NOT YET SCHEDULED FOR ORAL ARGUMENT

No. 20-5193

In the United States Court of Appeals for the District of Columbia Circuit

THE AMERICAN HOSPITAL ASSOCIATION, ET AL.,
APPELLANTS

v.

ALEX M. AZAR II,
SECRETARY OF HEALTH AND HUMAN SERVICES,
APPELLEE

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA (CIV. NO. 19-3619)

BRIEF OF APPELLANTS AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FEDERATION OF AMERICAN HOSPITALS, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS, MEMORIAL COMMUNITY HOSPITAL AND HEALTH SYSTEM, PROVIDENCE HEALTH SYSTEM – SOUTHERN CALIFORNA D/B/A PROVIDENCE HOLY CROSS MEDICAL CENTER, AND BOTHWELL REGIONAL HEALTH CENTER

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28(a)(1), Appellants provide the following information:

A. Parties and Amici

1. The following parties and amicus curiae appeared before the District Court:

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

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

Amicus Curiae
Thirty-Seven State Hospital Associations (enumerated below)
The Chamber of Commerce of the United States of America
PatientRightsAdvocate.org
The Independent Women's Law Center
The Texas Public Policy Foundation
The Association of Mature American Citizens

2. The following parties currently appear before this Court:

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

Appellee

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

3. Appellants make the following disclosures:

Appellant American Hospital Association (AHA) is a national, not-for-profit organization that represents and serves nearly 5,000 hospitals, health care systems, and networks, plus 43,000 individual members. AHA has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Appellant Association of American Medical Colleges (AAMC) is a national, not-for-profit association that serves all 155 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and more than 80 academic societies. AAMC has no parent corporation and no publicly held company has a 10% or greater ownership interest.

Appellant The Federation of American Hospitals represents more than 1,000 investor-owned or managed community hospitals and health systems nationwide. FAH has no parent corporation and no publicly held company has a 10% or greater ownership interest.

Appellant National Association of Children's Hospitals, Inc. represents more than 220 children's hospitals nationwide. NACH has no parent corporation and no publicly held company has a 10% or greater ownership interest.

Appellant Memorial Community Hospital and Health System is a 501(c)(3) not-for-profit organization that serves a population of approximately 20,000 residents throughout its primary service area in Nebraska. Memorial Community has no parent corporation, and Alegent Health, 1010 N. 96th Street, Omaha, NE 68114, has 40% minority ownership of Memorial Community Hospital and Health System.

Appellant Providence Health System – Southern California d/b/a Providence Holy Cross Medical Center Hospitals is a 377-bed, not-for-profit Catholic hospital offering both inpatient and outpatient health services in the San Fernando, Santa Clarita, and Simi Valleys in Southern California. Providence's parent corporation is Providence Health & Services and no publicly held company has a 10% or greater ownership interest.

Appellant Bothwell Regional Health Center is a city-chartered health center that provides diagnostic, medical, and surgical services across 12 locations in central Missouri. Bothwell has no parent corporation and no publicly held company has a 10% or greater ownership interest.

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

The Chamber of Commerce of the United States of America participated as amicus curiae in the District Court. The Chamber is a not-for-profit organization incorporated in the District of Columbia. The Chamber has no parent company, and no publicly held company has 10% or greater ownership of the Chamber.

Thirty-Seven State Hospital Associations participated as amici curiae in the District Court. Amici are not-for-profit organizations, they have no parent corporations, and they do not issue stock. Those amici are:

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
Wisconsin Hospital Association

PatientRightsAdvocate.org (PRA) participated as amicus curiae in the District Court. PRA is a not-for-profit organization, it has no parent corporation, and it does not issue stock.

The Independent Women's Law Center (IWLC) participated as amicus curiae in the District Court. IWLC is a not-for-profit organization, it has no

parent corporation, and it does not issue stock.

The Texas Public Policy Foundation (TPPF) participated as amicus curiae in the District Court. TPPF is a not-for-profit organization, it has no parent corporation, and it does not issue stock.

The Association of Mature American Citizens (AMAC) participated as amicus curiae in the District Court. AMAC is a not-for-profit organization, it has no parent corporation, and it does not issue stock.

B. Rulings Under Review

The ruling under review was entered in *American Hospital Association et al. v. Azar*, No. 1:19-cv-03619 (CJN) on June 23, 2020, as ECF No. 35, by the Honorable Carl J. Nichols.

C. Related Cases

None.

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INTRODUCTION

Section 2718(e) is an obscure subsection of the 2010 Affordable Care Act that requires "[e]ach hospital" to annually "establish … 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" Medicare. 42 U.S.C. § 300gg-18(e). From its inception, no one considered section 2718(e) the solution to patients' understandable desire for greater transparency about what they would pay out-of-pocket for hospital services or procedures. Particularly for patients with private insurance, hospitals lack the information that determines patients' out-of-pocket costs, like whether patients have co-insurance obligations or have satisfied their deductibles.

Instead, for nearly a decade, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), repeatedly instructed hospitals that complying with section 2718(e) involved disclosing a hospital's "gross charges" for the hospital's items and services. Hospitals thus explored other ways of helping patients ascertain out-of-pocket costs, investing in developing financial-counseling services and online tools that rely on patient or insurer-provided information to provide patients individualized estimates. HHS has lauded the effectiveness of those efforts as

"meeting or exceeding" the requirements HHS now seeks to impose. HHS, Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65,524, 65,576 (Nov. 27, 2019) (the Rule).

Nine years in, the government abruptly announced that section 2718(e) empowers HHS to compel hospitals to disclose the confidential rates that each insurer and insurance plan agrees to pay for every one of the hospital's items and services, as well as many other types of information. Additionally, the government contended, section 2718(e) lets HHS require hospitals to develop a consumer-friendly list of negotiated rates for 300 "shoppable services," *i.e.*, 300 common procedures (like colonoscopy) associated with various items and services (like lab tests and physician consultation time). That novel, sweeping interpretation originated in a June 2019 Executive Order requiring HHS to propose a rule embodying this interpretation.

HHS's ensuing Rule rests on a manifestly impermissible interpretation of section 2718(e). According to HHS, when Congress referred to "the hospital's standard charges for [its] items and services," Congress meant *any* payment rate, including rates that insurers or other payers agree to pay hospitals. But the rates that insurers agree to pay hospitals vary by payer, by plan, by

hospital location, by inpatient and outpatient setting, and by many other variables. HHS's interpretation would implausibly produce *thousands* of different "standard charges" for each of the thousands of items and services that hospitals offer—or millions of data points. And, according to HHS, when Congress required "a list," Congress authorized HHS to require two different disclosures: an enormous spreadsheet displaying multiple types of rates by each item or service, and a list of 300 "shoppable services" grouping items and services by hospital procedure.

HHS acknowledged that hospitals have never before had to disclose this trove of confidential information. But it defies credulity that Congress enacted such an unprecedented and convoluted disclosure mandate and that no one noticed for nearly a decade. The district court nonetheless upheld HHS's far-fetched interpretation of section 2718(e) as a "close call" under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). That doctrine is inapplicable here; regardless, HHS's interpretation is too far out of bounds to warrant deference.

HHS's Rule also violates the First Amendment even under the compelled-speech framework of *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985). HHS failed to demonstrate that its asserted interests in price

transparency and lower healthcare costs reasonably relate to the Rule's disclosure requirements. Nor did HHS show that its regime is not unduly burdensome; indeed, HHS eschewed myriad, less-speech restrictive alternatives. The district court erroneously relieved HHS of its burden to justify its speech restriction and impermissibly overvalued HHS's unsupported assertions.

Finally, HHS's Rule epitomizes arbitrary and capricious decision-making. HHS's paltry estimate of the Rule's costs—about $11,900 per hospital initially, and $3,000 a year thereafter—is far lower than the $500,000 initial costs that major hospitals project, because HHS ignored how hospital billing and insurer contracts work. Hospitals do not assemble rate information in the manner HHS prescribes, and HHS's mandate requires innumerable time-consuming judgment calls in navigating millions of rates. These burdens come at the worst possible time, as hospitals are combatting another COVID-19 surge. And those costs are for naught: HHS conceded that the Rule will not tell consumers their actual out-of-pocket costs, will likely produce confusion, and may be *less* effective than the price-transparency tools the hospital field has been developing. This Court should vacate the Rule.

JURISDICTIONAL STATEMENT

The district court had jurisdiction under 28 U.S.C. § 1331. On June 23, 2020, the court denied Appellants' motion for summary judgment and granted Appellee's motion for summary judgment. On June 24, 2020, Appellants timely noticed an appeal. This Court has jurisdiction under 28 U.S.C. § 1291.

STATUTES AND REGULATIONS

Section 2718(e) of the Public Health Service Act, 42 U.S.C. § 300gg-18(e), as amended by the Affordable Care Act, provides:

> 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.

STATEMENT OF THE ISSUES

1. Whether section 2718(e) authorizes HHS to compel two separate disclosures revealing multiple different types of rates for a hospital's items or services, including any amount the hospital agrees to accept for any patient subpopulation for any item or service.

2. Whether HHS's Rule violates the First Amendment.

3. Whether HHS acted arbitrarily and capriciously by inadequately considering the Rule's burdens or by irrationally overstating the Rule's benefits.

STATEMENT OF THE CASE

A. The Hospital Charge and Payment Process

1. Patients are understandably frustrated by their inability to easily determine in advance what they may pay out-of-pocket for hospital services. Hospitals share that frustration. The mission of America's 6,000 hospitals is to save lives—a mission that is especially vital in the current pandemic. Nonetheless, due to the complexities of the healthcare system, hospitals devote enormous resources just to comply with insurers' billing requirements. High administrative costs are one of many reasons why hospitals' margins are low. *See* A295, A369, A374-75, A437.

