ORAL ARGUMENT SCHEDULED FOR OCTOBER 15, 2020

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)

REPLY 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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SUMMARY OF ARGUMENT

For a decade, hospitals relied on HHS's view that section 2718(e) requires disclosure only of hospitals' list prices (or gross charges), and invested in their own price-transparency counseling tools accordingly. Then, to comply with a June 2019 Executive Order, HHS abruptly changed course, reinterpreting section 2718(e) to require hospitals to disclose millions of insurer-negotiated rates and to provide multiple lists of data.

HHS's Rule manifestly exceeds HHS's statutory authority. Instead of showing why the Rule is lawful, the government spends most of its brief arguing that section 2718(e) cannot be read to require hospitals to disclose only their gross charges—such that HHS's old interpretation is unlawful. Even if *Chevron* applies—it does not—HHS's new interpretation is impermissible. The government does not dispute that HHS's Rule implausibly deems thousands of different rates the "standard charge" for each item or service, and would vest HHS with a hitherto undiscovered disclosure power. The government does not contest that HHS compels disclosure of rates that depend on care that patients receive, which hospitals cannot calculate in advance. Nor does the government dispute that HHS's Rule radically surpasses what any

State requires, or that HHS mistakenly rested the Rule's projections of benefits and burdens on those inapposite state regimes. The Rule also transgresses the First Amendment's restrictions on compelled speech and the APA's bar on unreasoned agency action. This Court should vacate the Rule.

I. HHS UNREASONABLY INTERPRETED SECTION 2718(e)

A. HHS Impermissibly Interpreted "Standard Charges"

1. The government agrees that "standard" ordinarily means usual or common, and does not dispute that the "standard" version means the model version. U.S. Br. 19; AHA Br. 27. Applied here, a hospital's "standard" charges are its usual, common, or default charges "for [its] items and services." That ordinary meaning forecloses HHS's attempt to define a hospital's "standard" charges to include whatever prices apply in "particular circumstances" to individual patient subpopulations that hospitals agree to accept "in advance" in any "formalized" fashion. 84 Fed. Reg. at 65,537; U.S. Br. 20. The government does not deny that HHS's interpretation requires adding words, so that the statute says "standard charges *for each group of paying patients*" for items and services. AHA Br. 29-30. And the government does not deny that HHS's disclosure mandate announces significant new powers that HHS never

before believed it possessed. AHA Br. 40-41; *accord Loving v. IRS*, 742 F.3d 1013, 1021 (D.C. Cir. 2014).

The government (at 42) admits that its interpretation produces *thousands* of "standard charges" for just one item or service based on the permutations of variables that go into negotiated rates, like location, outpatient setting, and plan type. AHA Br. 30. And the government does not contest that many negotiated rates depend on the actual care a patient receives, and thus, the Rule compels disclosure of "charges" that do not exist. AHA Br. 53-56.

The government's rationale for this anomalous reading (at 19-20) is that the healthcare market is unique, few payers pay hospitals' list prices, and "no single [rate] predominates." But the purported lack of a single "standard rate" is a problem HHS created, by adopting a definition that mixes and matches the hospital's list price, insurer-negotiated rates, and perhaps payments the hospital receives. AHA Br. 28-29. This is no reason to disregard the ordinary meaning of "standard charges" as list prices (or gross charges), which *are* universal default prices irrespective of payer. Few pay law firms' rack rates, and no single rate predominates among private clients, insurers, government clients, or pro bono representations—but rack rates are still "standard." So too,

hotels' "standard" room rates are no less "standard" because corporate groups, last-minute or AAA travelers, and seniors rarely pay them.

HHS's interpretation renders the word "standard" superfluous. If *any* rate that hospitals "formalize" for *any* particular patient is "standard," everything is "standard"; hospitals generally are not paid without some formal agreement. AHA Br. 29. The government responds (at 20-21) that the Rule excludes all amounts hospitals actually *receive* under an agreement, or reduced agreed-upon amounts for charity care. But the government does not dispute that its interpretation logically includes these categories.

The government never explains how discounted cash prices, *i.e.*, departures from usual prices, are "standard." Nor does the government (at 30) deny that maximum and minimum rates are specific data points, which are not "usual" at all. The government (at 30) just casts maximum and minimum rates as a "different way" to display "subset[s]" of negotiated rates, saying (at 11, 20) that the Rule only "identif[ies] three categories of hospital 'standard charges' that must be disclosed." But HHS's Rule portrayed maximum and minimum rates as the standalone "fourth and fifth type[s] of standard charge[s]." 84 Fed. Reg. at 65,555. Just because those data points are a "familiar feature of consumer pricing tools," U.S. Br. 31, does not mean Congress

included them. Under HHS's interpretation, Congress implausibly authorized HHS to require myriad arbitrary data points, like the twentieth-lowest rate for outpatient CT scans offered by any multistate insurer.

