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COLORAOD COURT OF APPEALS Ralph L. Carr Judicial Center 2 East 14th Avenue Denver, CO 80203	
DISTRICT COURT, JEFFERSON COUNTY, *Honorable Randall C. Arp, District Court Judge,* *Case Number: 2019CV30826*	
Plaintiff-Appellee: RAPHAEL MUKENDI, v. **Defendants-Petitioners:** BRADLEY SCHROCK	▲COURT USE ONLY▲
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BRIEF OF AMICUS CURIAE COLORADO TRIAL LAWYERS ASSOCIATION

CERTIFICATE OF COMPLIANCE

I hereby certify that this amicus brief complies with all requirements of C.A.R. 28, 29, and 32, including all formatting requirements set forth in these rules.

Specifically, the undersigned certifies that the brief complies with the applicable word limits set forth in C.A.R. 28(g) and C.A.R. 29(d). It contains 4,717 words (no more than 4,750 words).

I acknowledge that my brief may be stricken if it fails to comply with any of the requirements of C.A.R. 28, 29, and 32.

Respectfully submitted,

s/ S. Paige Singleton
S. Paige Singleton, #49011

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STATEMENT OF INTEREST

The Colorado Trial Lawyers Association ("CTLA") consists of trial attorneys from across Colorado who represent plaintiffs, particularly individuals, in a wide variety of litigation. CTLA's stated mission is to protect the rights of the individual, advance trial advocacy skills, and promote high ethical standards and professionalism in the ongoing effort to preserve and improve the American system of jurisprudence. The organization is active in promoting fairness and equity in litigation, including the provisions at issue in this case.

This case is not about allowing defendants to present evidence to dispute plaintiffs presented medical bills. This case is a thinly veiled attempt by Defendant to get this Court to overturn the Colorado precedent from the last ten years. Clarification relating to the admissibility of collateral source or other irrelevant evidence to re-price medical expenses, supports the CTLA's missions of protecting injured individuals' rights in and through civil litigation by ensuring judicial economy in limiting these courtroom sideshows.

SUMMARY OF ARGUMENT

The collateral source rule is based on the rationale that, subject to very narrow exceptions, "making the injured plaintiff whole is solely the tortfeasor's responsibility." *Volunteers of Am. v. Gardenswartz,* 242 P.3d 1080 (Colo. 2010).

Despite the Supreme Court holding for the last decade that the collateral source rule does not permit the introduction of collateral source evidence given the risk of a jury improperly reducing a plaintiffs' damages, Defendant now seeks to overturn that precedent because he believes that the increasing costs of medical care is the responsibility of each individual plaintiff to justify.

This case arises out of a motor vehicle collision in which Raphael Mukendi ("Plaintiff") was severely injured when Bradley Schrock ("Defendant") crossed the center line and crashed head-on with Plaintiff. Mr. Mukendi was rushed from the scene of the collision to University of Colorado Hospital ("UCH") where he was treated for life-threatening injuries and then intubated. Mr. Mukendi endured three surgeries and then he was transferred from UCH to Swedish Medical Center ("SMC"), before he was transferred to a rehabilitation facility. Plaintiff had no choice over what hospital(s) treated him, which doctors operated on him, or what the charges would be for his medical care.

Before trial, Defendant endorsed Richard Lacy to opine on the reasonableness of the bills by analyzing the cost-to-charges ratio. (CF, p. 603). Mr. Lacy sought to opine that while the billed charges for UCH were $509,784, the market value of the services was $249,845, and that the $88,520 in billed charges from SMC had a market value of $28,675. *Id.* at 604-05. Additionally, Defendant sought to introduce

the testimony of Michael Bishop, designated as UCH's C.R.C.P. 30(b)(6) witness, regarding a self-pay discount offered by UCH for uninsured patients despite Plaintiff carrying health insurance at the time of the collision (CF, p. 922).