Patients compensate hospitals through different means. Some 31% of patients have private health insurance; insurers negotiate what they will pay hospitals for those patients' care. Another 4% of patients are uninsured; they pay for their care directly, or receive financial assistance from hospitals. Finally, 65% of patients are covered by Medicare and Medicaid, under which Federal and state governments set payment rates for hospitals.[1]

[1] *See* Am. Hosp. Ass'n, *Fact Sheet: Hospital Billing Explained* (Jan. 2019), https://www.aha.org/system/files/2019-01/fact-sheet-billing-explained-0119.pdf.

The common ground for all of these methods of payment is the starting point. Each hospital maintains a list of default charges (or "gross charges," as HHS puts it) for each item or service. 84 Fed. Reg. at 65,533. The average hospital has "tens of thousands" of distinct items and services; each has an associated gross charge. *Id.*; A268, A271, A550. Hospitals use gross charges to account and bill for items and services in a uniform manner—*i.e.*, hospitals record the same gross charge for each IV bag, knee brace, or other item or service, no matter what type of insurance the patient has. Hospitals have long organized these gross charges using a system called a "chargemaster," which can be either a spreadsheet or database. 84 Fed. Reg. at 65,533; *see, e.g.*, Inova, *Information About Hospital Charges*, https://www.inova.org/patient-and-visitor-information/hospital-charges (Inova hospital chargemaster).

Hospitals' gross charges are virtually never what hospitals ultimately receive as payment. 84 Fed. Reg. at 65,537; A27-28. But chargemasters are a universal system of accounting and billing for historical and legal reasons. Medicare guidelines prescribe that hospitals' charges for Medicare and non-Medicare patients must be "the same" for "a specific service," and that charges must be "uniformly applied to all patients whether inpatient or outpatient." Medicare Provider Reimbursement Manual No. 15-1, ch. 22 §§ 2202.4, 2204;

see 42 U.S.C. § 1320a-7(b)(6). Hospitals achieve that uniformity by applying the same gross charge to everyone, but receive different payments from Medicare, Medicaid, private insurers, and self-pay patients.

2. Hospitals' gross charges anchor the whole payment system. *See* 84 Fed. Reg. at 65,540. For patients covered by private insurance, hospitals' gross charges are the "starting point" for negotiations between insurers and hospitals. *Id.* Hospitals deal with approximately 1,000 private insurers, which negotiate payment rates with hospitals for tens of thousands of different insurance plans. Each contract sets out confidential payment rates ("negotiated rates") that insurers agree to pay hospitals.

Determining which negotiated rate applies to a particular patient for a particular item or service is exceedingly complex. Each contract sets rates based on any "number of different rules" documented "in many dozens of pages of text" or inputs that "fluctuate significantly." A120, A253, A335. A hospital's contract with an insurer usually breaks into numerous subcontracts fixing different rates for each type of benefit plan (*e.g.*, preferred provider plans or health maintenance organizations) and each market (*e.g.*, individual, small and large group). Hospitals thus effectively have thousands of contracts. *E.g.*, A204, A268, A271.

Further variables abound. Insurers negotiate different rates based on the hospital's location (*e.g.*, services in New York City cost more than in Albany), whether the patient receives care in an inpatient or outpatient setting, and whether the hospital would be providing specialized medical care. Insurers also vary payment methodologies: rates for a particular item or service can be per-visit or per-item. For a patient who receives five X-Rays in one visit, the insurer might agree to pay a hospital $100 per X-Ray under a plan with an item-based methodology, but $100 for all five under a plan with a per-visit methodology. A311, A531. These permutations quickly translate into thousands of different potential rates for a single item or service.[2] A208-09, A390.

Insurers also vary payment methodologies in other ways. Some insurers or plans may pay per item, while others may pay for the item or service only as part of a package deal for a procedure. *See* 84 Fed. Reg. at 65,534; A168, A319. For instance, one plan might have an agreed-upon rate for hospital room and board. Another of the insurer's plans might have no identifiable

[2] Variations on the X-Ray example illustrate the problem. For instance, a hospital with three locations offering inpatient and outpatient care that contracts with a single insurer offering ten benefit plans would have sixty rates for X-Rays—and hospitals often deal with hundreds of insurers, plus many other contractual variables.

rate for room and board, because the insurer pays the hospital for that service only as part of the amount the insurer pays for a procedure (*e.g.*, labor and delivery). A454, A491, A534. In other words, apples-to-apples rate comparisons between insurers and even between plans can be impossible. A120, A432, A491.

Negotiated rates are still far removed from a patient's out-of-pocket costs. The front-end negotiated rate often differs from the amount the insurer ultimately pays the hospital, because insurers also agree to pay hospitals different amounts depending on the treatment the patient actually receives. In some contracts, the insurer agrees to pay the lesser of (1) the hospital's gross charges or (2) a specific negotiated rate for a set of services (like knee surgery) that varies depending on how resource-intensive the patient's procedure is. A208-09, A396, A491, A534. Other rates are contingent on the care the patient actually receives: for instance, the insurer agrees to pay a set rate for the primary procedure (*e.g.*, hand nerve-repair surgery), but pays discounted rates for related procedures if the patient receives them at the same time (*e.g.*, tendon repair if the surgeon identifies the problem during surgery).

Determining what a patient pays out-of-pocket involves additional variables contained in the patient's health insurance plan, such as how much cost-

sharing a patient's plan requires, whether the patient has exceeded any coverage limits, or how much of a deductible the patient has paid so far. 84 Fed. Reg. at 65,528. Hospitals do not hold this information themselves. *Id.*

Gross charges are also important to the small population of "self-pay" patients without health insurance, who pay the hospital directly. Those patients may pay the gross charge amounts "if no other pre-arrangement has been worked out." *Id.* at 65,541. Alternatively, self-pay patients may receive "discounts off the gross charge" for paying in cash. *Id.* at 65,552. Hospitals usually offer uninsured patients lower rates, and work to provide discounts or payment plans based on patients' financial need. But "many hospitals" do not offer pre-determined, across-the-board cash-price discounts for insured patients. *Id.* at 65,553.

Finally, gross charges bear on Medicare reimbursements. For most Medicare inpatient services, CMS reimburses hospitals by diagnosis-related groups, *i.e.*, a suite of items and services CMS associates with a particular procedure or illness. Because CMS's reimbursements to hospitals can be too low (*e.g.*, because a particular patient has a severe medical situation requiring hospitals to provide more items and services than usual), CMS may adjust reimbursement amounts in those cases using hospitals' gross charges. *Id.* at

39,609; A535.

3. Hospitals have developed numerous tools to help patients estimate their out-of-pocket costs. 84 Fed. Reg. at 65,576-77. Hospitals regularly offer patients one-on-one financial counseling by formulating cost estimates using key information from patients or their insurers. *Id.* at 65,577; A121, A486. And hospitals have pioneered user-friendly tools that help patients project out-of-pocket costs using patient-inputted information. A121, A200-01, A236; 84 Fed. Reg. at 65,576.[3] State hospital associations have developed nearly 40% of all "consumer-orientated, State-based healthcare price comparison websites" since 2006. 84 Fed. Reg. at 65,526.

States have also enacted price-transparency laws, but no States require hospitals to publicly disclose confidential, negotiated rates. California hospitals must publish their chargemasters, provide individualized cost estimates to uninsured patients, and identify average charges for multiple inpatient and outpatient procedures. Cal. Health & Safety Code §§ 1339.51(a)(1)-(2), 1339.56; *see* 84 Fed. Reg. at 65,526, 65,549. Colorado requires hospitals to pub-

[3] *E.g.*, Memorial Healthcare Sys., https://price.mhs.net/ (out-of-pocket price estimator tool).

lish their chargemasters, but expressly *excludes* negotiated rates from the information hospitals must disclose. Colo. Rev. Stat. Ann. §§ 25-49-104(1)(a), 25-49-102(4)(b). Maine and New Hampshire have developed their own online price-transparency tools using data from paid claims.[4] Massachusetts law requires hospitals to file their chargemasters with the State and to provide patients with prospective cost estimates upon request. Mass. Gen. Laws Ann. ch. 111, § 228; 957 Code of Mass. Regs. § 9.06(2).

B. Section 2718(e)'s Enactment and HHS's Prior Interpretations

In 2010, as part of the Affordable Care Act, Congress revised the Public Health Service Act to add section 2718(e):

> Each hospital operating within the United States shall for 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 [42 U.S.C. §] 1395ww(d)(4).

42 U.S.C. § 300gg-18(e). The cross-reference to "section 1395ww(d)(4)" relates to Medicare reimbursement. As noted, CMS reimburses providers by paying for bundles of inpatient items and services—or "diagnosis-related groups"—

[4] *See* Me. Rev. Stat. Ann. tit. 22 §§ 1718, 1718-A, 1718-B, 1718-C; Me. Health Data Org., *Health Costs*, CompareMaine (2020), https://www.comparemaine.org/?page=methodology; New Hampshire Insurance Department, *Methodology for Health Costs for Consumers*, NH HealthCost (2018), https://nhhealthcost.nh.gov/methodology-health-costs-consumers.

rather than by item or service. *Id.* § 1395ww(d)(4). CMS has established several hundred of these groups for different procedures and diagnoses. *See* Medicare Claims Processing Manual No. 15-1, ch. 3 § 20.D.

Section 2718(e) took effect with little fanfare. For a decade, HHS interpreted the provision as requiring hospitals to disclose their gross charges. HHS's Fiscal Year 2015 proposed and final rules stated that "[h]ospitals are responsible for establishing their charges" under section 2718(e), and that hospitals could comply by "mak[ing] public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice)." 79 Fed. Reg. 27,978, 28,169 (May 15, 2014); 79 Fed. Reg. 49,854, 50,146 (Aug. 22, 2014). At the time, HHS heralded disclosure of "standard charges" (which the agency equated with gross charges) as a way to "greatly improve the public accessibility of charge information" by "help[ing] patients understand what their potential financial liability might be for services they obtain at the hospital [and] enabl[ing] patients to compare charges … across hospitals." *Id.* at 28,169, 50,146.

