SUMMARY
May 28, 2020

2020C0A85

No. 19CA0023, *Centura Health Corp v French* — Public Health and Environment — Hospitals — Hospital Service Agreements; Contracts — Ambiguity

A division of the court of appeals considers an issue of first impression in Colorado: whether a hospital services agreement's price term, requiring the patient to pay "all charges of the hospital," was ambiguous. The division holds that the patient's written promise to pay "all charges" unambiguously refers to the hospital's chargemaster rates and was sufficiently definite to be enforceable. Accordingly, the division concludes that the trial court erred by finding that "all charges" was ambiguous and allowing a jury to interpret the term and impose a reasonableness requirement.

COLORADO COURT OF APPEALS **2020C0A85**

Court of Appeals No. 19CA0023
Adams County District Court No. 17CV30884
Honorable Jaclyn C. Brown, Judge

Centura Health Corporation and Catholic Health Initiatives Colorado, d/b/a St. Anthony North Health Campus,

Plaintiffs-Appellants,

v.

Lisa Melody French,

Defendant-Appellee.

JUDGMENT REVERSED AND CASE
REMANDED WITH DIRECTIONS

Division VII
Opinion by JUDGE FOX
Navarro and Casebolt*, JJ., concur

Announced May 28, 2020

McConnell Van Pelt, LLC, Traci L. Van Pelt, Michael T. McConnell, David A. Belsheim, Denver, Colorado, for Plaintiffs-Appellants

FISHERBROYLES LLP, Frank C. Porada, Thomas E. Lavender III, Denver, Colorado; FISHER BROYLES LLP, Kristopher R. Alderman, Atlanta, Georgia, for Defendant-Appellee

*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art. VI, § 5(3), and § 24-51-1105, C.R.S. 2019.

¶ 1 Plaintiffs, Centura Health Corporation and Catholic Health Initiatives Colorado, doing business as St. Anthony North Health Campus (the Hospital), appeal the judgment entered on a jury verdict finding that defendant, Lisa Melody French, was only liable to the Hospital for the "reasonable value" of its services rather than the Hospital's bill.

¶ 2 On appeal, the Hospital argues that the trial court erred by ruling that the hospital services agreement (HSA) French signed was ambiguous and allowing the jury to decide the parties' contractual intent. We agree with the Hospital that the HSA's price term unambiguously referred to its chargemaster rates and was sufficiently definite to be enforceable. Therefore, we reverse the trial court's judgment that the term was ambiguous.

¶ 3 Because we reverse on this issue, we need not address the Hospital's remaining contentions that the trial court erred by denying the Hospital's motions for a directed verdict and judgment

notwithstanding the verdict, and its motion to amend its complaint.[1]

I. Background

¶ 4 In June 2014, French was admitted to the Hospital for elective spinal fusion surgery. French had health care benefits from her employer, who offered a self-funded plan to its employees administered by Professional Benefit Administrators, Inc. (PBA) and

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[1] Because we reverse, we also need not address the Hospital's contention that the trial court erred by excluding evidence of ELAP Services, LLC (French's health insurance administrator) paying French's attorney fees and satisfying any judgment entered against French, and references to other cases involving ELAP. Further, the Hospital waived this argument on appeal when it offered no analysis on why the court abused its discretion. *See Zolman v. Pinnacol Assurance*, 261 P.3d 490, 497 (Colo. App. 2011) (recognizing that arguments not advanced on appeal are generally deemed waived); *Antolovich v. Brown Grp. Retail, Inc.*, 183 P.3d 582, 600 (Colo. App. 2007) (declining to address party's argument because the party offered no evidence or authority in support of its argument). The Hospital argues in its reply brief that the trial court's exclusion of evidence resulted from the court's denial of the Hospital's motion to amend its complaint, but this claim is unsupported by the record because the trial court excluded the evidence following French's motion in limine, and we do not address arguments raised for the first time in the reply brief. *See Antolovich*, 183 P.3d at 591.