The government (at 30) dismisses HHS's lack of limiting principles, proclaiming that "[t]he Rule's validity turns on what it actually requires." But courts cannot write agencies blank checks by upholding boundless legal interpretations and trusting agencies to show restraint. *E.g.*, *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 325-28 (2014). Anyway, HHS's purported restraint in "*not* … adopt[ing]" a definition of "standard charges" that includes all allowed charges, modal negotiated rates, or median cash prices is illusory. *Cf.* U.S. Br. 30. HHS endorsed those definitions as among "many possibilities" and opted against requiring them "at this time." 84 Fed. Reg. at 65,537, 65,552. Similarly, that HHS "careful[ly] consider[ed]" how individual data points would "serve[] the statute's purposes" (U.S. Br. 31) is no limiting principle, especially since HHS considers all data inherently useful.

The government (at 24-25, 27, 31) invokes section 2718's title and purpose to reduce healthcare costs, but "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Rodriguez v. United States*, 480 U.S. 522,

526 (1987) (per curiam). Similarly, the government (at 17, 19, 32) relies on section 2718(e)'s reference to HHS's ability to develop "guidelines." But HHS's ability to instruct *how* hospitals disclose "a list" of "standard charges" is not license for HHS to redefine "standard charges" or "a list."

2. HHS also unreasonably defines "charges." The government no longer defends the Rule's equation of "charges" with "rates," *i.e.*, "a fixed price *paid or charged* for something." 84 Fed. Reg. at 65,539 (emphasis added); AHA Br. 32-33. But the Rule used that untenable definition to justify compelling hospitals' list prices (gross charges) and amounts that hospitals *agree to accept* from insurers or patients. 84 Fed. Reg. at 65,539, 65,544, 65,553. Courts "may uphold agency action only on the grounds that the agency invoked when it took the action." *Michigan v. EPA*, 576 U.S. 743, 758 (2015).

Now, the government (at 19, 26-27) maintains that a "'charge' ordinarily means the price demanded for something." That is appellants' point: the price hospitals "demand" (or, as dictionaries put it, "the price asked") is hospitals' list price. AHA Br. 33; *see* U.S. Br. 4, 11, 27, 39; 84 Fed. Reg. at 65,533, 65,539, 65,549 (equating hospitals' "list price[s]" with gross charges).

The government resists that conclusion by incoherently recharacterizing every stage of the payment process as a hospital "demand." The government sometimes says hospitals "demand" prices in negotiations with insurers. *See* U.S. Br. 19, 28. Other times, the government thinks that hospitals "demand" prices from patients in bills. U.S. Br. 5, 17. Elsewhere, the government (at 13, 27, 28, 39) equates "charges" with payments received—*e.g.*, by contending that hospitals' gross charges cannot be "standard charges" because they are not "what most patients will pay." Then, the government (at 21, 29) claims to exclude payments that hospitals receive.

But asking for one price and settling on another are not the same thing. The reduced price smaller hospitals ultimately accept from behemoth insurers is hardly the price *the hospital* demanded, any more than the price the car dealer accepts from a buyer is the price the dealer "demands," or the below-asking-price offer a home seller accepts from a buyer is what the seller "demands." That is why, in related contexts, Congress says "negotiated rates" when that is what Congress means, and distinguishes between "charges" and amounts "paid." AHA Br. 34. The government offers no response.

HHS's interpretation incongruously requires annual disclosures of rates that constantly change, a point the government (at 31) dismisses by defending

HHS's interpretation as literally possible, and by suggesting that hospitals include a "last updated" disclaimer. But the government never reveals how hospitals could disclose *in advance* the many negotiated rates that depend on the care a patient *actually receives*. Impossibility aside, Congress did not plausibly impose a once-a-year disclosure requirement for frequently-changing rates that are useless once obsolete. AHA Br. 35; *infra* p. 21.

3. Section 2718(e)'s reference to diagnosis-related groups undermines HHS's interpretation. Section 2718(e) requires "[e]ach hospital" to publish "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) (emphasis added). Medicare establishes diagnosis-related groups and reimburses hospitals for bundles of services associated with particular diagnoses, not by item or service. AHA Br. 13-14; U.S. Br. 21. Yet the government (at 22, 26) counterintuitively asserts that standard charges "for diagnosis-related groups established under" Medicare does *not* mean those standard Medicare reimbursement amounts.

Instead, the government (at 21-23, 25-26) deploys diagnosis-related groups as a Trojan horse to smuggle all insurer-negotiated rates into the statute. The government notes that some insurers, not just CMS, use Medicare-

established diagnosis-related groups as a unit of payment. So the government surmises those negotiated rates must be "standard charges." Since section 2718(e) uses the word "including," the government concludes that "standard charges" must encompass *all* negotiated rates for items, services, diagnosis-related groups, and different bundles of items and services.