Similarly, a 2018 rule reiterated that hospitals could satisfy section 2718(e) by publishing "the chargemaster itself," and added a requirement for

hospitals to publish chargemasters "via the internet in a machine readable format." 83 Fed. Reg. 20,164, 20,548 (May 7, 2018). An ensuing guidance document repeated that hospitals could display their "standard charges" in many ways, "as long as the information represents the hospitals' current standard charges as reflected in its chargemaster." A71.

C. The Price-Transparency Executive Order and HHS's Proposed Rule

In June 2019, the government changed course. The President issued an Executive Order directing HHS to "propose a regulation … to require hospitals to publicly post standard charge information," defined as "including charges and information based on negotiated rates and for common or shoppable items and services." A75. HHS "implement[ed]" that directive by issuing a notice of proposed rulemaking soon thereafter. 84 Fed. Reg. 39,398 (Aug. 9, 2019).[5]

The Proposed Rule jettisoned HHS's previous position that "standard charges" under section 2718(e) just meant hospitals' gross charges. Instead, HHS proposed requiring hospitals to disclose both gross charges and "payer-

[5] CMS, *CMS Takes Bold Action to Implement Key Elements of President Trump's Executive Order to Empower Patients with Price Transparency and Increase Competition to Lower Costs for Medicare Beneficiaries* (July 29, 2019), https://tinyurl.com/y7526uux.

specific negotiated charges," *i.e.*, every confidential rate hospitals negotiated with each third-party insurer for each plan and for each of a hospital's thousands of items and services. *Id.* at 39,402, 39,579-80.

HHS proposed two sets of disclosures. *First*, hospitals would include all rate information in a "single digital file that is machine-readable." *Id.* at 39,582. *Second*, hospitals would disclose a "consumer-friendly" separate "list" of "payer-specific negotiated charges for [300] 'shoppable' services." *Id.* at 39,589-90. HHS outlined a new enforcement regime for exacting civil monetary penalties from noncompliant hospitals. *Id.* at 39,591. HHS proposed an effective date of January 1, 2020. *Id.* at 65,585.

Appellants and many other commenters raised significant objections, singling out for particular concern HHS's misimpressions that compliance would cost just $1,017 per hospital, *id.* at 39,613, and would involve disclosing information that hospitals readily had on hand. *E.g.*, A117, A190-91, A290, A335, A422, A502. Commenters observed that complying with HHS's previous rule requiring online publication only of chargemasters in machine-readable format cost some hospitals more than $200,000 to implement and $100,000 a year to maintain. A268, A271, A400. Because many hospitals did not display chargemasters in machine-readable format before that rule, many hospitals

had to build new systems and hire vendors. A400, A454. Based on this experience, hospitals considered it implausible that a much broader disclosure regime would be less onerous. *E.g.*, A117-18, A290, A546.

Hospitals detailed the inordinate burdens of identifying negotiated rates for their offerings. Hospitals explained that the negotiated rate for each item or service reflects complicated formulae, so that hospitals cannot easily identify particular rates applicable to particular patient subgroups. *See, e.g.*, A491-92, A505. While many hospitals have programmed their billing systems to fill in expected payment rates for a particular patient based on that patient's insurer and plan using historical claims data, hospitals have no ready way to identify the *class* of patients who would receive that same rate. And the number of variables involved in insurance contracts translates to thousands of rate permutations for any particular item or service. A254, A304, A357, A460.

Hospitals also explained the "massively complicated" scale of the endeavor. A304. The Cleveland Clinic estimated that a spreadsheet just for its hospital services would require *210 million rate entries*, because the Cleveland Clinic has some 3,000 contracted rate schedules, which would apply to each of its items and services (of which it has 70,000). A271. Christus Health estimated that it had 6,500 contracted rates per item or service, and offers

80,000 items and services—resulting in 520 million rate entries. A268. Memorial Healthcare System has some 5,000 different payment arrangements and offers 40,000 items and services, producing "200 million rate cells." A390. The University of Tennessee has 73 payers and 519 fee schedules for each of its 57,000 items and services, producing "millions of data entry points." A545-46.

Creating and populating a spreadsheet of that magnitude is costly and requires many judgment calls. Hospitals estimated that producing and validating the spreadsheet, hosting a website that could display the file, coordinating with administrative, technical, and legal staff, and hiring vendors would cost hundreds of thousands of dollars. *E.g.*, A272 (Cleveland Clinic estimating $500,000 to $1 million to implement); A476 (Santa Clara Valley estimating $630,000 to start, $21,000 per year thereafter); A195 (Bassett Health estimating $500,000); A546 (University of Tennessee estimating $400,000 to start, $450,000 per year thereafter).

Hospitals commented that creating a separate list of 300 shoppable services would exacerbate the burdens. Hospitals would have to pick which services to feature, then identify associated ancillary services, ascertain the thousands of possible negotiated rates within those services, and create consumer-friendly descriptions. A497-98. One hospital explained that "it took five

months, with four people working on it full-time, to build a [price-transparency] tool with 130 services," and considered the 300-shoppable-services list far more difficult. A358; *see* A92, A120-21, A560-61, A563. Even before COVID-19, hospitals feared these burdens would sap them of resources to continue developing their interactive price-transparency tools or provide one-on-one financial counseling. A258, A305.

D. The Final Rule

On November 27, 2019, HHS published a Final Rule containing even broader disclosure requirements than the Proposed Rule.

1. The Rule mandated two separate disclosures: a "machine-readable list"—*i.e.*, a spreadsheet—containing five different types of "standard charges" for each item or service, and a "list of 300 shoppable services." 84 Fed. Reg. at 65,603-04. Hospitals that violate these requirements face civil monetary penalties. *Id.* at 65,586-87.

Starting with the spreadsheet, HHS required disclosure of the following putative "standard charges" for *every one* of a hospital's thousands of items or services—plus every "standard charge" for every bundled group of items and services (whether or not the group is a diagnosis-related group established by CMS). *Id.* at 65,525.

- *Gross charges*. HHS defined gross charges (or list prices) as the charges "reflected on a hospital's chargemaster." *Id.* at 65,540. HHS considered publication of gross charges "useful to the general public" because self-pay patients may pay the gross charge, and "hospitals routinely use gross charges as a starting point" in rate negotiations. *Id.*

- *Payer-specific negotiated charges*. HHS defined these charges as every confidential negotiated rate between a hospital and insurer, identified by individual payer, plan, and patient subgroup. HHS acknowledged that hospitals may have hundreds or thousands of negotiated rates for each item or service. *See id.* at 65,542.

- *De-identified minimum and maximum negotiated charges*. HHS added these categories in the Final Rule. They reflect the highest and lowest negotiated rates from third-party payers. HHS considered these data points "standard charges" because they could "provide consumers with an even more complete picture of hospital standard charges and drive value." *Id.* at 65,554-55.

- *Discounted cash price.* HHS added this category in the Final Rule, defined as "the price the hospital would charge individuals who pay cash (or cash equivalent) for an individual item or service or service package," for instance if patients self-pay. *Id.* at 65,552.

HHS acknowledged that hospitals often have no standard discounted cash price. Hospitals often arrange discounts or payment plans for uninsured or financially strapped patients, but HHS does not include those arrangements in its definition of cash prices. *Id.* Thus, HHS prescribed, this price will "simply be [the hospital's] gross charges as reflected in the chargemaster" for most hospitals. *Id.* at 65,554. HHS's main source for its discussion of discounted cash prices is a study of one hospital that developed such pricing for

Amish and Mennonite patients who only pay cash for religious reasons. *Id.* at 65,552-53 (citing Hempstead & White, A573). HHS's other cited study describes the former source as "highly unrepresentative," and studies ambulatory surgical centers' self-pay policies—but HHS's Rule does not cover ambulatory surgical centers. *Id.* (citing Bai et al., A568).

Moreover, HHS finalized the additional requirement that hospitals disclose a different, "consumer-friendly list" of 300 "shoppable services," which hospitals must create using 70 mandatory services and 230 of their choosing. That list must consist of packages of services, not individual items and services. Hospitals must group together "the primary shoppable service" (*e.g.*, colonoscopy), with "ancillary services customarily provided by the hospital" (*e.g.*, lab tests). *Id.* at 65,535. Because no uniform definition of ancillary services exists, different hospitals could include different ancillary services for each primary shoppable service. Each "shoppable service" must feature plain-English descriptions and a list of every negotiated rate, maximum and minimum negotiated rates, and any cash-discount price—but not the hospital's gross charge. *Id.* at 65,603-04. Alternatively, hospitals may satisfy this requirement by offering an out-of-pocket cost estimator tool. *Id.* at 65,604.

2. *HHS's Interpretation of Section 2718(e).* HHS interpreted section

2718(e)'s requirement that hospitals annually disclose "a list of the hospital's standard charges for [its] items and services" to mean that hospitals must disclose any "regular rate[s] established by the hospital for the items and services provided to a specific group of paying patients." *Id.* at 65,539. HHS explained that "regular" rates are any rates agreed upon or set in advance. *Id.* at 65,546. HHS also identified other "standard charges" (like "all allowed charges" or "modal negotiated charges") that HHS might require hospitals to disclose later. *Id.* at 65,551-52.