The pre-verdict evidentiary component of Colorado's collateral source rule – which has been well-settled in common law and codified by the legislature – unambiguously precludes direct and indirect evidence of collateral sources to prevent the unjustifiable risk that the jury will improperly diminish the plaintiff's damages award. While Defendant and the CDLA seek to water down *Crossgrove* and its progeny with backdoor attempts to admit evidence of collateral sources, this issue has been decided and there is no reason to disturb this longstanding law.

In addition to the collateral source rule, trial courts have broad discretion to exclude evidence and expert testimony that is irrelevant to the issues in the case or because any probative value it has is outweighed by the danger of unfair prejudice, confusion of the issues, misleading the jury, and undue delay. That is precisely what the trial court did in this case. It appropriately exercised its discretion by excluding, pursuant to C.R.E. 401-403, (1) expert testimony on hospital profit margins and "market value" where the Plaintiff had no control over his medical charges because he was emergently transported to one hospital and then transferred to another; and

(2) testimony from a hospital C.R.C.P. 30(b)(6) witness on a self-pay discount for uninsured patients that was inapplicable to Plaintiff.

Defendant further seeks to increase the burden of plaintiffs by asking this Court to impose a requirement that plaintiffs "prove" the reasonable value of their medical expenses through expert testimony or by other evidence beyond the amounts billed by their medical providers. Colorado courts have long held that the amount billed for medical services provides sufficient evidence of the reasonable value of medical services. Requiring any additional evidence of the reasonable value of medical services will place an unreasonable and unrealistic burden and expense on plaintiffs in personal injury cases.

This Court should affirm both the trial court's orders striking Mr. Lacy and Mr. Bishop from testifying and uphold the longstanding precedent in this State.

ARGUMENT

A. Colorado's Longstanding Collateral Source Rule Unequivocally Excludes Direct and Indirect Evidence of Amounts Paid by Collateral Sources for Medical Treatment for Any Purpose.

Prior to 1986, Colorado applied the common law collateral source rule. *Van Waters v. Keelan*, 840 P.2d 1070, 1074 (Colo. 1992). Under this rule, compensation that a tort victim received from a source unrelated to the tortfeasor would not reduce the damages recoverable from the tortfeasor. *Id*. at 1074. The purpose of the common law collateral source rule was to prevent the wrongdoer from receiving

reduced liability merely because the injured party had been indemnified by an outside, independent source. *Id*. It was considered fairer that any windfall should be realized by the plaintiff in the form of double recovery rather than by the tortfeasor in the form of reduced liability. *Id.*

In *Wal-Mart Stores, Inc. v. Crossgrove*, 276 P.3d 562, 568 (Colo. 2012) and *Sunahara v. State Farm Mut. Auto. Ins. Co.*, 280 P.3d 649, 655 (Colo. 2012), the Colorado Supreme Court held that the common law collateral source rule precludes evidence that a plaintiff's medical providers had accepted less than the full billed amounts from a plaintiff's medical insurer.

In so holding, the Court recognized an inherent tension between the collateral source rule and the historical rule in Colorado that a plaintiff was entitled at trial to recover the "necessary and reasonable value of the [medical] services rendered" to treat the plaintiff's injuries. *See Crossgrove*, 276 P.3d at 566 (quoting *Kendall v. Hargrave*, 349 P.2d 993, 994 (Colo. 1960). The *Crossgrove* Court noted that *Kendall* generally contemplated admission of the amounts paid for medical treatment as relevant evidence regarding the value of the treatment provided. In resolving this tension, *Crossgrove* and *Sunahara* held that the pre-verdict, evidentiary component of the collateral source rule prevailed over the "reasonable value" rule in *Kendall*.

Evidence of the amounts paid is therefore inadmissible. The Court concluded: "[a]dmitting amounts paid evidence for any purpose, including the purpose of determining reasonable value, in a collateral source case carries with it an unjustifiable risk that the jury will infer the existence of a collateral source – most commonly an insurer – from the evidence, and thereby improperly diminish the plaintiff's damages award." *Crossgrove*, 276 P.3d at 567. Furthermore, the Court found that a reasonable juror will likely infer the existence of a collateral source, whether one exists or not, if presented with a lower amount that may have been paid to a health provider in order to satisfy a higher amount billed, because providers routinely accept discounted rates to satisfy insured patients' bills, i.e., discounts, therefore it prohibited repricing evidence. *Id*.

