[ORAL ARGUMENT SCHEDULED FOR OCTOBER 15, 2020]

No. 20-5193

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

AMERICAN HOSPITAL ASSOCIATION, et al.,

Plaintiffs-Appellants,

v.

ALEX M. AZAR II, in his official capacity as
SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant-Appellee.

On Appeal from the United States District Court
for the District of Columbia

BRIEF FOR APPELLEE

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs-Appellants are the American Hospital Association, the Association of American Medical Colleges, the Federation of American Hospitals, the National Association of Children's Hospitals, the Memorial Community Hospital and Health System, Providence Health System--Southern California, d/b/a Providence Holy Cross Medical Center, and the Bothwell Regional Health Center.

Defendant-Appellee is Alex M. Azar, II, in his official capacity as Secretary of Health and Human Services.

The following amici have currently appeared before this Court: the Chamber of Commerce of the United States of America; the Healthcare Financial Management Association; and forty State hospital associations (Alaska State Hospital & Nursing Home Association, Arizona Hospital and Healthcare Association, Arkansas Hospital Association, California Hospital Association, Connecticut Hospital Association, District of Columbia Hospital Association, Florida Hospital Association, Georgia Hospital Association, Healthcare Association of Hawaii, Illinois Health and Hospital Association, Iowa Hospital Association, Kansas Hospital Association, Kentucky Hospital Association, Louisiana Hospital Association, Maine Hospital Association, Massachusetts Health and Hospital Association, Michigan Health and Hospital

Association, Mississippi Hospital Association, Missouri Hospital Association, Montana Hospital Association, Nebraska Hospital Association, Nevada Hospital Association, New Hampshire Hospital Association, New Jersey Hospital Association, New Mexico Hospital Association, Healthcare Association of New York State, Greater New York Hospital Association, North Carolina Healthcare Association, North Dakota Hospital Association, Ohio Hospital Association, Oregon Association of Hospitals and Health Systems, Hospital and Healthsystem Association of Pennsylvania, South Carolina Hospital Association, South Dakota Association of Healthcare Organizations, Tennessee Hospital Association, Texas Hospital Association, Washington State Hospital Association, West Virginia Hospital Association, Wisconsin Hospital Association, Wyoming Hospital Association).

Amici in the district court were the Chamber of Commerce of the United States of America; PatientRightsAdvocates.org; Independent Women's Law Center; Texas Public Policy Foundation; Association of Mature American Citizens; and thirty-seven State hospital associations (Alaska State Hospital & Nursing Home Association, Arizona Hospital and Healthcare Association, Arkansas Hospital Association, California Hospital Association, Connecticut Hospital Association, District of Columbia Hospital Association, Georgia Hospital Association, Healthcare Association of Hawaii, Illinois Health and Hospital Association, Iowa Hospital Association, Kansas Hospital Association, Kentucky Hospital Association, Louisiana Hospital Association, Maine Hospital Association, Massachusetts Health and Hospital

Association, Mississippi Hospital Association, Missouri Hospital Association, Montana Hospital Association, Nebraska Hospital Association, Nevada Hospital Association, New Hampshire Hospital Association, New Jersey Hospital Association, New Mexico Hospital Association, Healthcare Association of New York State, Greater New York Hospital Association, North Carolina Healthcare Association, North Dakota Hospital Association, Ohio Hospital Association, Oregon Association of Hospitals and Health Systems, Hospital and Healthsystem Association of Pennsylvania, South Carolina Hospital Association, South Dakota Association of Healthcare Organizations, Tennessee Hospital Association, Texas Hospital Association, Washington State Hospital Association, West Virginia Hospital Association, and Wisconsin Hospital Association).

B. Rulings Under Review

Plaintiffs appeal from the memorandum opinion and order issued on June 23, 2020 by the Honorable Carl J. Nichols (D.D.C. Case No. 19-cv-03619), granting defendant's motion for summary judgment and denying plaintiffs' motion for summary judgment.

C. Related Cases

Counsel is not aware of any related cases within the meaning of D.C. Circuit Rule 28(a)(1)(C).

/s/ Courtney L. Dixon
Courtney L. Dixon

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GLOSSARY

CMS	Centers for Medicare & Medicaid Services
HFMA	Healthcare Financial Management Association
HHS	Department of Health and Human Services

INTRODUCTION

Patients generally learn the cost of hospital care only after that care has been provided, when the bill arrives. As a result, patients are frequently caught off guard by hospital charges; find it impossible to shop for more affordable care; and the market forces that would otherwise keep healthcare costs down are stifled.

To "[b]ring[] down the cost of health care coverage," 42 U.S.C. § 300gg-18, Congress enacted a provision that requires "[e]ach hospital" in the United States to "make public" "a list of the hospital's standard charges," "in accordance with guidelines developed by the Secretary" of Health and Human Services (HHS). *Id.* § 300gg-18(e). In 2019, HHS exercised its rulemaking authority to specify, for the first time, the "standard charges" that hospitals must publish. Because the rates for hospital items and services vary significantly depending on who is paying, HHS adopted a definition of "standard charges" that accounts for this reality, and requires hospitals to disclose three categories of standard charges: (1) the "gross" or "list" prices that hospitals may charge patients paying for their own care; (2) the rates that hospitals have contractually negotiated with third-party payers, like insurance companies, to charge the third party's members or beneficiaries; and (3) any standardized cash discount prices hospitals offer to patients paying for their care in cash, regardless of insurance status. As HHS explained, making these charges public will lead to better-informed consumers and, as a result, lower prices.

Plaintiffs challenge HHS's implementation of the disclosure requirement. Although plaintiffs stop short of offering any definitive interpretation of "standard charges," they suggest that it refers only to a hospital's "list prices," as reflected on a hospital's "chargemaster." But as the agency and district court correctly recognized, that interpretation is foreclosed by the statutory text, and cannot be reconciled with its purposes. Indeed, chargemaster prices are not "standard" for roughly 90% of patients. HHS's interpretation, including its determination that "standard charges" include charges negotiated with third-party payers, gives meaning to the provision's text, takes account of its context, and fulfills Congress's purpose of assisting patients in making informed healthcare decisions. HHS's interpretation is the best one, and is at a minimum permissible and therefore entitled to *Chevron* deference, as the district court held.

HHS's conclusions that the rule will meaningfully benefit consumers and lower healthcare prices is also amply supported by the record and is not arbitrary or capricious. The rule will directly provide many patients, including some with insurance, an estimate of their out-of-pocket expenses; for many more patients, the rule will provide them necessary information to calculate those expenses—information they currently lack prior to care. Contrary to plaintiffs' argument, HHS carefully considered the burden its rule would place on hospitals, and HHS's estimate of that burden is almost identical to the estimate submitted by plaintiffs' amicus, the Healthcare Financial Management Association (HFMA).

The rule also readily satisfies the First Amendment standard for factual commercial disclosure requirements, as it reasonably relates to HHS's interests in informing consumers about hospital charges and lowering healthcare prices, and does not burden plaintiffs' speech.

At bottom, plaintiffs argue that hospital charges are complicated; that hospitals will have to expend effort to disentangle them; and that if hospital charges are disclosed, it will be too much for consumers to comprehend. But plaintiffs cannot plausibly use the very reason why price transparency is needed—the complexity and obscurity of agreements between hospitals and insurance companies—as a justification for keeping consumers in the dark.

STATEMENT OF JURISDICTION

Plaintiffs invoke the district court's jurisdiction under 28 U.S.C. § 1331. The district court denied plaintiffs' motion for summary judgment and granted defendants' motion for summary judgment on June 23, 2020. A68.[1] Plaintiffs filed a timely notice of appeal on June 24, 2020. A69. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly held that HHS's hospital price transparency rule reasonably interprets 42 U.S.C. § 300gg-18(e)'s disclosure requirement.

[1] Citations to plaintiffs' Appendix are labeled "A." Citations to defendant's supplemental appendix, which is filed concurrently with this brief, are labeled "SA."

2. Whether the district court correctly held that the rule is not arbitrary or capricious.

3. Whether the district court correctly held that it does not violate the First Amendment for HHS to require hospitals to disclose their standard charges for the items and services they provide.

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

A. The Market for Hospital Care

The healthcare market consists of three types of actors: providers (*e.g.*, hospitals), patients, and payers. Payers fall into two general categories: "third-party payers," such as insurance companies; and "self-pay" patients, who pay directly for their own care, whether because they are uninsured, are receiving elective or out-of-network care, or have simply decided that paying directly is more affordable than relying on insurance.

The rates that hospitals charge for the same item or service vary "across categories of patients." SA60. For self-pay patients, hospital rates for items and services typically reflect a hospital's "chargemaster" rates. 84 Fed. Reg. 65,524, 65,533 (Nov. 27, 2019); *see* SA74-75. Every hospital maintains a chargemaster, a document that lists individual items and services provided by the hospital, along with their "list prices" or "'gross' charge[s]." 84 Fed. Reg. at 65,533; *see* SA69-70. Chargemaster

rates "bear little relationship to market rates, are usually highly inflated, and tend to be an artifact of the way in which Medicare used to reimburse hospitals." 84 Fed. Reg. at 65,538; *see* SA70. In other words, chargemaster rates are usually the worst-case scenario for a patient receiving a hospital bill. Many hospitals, however, offer discounts to self-pay patients. Some of these discounts are established, standardized cash discounts that a hospital offers to any patient who agrees to pay directly for their care in cash or a cash equivalent. *See* 84 Fed. Reg. at 65,553. Other discounts are negotiated on a case-by-case basis, often because of financial need (*i.e.*, a "charity" discount). *See* SA112.

"[M]ost consumers (over 90 percent)" are not self-pay, and instead "rely on a third party payer to cover a portion or all of the cost of healthcare items and services." *See* 84 Fed. Reg. at 65,542. Third-party payers include Medicaid and Medicare, which reimburse hospitals at rates determined by the States and the Centers for Medicare & Medicaid Services (CMS), respectively. *See id.* at 65,552. Those rates are already made public. *See id.*

Third-party payers other than Medicaid and Medicare (*i.e.*, insurance companies) have "contractual agreements" with particular hospitals under which the third party and hospital agree to negotiated rates. SA112; *see* SA70-71. If a hospital has negotiated rates with a third-party payer—*i.e.*, an insurance company where the hospital is in-network—then patients who have coverage from that third party are generally charged the negotiated rate, not the chargemaster rate. *See* SA112; SA70.