3. *HHS's Policy Justifications.* The Rule asserted two intertwined aims: helping consumers "understand their potential out-of-pocket cost obligations" so that consumers can make choices that reduce healthcare costs. *Id.* at 65,539. HHS acknowledged that the Rule would not be "sufficient by itself" to promote price transparency, since hospitals lack the information necessary to predict out-of-pocket expenses. *Id.* at 65,529. HHS added that the standard-charge spreadsheet "may not be immediately or directly useful for many health care consumers because the amount of data could be overwhelming or not easily understood." *Id.* at 65,564. HHS explained that it was mandating the shoppable-services list as an "addition[al]" requirement to mitigate that problem. *Id.*

Nonetheless, HHS considered its broad disclosure regime a "good first step" towards its objectives. *Id.* HHS estimated that compliance would average about $11,900 per hospital for the first year and $3,600 per hospital per year thereafter. *Id.* at 65,525. Citing States' transparency initiatives, HHS dismissed concerns that disclosing confidential negotiated rates would threaten anticompetitive harm to consumers. *Id.* at 65,544.

E. Proceedings Below

Appellants filed this action in district court days after HHS issued the Final Rule. On June 23, 2020, the district court rejected Appellants' challenges. A25. Though noting it was a "close call," the court deemed HHS's interpretation of section 2718(e) reasonable under *Chevron*. A45. The court also rejected Appellants' First Amendment challenge, holding that the Rule was constitutional under *Zauderer* as a compelled disclosure of "factual and uncontroversial" information that "reasonably related" to HHS's transparency aims. A57-62. Finally, the court concluded that the Rule was not arbitrary and capricious by deferring to HHS's reasons for rejecting hospitals' objections about the Rule's disproportionate costs and dubious benefits. A63-67.

On July 2, 2020, Appellants asked HHS to delay the Rule's effective date until the end of litigation due to the ongoing pandemic. Appellants noted:

"Even attempting to comply with the rule will require a significant diversion of financial resources and staff time that hospitals and health systems cannot afford to spare as they prepare to or care for patients with COVID-19."[6] HHS has not responded.

SUMMARY OF ARGUMENT

This Court should reverse the judgment below and vacate the Rule for three reasons.

First, the Rule rests on an interpretation of section 2718(e) that is plainly unlawful. Section 2718(e) authorizes HHS to require hospitals to disclose "a list of the hospital's standard charges for [its] items and services." Under no sensible reading of that text did Congress authorize HHS to demand disclosure of negotiated rates that apply to each item or service in "particular circumstances." 84 Fed. Reg. at 65,537. Nor can "standard charges" reasonably refer to multiple different types of rates (the gross charge, negotiated rate, maximum and minimum negotiated rate, cash-price discount, and many more). Likewise, by authorizing "a list," Congress did not give HHS license to demand many different lists.

[6] Am. Hosp. Ass'n, Letter to Hon. Alex M. Azar II, Sec'y, HHS (July 2, 2020), https://tinyurl.com/ybz9n829.

Second, the Rule violates the First Amendment. Even under the compelled-speech framework of *Zauderer*, the Rule is unconstitutional, because HHS has failed to establish that its asserted interests in price transparency and lower healthcare costs reasonably relate to the Rule's disclosure requirements. HHS also failed to show that its compelled disclosures are not unduly burdensome. Nor could HHS carry that burden: many less-speech restrictive alternatives were available.

Third, HHS's Rule is arbitrary and capricious. HHS failed to consider fundamentals of hospital billing and insurer contracts that make this Rule inordinately costly and difficult to implement. And HHS overstated the Rule's benefits. HHS itself acknowledged that the Rule will not tell consumers out-of-pocket costs, may prompt consumer confusion, and may be *less* effective than the cost-estimator tools hospitals have been developing. Saddling hospitals with burdensome disclosure requirements that are less consumer-friendly than hospitals' existing efforts is the definition of arbitrary decision-making.

STANDARD OF REVIEW

Where a district court "review[s] an agency action under the [Administrative Procedure Act]," this Court "review[s] the administrative action directly, according no particular deference to the judgment of the District

Court." *Fox v. Clinton*, 684 F.3d 67, 74 (D.C. Cir. 2012). Under the APA, this Court "shall … hold unlawful and set aside agency action … found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law … contrary to constitutional right, [or] in excess of statutory jurisdiction." 5 U.S.C. § 706(2)(A)-(C). An agency's failure to "articulate a satisfactory explanation for its action," or to "consider an important aspect of the problem," is arbitrary and capricious. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

ARGUMENT

I. HHS IMPERMISSIBLY INTERPRETED SECTION 2718(e)

Section 2718(e) requires hospitals "for each year" to "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 [Medicare]." 42 U.S.C. § 300gg-18(e). HHS's breathtaking interpretation of section 2718(e) is impermissible and unreasonable, and thus the Rule is invalid. *E.g.*, *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015); *Util. Air Grp. v. EPA*, 573 U.S. 302, 321 (2014); *Merck & Co. v. HHS*, 962 F.3d 531, 535-36 (D.C. Cir. 2020).

A. A Hospital's "Standard Charges" Cannot Mean the Unlimited Number of Rates Associated With Different Groups of Patients

1. As the district court observed, a "standard" version ordinarily means the usual, common, or model version.[7] That definition is the antithesis of HHS's interpretation of "standard charges" to mean the charges that apply in "particular circumstances," 84 Fed. Reg. at 65,537, *i.e.*, any amounts that hospitals set as their list price or agree to accept or are paid for every conceivable patient subpopulation, *see id.* at 65,539, 65,541, 65,546.

The most natural way to think of "standard charges" is as the seller's default or list price. Even if "standard charges" could mean something else, HHS's interpretation implausibly produces thousands of different "standard charges" for each item or service a hospital offers. Take one HHS category of purported "standard charges," *i.e.*, negotiated rates that hospitals contract to

[7] *See* A39 (relying on citations to Dictionary.com (2019) ("serving as a basis of weight, measure, value, comparison, or judgment"); Merriam-Webster (2019) ("regularly and widely used, available, or supplied"); Oxford English Dictionary (2019) ("[h]aving the prescribed or normal size, amount, power, degree of quality, etc."); Black's Law Dictionary (11th ed. 2019) ("A model accepted as correct by custom, consent, or authority.")); *see also* The American Heritage Dictionary of the English Language 1703 (5th ed. 2018) ("Widely recognized or employed as a model of authority or excellence; a standard reference work."); New Oxford American Dictionary 1699 (3d ed. 2010) (a "thing used as a measure, norm, or model in comparative evaluations").

receive from specific insurers. As noted, insurers' contracts with hospitals divide into specific terms for each separate plan the insurer offers, and further vary by hospital location, by inpatient or outpatient setting, payment methodology (*e.g.*, per item or per package of services), and other factors. Just for this one HHS category of "standard charges," hospitals have thousands of rates that could apply to a single item or service. A271, A390, A268 (estimating 3,000 rates, 5,000 rates, and 6,500 rates per item or service). No patient requesting the "standard charge" for an X-Ray would expect a quagmire of thousands of different data points for that one item.

HHS's interpretation flows from the counterintuitive premise that Congress made a mistake. In HHS's view, no "single 'standard charge' can be identified for purposes of implementing section 2718(e), since factors such as insured status and the particular third-party payer plan drive the hospital charges borne by consumers." 84 Fed. Reg. at 65,546; *see id.* at 65,541. Thus, HHS contends, Congress must have intended to authorize HHS to compel hospitals to disclose all sorts of different "standard" charges.

But that problem is entirely of HHS's own making. By picking a definition of "standard charges" that includes the hospital's list price, rates hospitals negotiate with each insurer, and payments the hospital actually receives, *id.*

at 65,539, HHS's definition guaranteed there would be no single "standard" charge. All markets have unique features; describing the healthcare context as *sui generis*, A45, does not give HHS license to perform statutory surgery to make Congress's text fit the market features HHS considers significant.

HHS's ensuing interpretation—that "standard charges" are "regular" rates, and "regular" rates are any rate "formalized" in some sort of agreement or policy (like a hospital's "rate sheets") for "identifiable groups of patients"—impermissibly reads the word "standard" out of the statute. 84 Fed. Reg. at 65,539, 65,541, 65,546. Every amount the hospital agrees to receive as payment from every single patient or other payer reflects some agreement or policy, so the word "standard" is superfluous under HHS's interpretation. And just because HHS's Rule does not demand all those rates now is no protection against HHS demanding those rates later.

HHS's definition of "standard" charges also impermissibly reads extra words into the statute. "It is a fundamental principle of statutory interpretation that absent provision[s] cannot be supplied by the courts." *Rotkiske v. Klemm*, 140 S. Ct. 355, 360-61 (2019) (quotations omitted). But HHS's interpretation rewrites "standard charges for items and services provided by the hospital" into "standard charges *for each group of paying patients*" for items,

services, and packages of services provided by the hospital. HHS would thus transform section 2718(e) from a provision focused on charges for hospitals' items and services into a provision focused on particular payers' arrangements for particular patients.

HHS's interpretation has no logical limit, and could produce infinite "standard charges." HHS asserts that "standard charges" must be fixed, formal rates associated with an "identifiable group of individuals." 84 Fed. Reg. at 65,546. But patients insured by Aetna under a health maintenance organization plan who visit a hospital's Houston location on an outpatient basis are an "identifiable group." The same goes for a single family that enters into a specific payment agreement with a hospital in advance. The possible permutations of identifiable patient groups are infinite given other conceivable variables, like the patient's diagnosis, whether the insurer pays per item or per visit, and whether the insurer packages multiple items and services together and negotiates the price for the whole suite. It is not reasonable to conclude that the authority to require "a list of the hospital's standard charges for [its] items and services" empowers HHS to force hospitals to play out all these permutations and calculate rates for each identifiable group.

Further, under HHS's unbounded interpretation, the agency could demand whatever additional information HHS deems related to "standard charges." HHS's definition of "standard" charges to include a "discount" (as in, any discounted price hospitals offer to patients who pay cash in advance) is illustrative. A "discount" is, by definition, a departure from the norm. The discounted cash price category is all the less "standard" because, as HHS acknowledged, few hospitals offer such discounts as HHS defines the term. *Id.* at 65,552. HHS also defined "standard" charges to include maximum and minimum negotiated charges "across all third party payer plans and products." *Id.* at 65,553. The highest and lowest negotiated rates for a particular item or service are anything but "standard"; they are specific data points. The district court's contrary conclusion (at A48) that HHS reasonably included these figures because they are useful to consumers ignores the statutory text.