In 2010, after the claims in *Sunahara* and *Crossgrove* had accrued but before the appeals were decided, the General Assembly enacted C.R.S. § 10-1-135. Subsection 10(a) of that statute states:

> The requirement of section 13-21-111.6, C.R.S., regarding the reduction of damages based on amounts paid for damages from a collateral source. The fact or amount of any collateral source payment or benefits shall not be admitted as evidence in any action against an alleged third-party tortfeasor or in an action to recover benefits under section 10-4-609.

C.R.S. § 10-1-135(10)(a).

In *Smith v. Jeppsen*, 277 P.3d 224 (Colo. 2012), the Colorado Supreme Court held that this provision codified the common law collateral source doctrine, rendering evidence of collateral source payments inadmissible by statute under any circumstances.

Under the collateral source rule, as codified by the General Assembly and applied by Colorado courts, evidence that a plaintiff received a discount from a collateral source is ***inadmissible at trial for any purpose***. This rule precludes a defendant from introducing evidence suggesting that the plaintiff was covered by any form of insurance collateral to the tortfeasor, and it prevents a defendant from introducing evidence showing that the plaintiff's medical providers wrote off a portion of the plaintiff's medical expenses owing to the involvement of a collateral source in paying for the plaintiff's care.

None of the arguments advanced by Defendant and the CDLA in their briefs support overturning or diluting *Crossgrove* and giving a windfall to the tortfeasor. *Crossgrove* was published ten years ago. Since then, Colorado appellate courts have decided numerous cases that expand on, and uphold, *Crossgrove*. And yet, over the past decade, defendants have consistently retained "repricing experts" that either directly or indirectly rely on collateral source paid evidence in order to attempt to

reduce a plaintiff's damages award and, ultimately, pay less for their negligence. That is exactly what Defendant did here.

i. Richard F. Lacy

Defendant retained Richard Lacy to reprice Plaintiff's past medical expenses of $712,219.03. (CF, p. 604). Mr. Lacy applied an 83.1% reduction to Plaintiff's medical bills from University of Colorado, and an 88% reduction to Plaintiff's medical bills from Swedish Medical Center. *Id*. at 604-05. He then added a "45% profit margin" to the reduced bills to determine "the market value of services provided" by each of these hospitals. *Id*. Mr. Lacy's opinion reduced the past medical bills from these facilities from $598,286 to $278,520. *Id*.

Defendant posits that Mr. Lacy's opinions do not run afoul of the collateral source rule because he does not rely on health insurance contracts or paid amounts. However, a hospital can only make a profit if its assets are greater than its liabilities. While many factors determine the profits and liabilities of a hospital, one of those factors are the contracts a hospital has with health insurance companies. These health insurance contracts are both assets and liabilities depending on the contract and the insurer. Additionally, it is not uncommon for a hospital to lose money by taking Medicaid and Medicare patients, whereby a hospital must make up those

losses in its other contracts and charges with other patients. Hospitals also lose money treating uninsured patients and must recuperate those expenses elsewhere.

In order to rebut the type of opinions proffered by Mr. Lacy, an injured victim is forced to delve into all the factors that go into a hospital's profits, including the health insurance contracts. Unlike some other repricing experts, who directly utilize collateral source payments to reduce an economic damages award, Mr. Lacy's opinion implicates collateral source payments indirectly, still in violation of *Crossgrove* and its progeny.

ii. Michael Bishop

Defendant deposed Michel Bishop, who was designated as UCH's 30(b)(6) representative in order to attack UCH's bills in this case. According to Defendant's own Brief, Mr. Bishop testified that "[e]ach service on the Chargemaster was 'priced based off a complex cost structure evaluation' that included consideration of fixed direct, fixed variable, indirect variable, and indirect fixed costs." Defendant's Brief at 13, (citing CF, p.925). Additionally, Mr. Bishop "further explained that the Chargemaster price considered uncompensated care, ER services, uninsured patients, and was 'generally' increased by 'about 6 percent' annually." *Id*. (citing CF p. 925-26). "Mr. Bishop also testified that while University Hospital does not provide discounted charges (all patients are charged the same for every service), the

amounts it will ultimately accept for services are discounted based on the payor." *Id*. (citing CF, p. 930).