ELAP Services, LLC (ELAP).[2] ELAP was the "designated decision maker" for the plan. The Hospital had no provider agreement or negotiated contract with French's employer, PBA, or ELAP; thus, the Hospital considered French to be an out-of-network patient.

¶ 5 Before the surgery, French received a cost estimate, stating that the spinal fusion surgery would cost $57,601.77, and that after her insurance payment, she would only be responsible for $1336.90.[3] French also signed, three separate times before the surgery, a two-page HSA providing that she "understood that there is no guarantee of reimbursement or payment from any insurance

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[2] At trial, French's employer's human resources representative testified that a self-funded plan

> means that instead of having a fully insured insurance company, like BlueCross/Blue Shield or United Healthcare, the company pays the bills . . . . So when a claim comes in, it goes through a third-party administrator to be processed, to say this is what the insurance is going to pay on this bill. Then we have an account set up with that third-party administrator that they write checks to the providers, from the money that we deposit into that account.

[3] French's insurer provided the Hospital with French's estimated responsibility, based on her deductible and coinsurance cost, and the Hospital shared it with French.

company." French also "acknowledge[d] full financial responsibility for, and agree[d] to pay, all charges of the Hospital . . . not otherwise paid by my health insurance."

¶ 6 French's surgery had complications, and after a five-day hospital stay, French was billed $303,709.48. French paid the Hospital $1000, and after ELAP audited the bill, French's health insurance paid $73,597.35, leaving a balance of $229,112.13. The charges on French's bill were based on the Hospital's "chargemaster" rates, whereby the Hospital used a computer billing system to set predetermined rates for specified medical services. Specifically, when a patient receives a service, the service is recorded in the patient's medical record, which interacts with the chargemaster database by identifying the service's code, and then an automatic bill is generated for that service.

¶ 7 In June 2017, after failed collection attempts, the Hospital sued French for breach of contract to recover the unpaid hospital bill. Before trial, the Hospital sought to amend its complaint to add French's employer, PBA, and ELAP as defendants, but the trial court denied its request. The trial court also denied the Hospital's

pretrial motion asking the court to declare that, as a matter of law, the HSA's phrase, "all charges of the Hospital," unambiguously referred to the Hospital's chargemaster rates.

¶ 8 Following trial, the jury found that French had breached the HSA, which it found was a binding contract requiring French to pay "all charges of the Hospital . . . not otherwise paid by my health insurance or other payor." However, because the trial court had previously held that the term "all charges" was ambiguous, the jury was asked to interpret the term, and it concluded that "all charges" meant the "reasonable value of the goods and services" provided to French. Employing that definition, the jury found that French owed the Hospital $766.74 (rather than the $229,112.13 billed balance).

II. HSA

¶ 9 The Hospital argues that the trial court erred by ruling that the term "all charges" in the HSA was ambiguous, thereby allowing the jury to decide that the term meant the "reasonable value" of the services French received. We agree.

A. Additional Background

¶ 10 Three separate times before the surgery, French signed a two-page HSA and a two-page patient bill of rights. The HSA provided that French

> understood that there is no guarantee of reimbursement or payment from any insurance company . . . . I acknowledge full financial responsibility for, and agree to pay, all charges of the Hospital and of physicians rendering services not otherwise paid by my health insurance or other payor. . . . Any remaining charges are due and payable upon receipt of the bill.

¶ 11 The HSA also stated that French understood that she was "financially responsible to the Hospital or my physicians for charges not covered or paid[.]" Under the acknowledgment of patient rights and responsibilities, the HSA reiterated, "I agree to accept the consequences if I disregard my rights and responsibilities."

¶ 12 The patient bill of rights listed ten patient responsibilities, including that the patient must "[u]nderstand and honor financial obligations related to your care, including understanding your own insurance coverage." The patient bill of rights also stated that a patient has the right to "[r]equest and receive, prior to the initiation of non-emergent care or treatment, the charges (or estimate of

charges) for routine, usual, and customary services and any co-payment, deductible or non-covered charges, as well as the facility's general billing procedures including receipt and explanation of an itemized bill."