These "payment arrangements vary." SA70. A hospital and insurer might agree to "fixed" fees for individual items and services. *Id.*; *see* 84 Fed. Reg. at 65,533. But hospitals and insurers can also agree to bundle items and services into "service packages," and rather than establish charges for individual items and services, may establish charges based on common procedures, per diem rates, or other factors. *See* 84 Fed. Reg. at 65,533; SA70.

Of particular relevance here, some hospitals and insurers have adopted a "diagnosis-related group" methodology, under which hospital items and services are grouped, and a payment rate is prospectively established, based on the typical care provided to a patient with a particular diagnosis. *See* 84 Fed. Reg. at 65,534; SA70. The Medicare statute requires the establishment of diagnosis-related-group classifications for inpatient Medicare reimbursements, *see* 42 U.S.C. § 1395ww(d)(4)(A), and "[p]rivate insurers typically use Medicare's list of" diagnosis-related groups when establishing rates with hospitals, SA70; *see* SA238. Others have adopted their own systems. *See* SA239; 84 Fed. Reg. at 65,534.

"Consumers generally learn of their health care costs after receiving care," when they get the bill. SA106. Patients with insurance typically receive an Explanation of Benefits from their insurance company. That document sets forth the individual items and services received, the chargemaster rates for those services, the particular rate their insurance provider has negotiated with the hospital, and, finally, the patient's out-of-pocket costs. *See* 84 Fed. Reg. at 65,539.

B. Statutory and Regulatory Background

1. Healthcare costs continue to grow each year, and national healthcare spending is projected to reach $6.2 trillion by 2028. *See* CMS, *National Hlth. Expenditure Projections 2019-2028*, at 1.[2] Among the problems contributing to this rise in spending is a lack of transparency in healthcare pricing, which prevents patients from using pricing information to make informed spending decisions. *See, e.g.*, SA40; SA49.

In 2010, Congress enacted Section 2718 of the Public Health Service Act, codified at 42 U.S.C. § 300gg-18, as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 885. That section, entitled "Bringing down the cost of health care coverage," addresses the difficulties involved in making informed choices for hospital healthcare by requiring "[e]ach hospital operating within the United States" to "each year establish (and update) and make public . . . a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title [*i.e.*, the Medicare statute]." 42 U.S.C. § 300gg-18(e). Congress did not define "standard charges," instead directing hospitals to establish and make public standard charges "in accordance with guidelines developed by the Secretary." *Id.*

[2] https://www.cms.gov/files/document/nhe-projections-2019-2028-forecast-summary.pdf (last visited Aug. 11, 2020).

2. HHS initially provided guidance to hospitals, and allowed hospitals "flexibility to determine how they make a list of their standard charges public." 79 Fed. Reg. 27,978, 28,169 (May 15, 2014). Under this guidance, hospitals were required to make only their "chargemaster" available in some form. *See id.*

In 2018, HHS revisited the disclosure requirement. HHS expressed "concern[] that challenges continue to exist for patients due to insufficient price transparency." 83 Fed. Reg. 20,164, 20,549 (May 7, 2018). HHS was troubled, in particular, by the fact "that chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay." *Id.* As "one step" toward greater transparency, HHS updated its guidance to require hospitals to make their chargemasters available online in machine-readable format and to update them at least annually. *Id.* HHS further announced that it was seeking public comment on, *inter alia*, how "standard charges" should be defined, and "[w]hat types of information would be most beneficial to patients." *Id.*

In August 2018, after receiving public comment, HHS expressed its intent to "continue to work with stakeholders to determine the best approach to making price transparency information available to consumers." 83 Fed. Reg. 41,144, 41,687 (Aug. 17, 2018). HHS agreed that "providing patients with more specific information on their potential financial liability is needed," and that hospitals "should and can" provide additional information. *Id.* HHS explained, however, that it was "not requiring [hospitals] at this time" to publish additional information. *Id.*

3. In June 2019, the President issued an Executive Order entitled Improving Price and Quality Transparency in American Healthcare to Put Patients First, Exec. Order No. 13,877, 84 Fed. Reg. 30,849 (June 24, 2019). The Executive Order highlighted the challenges patients face in accessing "useful price and quality information," which impedes their ability "[t]o make fully informed decisions about their healthcare." *Id.* § 1. To address those challenges, the President directed certain agencies to take steps that would "eliminate unnecessary barriers to price and quality transparency." *Id.* § 2. As relevant here, the President instructed the Secretary of HHS to "propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format." *Id.* § 3.

4. In August 2019, HHS proposed to establish, for the first time through notice-and-comment rulemaking, "requirements for all hospitals in the United States" to make their "standard charges available to the public." 84 Fed. Reg. 39,398, 39,398 (Aug. 9, 2019).

HHS explained that "despite prior requirements for hospitals to publicly post their chargemaster rates online," "consumers continue to lack the meaningful pricing information they need." 84 Fed. Reg. at 39,574. Several stakeholders, HHS noted, had "commented that gross charges as reflected in hospital chargemasters may only apply to a small subset of consumers," such as those who are self-pay. *Id.* at 39,577.

"[F]or the insured population," by contrast, "hospitals[']charge amounts" were not the "charges listed in a hospital's chargemaster," but were instead the rates that hospitals had contractually negotiated with particular third-party payers. *Id.* Because "hospitals can have different standard charges" depending on the payer, HHS proposed to identify a "standard charge" as "a charge that is the regular rate established by the hospital for the items and services provided to a specific group of paying patients." *Id.* at 39,578. In light of public feedback, HHS proposed to define two types of standard charges that must be made public: (1) a hospital's "gross" charges, as "reflected on a hospital's chargemaster, absent any discounts," *id.*; and (2) a hospital's "payer-specific negotiated charges," or "all charges that the hospital has negotiated with third party payers for an item or service," *id.* at 39,579. HHS requested comment on this proposal, as well as alternative definitions. *See id.* at 39,580.

The proposed rule also included details for how hospitals would be required to publish their standard charges, and, consistent with the President's Executive Order, proposed to require hospitals to (1) make public their standard charges for all items and services in a single, machine-readable file; and (2) display and package in a consumer-friendly manner the payer-specific negotiated charges for 300 items and services that are "shoppable"—i.e., can be scheduled in advance (like a colonoscopy). 84 Fed. Reg. at 39,574, 39,586. HHS explained its understanding that "many (if not all) hospitals already keep" information about their gross and payer-specific negotiated

charges "in electronic format in their accounting systems for purposes of, for example, ensuring accurate billing." *Id.* at 39,583. But HHS sought "comment on this assumption." *Id.*; *see id.* at 39,580.

5. HHS issued a final rule in November 2019. *See* 84 Fed. Reg. 65,524 (to be codified at 45 C.F.R. pt. 180) (hereinafter, "the Rule"). After considering relevant comments, HHS finalized its definition of "standard charges" to mean the "regular rate[s] established by the hospital for an item or service provided to a specific group of paying patients," and identified three categories of "standard charges" that hospitals must disclose. *Id.* at 65,540; *see* 45 C.F.R. § 180.20.

First, as proposed, HHS identified hospitals' "chargemaster" (or "gross") charges as a type of standard charge, since that is the "regular rate" established by hospitals for patients who are self-pay. 84 Fed. Reg. at 65,540-41; *see* 45 C.F.R. §§ 180.20; 180.50(b)(2).

Second, also as proposed, HHS identified hospitals' "payer-specific negotiated charges" as a type of "standard charge," since these rates "are the standard charges that apply to consumers with" third-party coverage. *Id.* at 65,541-42, 65,546; *see* 45 C.F.R. §§ 180.20; 180.50(b)(3). HHS found particular support for including this type of charge as a standard charge in § 300gg-18(e)'s reference to "diagnosis-related groups," since "[h]ospital chargemaster[s] contain[] only list prices for individual items and services," and "do not include" diagnosis-related-group-based charges, which are negotiated between private insurers and hospitals. *See* 84 Fed. Reg. at 65,539.

Third, in response to comments, HHS identified hospitals' "discounted cash prices" as standard charges, defined as the charges established by a hospital for "individuals who pay cash (or cash equivalent)." 84 Fed. Reg. at 65,552-53; *see* 45 C.F.R. §§ 180.20; 180.50(b)(6). HHS explained that this definition refers only to cash discounts that are standardized, and does not include any "charity care or bill forgiveness that a hospital" might "apply to a particular individual's bill." 84 Fed. Reg. at 65,553.

In response to comments, HHS also required hospitals to publish their highest and lowest third-party negotiated charges for items and services, unidentified to a specific payer (*i.e.*, "de-identified maximum" and minimum negotiated charges). 84 Fed. Reg. at 66,553-55; *see* 45 C.F.R. §§ 180.20; 180.50(b)(4)-(5). Display of maximum and minimum prices, HHS explained, was common in price-transparency tools, and would allow consumers to see the "range" of a hospital's negotiated prices. 84 Fed. Reg. at 65,554-55.

HHS also finalized its proposal for how hospitals must publish their data, requiring hospitals to make all of their standard charges available in a comprehensive machine-readable file and in a consumer-friendly display for 300 shoppable services. 84 Fed. Reg. at 65,525; *see id.* at 65,576-80; 45 C.F.R. §§ 180.50(c), 180.60. HHS noted that some hospitals "already provide internet-based price estimator tools." 84 Fed. Reg. at 65,577. To alleviate some of the compliance burden on these hospitals, HHS provided that hospitals that offered price-estimator tools that met certain minimum

requirements would be deemed in compliance with the consumer-friendly-display requirement. *See id.* at 65,577-79; 45 C.F.R. § 180.60(a)(2).

In response to comments, HHS estimated that, on average, compliance with the Rule would require 150 hours (or $11,898.60) per hospital in the first year, and 46 hours (or $3,610.88) per hospital in subsequent years—a substantially higher cost than HHS had initially estimated. 84 Fed. Reg. at 65,591-94, 65,596. In response to hospitals' comments, HHS delayed the Rule's effective date by one year, from January 1, 2020, to January 1, 2021. *Id.* at 65,585. HHS concluded that the Rule's burdens were outweighed by its substantial public benefits. *See, e.g.*, *id.* at 65,529.

C. Prior Proceedings

Plaintiffs challenged the Rule in district court, asserting that "standard charges" unambiguously refers only to a hospital's "chargemaster" rates and that HHS exceeded its statutory authority in defining the term to include hospitals' third-party negotiated rates. *See* Pls. Mot. for Summ. J., Dkt. No. 13, at 2, 11-12. Plaintiffs additionally alleged that the Rule was arbitrary and capricious and violated the First Amendment. *Id.* at 19-29.