Defendant sought to utilize Mr. Bishop's testimony regarding a "self-pay discount" given to patients that do not have health insurance, which would reduce the billed amount by 40%-45%. Accordingly, Defendant would ask the jury to reduce Plaintiff's past medical expenses by at least 40%, from $509,783.96 to $229,402.78, even though Plaintiff was insured at the time he required emergency treatment at UCH and he did not receive this discount. The trial court properly struck Mr. Bishop's testimony because it was irrelevant to Plaintiff who did have health insurance and was not given a self-pay discount. (TR 3/24/2021, p. 16:13-21; 18:11-12).

It appears that Defendant ignores or is not aware that Mr. Bishop's testimony regarding the complexities that go into hospital billing charges only serves to support the trial court's order striking Mr. Lacy's arbitrary reduction as well as the indirect implication that (1) health insurers affect overall hospital billing practices, and (2) hospitals provide discounts to patients depending on the payor, i.e. sometimes the health insurer. Each of these points affect the profit margin of the hospital.

Defendant attempted to elicit testimony regarding a self-pay discount that had nothing to do with Mr. Mukendi. The only way Plaintiff could rebut this evidence

would be to introduce the fact that it did not apply to him because he was insured by a collateral source. As the trial court correctly concluded, this flies in the face of *Crossgrove*.

B. Evidence of Amounts Paid for Medical Expenses is Irrelevant to the "Reasonable Value" of Medical Services.

The amounts accepted by medical providers from private health insurers, Medicare, Medicaid, or even uninsured patients has nothing to do with the value of the medical services provided, but, rather, reflects other unrelated factors, including the negotiating power of the payer of benefits, the relationships between the parties, the collectability of the reduced amount, and/or the rates set by the government. Conversely, the amounts billed reflect the medical provider's opinion of the reasonable value for each service and is consistent for all patients, regardless of their insurance status.

In holding that the collateral source rule prevailed over the reasonable value rule, the Supreme Court in *Crossgrove* did not need to reach the question of whether evidence of amounts paid for medical expenses is relevant to the issue of the reasonable value of those expenses. 276 P.3d at 565 n.4. However, the Court acknowledged that there are various reasons healthcare providers accept discounted payments from collateral sources that have nothing to do with "reasonable value:"

> "Healthcare providers routinely accept payment from private insurance companies significantly below the amount billed to a patient because the provider receives advantages from dealing with insurance companies beyond simple payment. These benefits include the assurance of prompt reimbursement, assured collectability of the reduced amount, increased administrative efficiency in collection, and access to a larger patient pool comprised of the insurer's customers.
>
> Additionally, the government sets the rates that providers who honor public insurance programs, like Medicare and Medicaid, must accept for certain services. These amounts are often significantly lower than those billed by the provider. Thus, as is the case with private insurance companies, healthcare providers accept significantly less than the amount billed for certain services in satisfaction of government insured patients' bills."

Id. at 567 (internal citations omitted). *See also See Seely v. Archuleta*, No. 08-cv-02293-LTB-MKT, 2011 U.S. Dist. LEXIS 77514, 2011 WL 2883625, at *5 (D. Colo. July 18, 2011) ("The discounted amount of medical services does not necessarily, and in fact probably does not, reflect the true value of services rendered…. A discounted rate…generally reflects the third-party payor's negotiating power and the fact that providers enjoy prompt payment, assured collectability.").