¶ 13 When the trial court denied the Hospital's motion for a declaratory judgment, which asked the court to hold that the HSA's price term "all charges" unambiguously referred to the Hospital's chargemaster rates, the court ruled that it

> cannot find that the hospital-patient forms incorporate or refer to the chargemaster as a matter of law. At issue in all of plaintiffs' declaratory judgment claims is the phrase "all charges" in Paragraph 5 of the Hospital Service Agreement. According to plaintiffs, the plain meaning of "all charges" unambiguously refers to rates generated from the chargemaster. The court disagrees and finds that the term is ambiguous. The document signed by defendant is devoid of any reference to the Hospital's chargemaster and does not define the meaning of "all charges." At the very least, the hospital-patient forms are reasonably susceptible to more than one meaning. Therefore, the definition of "all charges" is a question of fact appropriately decided by the jury at trial.

¶ 14 At trial, French testified that she did not read the HSA, she did not understand that her insurer was out of network, and she

believed she would only be responsible for her deductible and coinsurance (estimated at $1336.90). When asked if she expected to see a bill following her surgery, she responded that she believed her insurance company would handle the remaining balance, testifying that she "never expected a bill because [she] assumed [she] paid what [she] was supposed to pay." French further testified that she was unaware of any limits to her insurance coverage or limitations on what her insurance would pay the hospital, testifying, "I assumed when I was told [the surgery's] covered, it's covered."

B. Preservation, Standard of Review, and Applicable Law

¶ 15 The parties agree that the Hospital preserved this issue for appeal.

¶ 16 We review de novo whether a contract is ambiguous. *Am. Family Mut. Ins. Co. v. Hansen*, 2016 CO 46, ¶ 23; *see also Ravenstar, LLC v. One Ski Hill Place, LLC*, 2017 CO 83, ¶ 9 (whether a contract is enforceable is a question of law that we review de novo). We also review de novo whether the trial court applied the

correct legal standard. *Wal-Mart Stores, Inc. v. Crossgrove*, 2012 CO 31, ¶ 7.

¶ 17 A contract's term is ambiguous "if it is susceptible on its face to more than one reasonable interpretation." *Hansen*, ¶ 24 (quoting *USAA Cas. Ins. Co. v. Anglum*, 119 P.3d 1058, 1059–60 (Colo. 2005)). If a contract is free from ambiguity, we enforce it as written. *Id.*

¶ 18 In determining whether a contractual provision is ambiguous, we examine and construe the language in harmony with the plain and generally accepted meaning of the words employed. *Parrish Chiropractic Ctrs., P.C. v. Progressive Cas. Ins. Co.*, 874 P.2d 1049, 1055 (Colo. 1994). We also examine the entire contract and do not view clauses or phrases in isolation in order to give effect to all provisions. *Mid Century Ins. Co. v. Gates Rubber Co.*, 43 P.3d 737, 739 (Colo. App. 2002); *Town of Silverton v. Phx. Heat Source Sys., Inc.*, 948 P.2d 9, 11 (Colo. App. 1997).

¶ 19 Mere potential for more than one interpretation does not, by itself, create an ambiguity. *Branscum v. Am. Cmty. Mut. Ins. Co.*, 984 P.2d 675, 678 (Colo. App. 1999). And mere disagreement

between the parties about the meaning of a term does not create an ambiguity. *Morley v. United Servs. Auto. Ass'n*, 2019 COA 169, ¶ 16. Nor may an unambiguous contract be made ambiguous by extrinsic evidence. *Hansen*, ¶ 27. Rather, ambiguity must first be shown to exist on the face of the contract. *Parrish Chiropractic Ctrs., P.C.*, 874 P.2d at 1056.

C. Analysis

¶ 20 Whether a patient's written promise to pay "all charges of the hospital" unambiguously refers to the chargemaster rates appears to be an issue of first impression in Colorado. Accordingly, we look to the decisions of other jurisdictions for persuasive guidance. *See P.W. v. Children's Hosp. Colo.*, 2016 CO 6, ¶ 23.