The district court granted summary judgment in favor of the government. The court first rejected plaintiffs' argument that "standard charges" means only chargemaster rates. A37-44. As plaintiffs admitted, "standard" "means 'usual, common, or customary,'" but as the court pointed out, "[i]t is undisputed that chargemaster rates are not the amounts paid on behalf of *90%* of hospitals' patients,

and thus it is hard to see how they can be considered usual, common, or customary." A39. "[H]ad Congress intended to require the publication of just a hospital's chargemaster," the court explained, "it could easily have done so by using the term 'chargemaster,'" but it did not. A38. Moreover, "standard charges" could not mean only "chargemaster charges," because § 300gg-18(e) requires hospitals to publish their "standard charges for items and services . . . *including for diagnosis-related groups*," and "it is undisputed" that charges for diagnosis-related groups "do not appear on a chargemaster, which only lists the prices of individual items and services." A41-42.

Having rejected plaintiffs' interpretation, the district court concluded that HHS's interpretation was reasonable, and therefore entitled to *Chevron* deference. The healthcare market, the court explained, is "exceptionally unique," and "[i]t is undisputed that different groups (or sub-groups) of patients have different economic relationships with both hospitals and third-party payers." A45. In this context, the court concluded, "[t]he agency's decision to define 'standard charges' based on the different patient groups" was a "reasonable construction that accounts for the peculiar dynamics of the health care industry." *Id.*

The district court also rejected plaintiffs' argument that the Rule was arbitrary and capricious. The court explained that HHS had fully considered counter-arguments, and had reasonably concluded in light of the rulemaking record that the Rule would benefit patients and lead to lower healthcare costs. *See* A64-65. The court further noted that plaintiffs' proposed approach—publication of just chargemaster

charges—would provide consumers with only "opaque and misleading" charges that would not promote the statute's goals. A65. The court also found that HHS had not underestimated hospitals' compliance burdens. A65-66.

Finally, the district court rejected plaintiffs' First Amendment claim. Applying the constitutional standard set forth in *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985), for compelled disclosure of factual commercial information, the court concluded that the Rule's requirements were reasonably related to HHS's interests in "facilitat[ing] more informed health care decisions" and "lowering healthcare costs," A57, and did not unduly burden plaintiffs' speech, A57-62.

SUMMARY OF ARGUMENT

I. HHS interpreted § 300gg-18(e)'s disclosure requirement in light of the statutory text, context, and its purpose. Hospitals do not have one, single "usual, common, or customary" charge for items and services that they demand from all patients; they instead have established different "standard charges" that apply depending on who is paying. In light of this reality, HHS defined "standard charges" to require hospitals to publish their chargemaster rates; the specific rates they have negotiated with third-party insurance companies; and any standardized cash discount prices. Plaintiffs' arguments fail to account for the entire statutory text, the market for hospital care, and the problems Congress sought to solve. Contrary to plaintiffs' assertions, the Rule requires hospitals to disclose only one "list" of their "standard

charges"; HHS merely specified two ways hospitals are to display that information, in accordance with HHS's explicit statutory authority to specify guidelines for how hospitals are to "make public" their standard charges. HHS's interpretation of the statute is the best one, and is at a minimum permissible and therefore entitled to *Chevron* deference, as the district court correctly held.

II. The Rule is not arbitrary or capricious. The record amply supports HHS's conclusion that its Rule will benefit consumers and lead to lower healthcare costs. HHS fully considered counter-arguments, but reasonably disagreed with those arguments in light of the statute and the rulemaking record. HHS also adequately evaluated the burden its Rule would place on hospitals. Indeed, HHS's burden estimate is nearly identical to that provided by plaintiffs' amicus, HFMA. It is a feature, not a bug, that the Rule shifts to hospitals some of the burdens consumers currently bear.

III. The Rule readily satisfies the First Amendment. Hospitals must disclose "purely factual and uncontroversial information about the terms under which [hospital] services will be available," *Zauderer v. Office of Disciplinary Counsel of S. Ct. of Ohio*, 471 U.S. 626, 651 (1985)—their price. The Rule reasonably relates to HHS's interest in better informing consumers about their healthcare costs and does not unduly burden speech. Indeed, plaintiffs make no argument that their speech has been burdened.

STANDARD OF REVIEW

This Court reviews a grant of summary judgment de novo. *See Silver State Land, LLC v. Schneider*, 843 F.3d 982, 989 (D.C. Cir. 2016). The challenged rule may be set aside only if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

ARGUMENT

I. HHS Permissibly Interpreted the Duty to Disclose Hospitals' "Standard Charges"

Congress obligated hospitals to publicly disclose their "standard charges" for the items and services that they provide. 42 U.S.C. § 300gg-18(e). Congress charged HHS with establishing guidelines for this disclosure requirement and obligated hospitals to proceed "in accordance with" those guidelines. *Id.* HHS has adopted a price transparency rule that gives meaning to this disclosure policy by requiring hospitals to disclose several categories of standard charges, including the rates hospitals charge insured patients pursuant to third-party agreements. *See* 45 C.F.R. § 180.50.

In reviewing the interpretation of regulatory statutes by the agencies charged with administering them, this Court applies the familiar standards of *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). The Court first asks whether "'the intent of Congress is clear,'" in which case the Court must "give effect to Congress's clear intent." *Village of Barrington v. Surface Transp. Bd.*, 636 F.3d 650, 659

(D.C. Cir. 2011) (quoting *Chevron*, 467 U.S. at 842). But if the statute is "ambiguous," the Court must defer to the agency's position so long as it is "based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843.

Before the district court, plaintiffs asserted that "standard charges" has a single, unambiguous meaning: the charges contained in a hospital's chargemaster. *See* A36. On appeal, plaintiffs have abandoned that position. Indeed, not only do plaintiffs no longer assert that "standard charges" means only chargemaster charges, but they decline to offer *any* definitive interpretation of the statutory text. By contrast, HHS has undertaken to construe "standard charges" in § 300gg-18(e) with careful attention to its text, context, and purpose. HHS's interpretation is the best one and, at a minimum, is permissible. Plaintiffs' contrary arguments misconstrue the Rule's requirements, ignore key statutory provisions, and fail to come to terms with the statute's objectives.

A. HHS Reasonably Interpreted "Standard Charges"

1. HHS's Interpretation Is Consistent with the Statutory Text, Context, and Purpose

a. Section 300gg-18(e) requires hospitals to disclose "a list of the hospital's standard charges for items and services . . . , including for diagnosis-related groups established under" the Medicare statute. 42 U.S.C. § 300gg-18(e). Congress did not define "standard charges," nor is that term defined elsewhere in the U.S. code. *See* 84 Fed. Reg. at 65,539. Instead, Congress expressly provided for the list of standard

charges to be established and made public "in accordance with guidelines developed by the Secretary." 42 U.S.C. § 300gg-18(e).

In common usage, as the district court noted, and as plaintiffs do not dispute, the term "standard" typically "means 'usual, common, or customary.'" A39; Br. 27. And "[t]he word 'charge'" ordinarily "means 'the price demanded for something.'" A40; Br. 33.

In the "exceptionally unique market" for hospital care, A45, there is not a single "usual, common, or customary" price that hospitals demand from all payers for an item or service. 84 Fed. Reg. at 65,546. Rather, hospital items and services have more than one charge, which apply depending on who is paying. When a hospital provides care to a patient who is self-pay, the usual or common rate the hospital will demand is typically its chargemaster rate. *See id.* at 65,540; SA75. But when a hospital provides care to an insured patient, the usual or common rate demanded by the hospital is instead the specific rate that the hospital has negotiated with the patient's third-party payer and contractually agreed to accept when treating the third party's members or beneficiaries. *See* 84 Fed. Reg. at 65,546, 65,575; SA112. Adding to the complexity, some hospitals have established a standardized "cash discounted price" that the hospital will charge any "self-pay individual[], regardless of insurance status," who pays for his or her care directly in cash. *See* 84 Fed. Reg. at 65,553.

HHS correctly took this unique aspect of the hospital care market into account when defining "standard charges" in § 300gg-18(e)—a disclosure requirement specific

to that market. In light of the fact that hospitals have established different rates for the same item or service—no single one of which predominates—HHS defined a hospital's "standard charge[s]" to mean the "regular rate[s]" the hospital has established for "items and services provided to a specific group of paying patients." 84 Fed. Reg. at 65,541-42; *see* 45 C.F.R. § 180.20. To be a "regular rate" under HHS's definition, the rate must be formalized in advance (through "hospital contracts" or "fee schedules," for example). *See* 84 Fed. Reg. at 65,546. And there must be an "identifiable" group of patients for whom that rate would usually apply. *See id.* at 65,539, 65,542. From this general definition, HHS identified three categories of hospital "standard charges" that must be disclosed under its Rule: a hospital's chargemaster rates, its standardized cash-discount prices, and its third-party negotiated rates. *Id.* at 65,540; *see* 45 C.F.R. § 180.50(b).

Plaintiffs are therefore wrong to assert (Br. 27) that HHS defined "standard charges" to mean "any amount[]" that a hospital will agree to accept in any "particular circumstance[]." To the contrary, HHS explicitly excluded from its definition of "standard charges" "the amount the hospital is ultimately paid." 84 Fed. Reg. at 65,546. Hospitals may of course choose in a particular case to charge an amount that is specific to an individual patient; for example, some hospitals may offer an individualized "charity" discount to a patient who lacks insurance. But that is an example of a charge that is *not* "standard" under HHS's definition. *See id.* at 65,553 (explaining that "charity care," "bill forgiveness," and individualized cash discounts

are not "standard charges"). In contrast to a one-off rate, or the amount that a hospital is ultimately paid—which could depend on many variables—HHS defined "standard charges" to include only rates for items and services that a hospital has established through formal means and can therefore make "public in advance." *Id.* at 65,546; *see* A45-46 ("[T]he agency specifically focused on the contracted rates as the standard charges because such rates can be made public in advance . . . .").

b. The propriety of defining "standard charge" to include negotiated third-party rates is confirmed by the statute's directive that hospitals publish their "standard charges for items and services . . . , including for diagnosis-related groups established under" the Medicare statute. 42 U.S.C. § 300gg-18(e).

