IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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, and BOTHWELL REGIONAL HEALTH CENTER, *Plaintiffs*, v. ALEX M. AZAR II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, *Defendant*.	Civil Action No. 1:19-cv-3619-CJN

REPLY IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT
AND
PLAINTIFFS' OPPOSITION TO DEFENDANT'S
MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

This is a straightforward case. In the Medicare statute, Congress mandated that hospitals publish a list of "*standard charges* for items and services provided by the hospital." 42 U.S.C. § 300gg-18(e) (emphasis added). That requirement is unambiguous: Hospitals must disclose a list of their regular charges for the items and services they offer. CMS cannot rely on that provision as statutory authority to mandate disclosure of *non-standard* payment rates privately negotiated with various insurers.

The Government's primary argument in response, in contrast, is anything but straightforward. It goes something like this. The statute references diagnosis-related groups (DRGs) established under Medicare as among the "items and services" for which "standard charges" are to be disclosed. And while hospitals bill their standard chargemaster (*i.e.*, list price) charges even for items and services grouped together into Medicare DRGs, some hospitals also separately negotiate payment rates for grouped services with private insurers. The Government concludes that Congress therefore *must* have intended to reach beyond "standard charges" to encompass negotiated payment rates in the definition of "standard charges." That is a gymnastical effort, but not a sound one. The statute makes clear that the only charges that must be disclosed are "standard" ones—whether for individual items and services or for grouped items and services. And the standard charge, whether for individual items and services or for DRGs, is the chargemaster. (In any event, even to the extent that the statute could be read to address what payers actually pay rather than what hospitals "charge," it does so only for Medicare, which does not negotiate payment amounts.)

The Government's other arguments fare no better. Even in its litigation brief, the agency still cannot explain why forced disclosure of the confidential prices commercial health *insurers* will pay for specific services would put knowledge into patients' hands about *their own* out-of-

pocket costs. As a result, the Final Rule fails all forms of First Amendment scrutiny, as well as arbitrary and capricious review.

I. THE FINAL RULE EXCEEDS CMS'S STATUTORY AUTHORITY.

A. "Standard Charges" Means Standard Charges.

Section 2718(e) of the Public Health Service Act requires disclosure of hospitals' "standard charges." Pub. L. No. 116-94, § 2718, 133 Stat. 2534 (Dec. 20, 2019) (codified at 42 U.S.C. § 300gg-18(e)). "Standard charges" means just that: the customary, regular, or normal price for an item. A "standard charge" is not an individualized or privately negotiated price. The statutory text at issue here forecloses the Government's interpretation of its statutory powers. Pls.' Br. at 11–16.

In response to that simple argument, the Government offers a complicated one: It contends that notwithstanding the plain meaning of "standard charges," Congress must have intended that phrase to include non-standard, payer-specific rates based on the fact that the statute requires disclosure of standard charges for Medicare DRGs. Gov. Br. at 11–21. The Government's argument rests on both a flawed reading of Section 2718(e) and a misunderstanding of how hospitals charge for patients whose insurers pay for care based on DRG groupings.

1. *"a list of the hospital's standard charges for items and services provided by the hospital"*

We begin, as always, "with the plain language of the statute." *United States v. Braxtonbrown-Smith*, 278 F.3d 1348, 1352 (D.C. Cir. 2002). And so we start with the basic statutory text at issue: Section 2718(e) requires hospitals to publish "a list" of their "standard charges for items and services provided by the hospital." 42 U.S.C. § 300gg-18(e). As noted in Plaintiffs' opening brief, "standard" means usual, customary, or regular, especially for purposes

of comparison.[1] And a "charge" is the fee demanded for an item or service.[2] Taken together, a "standard charge" is akin to a "list price"—the default or base price for an item or service from which non-standard prices may vary. Pls.' Br. at 11–12.