Courts in other jurisdictions have similarly found that there is no relationship between amounts accepted by hospitals for medical services and "reasonable value." *See Radvany v. Davis*, 262 Va. 308, 551 S.E.2d 347, 348 (Va. 2001) (holding that amounts accepted by medical providers "are not evidence of whether the medical bills are "reasonable, i.e., not excessive in amount, considering the prevailing cost

of such services."); *Fye v. Kennedy*, 991 S.W.2d 754, 764 (Tenn. Ct. App. 1998) (holding that payments that are forgiven, or paid by a third party is not evidence of the reasonableness of a charge); *Hillsborough Cty. Hosp. Auth. v. Fernandez*, 664 So. 2d 1071, 1072 (Fla. Dist. Ct. App. 1995) (holding that evidence of contractual discounts was insufficient to prove that a hospital's charges were unreasonable).

Further, permitting evidence of amounts accepted by medical providers would inescapably lead to significant variations in jury awards of medical expenses for the same medical services depending on whether a plaintiff was covered by private insurance, Medicaid, Medicare, or was uninsured. *See Dedmon v. Steelman*, 535 S.W.3d 431, 461 (Tenn. 2017) (observing that "[i]f the 'actual amount paid' approach were applied to all of these scenarios, even if the plaintiffs had all received exactly the same medical services, it would cause the awards for their reasonable medical expenses to vary greatly as a matter of law.").

Discounted rates accepted by hospitals for self-pay, uninsured patients are equally irrelevant to determining the reasonable value of medical services. First, as the district court properly concluded in this case, a "self-pay discount" rate is wholly irrelevant to an insured plaintiff who is not entitled to such a discount. Second, it is highly unlikely that even an uninsured personal injury plaintiff would be entitled to a hospital's self-pay discount in light of Colorado's Hospital Lien Statute, C.R.S. §

38-27-101, which permits a hospital to "have a lien for all reasonable and necessary charges for hospital care" out of the total amount collected by an injured person from a tortfeasor "[if] no payers of benefits are identified for the injured person due to lack of insurance." C.R.S. § 38-27-101(4), (2). When faced with the option of accepting a discounted rate for medical services or asserting a lien for the full amount of the charges, it is reasonable to presume that hospitals will almost always choose the latter. Consequently, self-pay discounts are never relevant in personal injury cases.

The amount billed by a plaintiff's medical providers is the only consistent benchmark by which a jury can analyze the reasonable value of a plaintiff's medical services. There is no rational basis to allow a jury to determine the reasonable value of medical services based upon the payer of benefits, whether it is a private health insurer, the state or federal government, a charitable organization, a family member, or the plaintiff paying out-of-pocket. Evidence of amounts accepted by hospitals and other medical providers is irrelevant, prejudicial to injured plaintiffs, and will inevitably result in inconsistent verdicts based upon variable contractual agreements between medical providers and payers of benefits.

C. Trial Courts are Vested with Broad Discretion to Exclude the Testimony of Repricing Experts and Other Purported Evidence of the "Reasonable Value" of Medical Services under C.R.E. 401-403.

A trial court has broad discretion to admit or exclude evidence. *Mullins v. Med. Lien Mgmt., Inc.*, 411 P.3d 798 (Colo. App. 2013). While trial courts must exclude evidence that contravenes the pre-verdict evidentiary component of Colorado's collateral source rule, the analysis does not end there. Evidence concerning the "reasonable value" of medical expenses is also properly excluded by trial courts under C.R.E. 401-403 where it is irrelevant to the issues in the case, or where any probative value it has is outweighed by the danger of unfair prejudice, confusion of the issues, misleading the jury, and undue delay.

The testimony of repricing experts is particularly irrelevant where, as here, a plaintiff receives emergent care and therefore has no choice in what hospital(s) he goes to, which doctors operate on him, or what the charges will be for the medical care. However, in any case, this type of evidence carries the risk of substantial prejudice, jury confusion, and a waste of time.