That interpretation is wrong. Congress does not just use "including" to indicate an illustrative example; "include" can also "tell[] readers that *a different* type of [something] should receive the same treatment … as the type described in the [other] definition." *Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652, 1658 (2017). "That use of the word 'include' is not literal—any more than when Congress says something like 'a State includes Puerto Rico and the District of Columbia.'" *Id.* Congress unambiguously used "including" that way when referring to "standard charges for items and services … including for diagnosis-related groups." As the government concedes (at 22), diagnosis-related groups are not "items" or "services" at all, so the word "including" cannot be an "illustrative term." *Cf. Bloate v. United States*, 559 U.S. 196, 207 (2010). Under the government's reasoning, if Congress said "a State 'includes' Puerto Rico," the statute also encompasses other territories. And by

listing some non-States, Congress must have meant to include them all—so France would count as a State, too. That is absurd.

The government (at 26) incorrectly claims that section 2718(e) cannot merely require disclosure of Medicare diagnosis-related-group rates. HHS previously believed the opposite. A72. The government (at 23) notes that CMS already discloses Medicare rates. But *hospitals* do not, so section 2718(e) would not be redundant.

4. The government (at 25-29) bizarrely insists that section 2718(e) "forecloses interpreting 'standard charges' to mean only chargemaster rates," *i.e.*, gross charges. HHS long embraced that interpretation. *E.g.*, 79 Fed. Reg. 27,978, 28,169 (May 15, 2014). Even HHS's Rule deemed that interpretation permissible, promising to proceed with a rule that *only* mandates "gross charges" if a court invalidates HHS's other definitions of "standard charges." *See* 84 Fed. Reg. at 65,555. It hardly inspires confidence when the government defends a new interpretation by insinuating that the agency previously violated the statute for years. Rejecting HHS's old interpretation would not make HHS's current interpretation the best, or even permissible.

Nevertheless, the government's objections are incorrect. The government (at 26-27) repeats that "standard charges" cannot mean only gross

charges because most patients do not "pay" gross charges. Again, that erroneously equates a "charge" with what patients pay, not what hospitals ask.

The government (at 27-29) sees "no reason why Congress would have limited HHS to requiring hospitals to disclose only charges that 'virtually no one' … pays." Even HHS's Rule explained that disclosure of gross charges conveys patients' maximum exposure and is "useful to the general public, necessary to promote price transparency, and necessary to drive down premium and out-of-pocket costs." 84 Fed. Reg. at 65,540; *see id.* at 65,539, 65,541; AHA Br. 7-8. HHS also stated that even a gross-charges-only rule "could also further hospital price transparency." 84 Fed. Reg. at 65,555.

The government (at 28) asserts that "standard charges" cannot mean gross charges because hospitals have only one set of those charges, so "standard" would be superfluous. That proves too much, indicting HHS's decision to include gross charges as "standard charges" at all. And "standard" does important work, reinforcing that "charges" refers to the hospital's universal asking price, not to an unlimited number of buyer-side acceptance prices. *Supra* pp. 2-5. It is irrelevant (at 29) whether "chargemaster" is a term of art Congress could have used instead. Chargemasters are documents memorializing hospitals' gross charges. Congress sensibly required disclosure of the

substance—gross charges—not a particular form. *Accord* 79 Fed. Reg. at 28,169 (HHS previously told hospitals to disclose standard charges via "the chargemaster itself or in another form of their choice.").

B. HHS Impermissibly Interpreted "A List"

1. All agree section 2718(e) authorizes HHS to require only one list. U.S. Br. 32. But the Rule demands at least two: (1) a spreadsheet listing millions of "standard charges" for all hospital items and services, and (2) a list of rates for 300 shoppable services, by procedure. AHA Br. 21, 38-39.

The government (at 32-33) claims that only the spreadsheet is a "list," while "[t]he separate display of charges for 300 shoppable services is merely a different way that hospitals must 'make public' that list." That argument is frivolous, and would let HHS redefine a million-list requirement as many "formats." That argument also contradicts HHS's proposed regulatory text, which identified *each* disclosure as its own "list"—another point the government ignores. 84 Fed. Reg. at 65,603 (proposed 45 C.F.R. § 180.40). The spreadsheet and shoppable-services lists disclose different information, in different formats, for different audiences. AHA Br. 21, 38-39. And hospitals satisfy the shoppable-services mandate, but not the spreadsheet mandate, by offering price-transparency tools. 84 Fed. Reg. at 65,551.

The government (at 33) is wrong that HHS "fully explained why requiring hospitals to display their standard charges in two different manners was consistent with the statutory text." HHS explained that the shoppable-services list could aid patients overwhelmed by the spreadsheet. 84 Fed. Reg. at 65,555-56, 65,564-65. That reveals why HHS *wanted* multiple lists, not HHS's statutory authority to compel them.

The government's contention (at 32) that appellants forfeited this argument is ironic given the government's prolific reliance on points that appear nowhere in HHS's Rule, and is wrong besides. Appellants argued below that HHS exceeded section 2718(e)'s limit by mandating more than one list. Compl. ¶¶ 80-81, 83; Pls. S.J. Mem. 13-14. Further elaboration is fair game. *See Yee v. City of Escondido*, 503 U.S. 519, 534 (1992) ("Once a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below."); *Davis v. District of Columbia*, 925 F.3d 1240, 1252-53 (D.C. Cir. 2019). Regardless, courts properly consider forfeited statutory arguments when, as here, addressing a statutory argument could bypass a constitutional question. *Matal v. Tam*, 137 S. Ct. 1744, 1755 (2017).