A standard charge is *not* the amount privately negotiated between two specific parties. For example, if you walk into a restaurant, the regular price you might pay for a sandwich—*i.e.*, the "standard charge"—might be $15. But the restaurant may agree to supply hundreds of sandwiches for a community service event at $13 each. That price is not "standard." It is a tailored rate negotiated between two specific parties.

Hospitals do not trade in sandwiches (quite the contrary), but they do publish a menu—the chargemaster—listing items and services along with each item's "standard charge," or list price. Hans B. Christensen et al., *The Only Prescription is Transparency: The Effect of Charge-Price-Transparency Regulation on Healthcare Prices*, Chicago Booth Research Paper No. 14-33 (Feb. 21, 2019), AR 6733. A hospital's chargemaster lists the standard charge for individual items and services offered by the hospital. *See* Price Transparency Requirements, 84 Fed. Reg. 65,524, 65,539 (Nov. 27, 2020) (to be codified at 45 C.F.R. pt. 180) (the "Final Rule" or the "Rule"). Thus, a hospital's chargemaster contains the default charges Congress intended hospitals to disclose under Section 2817(e). From that menu of base prices, hospitals and insurers are able to negotiate tailored payment rates for items and services that account for payer-specific variables. *See* Christensen, *supra*, at AR 6733 (explaining the difference between the hospital's "charge"—described as an "initial list price"—and the reimbursement amount

[1] *See Standard*, Merriam-Webster (2019) ("regularly and widely used, available, or supplied"); *Standard*, Oxford English Dictionary (2019) ("[h]aving the prescribed or normal size, amount, power, degree of quality, etc.").

[2] *See Charge*, Merriam-Webster (2019) ("the price demanded for something"); *Charge*, Oxford English Dictionary (2019) ("The price required or demanded for service rendered, or (less usually) for goods supplied.").

negotiated separately with payers). Those insurer-specific rates are not "standard." Like the $13 sandwiches, they vary from the "standard charge" based on private negotiations.

The Government suggests that hospitals' chargemaster charges cannot be "standard" because patients often pay a different, lower rate. *See* Gov. Br. at 15. But the same is true when consumers purchase cars. Some customers pay the list price, but many negotiate for a lower price. Nevertheless, the list price is the "standard charge"—the default, common price—while the various negotiated prices are individualized based on payer-specific factors. A "charge"—the fee demanded for an item or service—is not necessarily the same as the ensuing payment.[3] And contrary to the Government's argument, Gov. Br. at 17, the word "standard" demands something other than the individualized amounts negotiated by specific insurers that show up on plan-specific rate sheets. "Standard" means the charge must apply *across* groups of insurers and patients, not solely within them.[4]

Indeed, CMS itself has long held the same view about the meaning of "standard charges." As Plaintiffs pointed out in their opening brief, the agency previously instructed hospitals that to comply with Section 2718(e), "hospitals could choose the format they would use to make public a list of their standard charges," but "the publicly posted information should represent their *standard charges as reflected in the hospital's chargemaster*." Medicare Program, 84 Fed. Reg. 39,398, 39,572 (proposed Aug. 9, 2019) (the "Proposed Rule") (emphasis added); *see* Medicare Program, 83 Fed. Reg. 41,144, 41,686–87 (Aug. 17, 2018) (explaining that CMS did not then require "that any information be published in a payer-specific manner" and reiterating the agency's prior reading of Section 2718(e) that hospitals are required to make public a list of their

[3] *See Payment*, Merriam-Webster (2019) ("something that is paid"); *Payment*, Oxford English Dictionary (2019) ("[a] sum of money (or equivalent) paid or payable, esp in return for goods or services or in discharge of a debt").
[4] *See also* 42 U.S.C. § 300gg-18(e) (requiring publication of "a list," not multiple lists).

"standard charges (whether that be the chargemaster itself or in another form of their choice)."); Pls.' Br. at 13.

The "standard charge" referenced in the statute, then, is quite plainly the basic "list price" included on the chargemaster.