To summarize briefly, "[u]nder a diagnosis-related group methodology," a hospital and an insurer prospectively agree on a bundled rate of payment for all treatment provided to a particular patient "group[]" (i.e., treatment for a particular diagnosis). SA238. The rate of payment under this methodology thus stems from the nature of the patient's case, not from the individual items and services that are actually provided to a particular patient in an individual circumstance. Medicare relies on diagnosis-related-group classifications in calculating Medicare reimbursements, *see* 42 U.S.C. § 1395ww(d)(4), and commercial insurers have also "adopted this prospective payment method as an alternative to other retrospective methods of payment," SA238. Many insurers and hospitals have chosen to use the same diagnosis-related-

group classifications that Medicare uses, though some have established their own classifications. *See* SA70, SA239.

Because a hospital's charges under a diagnosis-related-group methodology are not charges for individual items and services, these charges are not listed on hospital chargemasters. *See* 84 Fed. Reg. at 65,539; *see* A42 ("[I]t is undisputed that the costs or bundled charges associated with [diagnosis-related groups] do not appear on a chargemaster . . . ."). When commercial insurers and hospitals rely on a diagnosis-related-group based methodology for payment, the payment rates are, like other third-party rates, "determined as a result of negotiations," and set forth in hospitals' contracts with the particular insurance provider. 84 Fed. Reg. at 65,539; *see* SA238-39.

Congress's specification in § 300gg-18(e) that hospitals must publish their "standard charges . . . , including for diagnosis-related groups," thus makes two things clear. First, it confirms that hospitals' "standard charges" must include something "other than [hospitals'] list prices as found in the hospital chargemaster," since diagnosis-related-group-based charges are not listed on hospital chargemasters. 84 Fed. Reg. at 65,539. Second, it confirms that Congress understood that at least one type of third-party negotiated rate is a "standard charge[]." *Id.* And since Congress used the illustrative term "including," it is reasonable to interpret "standard charges" as "including" other third-party negotiated rates, as well. *See id.* at 65,539; *see also Bloate v. United States*, 559 U.S. 196, 207 (2010) ("including" is "expansive or illustrative");

Federal Land Bank of St. Paul v. Bismarck Lumber Co., 314 U.S. 95, 100 (1941) ("including" "connotes . . . an illustrative application of the general principle").

That the statute refers to "diagnosis-related groups established under" the Medicare statute does not mean that Congress meant to require hospitals to publish Medicare reimbursement rates. *See* A43. As noted, third-party payers use the diagnosis-related-group classifications established under Medicare when negotiating their own rates. *See* 84 Fed. Reg. at 65,534. For several reasons, the best reading of the statute is that it requires hospitals to publish those negotiated rates (and other similar negotiated rates), rather than Medicare rates. For one, Medicare rates "are already publicly disclosed," whereas third-party rates are not. *Id.* at 65,552. It is reasonable to assume that Congress did not impose a "redundant" requirement on hospitals "to re-disclose already public rates and create an unnecessary burden." *Id.* Moreover, § 300gg-18(e) requires hospitals to disclose "the *hospital*'s standard charges," *id.* (emphasis added), and Medicare's reimbursement rates for diagnosis-related groups are not set or negotiated by hospitals—they are set by CMS, *see, e.g.*, 84 Fed. Reg. 42,044, 42,044 (Aug. 16, 2019). By contrast, when hospitals *do* set rates for "diagnosis-related groups established under" Medicare, those rates are negotiated charges with third-party payers based on Medicare's diagnosis-related-group classifications. *See* A48-49.

c. HHS's interpretation is also consistent with the explicit statutory purpose of § 300gg-18(e)—part of a statutory section entitled "Bringing down the cost of health care coverage." 42 U.S.C. § 300gg-18.

By defining "standard charges" as the regular rates that hospitals have formally established for identifiable groups of payers, including third-party negotiated rates and standardized cash discounts, the Rule requires hospitals to disclose rate information that is essential for patients to be able to meaningfully shop for more affordable care. *See* 84 Fed. Reg. at 65,527. That is particularly so for the large group of patients with third-party coverage, for whom hospitals' chargemaster rates are essentially meaningless, and for whom the rates that truly drive patients' expenses—the rate their insurer has negotiated with a hospital—are unknown in advance of care. *Id.* at 65,539. By requiring the disclosure of third-party negotiated rates and standardized cash discounts, the Rule provides patients with necessary information to "determine their potential out-of-pocket" costs in advance, and to even determine whether it is cheaper to pay directly in cash, rather than go through insurance at all. 84 Fed. Reg. at 65,543; *see, e.g.*, SA293 (patient could save over $1,000 if they "paid upfront" for procedure rather than using insurance). And when patients use pricing information to shop for more affordable care, the evidence suggests that "cost savings result[] for both inpatient and outpatient care without sacrificing quality." 84 Fed. Reg. at 65,545-46.

These benefits are discussed further *infra* pp. 37-45, but the critical point is that HHS interpreted "standard charges" with close attention to the realities of the

healthcare market and the "problem Congress sought to solve" in § 300gg-18(e). *See PDK Labs. Inc. v. DEA*, 362 F.3d 786, 796 (D.C. Cir. 2004). And "[a] 'reasonable' explanation of how an agency's interpretation serves the statute's objectives is the stuff of which a 'permissible' construction is made." *American Hosp. Ass'n v. Azar*, 964 F.3d 1230, 1244 (D.C. Cir. 2020).

2. Plaintiffs' Contrary Arguments Are Not Persuasive

As discussed, plaintiffs no longer contend that the term "standard charges" is unambiguous. *See* Br. 26-27. Nor do they offer a definitive interpretation of what "standard charges" means. *See* Br. 26-27, 31-32. Plaintiffs suggest that "standard charges" should be read to refer to only a hospital's chargemaster charges (the argument that plaintiffs pressed in district court, *see* A35), but plaintiffs stop short of fully embracing that definition on appeal. *See* Br. 26-27, 31-32. That hesitation is understandable: as HHS explained, and as the district court likewise concluded, the statute forecloses interpreting "standard charges" to mean only chargemaster rates.

a. First, as discussed, that interpretation cannot be reconciled with § 300gg-18(e)'s specification that "standard charges" "includ[e]" charges for diagnosis-related groups. *See* A43-44. Plaintiffs do not (and cannot dispute) that charges for diagnosis-related groups, whether under Medicare or otherwise, do not appear on hospitals' chargemasters. *See* A43. That alone forecloses interpreting "standard charges" to mean only chargemaster rates.

Plaintiffs offer no meaningful response to this fact, other than to baldly assert that, even if the statute requires the disclosure of *some* third-party negotiated rates, HHS was unreasonable to require hospitals to disclose *all* of the rates they have contractually negotiated with third parties. *See* Br. 36-37. That assertion ignores the breadth of the statutory text, which, as discussed, uses the "expansive" and "illustrative" term "including." *Bloate*, 559 U.S. at 206-07.

Plaintiffs also suggest (Br. 37) that Congress intended to require hospitals to publish "only" Medicare reimbursement rates for diagnosis-related groups, but that similarly cannot be squared with the statutory text and ignores the statute's purpose. *See supra* pp. 22-23; *see also* A43 & n.12. In any event, even if it would be permissible to interpret the diagnosis-related-groups clause as referring to Medicare rates, plaintiffs fail to demonstrate that HHS's broader interpretation is foreclosed by the statutory language, and thus plaintiffs' arguments are not sufficient to overcome *Chevron*. *See Serano Labs., Inc. v. Shalala*, 158 F.3d 1313, 1321(D.C. Cir. 1998) ("[U]nder *Chevron*, courts are bound to uphold an agency interpretation as long as it is reasonable—regardless whether there may be other reasonable, or even more reasonable, views.").

b. Even setting aside § 300gg-18(e)'s reference to diagnosis-related groups, plaintiffs' suggestion that "standard charges" means only chargemaster charges fails on its own terms. Again, plaintiffs do not dispute that the term "standard" typically means "usual" or "common," Br. 27, and that "charge[]" ordinarily means "the price

demanded for something," Br. 33. Chargemaster charges cannot plausibly be described as the only "usual, common, or customary" price demanded by hospitals. As discussed, the chargemaster rate "does not apply to most consumers of hospital services." 84 Fed. Reg. at 65,575. In fact, the chargemaster charge is not the applicable charge "for approximately 90 percent" of patients. *Id.* at 65,575; *id.* at 65,538. Interpreting "standard charges" to mean only chargemaster charges stretches the ordinary meaning of those terms beyond recognition. That interpretation is particularly untenable in light of the purpose of § 300gg-18. It makes little sense that, in requiring hospitals to disclose their "standard charges" to "[b]ring[] down the cost of health care coverage," *id.*, Congress would have limited HHS to requiring hospitals to disclose only their highly inflated list prices that apply to an exceedingly small amount of patients. *See* 84 Fed. Reg. at 65,542.

Plaintiffs argue by analogy that chargemaster charges are similar to the "sticker price" on a car, which can be described as the "standard charge for a car" even though most customers negotiate down. Br. 32. But here again, plaintiffs ignore the realities of the hospital care market—the market specifically addressed by § 300gg-18(e). At a car dealership, all customers are presented with a sticker price, and then may try to negotiate a truly individualized rate. By contrast, in the hospital industry, when an insured patient goes to an in-network hospital for treatment, the rates that the hospital will charge for that patient have already been set in advance by an agreement between the hospital and the insurer, and it is that negotiated rate that the

hospital will usually and customarily "demand[]" for items and services provided to that insured patient, and similarly situated patients. Indeed, the entire market for hospital care relies on that premise. *See, e.g.*, SA191 ("In the market for private health care, prices are determined through bilateral negotiations between providers and insurers."); *see also, e.g.*, SA70; SA112; SA232. Whatever may be a "standard charge[]" in other industries, a hospital's "standard charges" include the regular rates it negotiates with third-party payers. Plaintiffs' references to other contexts (i.e., "Standard English"), are even further removed, and again ignore the purpose of § 300gg-18(e). Plaintiffs offer no reason why Congress would have limited HHS to requiring hospitals to disclose only charges that "virtually no one" (Br. 32) pays.