2. HHS also impermissibly folded a multi-list mandate into its spreadsheet requirement. HHS envisioned that hospitals would create one tab for gross charges, another tab for negotiated rates, and so on. AHA Br. 39-40. If each tab is not its own "list," why would HHS describe them as such? 84 Fed. Reg. at 65,559. The government does not say, instead (at 33) citing definitions that further refute its position. A "list" is "a catalogue or roll consisting of a row or series of names, figures, words, or the like," or "a simple series of words or numerals"—not discrete compilations of different information.[1] HHS's interpretation implausibly would call dozens of different disclosures one "list" so long as everything fits in one Excel file.

Further, HHS requires a multi-location hospital to disclose multiple lists; *each location* must supply a "separate identifiable list of standard charges." 84 Fed. Reg. at 65,563-64. The government (at 34) responds that this problem would arise under any definition of "standard charges." But it is HHS's Rule that defines a "hospital" as the hospital system, not each location. 84 Fed. Reg. at 65,530-32. HHS's failure to find a lawful way to require "each hospital" to disclose "a list" is a sign something went awry.

[1] *List*, OED Online, www.oed.com/view/Entry/108991; *List*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/list.

C. *Chevron* Does Not Save the Rule

The district court upheld the Rule under *Chevron*, A45, and the government now cites *Chevron* 17 times. But *Chevron* has no place here. Section 2718(e) clearly forecloses HHS's unreasonable interpretation of "standard charges." And the government (at 32) admits that "a list" is unambiguous, so *Chevron* cannot justify HHS's impermissible multi-list requirements. Even were "standard charges" unclear, the canon of constitutional avoidance trumps *Chevron* and resolves any ambiguity in appellants' favor. AHA Br. 42.

Chevron also is inapplicable because the Rule inadequately acknowledged HHS's about-face from its previous interpretation that section 2718(e) requires hospitals only to disclose gross charges. AHA Br. 42-43. The government does not defend the Rule's failure to acknowledge many pre-2019 HHS interpretations equating "standard charges" with gross charges. AHA Br. 14-15, 42. And the government's citations (at 34) belie its claim that the Rule "acknowledged that [HHS's] prior guidelines had allowed hospitals" to "mak[e] only their chargemasters available" and "thoroughly explained" why HHS abandoned that view. The Rule stated that CMS's previous guidance "unnecessarily limited the reporting of [diagnosis-related groups] by hospitals" by limiting disclosure obligations to "hospitals paid under the Medicare

IPPS"—not that HHS's old interpretation was too narrow. 84 Fed. Reg. at 65,535. And the Rule noted "feedback that our current guidelines" are insufficiently informative, without revealing *how* those guidelines interpreted section 2718(e). *Id.* at 65,544.

Given the Rule's refusal to acknowledge that HHS for nearly a decade equated "standard charges" with gross charges alone, the government's assertion (at 34-35) that HHS "considered" the "reliance interests" from its prior interpretation is baffling. The Rule never mentions reliance interests, let alone cites them as the basis for delaying the Rule's effective date. *Cf.* U.S. Br. 34-35. HHS long interpreted section 2718(e) as a limited disclosure regime. Hospitals responded by investing in one-on-one patient counseling and other tools. *E.g.*, A189, A305; AHA Br. 12. The APA required HHS to consider hospitals' reliance interests before whipsawing hospitals with an unprecedented data-disclosure mandate. HHS's "scant explanation and casual disregard for its former position" render its new interpretation arbitrary and capricious, and unworthy of *Chevron* deference. *Music Choice v. Copyright Royalty Bd.*, 2020 WL 4782379, at *8 (D.C. Cir. Aug. 18, 2020); *see Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020); *Encino Motorcars v. Navarro*, 136 S. Ct. 2117, 2125-26 (2016).

Finally, HHS receives no *Chevron* deference because the President, not HHS, prescribed HHS's interpretation of "standard charges." AHA Br. 43-44. Whether HHS's plans to reinterpret "standard charges" pre-dated the Executive Order or incorporated comments is irrelevant. U.S. Br. 35-36. The Executive Order *required* HHS's proposal that "standard charges" must "in-clud[e] charges and information based on negotiated rates and for common or shoppable items and services." A75. HHS does not contest that, by dictating the Proposed Rule's interpretation of "standard charges," the Executive Order constrained HHS's choices in the Final Rule. AHA Br. 44.