If "standard" means anything that HHS believes could conceivably educate consumers, nothing would be off-limits. Under HHS's logic, HHS could demand the third-highest and third-lowest negotiated rates for identifiable individuals. HHS's Rule proves just how unbounded its interpretation is. HHS asserts that "many possibilities" to define "standard" charges exist, *id.* at 65,537, including "modal negotiated charges," *id.* at 65,551, "all allowed

charges," *id.* at 65,552, and "median cash prices," *id.* at 65,553. HHS just decided not to compel disclosure of those "standard charges" now. HHS does not even define the universe of what "standard charges" might be, but it is implausible that Congress wrote HHS a blank check.

In sum, this Court should reject HHS's impermissible interpretation of section 2718(e). As noted, "standard" most naturally means usual or common charges, and can refer to a default or jumping-off point. Thus, Standard English is grammatically proper English—even though virtually no one follows all the rules and English usage varies regionally. Standard law firm rates mean the firm's hourly rack rates—even though most clients negotiate discounts. And the standard charge for a car is most naturally the manufacturer's suggested retail price (MSRP)—even though buyers negotiate down the sticker price. So too, "the hospital's *standard* charges for [its] items and services" most naturally means the hospital's list price, which hospitals ordinarily put in chargemasters. But the provision cannot reasonably be read as authorizing HHS to demand disclosure of whatever payment information HHS desires.

2. HHS's interpretation of "standard charges" also unreasonably defines the concept of "charges" under the statute. HHS equated "charges" with "rates" and defined "rates" as "a fixed price *paid or charged* for something."

Id. at 65,539 (emphasis added). HHS cites no authority for that roundabout definition of "charges," which takes the illogical tack of defining a term by parroting its verb form ("charged") and adding another verb ("paid") to broaden the meaning. Just as A does not mean A + B, "charges" do not mean *any* amount the hospital demands, agrees to accept, or is actually paid.

Instead, as the district court observed, the term "[c]harges" ordinarily means "the price *demanded* for something." A40 (emphasis added); *see* New Oxford American Dictionary 291 (3d ed. 2010) ("charge" is "a price asked for goods or services"); The American Heritage College Dictionary 242 (4th ed. 2007) ("The price asked for something."). It follows that "[t]he hospital's standard *charges*" are its list prices—not the rates hospitals negotiate with insurers, or list prices adjusted for cash discounts, or amounts patients actually pay. Unsurprisingly, the healthcare field understands hospital "charges" as the hospital's list prices for items and services (usually commemorated in chargemasters). *E.g.*, A269-70, A381, A480, A492; 84 Fed. Reg. at 65,541. That is also how HHS defines hospital "charges" for Medicare purposes: those "[c]harges refer to the regular rates established by the provider [*i.e.*, hospital] for services rendered to both beneficiaries and to other paying patients," which are generally "reflected on a hospital's chargemaster." *See* 84 Fed. Reg.

at 65,541.[8] The district court's erroneous conclusion that the myriad rates hospitals agree to receive from insurers are "charges" inexplicably departed from this ordinary meaning. A45-46.

Other features of section 2718(e) refute HHS's interpretation. Section 2718(e) focuses on the hospital—the provider of care—as the only relevant actor, which must compile "the hospital's standard charges" with respect to "items and services provided by the hospital." But one would not describe a hospital's compromises on insurer-negotiated rates as "*the hospital's* standard charges." When Congress wants to refer to "negotiated prices," it does so expressly—as in the Medicare statute. *E.g.*, 42 U.S.C. § 1395w-141(h)(8) (distinguishing between the "negotiated prices or the usual and customary price"). Congress also distinguishes between "charges" and prices "paid" in the Medicare context, using "charges" to refer to the list prices of services, not the amounts "paid" under Medicare. *E.g.*, *id.* § 1395*l*(a).

[8] The district court (at A40) rejected Appellants' reliance on the Medicare definition of a "charge" as "regular rates," reasoning that if a "standard charge" meant "standard regular rates," the word "standard" would be superfluous. But that logic highlights inconsistencies in HHS's interpretation. If a "charge" ordinarily means "regular"— *i.e.*, default—rates in the Medicare context, it would be particularly perverse for Congress to add the word "standard" to "charge" to mean individualized charges.

HHS's interpretation also makes no sense given section 2718(e)'s requirement that hospitals "for each year" publicly list their standard charges. The "charges" Congress had in mind must be amounts that hospitals could meaningfully disclose annually. But hospitals renegotiate thousands of insurer contracts per year on a rolling basis. A120, A383. An annual disclosure of those rates in, say, January would mislead patients when insurers conclude new contracts in, say, February that set different prices for items and services, or stop covering particular items or services entirely. It would make no sense for Congress to require annual disclosures that would be obsolete virtually from issuance.[9]

3. HHS's rulemaking fleetingly invoked section 2718(e)'s mention of diagnosis-related groups to support HHS's interpretation of "standard charges," but that point does not help HHS. *See* 84 Fed. Reg. at 65,539. Section 2718(e) refers to "diagnosis-related groups established under [42 U.S.C.]

[9] The district court (at A39 n.10) suggested that by requiring hospitals to annually "establish" a list, Congress intended for hospitals to create a list that did not hitherto exist, whereas hospitals already commemorated gross charges in chargemasters. That reasoning does not follow. Gross charges change over time; requiring hospitals to create a new, annual list of those charges would still "establish" a new list.

1395ww(d)(4)" as a subset of hospitals' "standard charges" for "items or services." CMS establishes diagnosis-related groups by grouping together items and services associated with a single diagnosis or procedure for Medicare payment purposes. *Supra* p. 11. HHS contended, and the district court agreed, that the existence of these groups means that "standard charges" includes something beyond the chargemaster, since chargemasters identify the list prices for items and services, but not packages of items and services. *See* 84 Fed. Reg. at 65,539; A42-43.

That point does not salvage HHS's interpretation. HHS stated that section 2718(e) not only allows the agency to compel hospitals to disclose any discounts negotiated with individual insurers for diagnosis-related groups, "but also all other services packages provided by the hospital." 84 Fed. Reg. at 65,534. HHS thus reads "diagnosis-related groups established under section 1395ww(d)(4) [by CMS]" to mean any "groups" of items or services established by hospitals, insurers, or anyone else. But referring to a specific type of packaged payment that exists under Medicare would be a bizarre way for Congress to require disclosure of all groupings of items or services under the sun.

The fact that some insurers use CMS's diagnosis-related groups to negotiate specific discounted rates for those bundles of services does not show

that Congress wanted hospitals to disclose *all* negotiated rates for items, services, and grouped packages. And CMS's reimbursement rates for diagnosis-related groups can influence hospitals' negotiations with insurers. *See* Grace M. Carter et al., *Use of Diagnostic-Related Groups by Non-Medicare Payers*, 116 Health Care Financing Rev. 127, 146, 154 (1994). It would thus make sense for Congress to refer to that particular rate for groups of items or services, and HHS previously interpreted this provision as referring only to CMS rates. *See* A72.

B. Authorizing HHS To Require "A List" Does Not Let HHS Compel Many Lists

Section 2718(e) also mandates that hospitals disclose "a list" of standard charges. HHS "does not dispute that the statute mandates the publication of only a single list." A48 n.16. HHS's Rule unlawfully transmutes that limited authority into the power to compel multiple, burdensome lists of different information in different formats.

1. When confronted with a spreadsheet displaying millions of "standard charges" for all a hospital's items, services, and groups of services, plus a separate "list" of rates for 300 shoppable services based on the type of procedure, no one—including HHS—would describe the result as a single list. HHS's

proposed regulation gives the game away, mandating disclosure of "[a] machine-readable file containing *a list* of all standard charges for all items and services as provided," plus a separate "consumer-friendly *list* of standard charges for a limited set of shoppable services." 84 Fed. Reg. at 65,603 (proposed 42 C.F.R. § 180.40) (emphases added).

These disclosures are obviously different lists. They are different sets of information, in different formats, for different audiences. The spreadsheet must include chargemaster charges, and covers all items, services, and groups of items and services the hospital offers. *Id.* at 65,603. But the shoppable services list is 300 *procedures* (*e.g.*, colonoscopy), not individual items or services. For each procedure, hospitals must identify the "primary" service (*e.g.*, primary diagnosis) and common "ancillary" services (*e.g.*, facility fee, lab tests, etc.), before listing all payer-negotiated rates by plan. *Id.* at 65,604. And HHS does not require disclosure of gross charges there. *Id.*

Those two disclosures also present information differently. HHS described the spreadsheet as a "quite large" assemblage of rates in a "machine-readable format." *Id.* at 65,556, 65,560. But the 300 shoppable-services list must be in "plain English," "consumer-friendly," and formatted differently. *Id.* at 65,527. HHS acknowledged that the shoppable-services list demands

"more thoughtful effort … than simply making [hospitals'] standard charge information public in a comprehensive machine-readable file." *Id.* at 65,575.

Further, the lists target different audiences. HHS expected only third-party developers will use the spreadsheet, while "the shorter data set" in the shoppable-services list "is more likely to be directly useful to consumers." *Id.* at 65,556. Finally, hospitals can satisfy the shoppable-services requirement—but *not* the spreadsheet requirement—if hospitals offer online price-transparency tools. *Id.* at 65,551. By authorizing HHS to require "a list," Congress did not allow HHS to impose two completely different disclosure mandates.