2. "including for diagnosis-related groups established under [Medicare]"

The Government's statutory argument is premised on its assertion that the clause that follows the key text at issue—"including for diagnosis-related groups established under [Medicare]"—changes the plain meaning of the term "standard charges." The Government suggests that, because Section 2718(e) references DRGs as "includ[ed]" among the "items and services" for which hospitals must show their "standard charges," and because hospitals *also* sometimes privately negotiate payment rates with commercial insurers for DRGs, that must mean that Congress intended to require disclosure of all privately negotiated payment rates. *See* Gov. Br. at 12–13, 18–20. That is simply wrong.

To begin with, DRGs are not themselves "charges."[5] They are a classification system for inpatient charges that bundle the services provided to the patient into a single unit for payment purposes.[6] Now look at the disputed phrase in the context of the statute:

> Each hospital operating within the United States shall . . . make public . . . a list of the hospital's standard charges *for items and services* provided by

[5] CMS wrongly conflates the two. *See* Gov. Br. at 16 (criticizing the court in *Brown v. Blue Cross & Blue Shield of Michigan, Inc.*, No. 94-CV-75033-DT, 1996 WL 608546, at *1 (E.D. Mich. Sept. 16, 1996), *vacated*, No. 94-CV-75033-DT, 1997 WL 858746 (E.D. Mich. Jan. 23, 1997), for allegedly misunderstanding "Congress's decision to include DRGs as 'standard charges'"). In fact, the court in *Brown* correctly distinguished between *payments* using a DRG methodology and hospital's *standard charges*. 1996 WL 608546, at *1.

[6] HHS, Medicare Hospital Prospective Payment System: How DRG Rates Are Calculated and Updated 5 (Aug. 2001), *available at* https://tinyurl.com/hhswhpa ("A key part of [the Prospective Payment System] is the categorization of medical and surgical services into [DRGs]. The DRGs 'bundle' services (labor and non-labor resources) that are needed to treat a patient with a particular disease.").

> the hospital, *including for diagnosis-related groups* established under section 1395ww(d)(4) of this title.

42 U.S.C. § 300gg-18(e) (emphases added). Based on the plain language of the statute, CMS found in the Final Rule that when Congress referenced DRGs, it was providing an example of the types of "items and services" covered by the statute. *See* 84 Fed. Reg. at 65,534 (describing "the inclusion of DRGs as an item or service" in Section 2718(e) and explaining that the statute "specifically includes items and services grouped into DRGs as an example of the items and services for which hospitals must list their standard charges"). That the statutory requirement may extend to standard charges for *groups* of "items and services" does not alter the meaning of "standard charges."

The Government's sleight-of-hand—its transmogrification of "standard charges" for "DRGs" into "negotiated charges" for everything—rests on the fact that hospitals sometimes negotiate payment rates for DRGs with commercial insurers. Gov. Br. at 10, 12–13. True. And also irrelevant. Hospitals also frequently negotiate payment rates for *individual* items and services with commercial insurers, just like they do for DRGs. Christensen, *supra*, at AR 6733–34. That they do so does not mean that such negotiated rates are subsumed within the statutory phrase "standard charge." Other than the fact that both concepts have the word "DRG" in them, there simply is no connection between the statutory reference to DRGs and the unrelated fact that hospitals sometimes negotiate payment rates with insurers for services included in payments based on DRGs.

Returning to the restaurant analogy: DRGs are like combo meals. They bundle commonly linked items into a distinct menu item with its own list price. Insurers may negotiate a tailored payment amount for DRGs, just as they do for individual items and services, but those negotiated rates are still not "standard." Imagine a restaurant agreeing on a discounted price on a

boxed lunch (containing a sandwich, chips, and an apple) for volunteers at a community service event. Those discounted prices are no more "standard charges" than the privately negotiated price for each individual sandwich. The standard charge for a boxed lunch combo meal is what is printed on the menu.