The government (at 36) expresses incredulity that *Chevron* might not apply to presidentially-proposed agency interpretations. But when Congress delegates authority to fill statutory gaps to an agency, only the agency's interpretations—those "promulgated in the exercise" of the agency's "delegated authority"—receive deference. *United States v. Mead Corp.*, 533 U.S. 218, 226-27 (2001); *see* AHA Br. 43. "[I]t is the expertise of the agency, not its lawyers"—or anyone else in the Executive Branch—"that underpins *Chevron*." *Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 920 F.3d 1, 22 (D.C. Cir. 2019) (citation omitted). The government's citations do not show otherwise. *Public Citizen v. Burke*, 843 F.2d 1473 (D.C. Cir. 1988), declined to

"decide … whether … deference should not be afforded because the interpretation is not truly that of the [agency]." *Id.* at 1478. And *Chevron* states that "an agency to which Congress has delegated policy-making responsibilities may … properly rely upon the incumbent administration's views of wise policy to inform its judgments"—not that the administration can claim deference when substituting the agency's judgment with its own. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 865 (1984).

II. THE RULE VIOLATES THE FIRST AMENDMENT

The Rule's compelled disclosure of an enormous amount of misleading and confusing speech violates the First Amendment. AHA Br. 44-51.

1. The government does not dispute that HHS's Rule dictates the content of hospitals' speech, that content-based speech regulations generally trigger strict scrutiny, or that the Rule would flunk strict scrutiny. Nor could the Rule pass intermediate scrutiny in light of the less-speech-restrictive alternatives HHS disregarded. AHA Br. 50-51.

The government (at 50) instead argues strict scrutiny applies only to speech restrictions. But the First Amendment protects "both the right to speak freely and the right to refrain from speaking at all," *Janus v. Am. Fed. State, Cnty. & Mun. Emps.*, 138 S. Ct. 2448, 2463 (2018) (invalidating content-

based compelled-speech mandate). Nor do recent Supreme Court precedents center on non-commercial speech. *Cf.* U.S. Br. 50. *Barr v. Am. Ass'n of Pol. Consultants, Inc.*, 140 S. Ct. 2335 (2020), for instance, applied strict scrutiny to a provision involving government debt-collection efforts. *Id.* at 2346-47 (plurality op.). That the case "primarily involve[d] commercial regulation," *id.* at 2358 (Breyer, J., concurring in the judgment and dissenting in part), did not preclude strict scrutiny.

2. The government radically misconstrues *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985). The government (at 49) contends that *any* factual disclosure inherently advances the government's interest in providing consumers with more information. The government (at 51) demands deference to agencies' justifications. And the government (at 52-53) claims that compelled speech is *never* "unjustified or unduly burdensome" unless speakers must showcase a government-drafted message or relinquish space on existing labels or billboards.

Precedent forecloses that Orwellian view. HHS cannot support a disclosure with a "circular" interest in informing consumers that "any and all disclosure requirements" would fulfil. *Am. Meat Inst. v. U.S. Dep't of Agric.*, 760

F.3d 18, 31 (D.C. Cir. 2014) (en banc) (Kavanaugh, J., concurring in the judgment). The government cannot lean on deference to its predictive judgments; HHS must offer more than "purely hypothetical" or "speculat[ive]" justifications. *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2367 (2018) (*NIFLA*); *Nat'l Ass'n of Mfrs. v. SEC*, 800 F.3d 518, 526 (D.C. Cir. 2015). Further, the government cannot impose whatever burdens it wants just by requiring wholly *new* content. That view would give the government free rein to compel parties to create new websites consisting of millions of words, and would let the government freely pick between equally effective disclosure regimes costing speakers wildly different amounts. And, "[e]ven under *Zauderer*," a disclosure may "extend no broader than reasonably necessary," *i.e.*, HHS must account for less-restrictive alternatives to its burdensome regime. *NIFLA*, 138 S. Ct. at 2377; *see* AHA Br. 49-51.

3. HHS's Rule does not reasonably relate to HHS's price-transparency interests, and imposes unwarranted and unnecessary burdens on hospitals.

a. The government fails to show the Rule's particular disclosures are "reasonably crafted" to accomplish its asserted interests in price transparency and reduced healthcare costs. *Am. Meat*, 760 F.3d at 26. The government's constant refrain (at 2, 3, 24-25, 37-39, 42, 51) is that some additional disclosure

is better than nothing. *Accord* PatientsRightsAdvocate.Org Br. 5-6, 21-22, 27. But that observation would apply to any informational disclosure, no matter how ineffectual. And while the government (at 24) emphasizes the importance of telling consumers their out-of-pocket costs "in advance," HHS acknowledged that the Rule is not "sufficient by itself" to tell many patients their out-of-pocket costs. 84 Fed. Reg. at 65,528-29.

The Rule's disclosures also would be misleading, and thus fall outside *Zauderer*. AHA Br. 48-49; *see* Chamber Br. 24-25. Negotiated rates change constantly as different plans change, so the required rates would often be outdated. The government's response (at 41-42)—that hospitals could list the "last update[d]" date, and that semi-recent rates are better than nothing—is false for patients who look at the disclosure, see that their plan covers an item, and have no idea that their insurer since ceased coverage.