¶ 21 The Hospital contends that most jurisdictions hold that a hospital-patient agreement requiring a patient to pay "all charges" (or similar language) unambiguously refers to a hospital's chargemaster rates. We agree.

¶ 22 Most jurisdictions have interpreted express hospital contracts, like the HSA French signed requiring her to pay "all charges," as unambiguously incorporating a hospital's chargemaster rates and

have therefore held that such contracts' price terms were sufficiently definite to be enforceable.[4] *See DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 263–64 (3d Cir. 2008) (holding that the hospital's form requiring patient to pay "all charges" unambiguously referred to the hospital's chargemaster rates); *Banner Health v. Med. Sav. Ins. Co.*, 163 P.3d 1096, 1100–01 (Ariz. Ct. App. 2007) (holding that when patients sign hospital agreements, agreeing to be

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[4] The cited majority-rule cases are distinguished from those cases where a reasonableness requirement was imposed on an implied-in-fact contract. In such cases, plaintiffs obtain recovery under unjust enrichment or quantum meruit theories. *See Portercare Adventist Health Sys. v. Lego*, 312 P.3d 201, 206 (Colo. App. 2010) ("Where the parties have not expressed the price to be paid under a contract implied in fact, the amount of recovery is the reasonable market value of the services or goods provided."), *rev'd on other grounds*, 2012 CO 58; *In re Estate of Reed*, 201 P.3d 1264, 1269 (Colo. App. 2008) (recognizing that to recover under a theory of unjust enrichment, a provider is entitled to recover only the fair and reasonable value of the services provided, which may or may not be the same as the amount of the provider's bill); *see also Galloway v. Methodist Hosps., Inc.*, 658 N.E.2d 611, 614 (Ind. Ct. App. 1995) (looking to the reasonableness of a hospital's bills where the patient entered into an implied contract and the court held that equity demanded the patient pay the hospital to prevent an unjust enrichment); *Landmark Med. Ctr. v. Gauthier*, 635 A.2d 1145, 1148 (R.I. 1994) (looking to whether hospital fees were necessary and reasonable "in the absence of a valid contract, under the quasi-contract theory," and noting that a "quasi-contract or an implied-in-law contract is formed when medically necessary services are rendered even without mutual assent").

responsible for the "bill" and to "pay the account" based on the hospital's "usual and customary charges," they are expressly and unambiguously agreeing to pay the hospital's chargemaster rates); *William W. Backus Hosp. v. Belisle*, Nos. KNLCV156023749S, KNLCV156023765S, KNLCV156023766S & KNLCV156023778S, 2016 WL 6118987, at *4 (Conn. Super. Ct. Sept. 6, 2016) (unpublished opinion) (holding that the hospital was entitled to judgment as a matter of law after concluding that the patients promised to pay the hospital's chargemaster rates, which "could be certainly and definitely ascertained by comparing the services performed to the publicly published [charge]master rates"); *Satterfield v. S. Reg'l Health Sys., Inc.*, 634 S.E.2d 530, 531 (Ga. Ct. App. 2006) (holding that because the patients had the opportunity to request pricing information, but did not do so, and the patients agreed to pay the hospital's fees and charges by signing the hospital contract, the patients "cannot now argue that they agreed to something else"); *Allen v. Clarian Health Partners, Inc.*, 980 N.E.2d 306, 311 (Ind. 2012) ("We align ourselves with those courts that have recognized the uniqueness of the market for health care

services delivered by hospitals, and hold that Patients' agreement to pay 'the account' in the context of Clarian's contract to provide medical services is not indefinite and refers to Clarian's chargemaster. As a result, we cannot impute a 'reasonable' price term into this contract."); *Butts v. Iowa Health Sys.*, 863 N.W.2d 36, 2015 WL 1046119, at *8 (Iowa Ct. App. 2015) (unpublished table decision) (holding that the hospital-patient contract's "regular rates" price term was not indefinite and therefore the price was contracted for and "the court need not supply a 'reasonable' rate"); *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724, 726 (Mich. Ct. App. 2010) (holding that the hospital's agreement requiring an uninsured patient to pay its "usual and customary charges" unambiguously referred to chargemaster prices even though those prices "are higher than the discounted prices charged to insured patients"); *Shelton v. Duke Univ. Health Sys., Inc.*, 633 S.E.2d 113, 115–16 (N.C. Ct. App. 2006) (holding that the price term of the hospital-patient contract requiring the patient to pay "the regular rates and terms of the Hospital at the time of patient's discharge" was "definite and certain or capable of being made so" and "necessarily