2. Even looking at the spreadsheet requirement alone, HHS pushes the meaning of "a list" past the breaking point by requiring multiple lists. HHS's explanation of how to implement the spreadsheet illustrates this: "[O]ne tab could show *a list* of individualized items and services and associated gross charges derived from the hospital's chargemaster while another tab could display the individual items and services and service packages for a specific payer's plan based on the rate sheet." *Id.* at 65,559 (emphasis added). HHS also mandated that, for hospitals with locations subject to different rates, each hospital location must provide its own "list" of "standard charges"—meaning that one hospital might furnish dozens of lists. *Id.* at 65,603.

The district court reasoned that "a list can contain multiple categories," and that grouping everything "in a single data file" means there is just one "list." A48 n.16. But no one would call a compilation of a child's birthday wish lists over the years a single "list" just because her parents assembled them together. If the government can redefine a "list" as any collections of data in a single Excel file, nothing stops the government from defining a "list" as every byte of data hospitals retain.

C. HHS's Interpretation Implausibly Presumes Congress Enacted an Unprecedented Disclosure Mandate

The unprecedented scale of disclosures that arise under HHS's interpretation is further reason to reject HHS's view. Courts reject "enormous and transformative expansions" in agency authority "without clear congressional authorization." *Util. Air*, 573 U.S. at 324; *see Merck*, 962 F.3d at 540-41. If Congress meant to grant HHS roving license to demand troves of whatever pricing information HHS considered potentially useful to consumers, requiring "a list" of "standard charges" for each hospital item or service would be an odd way to do it. That watershed development is especially unlikely given that the federal disclosure regime that HHS envisions far exceeds what any State has required. *Supra* pp. 12-13.

The district court's observation (at A47) that the statute's purpose was

reducing healthcare costs does not help HHS. Congress buried section 2718(e) in a section otherwise concerned with insurers. It is implausible that Congress would have hidden a far-reaching mandate on the hospital industry in such an obscure subsection. *See Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 468 (2001). It is especially implausible that Congress enacted such a "sea change" when neither HHS nor hospitals nor anyone else "signal[ed]" that any such mandate existed for the first decade after section 2718(e)'s enactment. *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1324-25, 1321 n.6 (2020); *supra* pp. 14-15.

D. *Chevron* Does Not Save HHS's Interpretation

The district court upheld the Rule solely by giving HHS's interpretation controlling weight under *Chevron*. A47. The court acknowledged that "there may have been other reasonable interpretations," A48, but deemed HHS's interpretation "a close call," A45, *i.e.*, just barely reasonable. That analysis is incorrect given how comprehensively HHS's interpretation defies the statutory text. Regardless, even if *Chevron* remains viable, it is inapplicable several times over.[10]

[10] Appellants question the validity of *Chevron* deference, but recognize the doctrine binds this Court.

First, *Chevron* is a doctrine of last resort, subordinate to "traditional tools of statutory construction" like the canon of constitutional avoidance. *See Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1630 (2018); *Merck*, 962 F.3d at 540-41. Even were section 2718(e) ambiguous, the canon of constitutional avoidance rules out HHS's interpretation, which raises profound First Amendment concerns. *Infra* pp. 44-51.

Further, *Chevron* is inapplicable when, as here, the agency's new statutory interpretation represents an unacknowledged or unexplained break from the agency's prior position. *Encino Motorcars v. Navarro*, 136 S. Ct. 2117, 2125-26 (2016). For years—until proposing this Rule in August 2019—HHS repeatedly represented that hospitals could disclose "standard charges" by simply disclosing their chargemasters. *Supra* pp. 14-15. Yet HHS failed to acknowledge how much its new position breaks from the past. HHS portrayed its earlier pronouncements as instructing hospitals "to make available a list of their current standard charges," without acknowledging that the "standard charges" HHS told hospitals to disclose are not "standard charges" as HHS redefined them. *See* 84 Fed. Reg. at 39,572, 66,525. HHS suggested that a 2019 CMS guidance document "originated" the interpretation that "standard charges" mean gross charges as displayed in chargemasters. *Id.* at 65,544.

But HHS completely ignored years of prior interpretations in rules and proposed rules, thereby failing to grapple with the reliance interests HHS's interpretations engendered.

Finally, *Chevron* does not apply because the President picked the definition of "standard charges" that HHS adopted. *Chevron* deference rests on the notion that when Congress delegates to an agency the power to make binding legal rules, Congress authorizes the agency to fill statutory gaps using the agency's expertise. *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013); *United States v. Mead Corp.*, 533 U.S. 218, 227-28 (2001). The basis for *Chevron* deference disappears when the President directs what legal interpretation to adopt. Allowing the President to arrogate legislative power that Congress granted to the agency would explode the limits Congress placed on that delegation. *See Kisor v. Wilkie*, 139 S. Ct. 2400, 2416-17 (2019); *SoundExchange, Inc. v. Copyright Royalty Bd.*, 904 F.3d 41, 54 (D.C. Cir. 2018).

Here, the President's Executive Order required HHS to "propose a regulation … to require hospitals to publicly post standard charge information," which the Order defined to "includ[e] charges and information based on negotiated rates and for common or shoppable items and services." A75. HHS

duly adopted that interpretation of "standard charge[s]," requiring the disclosure of negotiated rates in a spreadsheet and in the separate shoppable-services list. 84 Fed. Reg. at 65,603-04.

The district court (at A49) concluded that the President's directive to "propose the rule" did not prevent HHS from applying its expertise. But the Executive Order prohibited HHS from proposing any interpretation that did *not* reflect the President's interpretation of "standard charges," even if HHS would have picked differently. The Executive Order also anchored HHS's rulemaking. Any final rule HHS adopted had to logically flow from the proposed rule in order to provide fair notice. *See Long Island Care at Home v. Coke*, 551 U.S. 158, 174-75 (2007). Extending *Chevron* to presidentially instigated agency interpretations would unmoor the doctrine from its rationale.

II. THE RULE VIOLATES THE FIRST AMENDMENT

The Rule flouts bedrock First Amendment protections, which include protecting "the choice of what not to say." *Pac. Gas & Elec. Co. v. Pub. Utils. Comm'n of Cal.*, 475 U.S. 1, 16 (1986) (plurality op.). The district court questioned whether the Rule compelled any "expressive message," A52, but the First Amendment protects commercial speech as well as Shakespeare. The Rule regulates the content of hospitals' speech by compelling hospitals to

speak about various rates in ways hospitals consider unintelligible and counterproductive. Under any standard of scrutiny, the Rule is unconstitutional.

1. The Rule, like all content-based speech regulations, is presumptively unconstitutional and can stand only if narrowly tailored to advance a compelling state interest. *See Barr v. Am. Ass'n of Political Consultants, Inc.*, No. 19-631, 2020 WL 3633780, at *5-*6 (U.S. July 6, 2020) (plurality op.); *id.*, at *20-*21 (Gorsuch, J., concurring in the judgment in part and dissenting in part); *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2226-27 (2015).[11] If strict scrutiny applies, HHS cannot prevail, because a legion of less-speech restrictive alternatives are available. Those alternatives are likewise fatal to the Rule under intermediate scrutiny. *See Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y.*, 447 U.S. 557, 565, 570 (1980).

The district court (at A54) applied the less-exacting standard of *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985). Under *Zauderer*, the government can compel disclosures only of "purely factual and uncontro-

[11] The above control over decisions of this Court holding that commercial speech warrants less protection. *E.g.*, *R.J. Reynolds v. FDA*, 696 F.3d 1205, 1217 (D.C. Cir. 2012), *overruled on other grounds by Am. Meat Inst. v. U.S. Dep't of Agric.*, 760 F.3d 18 (D.C. Cir. 2014) (en banc).

versial" information, and only if the government shows its compelled disclosures are reasonably related to a substantial interest and are not "unjustified or unduly burdensome." *Nat'l Inst. Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2372 (2018) (*NIFLA*) (quoting *Zauderer*, 471 U.S. at 651). But *Zauderer* has "no application" to "disclosures that are unconnected to advertising or product labeling at the point of sale." *Nat'l Ass'n of Mfrs. v. SEC*, 800 F.3d 518, 522, 524 (D.C. Cir. 2015). *Zauderer* thus does not apply to the Rule, which involves neither.[12]

2. Even if *Zauderer* applies, the Rule flunks that standard, for two reasons. First, HHS has not demonstrated that the Rule's avowedly "unprecedented" compelled-speech mandate reasonably relates to HHS's stated interests in promoting price transparency and lowering the cost of healthcare. 84 Fed. Reg. at 65,597. HHS asserts two intertwined interests: "providing consumers with factual price information to facilitate more informed healthcare decisions," which HHS believed would reduce healthcare costs by creating a

[12] Contrary to this Court's analysis in *American Meat*, 760 F.3d at 23, the Rule also falls outside the *Zauderer* framework because that framework is properly limited to disclosures correcting misinformation. *See Allstate Ins. Co. v. Abbott*, 495 F.3d 151, 166 (5th Cir. 2007); *Entm't Software Ass'n v. Blagojevich*, 469 F.3d 641, 652 (7th Cir. 2006); *Am. Beverage Ass'n v. City & Cty. of S.F.*, 916 F.3d 749, 768 (9th Cir. 2019) (en banc) (Nguyen, J., concurring).

more efficient market. *Id.* at 65,544-45. But a nebulous interest in price transparency is not carte blanche for the government to compel whatever speech it wants on the theory that more information is always better. "[T]hat would be true of any and all disclosure requirements." *Am. Meat*, 760 F.3d at 31 (Kavanaugh, J., concurring in the judgment). Rather, HHS must show that the *specific* disclosures it requires would meaningfully inform consumer decision-making—and HHS cannot carry that burden. *See Nat'l Ass'n of Mfrs.*, 800 F.3d at 527; *Am. Meat*, 760 F.3d at 27.