The Rule also misleadingly requires the "many hospitals" without preset cash-discounted prices to list their gross charges as "cash price discounts." 84 Fed. Reg. at 65,553. Doing so would falsely convey that hospitals do not make significant financial accommodations for uninsured, cash-paying patients of limited means, threatening to "deter [them] from accessing the

healthcare that they require." A475; *see* AHA Br. 49; Chamber Br. 25. Further, the Rule compels misleading speech about whether an insurer covers a particular item (like an X-Ray) that is bundled with a procedure (like setting a fracture). The government (at 48) says hospitals must report "not applicable" as the negotiated rate for X-Rays under that plan—which would mislead insured patients into thinking X-Rays are not covered. The government's response (at 42) that hospitals could add "additional explanations or disclaimers" exacerbates the Rule's First Amendment burdens, AHA Br. 49, and is unworkable, *infra* p. 26.

b. HHS failed to show that the Rule does not "unduly burden[]" speech. *NIFLA*, 138 S. Ct. at 2377. Complying with the Rule's mandate to disclose millions of proprietary rates is impossible in many instances and invariably costly. *Infra* pp. 24-29; AHA Br. 16-18; State Hosp. Ass'ns Br. 23-28. The government (at 53) dismisses these costs as irrelevant, but forcing hospitals to produce a ten-word disclosure costing $10 vastly differs from a ten-million-entry spreadsheet costing $1,000,000.

HHS also bypassed many less-restrictive alternatives, and thus compels more speech than "reasonably necessary." *NIFLA*, 138 S. Ct. at 2377; *see* AHA Br. 50-51; HFMA Br. 25-29; State Hosp. Ass'ns Br. 24. Take HHS's

shoppable-services requirement, which (though plagued by other issues, *infra* p. 29) compels less speech than does HHS's spreadsheet mandate, while (in the government's telling, at 32, 43) providing the information "average patients" would use. The government also has no response to why the state transparency exemplars that HHS touts are not less-restrictive alternatives. AHA Br. 51. If those States were as successful as HHS claims, the Rule's added burdens are unreasonable. Likewise, States' ability to develop effective "price transparency comparison tool[s]" without requiring broad disclosures of negotiated rates shows the Rule is not necessary to facilitate those tools. 84 Fed. Reg. at 65,549; AHA Br. 12, 50-51; State Hosp. Ass'ns Br. 24. And if state initiatives are inadequate, HHS's reliance on those regimes to prove the Rule's efficacy fails.

The government (at 48-49) says HHS's insurer-disclosure rule is no alternative because section 2718(e) requires disclosures from hospitals. But that rule shows that HHS's interpretation of "standard charges" to encompass negotiated rates is unnecessary and overbroad; the insurer rule would already require insurers to disclose those negotiated rates and provide patients with out-of-pocket estimates. 84 Fed. Reg. at 65,469-70.

III. THE RULE IS ARBITRARY AND CAPRICIOUS

1. The Rule is arbitrary and capricious because HHS did not meaningfully address hospitals' compliance concerns. AHA Br. 52-58.

a. HHS's Rule failed to address objections that HHS's misapprehension of hospital contracting and billing made compliance with the Rule impracticable, and often impossible.

Many insurer-negotiated rates depend on the care patients receive, and thus cannot be disclosed in advance as a fixed amount. AHA Br. 53-56; State Hosp. Ass'ns Br. 23-28; HFMA Br. 17-19. Consider someone trying to comparison-shop for X-Rays. One plan might pay per X-Ray. Another might pay hospitals per visit, so the actual rate *per X-Ray* is unknown in advance. If one plan offers $300 per X-Ray and the other offers a per-visit price of $500, the latter might be the lower-cost option for five X-Rays, but the higher-cost option for one. Similarly, contracts often provide that insurers will pay hospitals the lesser of gross charges or the negotiated rate, depending on the patient's treatment. HHS never addressed how hospitals should resolve those problems in producing spreadsheets that HHS envisioned would compile fixed amounts in each data cell. *See* 84 Fed. Reg. at 65,558 & tbl.1.

The government offers no response, either, even though negotiated rates tied to actual care are ubiquitous. AHA Br. 17, 52-54; *see* A191, A208-09, A254, A365, A396, A456, A505, A537-38. Should hospitals risk civil penalties by omitting those rates? Should hospitals instead list math formulae? Must hospitals manually flag every instance of the problem within multi-million-entry spreadsheets (a massive added cost HHS ignored)? The government's silence speaks volumes given that this problem magnifies the Rule's burdens and decimates its benefits.

HHS's Rule also ignored a related problem: many insurer-negotiated rates are not per item or service, but instead fold multiple items and services into bundled rates for a particular procedure (*e.g.*, colonoscopy). AHA Br. 55-56; *e.g.*, A425, A479, A491, A537. While one plan might have a fixed amount for an X-Ray, another might have no per-item X-Ray rate at all. The government (at 48) now says hospitals should just list "not applicable" as the X-Ray rate for that latter plan. But HHS did not say this in its Rule, and the government's *post hoc* answer would misleadingly convey that the plan does not cover X-Rays at all. *Supra* p. 22. The government (at 42) suggests hospitals could reduce confusion by explaining the bundled rates in the spreadsheet for the thousands or millions of entries affected by this rampant problem. How?