implied" the hospital's chargemaster rates) (citations omitted); *Limberg v. Sanford Med. Ctr. Fargo*, 881 N.W.2d 658, 661–62 (N.D. 2016) (holding that the hospital-patient contract requiring patients to pay "all charges" was not an "open price" term but rather was "reasonably definite and certain" and referred to the hospital's chargemaster rates); *Nygaard v. Sioux Valley Hosps. & Health Sys.*, 731 N.W.2d 184, 191 (S.D. 2007) (holding that the hospital-patient contract incorporated the pre-set chargemaster rates and therefore the price term was fixed and determinable and, accordingly, "the law does not permit imputation of different, implied price terms for what patients later claimed were the reasonable values of the services provided"); *Pitell v. King Cty. Pub. Hosp. Dist. No. 2*, 423 P.3d 900, 905 (Wash. Ct. App. 2018) (holding that when the patient agreed to pay "the balance due" and was informed that he was "responsible for payment of [his] account," it was understood that the patient would be charged for the services received and "the amount charged would be determined by an extant set list of prices").[5]

[5] Some states, by statute, limit the portion of a hospital's

¶ 23 A minority of jurisdictions impose a reasonableness requirement on a hospital's charges, even where patients signed an express agreement to pay "all charges" or similar language. *See Payne v. Humana Hosp. Orange Park*, 661 So. 2d 1239, 1241 (Fla. Dist. Ct. App. 1995) (holding that because the hospital-patient contract failed to "express prices within the four corners of the contract," the price was indefinite and therefore a reasonable price was implied); *Doe v. HCA Health Servs. of Tenn., Inc.*, 46 S.W.3d 191, 197 (Tenn. 2001) (holding that the hospital-patient contract's price term was indefinite and therefore the contract was unenforceable because the contract did not reference the chargemaster rate or any other document allowing a patient to

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chargemaster rate that may be billed to uninsured or underinsured patients. *See, e.g.*, *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 263 (3d Cir. 2008) (recognizing that the New Jersey hospital at issue offers discounts to uninsured patients or those requiring financial assistance under N.J. Admin. Code § 10:52–11.8 (2019), which provides free care to those demonstrating income up to 200% of the federal poverty level and provides discounted services for patients with incomes greater than 200% but not more than 300% of the federal poverty level). Colorado's legislature has not done so.

determine the price; thus, the hospital was required to prove reasonableness to recover under quantum meruit).[6]

¶ 24 We conclude that the majority approach is more persuasive for four reasons.

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[6] Besides Tennessee and Florida, other jurisdictions have imposed a reasonableness requirement on a hospital's price term or declared hospital-patient contracts unenforceable. However, such cases are of limited relevance here when the patient received emergency medical services, *see St. John's Episcopal Hosp. v. McAdoo*, 405 N.Y.S.2d 935, 936–37 (N.Y. Civ. Ct. 1978) (concluding that an unenforceable contract of adhesion existed when a party was "powerless to do anything other than sign" a form contract so that the party's wife, who he believed was near death, could gain admission to the hospital), or the opinion is unclear as to whether the patient signed an express, written contract requiring the payment of "all charges" or similar language, *see Hutchinson Hosp. Corp. v. Neal*, 154 P.3d 521, 523–24 (Kan. Ct. App. 2007) ("The hospital is entitled to recover for its services even though the parties have not reached an agreement on the specific price to be paid. The law imposes a duty upon Neal to pay the hospital's reasonable charges for its services. If there was a written contract for services and the contract did not contain an explicit price term, the district court was required to set a reasonable price.") (citations omitted); *Howard v. Willis-Knighton Med. Ctr.*, 924 So. 2d 1245, 1253 (La. Ct. App. 2006) ("The contractual relationship between a health care provider and patient may result from an express or implied contract, and the rights and liabilities of the parties thereto are governed by the general law of contract. In the absence of a definite agreement as to what charges are to enter into the contract, the health care provider may decide upon and fix the charges, which must be reasonable.") (citation omitted).