Switching gears, plaintiffs point to a handful of rulemaking comments from hospitals to suggest that "charge[]" is as a technical term that means a hospital's chargemaster rates. That too makes little sense. As the district court pointed out (A41), if "charges" means "chargemaster charge," then § 300gg-18(e) would require hospitals to disclose their "usual or customary" "chargemaster charge," *see, e.g.*, A545. But hospitals have just one chargemaster, which lists all of its list prices for individual items and services, and that interpretation therefore renders the term "standard" superfluous. *Contra Natural Res. Def. Council v. EPA*, 489 F.3d 1364, 1373 (D.C. Cir. 2007) (courts should "give meaning to each word used by Congress"). Defining "charge" to mean "chargemaster charge" also runs into the same problem of the diagnosis-related groups clause—hospitals do not have a "chargemaster charge" for

diagnosis-related groups. *See supra* pp. 22-23. In any event, HHS considered in its rulemaking whether "standard charges" was a term of art, and it explained that it was "not aware of any historical usage of that term by the [hospital] industry." 84 Fed. Reg. at 65,544. Instead, it appeared that hospitals' "association" of the phrase "standard charges" with "the rates in a hospital chargemaster" "originated with" HHS's previous guidelines, which had allowed hospitals to satisfy § 300gg-18(e) if they posted their chargemaster rates. *Id.*

Indeed, if anything, the word "chargemaster" is the technical term of art. A38. Had Congress wanted to require hospitals to post only their chargemaster charges, it had an obvious way of saying so. Instead, Congress used the more expansive term "standard charges," which it did not define. *See Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 252 (2010) (adding a "term of art" that is "conspicuously absent" from the text "more closely resembles inventing a statute rather than interpreting one" (alterations and citations omitted)). Plaintiffs' reliance on the use of the word "charges" in the Medicare Provider Reimbursement Manual (Br. 33) fails for similar reasons. *See* 84 Fed. Reg. at 65,539, 65,541; *see also* A40.

c. Plaintiffs' remaining arguments fail. Plaintiffs contend that HHS's interpretation has "no logical limit" because any group of patients could be an "identifiable group," and thus HHS could theoretically require hospitals to disclose, for example, any payment amount a hospital agrees to accept from a particular patient or family. Br. 29, 30. As discussed, plaintiffs misconstrue HHS's definition. *See supra*

pp. 20-21. In any event, even assuming HHS's interpretation of "standard charges," in the abstract, could have the theoretical breadth that plaintiffs posit, the *Rule* requires hospitals to disclose only three discrete categories of standard charges—their chargemaster charges, standardized cash discounts, and payer-specific negotiated rates—all of which the Rule defines. *See* 45 C.F.R. §§ 180.20; 180.50(b)(2)-(6). The Rule's validity turns on what it actually requires, not on what plaintiffs think that it logically could have required but does not.

Plaintiffs' reference to definitions of "standard charges" that HHS chose *not* to adopt in light of the statutory text and purpose (Br. 31) only underscores the agency's reasoned analysis. *See* 84 Fed. Reg. at 65,552 (declining to interpret "standard charges" to mean "all allowed charges," a definition that would include "Medicare rates," which are "already publicly disclosed"); *id.* at 65,551-52 (declining to use "modal" payments as a "proxy" measurement because that would be less useful to consumers).

Plaintiffs additionally assert (Br. 31) that it was unreasonable for HHS to include as "standard charges" a hospitals' de-identified maximum and minimum charges. But those charges are a "subset of a hospitals' payer-specific negotiated charges," and merely represent a different way for hospitals to display that charge information. A48; *see* 84 Fed. Reg. at 65,554-55. The statute explicitly grants HHS broad discretion to specify how hospitals are to "make public" their "standard charges," 42 U.S.C. § 300gg-18(e), and HHS was well within its discretion to require

hospitals to display separately their maximum and minimum negotiated rates, *see* 84 Fed. Reg. at 65,555. As HHS explained, display of that information is a familiar feature of consumer pricing tools, and allows consumers to contextualize their own rate information. *See id.* at 65,554-55. Plaintiffs' suggestion that HHS could require hospitals to display any "data points" imaginable (Br. 31) ignores HHS's careful consideration of how the display of maximum and minimum rates directly serves the statute's purposes. *See id.*

Finally, plaintiffs contend that "standard charges" cannot bear HHS's interpretation because § 300gg-18(e) requires hospitals to make their standard charges public "for each year," and hospitals negotiate third-party contracts on a "rolling basis." Br. 35. That gains plaintiffs nothing. As HHS acknowledged, "for each year" most naturally refers to "at least once annually." 84 Fed. Reg. at 65,581; *see* 45 C.F.R. § 180.50(e). Even if negotiated rates change throughout the year, that does not negate the fact that, at least once a calendar year, hospitals can publish their rates that are in effect at the time, and can "indicate the date that the information was most recently updated," as the Rule requires. *See* 84 Fed. Reg. at 65,581; 45 C.F.R. § 180.50(e).

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In short, plaintiffs fail to offer a definition of "standard charges" that can be reconciled with § 300gg-18(e)'s text or purpose. HHS, by contrast, has interpreted that phrase in light of its ordinary meaning, the market for hospital care in particular, and the goals Congress sought to achieve in requiring hospital charges to be disclosed.

At a minimum, HHS's interpretation is permissible, and is therefore entitled to deference.

B. The Rule Requires Hospitals to Disclose "A List" of Their Standard Charges

Section 300gg-18(e) requires hospitals to "make public" their list of standard charges "in accordance with guidelines developed by the Secretary." The Rule requires hospitals to "make public" their list of standard charges in "two ways." 84 Fed. Reg. at 65,555. First, in a "comprehensive machine-readable file," which would place all of the data "in one place" and could be used in creating "price transparency tools," for "clinical decision-making and referrals," and "by researchers and policy officials to help bring more value to healthcare." *Id.* at 65,555-56; *see* 45 C.F.R. § 180.50(a), (c). And second, in a smaller, "consumer-friendly display" of 300 shoppable services, which would best allow the "average patient" to shop for care. *Id.* at 65,555-56; *see* 45 C.F.R. § 180.60(a).

Plaintiffs contend that the Rule impermissibly requires hospitals to disclose two "different lists" (Br. 37-39) because hospitals must publish both a single machine-readable file and "a consumer-friendly display" of standard charges for shoppable services. Plaintiffs did not raise this argument below, *see* Pls. Mot. for Summ. J. 11-16, and it is thus forfeited, *see, e.g.*, *Chichakli v. Tillerson*, 882 F.3d 229, 234 (D.C. Cir. 2018). It is also incorrect. Hospitals have to "establish" one "list" of their standard charges for all items and services, which is reflected in the hospitals' comprehensive machine-

readable file. *See* 84 Fed. Reg. at 65,555; 45 C.F.R. § 180.50(a), (c). The separate display of charges for 300 shoppable services is merely a different way that hospitals must "make public" that list, in accordance with HHS's explicit statutory discretion to specify how hospitals are to "make public" their standard charges. *See* 42 U.S.C. § 300gg-18(e); 84 Fed. Reg. at 65,555; 45 C.F.R. § 180.60(a). HHS fully explained why requiring hospitals to display their standard charges in two different manners was consistent with the statutory text and would aid consumers. 84 Fed. Reg. at 65,555-56; *id.* at 65,564-65.

Plaintiffs additionally repeat the argument they pressed in district court—that under the Rule, even a single display of hospital charges under the Rule would be more than "a list," because the list would have to contain multiple entries and rates. Br. 39-40. That is meritless. As the district court explained, "a list can contain multiple categories." A48. Indeed, the plain meaning of the word "list" encompasses a "catalog," which can of course include more than one type of entry or category of information. *See List*, OED Online, June 2020.[3] Had Congress required hospitals to publish "a list [of every payment the hospital received from each patient or third-party payer]," such "a list" would include orders of magnitude more entries than what the Rule requires, but hospitals could not evade that requirement by protesting that "a

[3] www.oed.com/view/Entry/108991; *see also, e.g.*, *List*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/list (last visited Aug. 12, 2020).

list" can have only two columns or a limited number of entries. Plaintiffs' argument that it violates the statute for HHS to require hospitals with different locations to provide each location's "standard charges" (Br. 39), is even further afield. Hospitals with different locations can have separate chargemasters, *see* 84 Fed. Reg. at 65,557, and thus under plaintiffs' theory, requiring these hospitals to each disclose even their own chargemasters would presumably be requiring more than "a list."

C. Plaintiffs' Arguments for Avoiding *Chevron* Fail

For the reasons set forth above, HHS's interpretation represents the best approach to construing the disclosure provision. In any case, it is at the very least permissible, and therefore entitled to deference under *Chevron*. Plaintiffs' arguments for avoiding *Chevron* fail.

First, plaintiffs contend that HHS inexplicably departed from its prior position. That is untrue. HHS acknowledged that its prior guidelines had allowed hospitals to satisfy the statute by making only their chargemasters available, and HHS thoroughly explained why it believed that was incorrect and why its Rule is better. *See, e.g.*, 84 Fed. Reg. at 65,535 ("In retrospect, we recognize that [earlier] guidance unnecessarily limited the reporting of" charges); *id.* at 65,544 ("[O]ur current guidelines are [not] sufficient to inform consumers (particularly those with insurance) what their charges for a hospital item or service will be.'"). Plaintiffs contend that HHS "fail[ed] to grapple" with reliance interests or the Rule's burdens (Br. 43), but HHS not only considered those concerns, it delayed the effective date of its Rule by a full year as a

result. 84 Fed. Reg. at 65,550-51; *see infra* pp. 45-46. HHS amply met its obligation to recognize and explain a change in position. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (an agency must ordinarily "display awareness that it *is* changing position" and "show that there are good reasons for the new policy," but "need not demonstrate to a court's satisfaction that the reasons for the new policy are *better* than the reasons for the old one").

Second, plaintiffs contend that *Chevron* is inapplicable because the President issued an Executive Order in 2019 directing the Secretary to "propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items." *See* 84 Fed. Reg. 30,849 (June 27, 2019). That is incorrect, for several reasons.

To begin, the origins of the rulemaking predate the Executive Order. HHS expressed concern in 2018 "that chargemaster data [is] not helpful to patients for determining what they are likely to pay for a particular service or hospital stay." 83 Fed. Reg. at 20,549. HHS requested public input at that time on how "standard charges" should be defined, and HHS explained throughout its Rule how those comments meaningfully informed its current interpretation. *See, e.g.*, 84 Fed. Reg. at 65,537. The Rule reflects HHS's experience, expertise, and judgment, not simply a Presidential directive. That is underscored by the fact that, as the district court noted, the Executive Order merely directed HHS to propose a rule, without obligating it to

adopt the rule or disregard public comments regarding the rule's appropriate contours.

