pricing*, https://www.elapservices.com/rbp-explained/ (click "See How RBP works") (last visited July 23, 2020). Remarkably, ELAP's clients have been immune from rising premiums, with rates remaining nearly flat year-over-year. *Id*. Most critically, this model increases choice for covered individuals while saving households each thousands of dollars annually. ELAP, *A Decade of Success With Reference-Based Pricing* at 4.[11]

As the Hospital admits, "the validity and price terms of the Hospital's contract with patients" directly implicates the design and business model of this plan. Opening Brief, 2020 COA 85 ("Opening Br.") at 40. The outcome here is critical to "maintaining a viable insurance Plan," and the sustainability of the "entire structure"

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at https://cdn.ymaws.com/www.naquitline.org/resource/resmgr/2011_seminar_series/health_plans_-__fully-_vs_se.pdf.

[11] Download at https://www.elapservices.com/whitepaper/managing-healthcare-costs-a-transformative-solution/.

of the plan. *Id*. at 41. In this one sense, the Hospital is right—by exempting its agreements with patients from common law contract principles, the Court of Appeals' decision eviscerates the potential cost savings created by these plans and will likely destroy this entire business model. Without review, the Hospital, unlike any other business, is protected from any limitation on the unreasonableness of the prices it forces upon patients it ensnares in out-of-network pricing—regardless how "ad hoc, bewildering, arbitrary, or cockamamie." (quoting Fuse Brown, *supra*).

But out-of-network provision of services is not peculiar to this particular self-insurance plan. In these uncertain economic times, few live without risk that their employer-provided insurance will suddenly cease. Stan Dorn, *The Covid-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History*, FamiliesUSA July 17, 2020.[12] Furthermore, enrollment in "narrow network" plans is rising, and with it, the possibility that patients will be forced to seek services out-of-network. Valarie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act:*

[12] https://www.familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf.

Recalling the Purpose of Health Insurance and Reform, 16 Minn. J.L. Sci. & Tech. 63, 67 (2015).

Moreover, a patient covered by traditional insurance could scrupulously select an in-network emergency facility, only to be similarly surprised by the bill when unexpectedly treated by an out-of-network physician. Haley Sweetland Edwards, *How You Could Get Hit with a Surprise Medical Bill*, Time, Mar. 7, 2016.[13] Or, a patient could carefully choose an in-network provider for a surgery, only to have an out-of-network individual join the medical team. Elisabeth Rosenthal, *After Surgery, Surprise $117,000 Medical Bill from Doctor He Didn't Know*, N.Y. Times, Sept. 20, 2014.[14] As one very recent Colorado story describes, increasing "unbundling" of services means the situation has gotten "out-of-hand" with more in-network patients getting "big" out-of-network bills. Markian Hawryluk, *The Knee Surgeon Was In-Network. The Surgical Assistant Wasn't, And Billed $1,167*, N.P.R., July 22, 2020.[15]

Regardless whether an out-of-network patient had any warning regarding their network status or opportunity to select a different provider or decline health care

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[13] http://time.com/4246845/health-care-insurance-suprise-medical-bill/.
[14] https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html.
[15] https://www.npr.org/sections/health-shots/2020/07/22/891909610/knee-repairs-use-of-surgical-assistant-leads-to-a-costly-surprise-bill.

entirely, the Opinion forces them to write a blank check for a potentially "life-crushing, overcharged medical bill that would make the Big Bad Wolf blush." Frank Griffin, *Fighting Overcharged Bills from Predatory Hospitals*, 51 Ariz. St. L.J. 1003, 1004 (2019); *see also* McLean & Datar, *supra* at 3 (referring to the chargemaster as a "Disneyland price structure"). Though acute medical intervention regularly saves citizens from immediate peril, for those who suffer not only a health care need, but also fall victim to unfortunate economic circumstances, unlucky geography, or as here a catastrophic clerical error by the same entity that promised to preserve life and health, Transcript ("TR") 6/5/18, pp. 501:1–503:25, a second reckoning begins at the arrival of the bill that may ultimately be significantly more life-altering than the problem that necessitated care in the first place.