¶ 25 First, hospitals cannot always accurately predict what services a patient will ultimately require. As the Third Circuit observed in *DiCarlo*, while the price term "all charges" is certainly less precise than a price term for an ordinary contract for goods or services in that it does not specify an exact amount to be paid, it is

> the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails . . . her. Besides handing the patient an inches-high stack of papers detailing the hospital's charges for each and every conceivable service, which . . . she could not possibly read and understand before agreeing to treatment, the form contract employed by [the hospital] is the only way to communicate to a patient the nature of . . . her financial obligations to the hospital.

530 F.3d at 264 (footnote omitted). Indeed, the balance bill at issue here resulted, at least in part, from the complications attending French's surgery. Because hospitals cannot accurately make such predictions, we cannot conclude that an HSA must contain a precise price for it to unambiguously incorporate a hospital's chargemaster rates and be enforceable. *See Shelton*, 633 S.E.2d at 116 ("It would be cumbersome, and against patients' interests, to

require hospitals to seek new authorization from a patient whenever some medical circumstance requires a new course of treatment. For this reason, it is entirely reasonable and predictable that patients would agree to pay the hospital's regular rates for whatever services might be necessary in treating their particular ailments or afflictions.").

¶ 26 Second, while the HSA did not explicitly reference chargemaster prices, the price term "all charges" was nonetheless sufficiently definite because the chargemaster rates are predetermined. *See Nygaard*, 731 N.W.2d at 191 (holding that the hospital-patient contract was enforceable and did not contain an open price term because the agreement incorporated predetermined prices that "were fixed and determinable"). French was not charged individualized prices that were set after her treatment, and French does not contend that she was charged a different rate than the Hospital's regular chargemaster rate. *See Shelton*, 633 S.E.2d at 116 (holding that the patient unambiguously agreed to pay the hospital's chargemaster rates where she made no argument that she was charged anything other than the "regular" rates). Further,

the two-page patient bill of rights that French signed on three occasions informed her of her right to request and receive the charges for "routine, usual, and customary services," as well as the hospital's general billing procedures. *Cf. Doe*, 46 S.W.3d at 197 ("To be clear, the Court's holding in this case does not invalidate all contracts that do not state a specific price; to the contrary, our holding is based upon the particular facts of this case, i.e., that HCA Donelson Hospital's contract signed by Jane Doe did not provide any reference to a document, transaction or other extrinsic facts by which the price could be determined and the meaning of the term "charge" made clear."). That French was not provided a copy of the chargemaster rates before her surgery — French does not contend that she requested, but was denied, the rates — does not automatically render the contract ambiguous or unenforceable. *See Shelton*, 633 S.E.2d at 115 (holding that the hospital's contract requiring the patient to pay its "regular rates" was sufficiently definite where the patient was not provided the chargemaster rates before she signed the consent form but she did not request to view the rates); *Limberg*, 881 N.W.2d at 662 (holding that the hospital-

patient contract contained a sufficiently definite price term where the patient did not "allege that he requested access to the Chargemaster and was denied such access").

¶ 27 Third, the majority approach persuasively recognizes that it would 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. *See supra* n.6; *see also Firelands Reg'l Med. Ctr. v. Jeavons*, 2008-Ohio-5031, ¶ 24, 2008 WL 4408600, at *3 (Ct. App. Sept. 30, 2008) (rejecting patient's claim that the hospital charged uninsured patients unreasonable amounts because "[w]hat is considered 'reasonable' is too amorphous for this (or, in our opinion any) court to determine"). In the United States, and in Colorado, many hospitals set chargemaster rates — often with little supervision — used for patient billing and applied to patients equally. However, hospitals may negotiate lower contract prices for insurers or be required to accept lower rates from the government for treatment of Medicaid and Medicare patients. *See DiCarlo*, 530 F.3d at 263 (recognizing the "peculiar circumstances of hospitals"