In an unpublished opinion, a division of this Court held that opinions from a billing expert regarding the "reasonable value" of the medical bills were properly excluded under C.R.E. 403 because there is danger of prejudice from the expert's opinion that medical providers always accept a discounted amount in satisfaction of

their billed expenses and the role that insurance plays in establishing the healthcare market. *See Sunahara v. State Farm Mut. Auto. Ins. Co.*, 14CA0798 (Colo. App. 2015) (unpublished). This matter came before the division after the Supreme Court issued its ruling in *Sunahara v. State Farm Mut. Auto. Ins. Co.*, 280 P.3d 649 (Colo. 2012) and remanded the case for a new trial. Upon remand, defendant endorsed a medical billing expert to testify about the reasonable market value of the medical services the plaintiff received. *Sunahara*, 14CA0798, at *5. The Court of Appeals affirmed the trial court's order striking the expert. *Id*. at 6.

The testimony of repricing experts and evidence regarding hospital billing practices leads to the prejudicial inference that a plaintiff's medical bills were covered by insurance. The impact of health insurance and public insurance programs, like Medicare and Medicaid, is the primary reason why hospitals and other healthcare providers receive payment of less than the full amount of their billed charges. As a result, healthcare providers and/or their billing representatives are not able to provide a meaningful explanation of why they often receive payment of less than the full amount of their billed charges if they are not allowed to mention the impact of health insurance. However, allowing such testimony will cause the jury to speculate about whether plaintiffs were insured and, if so, how that impacted the amount of their medical bills. Accordingly, the jury would base an award of damages

on factors that they properly are not to have considered. This is the type of prejudicial speculation that the Supreme Court stated it intended to prevent by its holdings in *Gardenswartz*, *Crossgrove* and *Sunahara*.

Additionally, this type of evidence, if not reasonably and carefully limited by the trial court, has the potential to turn into a "trial within a trial," that will prejudice the plaintiff and confuse the jury as to what the relevant, actual issues are in the case. In other words, allowing defendants to present evidence to challenge the reasonableness of the amounts billed for every medical service carries the strong risk of shifting the jury's focus from the negligence of defendants and into the rabbit hole of billing practices within the healthcare industry.

Trial courts have "the responsibility for seeing that the sideshow does not take over the circus." *People v. Taylor*, 545 P.2d 703, 706 (Colo. 1976). The trial court below properly exercised that responsibility by precluding the testimony of Mr. Lacey and Mr. Bishop under C.R.E. 401-403.

D. Plaintiffs are Not Required to Present Evidence of the "Reasonable Value" of their Medical Services Beyond the Amounts Billed.

Defendant urges this Court to place a burden on plaintiffs to establish the "reasonableness" of their medical expenses with additional evidence beyond the presentation of their medical bills. Defendant's position is contrary to well

established law in Colorado, which does not require plaintiffs to demonstrate, via expert testimony, that the medical expenses they seek are "reasonable." The medical bills provide sufficient evidence of the reasonable value of a plaintiff's medical services.

Plaintiffs are not required to provide an exact calculation of the economic damages sought but must only produce some evidence sufficient to allow the fact finder to reasonably estimate their economic damages. "On the question of damages, the law permits approximation of the amount of damages provided the fact of damages is certain, and provided the plaintiff introduces some evidence which is sufficient to allow a reasonable estimation of damages." *Phillips v. Monarch Recreation Corp.*, 668 P.2d 982, 987 (Colo. App. 1983). Significant latitude is given to juries to determine the amount of medical expenses to be included within a damage award. *See Tait v. Hartford Underwriters Inc. Co.*, 49 P.3d 337 (Colo. App. 2001), *cert. denied*. "The amount of damages to be awarded is a matter within the province of the jury and may not be disturbed unless it is completely without support in the record." *Dupont v. Preston*, 9 P.3d 1193, 1199 (Colo. App. 2000), *aff'd*, 35 P.3d 433 (Colo. 2001).