While the Hospital obviously prefers a rule that liberates it from common law limits and leaves its charges to out-of-network patients constrained only by the conscience of providers, courts should not stymie the operation of markets, *Town of Telluride v. Lot Thirty-Four Venture, L.L.C.*, 3 P.3d 30, 38 (Colo. 2000), especially where innovators are attempting to mitigate pressing problems. Accordingly, this new rule on an important issue warrants review.

2. Even if this case were "complex," that does not abdicate the Court of Appeals of its responsibility to apply black letter law.

The Court of Appeals justified its legal and factual errors by claiming it would be "impractical . . . to attempt to resolve the complexity of the health care system." Opinion ¶27. This reasoning allowed the Court of Appeals to "set aside [its] misgivings that the HSA may have lacked mutual assent . . . ." *Id.* ¶31.

As a threshold matter, the Court of Appeals' premise that this case was too complex to apply established Colorado law is incorrect. The trial court was able to resolve the legal issues before it by applying basic Colorado precedent on contract interpretation. As for the jury, it was perfectly capable of resolving the problem created by the Hospital's own chosen contract language, an ambiguous price term, by determining the reasonable value of the medical services the Hospital provided—a question juries routinely answer. *See, e.g.*, *Sunahara v. State Farm Mut. Auto. Ins. Co.*, 280 P.3d 649, 655 (Colo. 2012) (discussing assessing the value of medical services with the application of the collateral source rule). Consequently, the alleged complexities of the health care industry do not support the conclusion that Colorado courts and juries are unequipped to address the issues presented by this case.

Regardless, taking the Court of Appeals' complexity contention at face value, the complexities of a case do not justify ignoring black letter law. *Cooke v. Sch. Dist.*

No. 12, 21 P. 496, 498 (Colo. 1889) ("When courts undertake to make laws for 'hard cases' they pass out of their proper sphere."). The Opinion's reliance on facts and policy arguments far beyond the four corners of the contract is a solution in search of a problem. *See Ad Two, Inc. v. City & Cty. of Denver*, 9 P.3d 373, 376 (Colo. 2000) (extraneous evidence inadmissible to interpret contract terms where there is no finding of ambiguity).

Furthermore, complex issues should not be resolved by creating special rules that favor sophisticated parties (such as the Hospital here) over health care consumers who are "sick, unschooled in the subject matter (which is why they have turned to a professional), unschooled in the risks they confront (just by being human), uncertain whether any particular protocol will be successful, scared, and wholly ignorant of price." McLean & Datar, *supra* at 9.

IV. CONCLUSION

This Court should grant the Petition because the Court of Appeals incorrectly determined that Colorado health care providers are uniquely immune to established Colorado contract law. The Opinion renders Colorado courts powerless to enforce traditional limitations on arbitrary, adhesive, and undisclosed contract terms merely because an industry is "complex." Courts exist to answer hard questions by applying longstanding rules and principles. In the face of allegedly complex issues, courts

should not simply throw up their hands, pass the buck, and deny a jury trial to innocent health care consumers surprised by a hospital bill exceeding the original out-of-pocket estimate by 227 times.

Common law contract rules should apply to providers and consumers of health care just the same as they apply in any other setting. Given the unique pressures and stressors on consumers of out-of-network health care services, sound policy supports applying existing precedent. There is no reason to create a judicial rule unique to health care that squashes market innovation already proven to fairly and practically mitigate the significant burden and inequities of health care billing practices.

Respectfully submitted this 30th day of July, 2020.

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@flaw.com

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

CERTIFICATE OF SERVICE

I hereby certify on this 30th day of July 2020 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/ *Celeste Jourdonais*
Celeste Jourdonais