and "the bearing these circumstances have upon the interpretation of contracts between a patient and the hospital," where the hospital's chargemaster rate "applies to all patients, without regard to whether the patient is insured, uninsured, or a government program beneficiary," but the hospital may negotiate and accept "differing discounts with some managed care payors and insurance companies"). Given this complexity, which allows insurers to negotiate lower rates with hospitals, we cannot fault the Hospital for charging French its chargemaster rates when (1) her insurance was out of network; (2) the Hospital repeatedly informed French of her payment obligations and rights to obtain further pricing information; (3) the Hospital's initial cost estimate of $1336.90 was based on information provided to the Hospital by French's insurer; and (4) the Colorado legislature has yet to set limits on chargemaster rates.

¶ 28 Finally, like other jurisdictions that have similar statutes and have adopted the majority approach, Colorado law provides *some* public transparency for the Hospital's chargemaster rates. Specifically, section 25-3-705, C.R.S. 2019, and section 10-16-134,

C.R.S. 2019, require hospitals to report their average billed charges to the Colorado Hospital Association (CHA). Each year the CHA and the Division of Insurance are required to publish hospital prices and carrier reimbursement information online. Further, the CHA report publishes a sum of all charges, which is taken from the hospitals' chargemaster rates. Accordingly, these statutes and regulatory reports provide some price transparency to help consumers make more educated choices regarding health care. *See* Colo. Dep't of Regulatory Agencies, Div. of Ins., *Colorado Hospital Price Report* (Dec. 2019), https://perma.cc/Q9Q6-69X5.

¶ 29 And, section 6-20-101(1), C.R.S. 2019, requires hospitals to

> disclose to a person seeking care or treatment his or her right to receive notice of the average facility charge for such treatment that is a frequently performed inpatient procedure prior to admission for such procedure . . . . When requested, the average charge information shall be made available to the person prior to admission for such procedure.

The patient bill of rights that French signed three separate times disclosed her right to obtain pricing and billing information. Thus, Colorado's health care statutes further support our conclusion that the HSA's price term was sufficiently determinable and therefore

definite enough to be enforced. *See Banner Health*, 163 P.3d at 1100 ("Because of the statutory scheme and the resultant publishing of Banner's rates and charges, there are no 'open' or missing price terms" in the hospital agreements requiring patients to pay the hospital's "usual and customary charges," where the hospital's rates are filed annually.); *Belisle*, 2016 WL 6118987, at *4 (recognizing that the hospital was required, by state statute, to post its chargemaster rates on a public schedule called a "pricemaster"); *Satterfield*, 634 S.E.2d at 531 ("[A]ppellants do not allege that the pricing information was unavailable. . . . [A]ppellants were free to avail themselves of the procedure established by the General Assembly, at [Ga. Code Ann.] § 31–7–11 [(West 2019)], allowing purchasers of hospital services to use the mandatorily available pricing information to compare hospital charges and make cost-effective decisions.").

¶ 30 Of course, our holding is limited to the unique context of the health care system and hospital-patient contracts. To impose a reasonableness requirement on the HSA's price term here would require hospitals to litigate the reasonableness of their charges in

order to obtain recovery, thereby ignoring the reality of our health care system, which allows insurers to negotiate lower contract prices with hospitals. *See DiCarlo*, 530 F.3d at 264 ("A court could not possibly determine what a 'reasonable charge' for hospital services would be without wading into the entire structure of providing hospital care and the means of dealing with hospital solvency. These are subjects with which state and federal executives, legislatures, and regulatory agencies are wrestling and which are governed by numerous legislative acts and regulatory bodies.").