Furthermore, plaintiffs cite no authority for the remarkable proposition that "instigat[ion]" by the President (Br. 44) should diminish the deference an agency is owed under *Chevron*. *Chevron* itself suggests the opposite by emphasizing that although "agencies are not directly accountable to the people, *the Chief Executive is*, and it is entirely appropriate for this political branch of the Government" to "resolv[e] the competing interests which Congress" did not. *Chevron*, 467 U.S. at 865 (emphasis added). As this Court emphasized in *Public Citizen v. Burke*, it would be "anomalous for the Judiciary to refuse deference merely on the grounds that it can be shown that the agency's interpretation was one pressed by the President." 843 F.2d 1473, 1477-78 (D.C. Cir. 1988). In fact, the very regulation at issue in *Chevron* "arose, as the Court recognized, from a 'Government-wide reexamination of the regulatory burdens and complexities' that President Reagan ordered in his first months in office." Elena Kagan, *Presidential Administration*, 114 Harv. L. Rev. 2245, 2376 (2001) (quoting *Chevron*, 467 U.S. at 857)).

II. The Rule Is Not Arbitrary or Capricious

Plaintiffs also err in claiming that the Rule is arbitrary and capricious. Plaintiffs argue that HHS failed to consider whether its Rule would mislead consumers, and that HHS failed to appreciate hospitals' compliance burdens. But as discussed below,

HHS thoroughly considered and addressed these issues, and reasonably concluded that the Rule will have substantial benefits that will outweigh its costs.

A. HHS Reasonably Concluded the Rule Will Allow Consumers to Better Shop for Care and Lower Healthcare Costs

HHS thoroughly considered the evidence in the record and concluded that its Rule will "facilitate more informed health care decisions" and "lower[] healthcare costs." 84 Fed. Reg. at 65,544-45. That conclusion is reasonable, and plaintiffs fail to establish otherwise.

1. Plaintiffs principally contend the Rule is inadequate because it does "not inform patients of their out-of-pocket costs." Br. 58. That is wrong, for several reasons.

To begin, the Rule will directly provide out-of-pocket cost information for many patients, including some with insurance. Under the Rule, patients who are self-pay can see both the chargemaster rate and any discounted cash rate a hospital makes available, which may well end up as their out-of-pocket cost. *See* 84 Fed. Reg. at 65,553. Insured patients who have not yet hit their deductible—particularly those with high-deductible health plans—may also be able to determine the full cost of a service just by looking at the charge a hospital has negotiated with the patient's insurance company, since these patients will likely bear full financial responsibility for hospital items and services until their deductible is reached. *See id.* at 65,537 ("[C]ommenters indicated that knowing the rate the insurer had negotiated on their

behalf would be essential for patients with . . . [high-deductible health plans] to help determine their out-of-pocket cost estimates in advance."); *see also, e.g.*, SA1-SA3 (comments from high-deductible-health-plan enrollees expressing desire for cost information to shop for care). Significantly, under the Rule, these patients will also be able to compare the negotiated charge with any standardized cash discount price, and determine whether it is cheaper for them to pay in cash, rather than rely on insurance at all. *See* 84 Fed. Reg. at 65,552; *see also* SA293 (patient explaining they could save over $1000 if they "paid upfront" rather than use insurance). Even if the Rule helps only these subgroups, it will still provide a substantial benefit to many patients. That is particularly so given that enrollment in high-deductible health plans has increased in recent years. *See* SA12.

The Rule's benefits, however, are much broader. For insured patients, the Rule provides access to rates that were previously unavailable and that often are necessary to determine out-of-pocket expenses. Thus, for example, "if a healthcare consumer knows that he or she will be responsible for a co-pay of 20 percent of the charges for a hospital service, he or she can compare the charges that the third party negotiated with hospital A and hospital B and, from that, the consumer can determine his or her expected out-of-pocket costs at hospital A versus hospital B." 84 Fed. Reg. at 65,542. Without the Rule, the key input for that calculation—the charge the third-party has negotiated—is unknown in advance of care. *See id.* at 65,558.

Plaintiffs are therefore wrong in suggesting that HHS "conceded that the *most* useful information" for patients is the chargemaster rate. Br. 58-59. Chargemaster rates do not apply to the vast majority of hospital consumers, and indeed "bear little resemblance" to what most patients will pay. SA70; *see* A39. It is true that the chargemaster rate "reflect[s] the maximum patients could pay." Br. 59. But for a patient with a high-deductible health plan attempting to budget and shop for care, it is of little value to learn of hospitals' highly inflated list prices that likely bear no resemblance to the actual applicable charge. *See* 84 Fed. Reg. at 65,543.

HHS recognized, of course, that the Rule's disclosures would not fully eliminate the barriers that currently prevent patients from perfectly shopping for care. *See* 84 Fed. Reg. at 65,526. Nonetheless, HHS explained, the Rule would begin to bridge the significant "gap" in hospital pricing information that currently exists, thus better enabling consumers "to make more informed decisions." *Id.* at 65,527. In short, HHS reasonably determined that taking a "necessary first step" towards price transparency, *id.* at 65,528, is better than standing still. The APA allows HHS to make that choice. *See National Ass'n of Broads. v. FCC*, 740 F.2d 1190, 1207 (D.C. Cir. 1984) ("[R]eform may take place one step at a time, addressing itself to the phase of the problem which seems most acute to the [regulatory] mind." (alteration in original)).

2. Plaintiffs additionally contend that HHS failed to consider ways in which its Rule could "backfire" and "mislead[]" consumers. Br. 45-49. That is also incorrect. HHS fully considered whether disclosure of price information could have

"unintended consequences." 84 Fed. Reg. at 65,547. HHS explained that although it could not "discount the possibility that some consumers may find required hospital data disclosures confusing, [it] believe[d] that the vast majority" of consumers would find the disclosures "overwhelmingly beneficial." *Id.*

That conclusion is amply supported by the record, in which commenters expressed "resounding[]" support for access to pricing information, 84 Fed. Reg. at 65,545, and made clear their current "frustration at their current inability to prospectively access medical costs," *id.* at 65,527. Indeed, HHS noted, some consumers have taken it upon themselves to "crowdsourc[e] . . . the [payer-specific negotiated rate] information found on" Explanations of Benefits forms to create their own online databases of rate information in order "to assist the public in price shopping." *Id.* at 65,544; *see* SA292-93 (describing one such effort); SA254-56 (example of website). And given the desire expressed by physicians for pricing information to have cost-of-care conversations with their patients, *see* 84 Fed. Reg. at 65,549-50; SA306; SA298; as well as the interest expressed by the private sector in developing price-comparison tools, *see* 84 Fed. Reg. at 65,543-44, 65,549; HHS reasonably concluded that the effort required for patients to understand their costs should only diminish over time.

Plaintiffs' contrary arguments fail to overcome the deference owed to HHS's reasonable "prediction[s] about the future impact of [its] own regulatory polic[y]." *See Association for Cmty. Affiliated Plans v. U.S. Dep't of the Treasury*, -- F.3d ---, 2020 WL

4032806, at *7 (D.C. Cir. July 17, 2020). Plaintiffs assert that the Rule could "perversely drive patients to costlier options" because it does not require the disclosure of charges "from ambulatory surgical centers." *Id.* But the statute applies only to "hospital[s]," 42 U.S.C. § 300gg-18(e), and ambulatory surgical centers are not hospitals, *see* 84 Fed. Reg. at 65,531. Potential disparities in information between hospital and non-hospital charges inhere in the statute itself and cannot be eliminated by any price transparency rule HHS could promulgate under § 300gg-18(e). HHS fully recognized that the Rule does not (and cannot) apply to ambulatory surgical centers, and "encouraged non-hospital sites-of-care to make public their lists of standard charges in alignment with the proposed requirements so that consumers could make effective pricing comparisons." *See* 84 Fed. Reg. at 65,531. Although plaintiffs would presumably prefer HHS to have jettisoned any attempt to implement the statute altogether, HHS reasonably decided otherwise.

Plaintiffs additionally assert that consumers could be misled by the Rule because consumers might not realize that a hospitals' rates have been "updated" since the time of their disclosure. Br. 48-49. HHS fully considered that possibility, however, and as noted above, required hospitals to "clearly indicate the date of the last update they have made to the standard charge data." 84 Fed. Reg. at 65,563. Even if a rate changes during the year, a consumer looking up a hospital's charges would, under the Rule, at least be able to learn of the rate that their insurer has

negotiated with the hospital within the last year, a significant improvement over the current status quo. *See* 84 Fed. Reg. at 65,546.

Plaintiffs' concern that patients will be misled because hospitals without a standardized-cash discount must report their chargemaster charge (Br. 49, 59) is even further afield. As discussed, a standardized cash-discount price is a regular rate offered by a hospital to anyone who is paying for their care directly in cash. *See* 84 Fed. Reg. at 65,552-53. If a hospital has not established such a discount, then the chargemaster charge *is* the usual charge the hospital will demand from a cash-paying patient. *See id.* at 65,553. It is not misleading for hospitals to report their chargemaster charge in that circumstance—it is accurate. Hospitals are also free, of course, to provide consumers with any additional explanations or disclaimers about their charges as they see fit. *See id.* at 65,547.

At bottom, plaintiffs' argument is that hospital rates are complex, and that disclosure of all of a hospital's charges under the Rule will provide consumers with a "data overload" that they cannot possibly begin to comprehend (Br. 59-60). But it cannot be the case that the very reason consumers are confused and frustrated about hospital charges—the fact that those charges are the product of hundreds or thousands of complicated and opaque contractual agreements between hospitals and insurance companies—is a reason to deprive consumers of information about those charges. HHS rightfully concluded otherwise. *See* 84 Fed. Reg. at 65,547, 65,555-56. HHS explained how the public would use and benefit from a full list of hospital

charge information. *See id.* (explaining the data could be used for "price transparency tools," "clinical decision-making and referrals," and by "researchers and policy officials"). And how the "average patient" would use and benefit from a smaller consumer-friendly display for 300 shoppable procedures. *Id.*; *see id.* at 65,556. Plaintiffs' doubt about consumers' ability to engage with this information is, again, belied by the record. After all, if consumers are willing to manually input information gleaned from their Explanations of Benefits and medical bills, line by line, into "crowdsourcing websites," just to marginally improve the availability of hospital-rate information, *see* SA292-93; SA254-56; it is reasonable to assume that they will be willing and able to use the Rule's disclosures, and that they will benefit as a result. *See* 84 Fed. Reg. at 65,544.