HHS conceded that its spreadsheet mandate, which would compel hospitals to disclose millions of rates, "may not be immediately or directly useful for many health care consumers because the amount of data could be overwhelming or not easily understood." 84 Fed. Reg. at 65,564; *see id.* at 65,547. Yet HHS perversely invoked the spreadsheet's limited utility for consumers as grounds for yet further compelled speech, in the form of requiring hospitals to disclose a discrete, "consumer-friendly" list of 300 shoppable services. *Id.* at 65,564. When the government admits that one broad compelled-speech requirement fails to advance its asserted aim, the First Amendment does not let the government fix the problem by commanding *more* speech.

Further, HHS itself portrayed its disclosure mandates as a mere "first

step" towards providing consumers with the information they want, namely where they can get "needed healthcare services [and] determine out-of-pocket costs in advance." *Id.* at 65,529. HHS admitted that publication of all confidential rates negotiated with insurers will not tell consumers their out-of-pocket costs, because hospitals lack the information necessary to calculate those costs. *Id.* at 65,528. HHS further recognized that for consumers and the healthcare market, "the impact resulting from the release of negotiated rates is largely unknown." *Id.* at 65,542. But agencies cannot compel disclosure based on mere "speculation or conjecture." *Nat'l Ass'n of Mfrs.*, 800 F.3d at 526-27. Even under a generous reading of *Zauderer*, HHS cannot force hospitals to engage in immense amounts of compelled speech on the speculative possibility that their disclosures *might* dispel consumers' confusion about healthcare costs.

Worse, the Rule would mislead consumers in key respects. *See R.J. Reynolds*, 696 F.3d at 1216 (*Zauderer* does not license disclosures "subject to misinterpretation" by consumers). Take negotiated rates. The Rule would require hospitals to disclose those rates annually, yet those rates are the product of thousands of contracts that hospitals negotiate on a rolling basis with insurers. *See* 84 Fed. Reg. at 65,563. Failing to include updated rates could

grievously mislead consumers, who might not realize that rates had dramatically changed in the meantime or that a service was no longer covered. *Supra* p. 8; A120, A383.

Or take discounted cash prices. HHS and the district court (at A59) portrayed disclosures of cash prices as useful for consumers who might opt to pay cash instead of using insurance if they could compare cash prices and insurer-negotiated rates. But that reasoning shows how misleading HHS's Rule would be: patients who made that comparison would be picking between a rate that does *not* reflect their out-of-pocket amount (the negotiated rate) versus the out-of-pocket cash price. That choice is doubly false because, as HHS acknowledged, many hospitals do not offer pre-set cash discounts. Yet the Rule would force hospitals to incorrectly and misleadingly label their gross charges as cash-price discounts. 84 Fed. Reg. at 65,553; *supra* pp. 20-21. It is no response that hospitals could "add qualifiers" to clear up the misunderstanding. A57 n.20. It is HHS's burden to defend the constitutionality of its disclosure requirements, not the hospitals' job to clear up misimpressions HHS forces them to create.

Second, HHS failed to show that its Rule is not unduly burdensome. The Rule understated HHS's burden, asserting that HHS need merely establish a

"reasonable" fit between the compelled disclosure and HHS's asserted interests. 84 Fed. Reg. at 65,544-45; *see* A54, A57. The Supreme Court's decision in *NIFLA* requires more: "Even under *Zauderer*, a disclosure requirement cannot be unjustified or unduly burdensome," and may "extend no broader than reasonably necessary." 138 S. Ct. at 2377.

By any metric, HHS's Rule is excessively burdensome and overbroad. The Rule compels an astonishing amount of speech: multiple lists comprising hundreds of thousands of rows of data gathering millions of pricing data points. *Supra* pp. 17-18. And the Rule's costs are severe: hospitals will lose proprietary trade information, vital personnel time, and resources. *Id.*; *e.g.*, A422, A486, A509.

Yet HHS, by its own account, had several less-restrictive options, which should alone invalidate the Rule. *See NIFLA*, 138 S. Ct. at 2376-77; *Am. Beverage Ass'n*, 916 F.3d at 757. If, as HHS acknowledged, consumers will not use the massive spreadsheet that HHS compels, HHS could have adopted the Rule's "consumer friendly" shoppable-services list as an effective, less-speech restrictive alternative. And, given that HHS allows hospitals to satisfy the shoppable-services list requirement with online price-transparency tools,

those tools are obviously an even less-restrictive alterative. HHS also has proposed a rule that would require insurers to disclose cost information, underscoring that HHS did not need to target hospitals. *See* 84 Fed. Reg. 65,464 (proposed Nov. 27, 2019).

HHS and the district court contended that the success of States' price-transparency initiatives validate HHS's predictions about the Rule's likely benefits to consumers. *See id.* at 65,526-27, 65,544, 65,549; A58, A62. But no State has required anything like what the Rule mandates. *Supra* pp. 12-13. And HHS cannot have it both ways: Either those States have not been as successful as HHS claims, in which case HHS's reliance on them is faulty. Or those States have been successful using chargemasters, building price-transparency tools that use patient inputs, and compiling de-identified, after-the-fact claims information, in which case HHS's far broader Rule is not "reasonably necessary." *NIFLA*, 138 S. Ct. at 2377.

III. THE RULE IS ARBITRARY AND CAPRICIOUS

The APA requires that "an agency action must be the product of reasoned decisionmaking," or the rule is arbitrary and capricious. *Fox*, 684 F.3d at 74-75. Agencies must give a reasoned, record-based explanation that does

not "run counter to the evidence before the agency," shows a "rational connection between the facts found and the choice made," and considers all "important aspect[s] of the problem." *State Farm*, 463 U.S. at 42-43. HHS's Rule violates those precepts.

1. HHS failed to adequately address the difficulties hospitals face in compiling the negotiated rates and other information HHS demands. Scores of hospitals described the challenges of identifying what could be thousands of negotiated rates for each of their items and services, deeming the task "massively complicated" even before COVID-19. A304; *supra* pp. 16-19. Yet HHS exacerbated those burdens and required broader disclosures in the Final Rule.

HHS's response to hospitals' "substantial and important problem[s]" consisted of a "handful of conclusory sentences" and "unexplained inconsistencies" that do not pass muster. *Gresham v. Azar*, 950 F.3d 93, 103 (D.C. Cir. 2020); *District Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015). HHS dismissed compliance costs as minimal by envisioning straightforward contracts between hospitals and insurers that prescribe a set discount off hospitals' gross charges. *E.g.*, 84 Fed. Reg. at 65,542, 65,550-51. HHS repeatedly insisted that "most hospitals" already "keep and maintain" the necessary rate data "within their billing and accounting systems." *Id.* at 65,597;

see id. at 65,591, 65,594-95.

But hospitals calculate rate data *by patient*, and cannot readily identify the different rate groupings that HHS demands. Each hospital can have thousands of agreements, because insurers have individualized subcontracts for each of their plans. *See supra* pp. 8-9. And each contract features dozens of pages of complex conditions and formulae. *Id.* As hospitals explained, those rate provisions do not readily translate into spreadsheet headings describing which rate covers which subcategory of patients, because of the number of variables—like hospital location and outpatient or inpatient setting, not to mention discounts off list prices, volume discounts, incentive payments for meeting quality metrics, and exclusions of payment for certain items or services—that define the potential class of patients subject to a particular rate. *Supra* p. 17.

Hospitals ordinarily build algorithms so their billing, accounting, and other systems cross-reference each other and automatically calculate the applicable rate for a particular patient, taking into account that patient's insurer and plan (or other means of payment). A120, A357, A396, A558. Hospitals, in other words, translate contractual formulae into individual rates for insured

patients. For instance, the hospital's system is built to indicate that the negotiated rate for Patient X, who has a UnitedHealthcare health maintenance organization plan and receives an X-Ray as part of her outpatient care at the hospital's Albany location, is $500. But HHS demands something very different: for hospitals to identify, for any given item or service, all of the variables that went into Patient X's rate, so as to create some description of the subgroup of patients who get the same rate as Patient X, again for any given item or service. Reverse-engineering the process to tease out all of the possible patient subpopulations that could exist for any given item or service would be a herculean effort, as numerous hospitals explained. *E.g.*, A456, A537-38; *supra* pp. 17-20.

HHS's other response to hospitals' concerns—that hospitals could identify patient subpopulations and calculate associated rates just by asking insurers for rate sheets in electronic form, 84 Fed. Reg. at 65,550—is absurd. Seeing the formulae does not help hospitals identify all of the possible permutations of identifiable patient groupings. Hospitals collectively made those compliance challenges clear, yet HHS's Rule either ignored or contradicted them without reasoned explanation.

HHS briefly acknowledged the difficulties arising from accounting for

just one of the variables driving different negotiated rates, *i.e.*, hospital location. But HHS's analysis of that wrinkle undermines its dismissal of compliance costs. HHS stated: "different hospital locations may offer different services that have different associated standard charges." *Id.* at 65,563. But HHS's response was to require hospitals to disclose "all standard charges for all items and services [that] apply to each hospital location such that *a separate identifiable list of all standard charges applicable to each hospital location* would also have to be made public." *Id.* at 65,564 (emphasis added). Thus, HHS would require a hospital network with ten locations whose negotiated rates vary by location to create ten separate lists of all HHS-defined "standard charges." And each of those lists would still have to account for the other variables that go into negotiated rates. As one hospital system explained, "requiring each health system to fulfill these requirements separately for each hospital location would increase their burden exponentially." A525; *see* A168. Yet HHS did not factor this issue into its cost calculations.

HHS then left key compliance questions unanswered. The Rule requires hospitals to break out each negotiated rate for an item, service, or package of services into (a) insurer, (b) specific plan, and (c) inpatient/outpatient setting. 84 Fed. Reg. at 65,560. But HHS does not explain how hospitals

should address, for instance, an insurer that pays for X-Rays per diem, or that pays for X-Rays only in conjunction with a procedure. *See* A209, A425. Should hospitals list no amount at all for the X-Ray item for that insurer, and risk misleading patients into thinking that insurer will not cover X-Rays? And how can hospitals explain these differences to patients when they recur throughout millions of spreadsheet entries? Either hospitals must find some way to account for those variables in their disclosures, adding significant hours and expense, or HHS is requiring disclosure of negotiated rates that exclude critical factors and are thus inaccurate.