¶ 31 For such important policy considerations, we set aside our misgivings that the HSA may have lacked mutual assent, given French's testimony that she relied on the Hospital's cost estimate that she would only be responsible for her deductible and coinsurance and that she did not understand that her insurance was out of network.[7] *See Morley*, ¶ 16; *Branscum*, 984 P.2d at 678;

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[7] French's employer's human resources representative testified that employees were emailed a PowerPoint presentation informing them that, if treated at a hospital, they were out of network, and after treatment the hospital would send them a balance bill, and then

see also Shelton, 633 S.E.2d at 115–16 (holding that the hospital's contract requiring the patient to pay its "regular rates" was sufficiently definite to allow a meeting of the minds on the price term even though the patient was not provided the chargemaster rates); *PHC-Martinsville, Inc. v. Dennis*, No. 161019, 2017 WL 4053898, at *2 (Va. Sept. 14, 2017) (reversing court of appeals' opinion that the hospital's chargemaster rates were unreasonable and holding that the hospital's "use of a standard-form contract and the disparity in bargaining power between the parties did not affect Dennis's ability to assent to its terms," nor was the hospital's "refusal to provide Dennis with a copy of the charge description master *after* he received the bill for services rendered by the Hospital" relevant to the patient's assent at the time of contracting); *Pitell*, 423 P.3d at 905 (holding that the contract notified the patient that he could request an estimate of charges, which further acknowledged the existence of a list of prices from which an

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their insurance would provide employees with a lawyer free of cost to dispute the remaining balance. Accordingly, French's employer implied to its employees that they would only have to pay their deductible and coinsurance.

estimate could be constructed, and therefore the contract language demonstrated the parties' "mutual understanding that the amount owed by Pitell was definite or capable of being made so by reference to an extant list of charges — in this case, the chargemaster"). But our holding here does not suggest that patients have no right to question hospitals concerning any particular treatment or related costs, that patients cannot refuse (or delay) treatment for reasons of cost, or that patients and hospitals should not negotiate discounts to the chargemaster rates. *See Shelton*, 633 S.E.2d at 116.

¶ 32 The Hospital relies on two Colorado cases in arguing that the HSA's price term unambiguously incorporates chargemaster rates: *Wal-Mart Stores, Inc. v. Crossgrove*, 2012 CO 31, and *Portercare Adventist Health System v. Lego*, 2012 CO 58. But neither case is instructive here.

¶ 33 First, *Crossgrove* is of limited relevance here because, even assuming that Crossgrove's hospital bill was based on chargemaster rates, the rates appear to have been reduced because his insurer was an in-network provider. *See Crossgrove*, ¶ 27 (Eid, J., dissenting) ("The medical providers in this case billed the

plaintiff $242,000 for medical services, but accepted $40,000 from plaintiff's health insurer as payment in full."). Further, we are not interpreting tort principles to determine the reasonable value of a plaintiff's economic damages from a tort. *See id.* at ¶ 20 (majority opinion).

¶ 34 Likewise, our supreme court's holding in *Lego* is largely irrelevant here because Lego entered into an implied-in-fact contract. Unlike implied-in-fact contracts, where courts may impose a reasonableness requirement, *see Portercare Adventist Health Sys. v. Lego*, 312 P.3d 201, 206 (Colo. App. 2010) ("Where the parties have not expressed the price to be paid under a contract implied in fact, the amount of recovery is the reasonable market value of the services or goods provided."), *rev'd on other grounds*, 2012 CO 58, this case concerns a signed, written contract.

¶ 35 Because we conclude that the HSA's price term "all charges" unambiguously referred to the Hospital's chargemaster rates and was sufficiently definite to be enforceable, we reverse the trial court's judgment that the term was ambiguous. Accordingly, the

trial court erred when it allowed a jury to interpret "all charges" and impose a reasonableness requirement on the HSA's price term.

III. Conclusion

¶ 36 We reverse the trial court's judgment that the HSA's price term "all charges" was ambiguous. We remand this case to the trial court with directions to set aside the judgment entered on the jury's verdict and instead enter a judgment recognizing, consistent with this opinion, that the HSA's term "all charges" unambiguously incorporates the Hospital's chargemaster rates into the agreement. The trial court may entertain further requests for relief that follow from this remand.

JUDGE NAVARRO and JUDGE CASEBOLT concur.