3. Finally, contrary to plaintiffs' assertions (Br. 61-62), HHS fully considered whether its Rule would have anti-competitive effects, and reasonably concluded that the Rule was likely to result in lower, not higher, prices. *See* 84 Fed. Reg. at 65,547. HHS explained that there is extensive support for the economic theory underlying the Rule—that price transparency generally lowers costs—both at a high level of abstraction and specifically in the market for healthcare. *Id.* at 65,545-47; *see* SA62 ("[T]he majority of the empirical studies [from commercial markets] tend to find that greater price transparency . . . leads to lower and more uniform prices"); SA200 (finding, in study of medical imaging services, "evidence that price transparency can be effective in the long run, especially when it is available to the entire market");

SA258-59 (giving employees "access to [healthcare] price information [about healthcare] reduce[d] the average price paid by 1.6 percent"); SA291 ("Use of price transparency information was associated with lower total claims payments for common medical services.").

Research from State price-transparency efforts further support HHS's conclusions. *See* 84 Fed. Reg. at 65,527, 65,544. For example, studies have shown that consumers who used New Hampshire's price transparency website—which uses aggregated insurance claims data to estimate payer-specific negotiated rates and plan- and provider-specific out-of-pocket costs, SA157[4]—chose lower-cost options, which placed downward pressure on prices throughout the State, and benefitted even consumers who did not use the website. *See* 84 Fed. Reg. at 65,527; SA146; SA200; *see also* 84 Fed. Reg. at 65,529 (discussing how Maine's healthcare price transparency effort, which also releases some payer-specific rate information, has been linked to increased competition); SA204; SA216.

The above evidence is not, of course, definitive proof that nationwide disclosure of hospital charges under the Rule will have the same or similar effects, and HHS acknowledged that its Rule comes with some degree of uncertainty. *See* 84 Fed.

[4] New Hampshire law allows the State access to insurance claims data, SA125, which it uses to estimate payer-specific rate information "based on the median of all payments paid by [a] specific insurance plan to [a] provider for [a] service." SA123-24.

Reg. at 65,542. But plaintiffs are wrong (Br. 61) that HHS could not rely on the evidence before it to make reasonable and informed predictions about the efficacy of its Rule. "[I]t is not infrequent that the available data do[es] not settle a regulatory issue, and the agency must then exercise its judgment in moving from the facts and probabilities on the record to a policy conclusion." *Motor Vehicle Mfrs. Ass'n v. State Farm*, 463 U.S. 29, 52 (1983). HHS reasonably did so here—it "explained the available evidence," and ultimately "offered a rational connection between the facts found and the choice made." *New York v. EPA*, 413 F.3d 3, 31 (D.C. Cir. 2005) (quotations omitted).

B. HHS Adequately Evaluated the Rule's Burdens

Plaintiffs are similarly incorrect that HHS failed to adequately appreciate hospitals' compliance burdens. To the contrary, HHS thoroughly considered hospitals' comments, and explained that it was "aware that hospitals and payers utilize a variety of payment methodologies in their contracts"; that "different hospitals may face different constraints" in compiling rate information; and that hospitals may currently "house[]" their charge information "in disparate systems." 84 Fed. Reg. at 65,593; *see id.* at 65,550-51, 65,585. Indeed, acknowledging these complexities, HHS made two "accommodations" "to relieve hospital burden." *Id.* at 65,594. First, HHS delayed the effective date of the Rule by a year, until January 1, 2021. *Id.* at 65,551. Second, HHS concluded that hospitals that provide an online price-calculator tool that meets certain minimum standards—which some hospitals already voluntarily

offer—would be deemed in compliance with the Rule's consumer-friendly-display requirement. *Id.* at 65,578-79.

HHS also significantly increased its cost-of-compliance estimate from its original estimate. *See* 84 Fed. Reg. at 65,592-94. In its proposed rule, HHS estimated that the annual burden per hospital would be approximately 12 hours, *see id.* at 65,592; but in its final Rule HHS increased that estimate more than ten-fold, to approximately 150 hours (or $11,898.60) per hospital in the first year, and approximately 46 hours (or $3,610.88) per hospital each year thereafter, *id.* at 65,596.

Plaintiffs assert that this estimate is "ridiculously low" (Br. 57), but HHS's estimate of 150 hours per hospital is the same as the estimate that was submitted by plaintiffs' amicus, HFMA. *See* SA34 ("Based on estimates by HFMA's members . . . the average time required to comply is 150 hours"). HFMA asserts (Amicus Br. 15-16) that HHS should have adopted that figure for all years, not just the first year. But HHS reasonably recognized that hospitals' compliance costs would likely decrease annually once hospitals are able to "utilize the business processes and system infrastructures or software that would be built or purchased during the first year." 84 Fed. Reg. at 65,596.

Plaintiffs' examples of hospitals reporting "hundreds of thousands of dollars" in compliance costs (Br. 57) do not demonstrate that HHS's estimate was unreasonable. First, plaintiffs cite burden estimates from hospital systems comprising multiple hospitals. *See, e.g.*, A265; A269. HHS's estimate, however, is on a per-

hospital basis. *See* 84 Fed. Reg. at 65,593-94 (explaining that where hospitals estimated burdens "based on a hospital system," HHS "converted the estimate to a per-hospital basis"). A hospital system comprised of twenty hospitals that estimates approximately $200,000 in total compliance costs for the first year is estimating roughly the same per-hospital cost as HHS.

Second, HHS fully recognized that there would be a range of different compliance burdens and costs, and that there would be outliers. *See* 84 Fed. Reg. at 65,593-94. Indeed, as HHS explained, hospitals faced a range of compliance burdens even in posting their chargemasters. *See id.* at 65,593 ("[O]ne commenter indicated that chargemaster posting took 30 minutes to complete . . . while another commenter stated their experience . . . required 60 to 100 hours"). That does not demonstrate that HHS failed to appreciate hospitals' burdens, let alone that the Rule is unreasonable. The fact that HHS arrived at the same first-year burden estimate as plaintiffs' amicus HFMA strongly suggests otherwise.

Plaintiffs' assertion that the Rule will require hospitals to "identify" "all of the variables that" go into a particular rate "for any given item or service" (Br. 54) is difficult to understand. To use plaintiffs' example, if a hospital has contractually agreed to charge $500 for an outpatient X-Ray provided to a patient who has UnitedHealthcare's health maintenance organization plan, then the Rule requires hospitals to disclose $500 as the payer-specific negotiated rate for an outpatient X-Ray for UnitedHealthcare's health maintenance organization plan. If the same hospital

has also negotiated with Blue Cross to charge $500 for an outpatient X-Ray provided to its members, then the Rule requires hospitals to disclose $500 as the Blue Cross payer-specific negotiated rate for that procedure. And if that hospital has negotiated another contract with Anthem, in which it charges its members for X-Rays only as part of bundled service packages for particular procedures, then the hospital would disclose its Anthem payer-specific noted rates for those procedures, and would report there is no "applicable" payer-specific negotiated rate with Anthem for a standalone X-Ray. *See* 84 Fed. Reg. at 65,555 (explaining that hospitals must identify payer-specific prices for items and services only "as applicable"); 45 C.F.R. § 180.60(b), (c).

That hospitals may need to access different accounting and billing systems (Br. 53), or "manually scour" their contracts (State Hosp. Ass'n Amicus Br. 9), to report such information only underscores the need for the Rule. As discussed, the burdens of navigating a non-transparent hospital-care system currently fall on consumers, who are casting about for any information about hospital prices they can acquire. It is a feature, not a bug, that the Rule shifts to hospitals some of the burden that patients currently bear. HHS reasonably determined that burden would be a manageable one for hospitals, and would have significant benefits. *See* 84 Fed. Reg. at 65,551; *id.* at 65,598.

Finally, plaintiffs' suggestion that HHS has unreasonably "target[ed]" hospitals, rather than insurance companies, Br. 57-58, ignores that *Congress* put the onus on "[e]ach hospital" to disclose "the hospital's standard charges." 42 U.S.C. § 300gg-

18(e). That makes sense: hospitals are the entities from which patients receive services, and to which patients owe payment. Moreover, an important feature of the Rule is that it gives patients the opportunity to view different standard charges for the same hospital, allowing them to make useful comparisons, including with respect to any discounted cash rates the hospital provides. *See* 84 Fed. Reg. at 65,552. A disclosure requirement imposed on only insurance companies would not give patients the information necessary for those comparisons. For that reason, the separately proposed rule by HHS, the Department of Treasury, and the Department of Labor to put in place additional price transparency requirements for insurers and group health plans, 84 Fed. Reg. 65,464 (Nov. 27, 2019), is intended to be a "complement[]" to the Rule at issue here, and not a substitute, *see* 84 Fed. Reg. at 65,528.

III. The Rule Satisfies the First Amendment

Plaintiffs do not further their objections by seeking to give them constitutional weight. The Supreme Court has long recognized that disclosure requirements constitute a modest imposition on commercial speech, particularly where the seller must provide "purely factual and uncontroversial information about the terms under which [its] services will be available." *Zauderer*, 471 U.S. at 651. Rules requiring such disclosures are valid "as long as [they] are reasonably related to the State's interest." *Id.* By their nature, required disclosures of factual commercial information "will almost always demonstrate a reasonable means-ends relationship, absent a showing that the disclosure is 'unduly burdensome' in a way that 'chill[s] protected commercial

speech.'" *American Meat Inst. v. USDA*, 760 F.3d 18, 26 (D.C. Cir. 2014) (en banc) (*AMI*) (quoting *Zauderer*, 471 U.S. at 651).

As the district court held, *Zauderer* provides the appropriate standard to review the Rule, which requires hospitals to disclose only "purely factual and uncontroversial information about the terms under which [hospital] services will be available," 471 U.S. at 651—namely, their price. Plaintiffs "half-hearted[ly]" suggest that strict scrutiny applies, but they cite "inapposite cases" where the government sought to restrict speech or regulate the content of messages that were not unambiguously commercial. A52; *see* Br. 45. Plaintiffs additionally contend, relying on *National Association of Manufacturers v. SEC*, 800 F.3d 518 (D.C. Cir. 2015) (*NAM*), that *Zauderer* applies only to disclosures connected to advertising or labeling at the point-of-sale. Br. 46. But this Court has already rejected the argument that *NAM* "directs [the Court] to apply [intermediate] scrutiny to" any disclosures that are "unconnected to advertising or labeling at the point of sale." *United States v. Philip Morris USA, Inc.*, 855 F.3d 321, 327-28 (D.C. Cir. 2017); *see United States v. Philip Morris USA, Inc.*, 566 F.3d 1095, 1138, 1143-44 (D.C. Cir. 2009) (applying *Zauderer* to requirement that tobacco companies issue "corrective statements" in several locations, including "newspapers" "and [on] their company websites"); *see also* A54-57.