Further, HHS glossed over the additional burdens of compiling the 300 shoppable-services list, merely acknowledging that this list would require manual inputs and more "thought." 84 Fed. Reg. at 65,575. That is some understatement. HHS defined a "shoppable service" not as a single item or service, but a packaged bundle the hospital may have to invent that includes the "primary" service (like a colonoscopy) and any common "ancillary services" (like lab tests, drugs, therapy services, etc.). *Id.* at 65,564-67. HHS conceded that hospitals would have to make judgments about what "ancillary services" are, and might define ancillary services differently, resulting in different defi-

nitions of "shoppable services." *Id.* at 65,566. And for each bundle, the hospital must again provide HHS-defined "standard charges" (except not gross charges). *Id.*

Given HHS's failure to grasp what hospitals must do to comply with the Rule, HHS's adjusted cost estimates in its Final Rule for each hospital to comply—about $11,900 for initial implementation, and about $3,000 for each ensuing year, *id.* at 65,595-96—were ridiculously low. *See, e.g.*, A254, A268, A305, A335. HHS's estimates were still orders of magnitude less than the hundreds of thousands of dollars that leading hospitals projected. *Supra* pp. 18-19. Nor did HHS explain how its estimates could be correct given hospitals' comments explaining that just complying with HHS's 2019 rule mandating translation of chargemaster data into machine-readable formats cost upwards of $100,000 and took months—not hours—to implement. *See id.*

HHS justified its cost analysis by stating that "hospitals are already compiling and reporting similar data" to States. *Id.* at 65,593; *see id.* at 65,585; A26, A62. But States do not require hospitals to make anything resembling the same disclosures as this Rule. *Supra* pp. 12-13. Similarly, the fact that insurers list negotiated rates in the explanation of benefits forms they send to patients, A60, just shows that the Rule is targeting the wrong entities for its

disclosure regime. Insurers are better positioned to convey patient-specific rates. The same goes for HHS's contention that hospitals can get rate information if HHS's proposed rule mandating that insurers disclose their rate information takes effect. 84 Fed. Reg. at 65,550-51. If hospitals need another rule to take effect in order to comply with this Rule, that is a sure sign something is awry.

Finally, HHS's decision to finalize the Rule's effective date as January 2021 instead of January 2020, *id.* at 65,585, does not solve these disproportionate burdens. And the COVID-19 pandemic has only undermined overburdened hospitals' ability to comply. Am. Hosp. Ass'n July 2, 2020 Letter, *supra*.

2. HHS also relied on untenable reasoning in predicting that the Rule would advance HHS's primary aim of "providing consumers with factual price information to facilitate more informed health care decisions," so as to reduce healthcare costs. 84 Fed. Reg. at 65,544-45. The district court (at A64-65) deferred to HHS's prediction, but no crystal ball is necessary; HHS's own evidence and analysis defeat its assumptions.

The most HHS was willing to say is that this Rule is a "first step" that does not inform patients of their out-of-pocket costs. 84 Fed. Reg. at 65,529, 65,543. HHS conceded that the *most* useful information is hospitals' gross

charges in their chargemasters, which reflect the maximum patients could pay. *Supra* pp. 7, 14. By contrast, HHS admitted "the impact resulting from the release of negotiated rates is largely unknown." 84 Fed. Reg. at 65,542.

But HHS failed to adequately consider how the incompleteness of its Rule could backfire by misinforming consumers. For instance, the Rule does not (and could not) require disclosures from ambulatory surgical centers, which offer shoppable services, like medical imaging, identical to hospitals'—preventing comparison-shopping for these potentially less-expensive options. *Id.* at 65,531. Because patients will lack information about key pieces of the healthcare market, the Rule could perversely drive patients to costlier options. HHS likewise failed to address the misleading effect of disclosing negotiated rates and requiring hospitals to call their gross charges "discounted cash prices." *Supra* pp. 20-21, 49.

HHS's concession that consumers may find the data disclosures "confusing," 84 Fed. Reg. at 65,547, confirms the irrationality of HHS's analysis. Massive spreadsheets displaying what could be hundreds of millions of entries may be "machine-readable," but they are not human-comprehensible. No patient could use that document to comparison-shop among the thousands of disparate rates listed for a given item or service. The district court's conclusion

(at A65) that consumers cannot get any more confused than they already are gets it backwards. The answer to consumer frustration cannot possibly be an incoherent data overload.

Nonetheless, HHS asserted that "the vast majority" of consumers will benefit from the spreadsheet, "especially as it may be reformatted in consumer-friendly price transparency tools" or analyzed in "economics research." *Id.* at 65,547, 65,599. Imposing a massive disclosure regime that depends on further efforts by unspecified third parties is an irrationally convoluted means to improve existing price-transparency tools. *Id.* at 65,599.

HHS touted its 300-shoppable-services list as the real tool that patients will use. *Id.* at 65,556. It is not apparent what is consumer-friendly about a document listing 300 common procedures, each of which could easily have thousands of associated negotiated rates for each item or service associated with the procedure. Adding to the confusion, HHS requires hospitals to include all "ancillary" services associated with the procedure, but does not define what those ancillary services are, creating the potential for non-uniform and wildly varying bundles. *See* A121. Further, HHS's conclusion that price-transparency tools that many hospitals already employ would satisfy this requirement reveals the shoppable-services mandate as window dressing. The

true benefit to consumers comes from pricing tools that HHS has no authority to mandate under section 2718(e). *Supra* pp. 12, 51. As HHS candidly admitted, "many hospitals are already meeting or exceeding our proposed requirements" via "patient-friendly price transparency tools that calculate individualized out-of-pocket cost estimates." 84 Fed. Reg. at 65,576. If hospitals' existing tools are already *better* than the Rule's requirements, there is no need for the Rule and its inordinate burdens.

The district court also deferred to HHS's studies on the market effects of price-transparency disclosure. A64-A65. But HHS's oft-mentioned state initiatives do not show that this Rule would improve price transparency or drive down costs, because no State has required hospitals to disclose all negotiated rates in advance. As HHS acknowledged, "hospitals will be presenting much of their standard charge data in a manner that has historically not been made available to the public." 84 Fed. Reg. at 65,567. That is because, as noted, *supra* pp. 12-13, most States require either disclosure of gross charges in chargemasters or price-transparency tools that let patients estimate out-of-pocket costs by inputting information hospitals do not have, or States collect after-the-fact claims data. Rather than justifying the Rule, HHS's state exemplars demonstrate less burdensome alternatives. *See supra* p. 51.

Finally, HHS's speculation that its Rule would improve price competition and reduce healthcare costs gave short shrift to key evidence suggesting the opposite. HHS acknowledged studies observing that disclosure of negotiated rates—as opposed to disclosure of out-of-pocket prices that consumers pay—can facilitate anticompetitive effects. 84 Fed. Reg. at 65,542. Studies of state initiatives that do not compel disclosure of negotiated rates do not rebut that concern.

HHS also ignored reservations that the Federal Trade Commission and Department of Justice, the agencies entrusted with antitrust enforcement, expressed about disclosing negotiated rates. The FTC, for example, opposed Minnesota's proposal to publicly disclose certain hospital-payer negotiated rate contracts, reasoning that the proposal "would offer little benefit but could pose substantial risk of reducing competition in health care markets." FTC, Letter to Minn. House of Reps. (June 29, 2015), https://tinyurl.com/u7fryu8. The Department of Justice has echoed those concerns, and dozens of comments stressed those positions. *E.g.*, A104, A403-04, A492-93. Yet HHS did not even mention these agencies' objections, thereby failing to acknowledge an important facet of the problem.

3. The Rule is also arbitrary and capricious because HHS did not adequately acknowledge its about-face from its prior position that "standard charges" just means hospitals' gross charges. *Supra* pp. 14-15, 42-43.

IV. THE COURT SHOULD VACATE THE ENTIRE RULE

Courts must "hold unlawful and set aside agency action[s] found to be invalid." 5 U.S.C. § 706(2). When, as here, the agency predicates its rule upon an impermissible statutory interpretation or is arbitrary and capricious, vacatur is the appropriate remedy. *E.g.*, *Air All. Hous. v. EPA*, 906 F.3d 1049, 1069 (D.C. Cir. 2018); *Nat. Res. Def. Council v. EPA*, 489 F.3d 1250, 1261 (D.C. Cir. 2007); *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409-10 (D.C. Cir. 1998). Courts can also award injunctive relief. *Nat'l Mining Ass'n*, 145 F.3d at 1408-09.

This Court should vacate the entire Rule. HHS proposes that its five categories of "standard charges" are severable, such that courts should invalidate any unlawful category and leave the other required disclosures in place. 84 Fed. Reg. at 65,555. But the Rule's flaws are pervasive and, besides gross charges, HHS does not justify disclosure of other "standard charges" standing alone. Instead, HHS treats its categories of "standard charges" as interdependent; the negotiated-rate element in particular is the Rule's centerpiece.

See id. at 65,542. Under those circumstances, the Rule is inseverable, because the record does not show the agency would have adopted the severed portion alone. *See MD/DC/DE Broads.' Ass'n v. FCC*, 253 F.3d 732, 734-35 (D.C. Cir. 2001); *Am. Petrol. Inst. v. EPA*, 862 F. 3d 50, 71-72 (D.C. Cir. 2017). Regardless, HHS impermissibly required multiple lists, but Congress authorized just one, and there is no way to pick one permissible list to keep.

CONCLUSION

The Court should reverse the judgment below and vacate and enjoin the Rule.

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