HHS's spreadsheet-formatting requirements require disclosure of raw "standard charge" figures in machine-readable cells. *Cf.* 84 Fed. Reg. at 65,557 (rejecting "long text descriptions" of disclosed billing codes because they are burdensome and "not easily formatted into a machine-readable file").

Further, HHS ignored the immense difficulty with determining negotiated rates for "identifiable groups of paying patients," as the Rule requires. *Id.* at 65,537. To arrive at those rates, hospitals must manually cull their contracts to identify each variable (location, inpatient versus outpatient setting, plan, etc.) and run each permutation to define a particular subpopulation. Take the simplified example involving just three variables (location, inpatient or outpatient care, and the specific insurer plan) that affect negotiated rates for X-Rays. *See* AHA Br. 9 n.2. For a hospital with three locations and an insurer with ten benefit plans, that single X-Ray would produce 60 different negotiated rates. Such rates cannot be "found" in or "compile[d]" from hospital systems, "contracts," "rate tables," or "rate sheets," as HHS inexplicably insists, *e.g.*, 84 Fed. Reg. at 65,534-35, 65,539, 65,546, 65,550-51, 65,559, 65,595, 65,597, nor are they "house[d]" anywhere in hospitals' systems, U.S. Br. 45; *see* A317-18, A357, A384, A390, A471.

The government (at 47) dismisses these compliance nightmares as "difficult to understand," but therein lies the problem: HHS persistently misapprehends what negotiated rates entail. HHS never even identified the variables involved in insurance contracts, and has no idea how many rates each item or service might produce. HHS's ludicrous assertion that hospitals could avoid compliance headaches by requesting "electronic versions" of insurer contracts proves the point, AHA Br. 54; the government offers no defense. HHS's cursory acknowledgement that "hospitals and payers utilize a variety of payment methodologies," and may "house their charge information in disparate systems," U.S. Br. 45, did not discharge HHS's obligation to "actually consider[]" these concerns. *Gresham v. Azar*, 950 F.3d 93, 103 (D.C. Cir. 2020).

b. HHS's faulty grasp of compliance challenges led HHS to grossly underestimate the Rule's burdens. HHS dismissed the compliance difficulties for the spreadsheet as "minimal," estimating that the shoppable-services list would consume "most of the effort." 84 Fed. Reg. at 65,595, 65,597. HHS thus estimated an average, first-year cost-of-compliance of just 150 hours and $11,898 per hospital. *Id.* at 65,597.

Neither the Rule nor the government's brief address many identified flaws with that paltry estimate. HHS's estimate did not account for the Rule's

exponential compliance burdens for multi-hospital systems, which must create their own spreadsheets and shoppable-services lists for *every* location. AHA Br. 55. HHS inaccurately assumed that "some hospitals are already compiling and reporting similar data to meet State price transparency requirements," 84 Fed. Reg. at 65,593—but States require nothing like the Rule. AHA Br. 12-13, 57; *infra* pp. 30-32. The government never explains how HHS's estimate could be right given that hospitals spent more time and money translating gross-charge data from chargemasters to machine-readable formats than HHS thinks hospitals would spend creating elaborate spreadsheets and shoppable-services lists. AHA Br. 57; A211, A400, A454, A546.

The government (at 2, 16, 46) says HHS and the Healthcare Financial Management Association embraced the same estimates. Not so: the association's estimate did not account for the time physicians and clinicians would spend facilitating compliance, so "d[id] not fully capture the administrative burden." A347. Regardless, HHS did not explain why the association's estimate was more reasonable than hospitals' much higher estimates. The government (at 47) dismisses some estimates as "outliers," but ignores the consensus among hospital commenters that costs would far exceed HHS's projections. AHA Br. 18; *e.g.*, A390-91, A400, A505, A518. The government (at 46)

is wrong that hospitals' higher estimates reflect "hospital systems comprising multiple hospitals." Cleveland Clinic's projected burden of $500,000 to $1,000,000 is still many times HHS's estimate, even divided among Cleveland Clinic's 17 hospitals ($29,400 on the low end, and $58,800 on the high end). A272. The same goes for other hospitals. AHA Br. 18.[2]

The government (at 45-46) lauds HHS's "accommodation[]" of letting hospitals provide online price-transparency tools instead of the 300-shoppable-services list. That point underscores that HHS impermissibly requires multiple lists, *supra* pp. 12-13, and indicts the Rule's premise. Hospitals that offer price-transparency tools already provide what HHS acknowledged was a *more effective* tool than anything the Rule mandates. 84 Fed. Reg. at 65,576. And if hospitals do not offer price-transparency tools, the Rule would require hospitals to undertake the significant costs of developing those tools or the 300-shoppable-services list. AHA Br. 56-57.

[2] A474-76 (Santa Clara Valley's three-hospital system estimates $630,600—$210,200 per hospital—in first-year costs); A195 (Bassett's five-hospital system estimates $500,000—or $100,000 per hospital—in first-year costs); A544-46 (University of Tennessee's single "teaching hospital" estimates $400,000 in first-year costs).