The Rule readily satisfies *Zauderer*'s requirements that the compelled disclosures be reasonably related to the government's interest, and not "'unduly burdensome' in a way that 'chill[s] protected commercial speech.'" *AMI*, 760 F.3d at 26 (quoting

Zauderer, 471 U.S. at 651). Plaintiffs do not dispute that the government has a substantial interest in providing consumers with factual price information to facilitate informed healthcare decisions. *See* 84 Fed. Reg. at 65,544-45. Plaintiffs question whether the Rule's disclosure requirements "reasonably relate" to that interest. Br. 46. But "evidentiary parsing is hardly necessary when the government uses a disclosure mandate to achieve a goal of informing consumers about a particular product trait." *AMI*, 760 F.3d at 26. Here, HHS has required hospitals to disclose their charges for the items and services they provide in order to remedy the fact that most patients lack that information prior to care. *See* 84 Fed. Reg. at 65,544-45. As set forth above, HHS's conclusions that the Rule will benefit consumers are amply supported by the record, and indeed would satisfy even a more demanding standard of review. *See Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 555 (2001) ("We have permitted litigants to justify speech restrictions by reference to studies and anecdotes pertaining to different locales altogether, or even, in a case applying strict scrutiny, to restrictions based solely on history, consensus, and simple common sense.").

Plaintiffs' assertion (Br. 48) that the government cannot compel the disclosure of hospital charge information because that information is "subject to misinterpretation by consumers," *R.J. Reynolds Tobacco Co. v. FDA*, 696 F.3d 1205, 1216 (D.C. Cir. 2012), is also misconceived. As discussed, HHS thoroughly considered whether consumers would be confused or misled by the disclosure of charge information and concluded that the "vast majority" of consumers would find

the information "overwhelmingly beneficial." *See* 84 Fed. Reg. at 65,547. And in any event, in *R.J. Reynolds*, when this Court discussed whether a disclosure was "subject to misinterpretation" by consumers, it did so in the course of addressing whether the disclosure was "'purely factual and uncontroversial.'" 696 F.3d at 1216. There, the Court found that the "graphic warning[]" labels the government had chosen for cigarettes were "unabashed attempts to evoke emotion . . . and browbeat consumers," and were accordingly not subject to the *Zauderer* standard. *See id.* at 1216-17. That is nothing like the circumstance at issue here. Plaintiffs do not (and cannot) dispute that the Rule requires hospitals to disclose purely factual information about hospital charges; plaintiffs' argument is instead that if consumers are *told* purely factual information about hospital charges, it will be too complicated for them to understand. *See* Br. 48-49. But the very complexity of hospitals' opaque pricing arrangements, complexity for which the hospitals themselves are largely responsible, is an argument in favor of greater disclosure, not a justification for continued obscurity.

Finally, plaintiffs' arguments that the Rule is "unduly burdensome" (Br. 49) are wrong. The relevant question under the First Amendment is whether a disclosure requirement "unduly burdens protected speech." *National Inst. of Family & Life Advocates v. Becerra*, 158 S. Ct. 2361, 2377 (2018) (*NIFLA*); *see AMI*, 760 F.3d at 27 ("*Zauderer* cannot justify a disclosure so burdensome that it essentially operates as a restriction on constitutionally protected speech."). Plaintiffs make no claim that the Rule will chill commercial speech, and it is difficult to see how such a claim could be

plausible. This is not a case in which the government has "impose[d] a government-scripted, speaker-based disclosure requirement." *NIFLA*, 158 S. Ct. at 237. Nor is this a circumstance in which the government has required a disclosure on a finite amount of space (such as a label or letterhead) that is "so detailed that it" prevents the speaker from presenting any other message. *See AMI*, 760 F.3d at 27; *see also NIFLA*, 138 S. Ct. at 2378 (explaining that the notice at issue "drown[ed] out the facility's own message"). Plaintiffs' arguments about *economic* burdens do not demonstrate that their *speech* has been burdened in any way. And those arguments are undercut in any event by HHS's detailed analysis of why its Rule is necessary, why other alternatives would be less effective, and why the Rule will impose manageable costs on hospitals. *See* 84 Fed. Reg. at 65,529; *see supra* pp. 37-49.

For these reasons, the rule does not infringe the First Amendment. Plaintiffs' challenge to HHS's interpretation of the statute therefore cannot be sustained by invoking principles of constitutional avoidance. *Contra* Br. 42.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be affirmed.

Respectfully submitted,

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August 2020

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 12,987 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Courtney L. Dixon
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CERTIFICATE OF SERVICE

I hereby certify that on August 14, 2020, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Courtney L. Dixon
Courtney L. Dixon

ADDENDUM

TABLE OF CONTENTS

42 U.S.C. § 300gg-18

§ 300gg-18. Bringing down the cost of health care coverage.

*** * ***

(e) Standard hospital charges

Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title.

45 C.F.R. § 180.20 (effective Jan. 1, 2021)

§ 180.20. Definitions.

The following definitions apply to this part, unless specified otherwise:

Ancillary service means an item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service.

Chargemaster (Charge Description Master or CDM) means the list of all individual items and services maintained by a hospital for which the hospital has established a charge.

De-identified maximum negotiated charge means the highest charge that a hospital has negotiated with all third party payers for an item or service.

De-identified minimum negotiated charge means the lowest charge that a hospital has negotiated with all third party payers for an item or service.

Discounted cash price means the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.

Gross charge means the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.

Hospital means an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Items and services means all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. Examples include, but are not limited to, the following:

(1) Supplies and procedures.

(2) Room and board.

(3) Use of the facility and other items (generally described as facility fees).

(4) Services of employed physicians and non-physician practitioners (generally reflected as professional charges).

(5) Any other items or services for which a hospital has established a standard charge.

Machine-readable format means a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats.

Payer-specific negotiated charge means the charge that a hospital has negotiated with a third party payer for an item or service.

Service package means an aggregation of individual items and services into a single service with a single charge.

Shoppable service means a service that can be scheduled by a healthcare consumer in advance.

Standard charge means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. This includes all of the following as defined under this section:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

Third party payer means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service.

45 C.F.R. § 180.50 (effective Jan. 1, 2021)

§ 180.50. Requirements for making public hospital standard charges for all items and services.

(a) General rules.

(1) A hospital must establish, update, and make public a list of all standard charges for all items and services online in the form and manner specified in this section.

(2) Each hospital location operating under a single hospital license (or approval) that has a different set of standard charges than the other location(s) operating under the same hospital license (or approval) must separately make public the standard charges applicable to that location.

(b) Required data elements. A hospital must include all of the following corresponding data elements in its list of standard charges, as applicable:

(1) Description of each item or service provided by the hospital.

(2) Gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(3) Payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third party payer and plan.

(4) De-identified minimum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(5) De-identified maximum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(6) Discounted cash price that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(7) Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier.

(c) Format. The information described in paragraph (b) of this section must be published in a single digital file that is in a machine-readable format.

(d) Location and accessibility.

(1) A hospital must select a publicly available website for purposes of making public the standard charge information required under paragraph (b) of this section.

(2) The standard charge information must be displayed in a prominent manner and clearly identified with the hospital location with which the standard charge information is associated.

(3) The hospital must ensure that the standard charge information is easily accessible, without barriers, including but not limited to ensuring the information is accessible:

(i) Free of charge;

(ii) Without having to establish a user account or password; and

(iii) Without having to submit personal identifying information (PII).

(4) The digital file and standard charge information contained in that file must be digitally searchable.

(5) The file must use the following naming convention specified by CMS, specifically: <ein>_<hospital-name>_standardcharges.[json[verbar]xml[verbar]csv].

(e) Frequency of updates. The hospital must update the standard charge information described in paragraph (b) of this section at least once annually. The hospital must clearly indicate the date that the standard charge data was most recently updated, either within the file itself or otherwise clearly associated with the file.

45 C.F.R. § 180.60 (effective Jan. 1, 2021)

§ 180.60. Requirements for displaying shoppable services in a consumer-friendly manner.

(a) General rules.

(1) A hospital must make public the standard charges identified in paragraphs (b)(3) through (6) of this section, for as many of the 70 CMS–specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

(i) In selecting a shoppable service for purposes of this section, a hospital must consider the rate at which it provides and bills for that shoppable service.

(ii) If a hospital does not provide 300 shoppable services, the hospital must make public the information specified in paragraph (b) of this section for as many shoppable services as it provides.

(2) A hospital is deemed by CMS to meet the requirements of this section if the hospital maintains an internet-based price estimator tool which meets the following requirements.

(i) Provides estimates for as many of the 70 CMS–specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

(ii) Allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.

(iii) Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.

(b) Required data elements. A hospital must include, as applicable, all of the following corresponding data elements when displaying its standard charges (identified in paragraphs (b)(3) through (6) of this section) for its list of shoppable services selected under paragraph (a)(1) of this section:

(1) A plain-language description of each shoppable service.

(2) An indicator when one or more of the CMS–specified shoppable services are not offered by the hospital.

(3) The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Each list of payer-specific negotiated charges must be clearly associated with the name of the third party payer and plan.

(4) The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge for the shoppable service (and corresponding ancillary services, as applicable).

(5) The de-identified minimum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).

(6) The de-identified maximum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).

(7) The location at which the shoppable service is provided, including whether the standard charges identified in paragraphs (b)(3) through (6) of this section for the shoppable service apply at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.

(8) Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), or other common service billing code.

(c) Format. A hospital has discretion to choose a format for making public the information described in paragraph (b) of this section online.

(d) Location and accessibility of online data.

(1) A hospital must select an appropriate publicly available internet location for purposes of making public the information described in paragraph (b) of this section.

(2) The information must be displayed in a prominent manner that identifies the hospital location with which the information is associated.

(3) The shoppable services information must be easily accessible, without barriers, including but not limited to ensuring the information is:

(i) Free of charge.

(ii) Accessible without having to register or establish a user account or password.

(iii) Accessible without having to submit personal identifying information (PII).

(iv) Searchable by service description, billing code, and payer.

(e) Frequency. The hospital must update the standard charge information described in paragraph (b) of this section at least once annually. The hospital must clearly indicate the date that the information was most recently updated.