Further, Colorado courts have long held that the amount billed for medical services provides some evidence of the reasonable value of medical services. *Pyles*-

Knutzen v. Bd. of County Com'rs of County of Pitkin, 781 P.2d 164, 169 (Colo. App. 1989) (holding that the plaintiff's testimony that "he had incurred over $7,000 in medical bills for treatment of injuries sustained in the accident" was "admissible as evidence of the reasonable value of the medical services rendered."). *See also Lawson v. Safeway, Inc.*, 878 P.2d 127, 130-31 (Colo. App. 1994) (holding that evidence that a plaintiff's medical expenses were reasonable and necessary "does not have to be in the form of expert testimony"); *Dedmon v. Cont'l Airlines, Inc.*, No. 13-CV-00005-WJM-NYW, 2016 U.S. Dist. LEXIS 15047, 2016 WL 471199, at *7 (D. Colo. Feb. 8, 2016) ("[T]he Court agrees with Colorado courts that medical bills are 'some evidence' of reasonable value, even without supporting expert testimony.").

To require evidence of the "reasonable value" of medical expenses beyond the amounts billed by medical providers would place an unreasonable burden on personal injury plaintiffs, significantly increase the cost of litigation, and put a strain on judicial economy. It is not, and cannot be, the Plaintiff's burden to prove the reasonableness of his medical bills nor to fight a profit-margin argument such as the one presented by Mr. Lacy. According to the Colorado Hospital Association, the rising costs of healthcare in the United States are affected by factors such as the aging of the U.S. population, a growing incidence of obesity and chronic disease,

fee-for-service payment systems, maldistribution of health care workers and an overall decline on the availability of nurses and staff, advances in medical technology and research that can have high price tags and significant lags prior to widespread and effective adoption, and rising pharmaceutical costs. *See* Colorado Hospital Association, The Financial Health of Colorado Hospitals- Trends 2011-2015, (2017) (**App. 1**). These are only some of the main factors that affect the rising cost of health care.

Additionally, requiring expert testimony to establish the "reasonableness" of a plaintiff's medical expenses would significantly increase the costs of personal injury litigation and deny meaningful access to the judicial system for many injured people. Expert witness fees are the most substantial cost in every personal injury case. For some personal injury plaintiffs, the cost of retaining a medical billing expert exceeds the amount of medical expenses sought.

Extrinsic evidence of the "reasonable value" of medical expenses would also result in lengthier trials to accommodate the presentation of expert witness testimony on the "reasonableness" of the medical bills. Personal injury plaintiffs often receive treatment from multiple healthcare providers, many of whom are unfamiliar with the billing practices of the medical facilities in which they practice. Thus, requiring plaintiffs to present evidence of the reasonable value of their medical services

beyond the admission of the medical bills would necessitate the presentation of numerous healthcare providers and billing representatives to testify to the "reasonableness" of medical expenses. This would place a significant strain on Colorado trial courts.

Mr. Mukendi, after being slammed into by a negligent driver, who had no choice in the hospitals he was transferred to for treatment of his life-threatening injuries, should not carry the burden of substantiating hospital billing practices in order to be made whole for his injuries. Essentially, Defendant is asking the Court to open pandora's box by requiring plaintiffs – and permitting defendants – to introduce irrelevant, extraneous, and confusing evidence and testimony into the trial because Defendant does not think it is fair that Mr. Mukendi incurred these expenses while fighting for his life.

If Defendant wishes to initiate change to address the rising costs of healthcare, then Defendant should use the appropriate channels by seeking change through the legislature rather than making it the burden of every injured victim. Likewise, until this occurs, if there is any windfall due to the differences in the billed amounts versus the paid amounts, Colorado's longstanding collateral source rule mandates that the windfall shall go to the victim and not to the tortfeasor.

CONCLUSION

Amicus CTLA urges this Court to disregard the attempts of Defendant and the CDLA to secure a windfall for tortfeasors at the expense of innocent victims of wrongful conduct. For the foregoing reasons, CTLA respectfully requests that this Court affirm the result below.

Respectfully submitted June 27, 2022.

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CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of this **BRIEF OF AMICUS CURIAE COLORADO TRIAL LAWYERS ASSOCIATION** was timely served via the Colorado Court E-filing system to the following:

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