HHS's delay of the Rule's effective date by a year and HHS's marginal increase in the cost estimate are also inadequate. *Cf.* U.S. Br. 45-46. HHS's original notion that hospitals could comply with the Rule in *just one month*, with *just 12 hours* of preparations, 84 Fed. Reg. at 39,630, 65,585, shows HHS's incomprehension of what compliance entails. And a year-long delay is insufficient when hospitals spent much of that year grappling with COVID-19. HHS continues to ignore hospitals' requests for further delay due to the COVID-19 crisis.

The government (at 3, 42, 52) blames hospitals' "opaque" rates for the Rule's burdens. *Cf.* PatientsRightsAdvocate.Org Br. 16-17. But hospitals did not create this system; indeed, Medicare causes much of the complexity. AHA Br. 7-8. The compliance challenges and confusion come from HHS's unprecedented decision to require disclosure of thousands of negotiated rates per item or service—rates that often cannot be calculated in advance, and often do not reflect out-of-pocket costs regardless.

2. HHS unreasonably concluded that the Rule would advance its price-transparency interests. AHA Br. 58-62. HHS admitted that the Rule's effect is "largely unknown." 84 Fed. Reg. at 65,542. And HHS's prediction that the

Rule might help consumers and avoid anti-competitive effects rested on inapposite regimes in California, Colorado, Maine, Massachusetts, New Hampshire, and Oregon. *Id.* at 65,526-29, 65,542, 65,544, 65,549-50. *None* requires prospective disclosure of negotiated rates. AHA Br. 12-13, 51, 61. California and Colorado require disclosure of gross charges by hospitals or individualized, out-of-pocket estimates.

The government no longer defends the relevancy of those States' regimes, merely invoking (at 44) New Hampshire and Maine. But these regimes (like Massachusetts and Oregon) rely on insurer data regarding *paid, post-care* claims, which these States present as "aggregated price information" such as median prices. AHA Br. 12-13; SA122, SA125, SA190, SA204. Having insurers disclose what patients paid, or having hospitals or insurers provide individualized out-of-pocket estimates that rely on patient-provided data, avoids the intractable problems with trying to isolate negotiated rates *before* care. HHS's failure to address the inaptness of state regimes that are the centerpiece of HHS's analysis means HHS did not "explain[] the available evidence." *New York v. EPA*, 413 F.3d 3, 31 (D.C. Cir. 2005). HHS (and the government's brief) likewise never acknowledged FTC's and DOJ's concerns

about the anti-competitive effects of broad, prospective disclosures of confidential insurer rates. AHA Br. 62; SA120-21, SA213-14.

HHS also conceded that the Rule will often not give patients what they want—*i.e.*, an estimate of their out-of-pocket costs. 84 Fed. Reg. at 65,539. The government (at 37-38) pivots to a narrower justification, asserting that the Rule can be upheld "[e]ven if [it] helps only" patients who are self-pay or who have high-deductible-health-plans. The Rule would not help self-pay patients, though, given the incomplete, misleading nature of its cash-price-discount requirement. *Supra* pp. 21-22. As for high-deductible-health-plan patients, even assuming that such patients pay the negotiated rate out-of-pocket, the Rule would not reveal these patients' out-of-pocket costs in the many instances where negotiated rates depend on the care actually received. Nor could these patients determine if paying in cash would be cheaper. Patients looking at hospitals' listed discounted-cash prices would often see hospitals' gross charges, not realizing that hospitals offer individualized discounts that the Rule does not capture.

The government (at 39) urges deference to HHS's conclusion that a "first step" is better than nothing. But HHS's mandate misinforms consumers, and undercuts the better steps that hospitals (encouraged by HHS's prior

interpretation of section 2718(e)) have undertaken to develop price-transparency counseling tools. AHA Br. 12, 60-61; *supra* p. 16.

3. Finally, HHS arbitrarily failed to acknowledge the Rule's departure from HHS's longstanding interpretation of section 2718(e) as requiring disclosure of gross charges only, as well as the reliance interests that position engendered. *Supra* pp. 15-16.

CONCLUSION

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

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AUGUST 28, 2020

CERTIFICATE OF COMPLIANCE
WITH TYPEFACE AND WORD-COUNT LIMITATIONS

I, Lisa S. Blatt, counsel for appellants and a member of the Bar of this Court, certify, pursuant to Federal Rule of Appellate Procedure 32(g)(1), that the attached Reply Brief of Appellants American Hospital Association et al., is proportionately spaced, has a serif typeface of 14 points or more, and contains 6,488 words.

/s/ Lisa S. Blatt
LISA S. BLATT
Counsel for Appellants

AUGUST 28, 2020

CERTIFICATE OF SERVICE

I, Lisa S. Blatt, counsel for appellants and a member of the Bar of this Court, certify that on August 28, 2020, a copy of the attached Reply Brief of Appellants American Hospital Association et al., was filed with the Clerk through the Court's electronic filing system. I further certify that all parties required to be served have been served.

/s/ Lisa S. Blatt
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AUGUST 28, 2020