In fact, when hospitals *charge* for DRGs, they do not use the negotiated rate. They bill for each item and service used during the patient's hospital stay based on the total *chargemaster* charges associated with the provided items and services, just as the hospital would in a fee-for-service system. The payer simply pays the negotiated DRG amount. AR 3406 (Indiana Hospital Association comment letter noting that, "[w]hile it is true that some payers negotiate and pay on a packaged basis, the hospitals do not bill those payers any differently than they bill all other payers or self-insured individuals. In fact, it would be illegal to do so."); *see also* CMS, Provider Reimbursement Manual Ch. 22, § 2204 ("The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients . . .")[7]; Form CMS-1450 (Entry 47 requires hospitals to include total charges, *i.e*., the chargemaster rate, when it submits Medicare claims)[8]; AR 1441, 2433; Christensen, *supra*, at AR 6733.

So, for example, if a patient has an appendectomy, the hospital will charge the insurer (whether Medicare or a private payer) the chargemaster price for each item and service utilized—bed and board, operating room time, supplies, etc. Insurers may *reimburse* hospitals for a DRG at an amount different from the "standard charge," and in some cases that reimbursement amount may be negotiated between the hospital and a third-party. But that is not

[7] *Available at* https://tinyurl.com/wew3nu8.
[8] *Available at* https://tinyurl.com/yx6zq9g2.

a standard *charge*. The payment rates negotiated between hospitals and insurers are thus immaterial to Section 2718(e)'s disclosure requirements.[9]

And even if CMS were somehow correct that "standard charges" for DRGs could be read to refer to what is paid rather than what is charged, *see* Gov. Br. at 13, the relevant payment rates—based on both the plain language of the statute and its legislative history—would be those paid by *Medicare*, not private insurers, *see* 42 U.S.C. §300gg-18(e) (referring specifically to "diagnosis-related groups *established under section 1395ww(d)(4) of this title*" (emphasis added)); *see also* S. Rep. 111-89, at 62 (2009) ("each hospital operating within the U.S. [will] establish (and update) a list of its standard charges of items and services it provides, including each diagnosis-related group included *under Medicare*" (emphasis added)). And Medicare payment rates are not negotiated in any sense of the word. Medicare reimburses hospitals for inpatient hospital services based on a standard formula imposed by CMS. *See* Christensen, *supra*, at AR 6733 ("Importantly, DRG payment rates are predetermined by the government based on cost data submitted by the hospital and inflation, and therefore are not subject to individual negotiation."); *see also Billings Clinic v. Azar*, 901 F.3d 301, 303–305 (D.C. Cir. 2018) (detailing Medicare's complex prospective payment system). After the agency's number crunching runs its course, hospitals are left with a take-it-or-leave-it reimbursement amount from Medicare for each DRG. And only some hospitals at that—more than one quarter of acute care

[9] Although CMS admits that it has not required the majority of hospitals to comply with this "standard charges for items and services . . . including for DRGs" portion of the statute, 84 Fed. Reg. at 65,535, this is also consistent with how many hospitals have interpreted the mandatory disclosure obligations under Section 2718(e), *see* AR 1736 (comment from a healthcare finance consultant explaining that a list of standard charges for Medicare-established DRGs "presumably would be an average of the individual items and services paid via the [Medicare Severity]-DRGs"); *see also* AR 1441 (comment letter from Tampa General Hospital suggesting that "[g]ross charge averages could be provided for all [Medicare Severity-]DRGs")..

hospitals are not paid by Medicare under DRGs.[10] Thus, even if Section 2718(e) could be read to refer to the Medicare rates for DRGs, it would not require hospitals to *also* disclose non-standard rates privately *negotiated* with specific insurers for those same DRGs, let alone *all* negotiated charges for *all* items and services.

Not only does CMS's position rest on a crabbed reading of "standard charges" and a muddled theory about DRGs, it also requires this Court to assume that Congress did through silence what elsewhere it has made express. "Congress . . . does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Assocs.*, 531 U.S. 457, 468 (2001). As Plaintiffs' opening brief explained, Congress knew how to require the disclosure of insurer-specific information when it saw fit. Pls.' Br. at 14 (citing 48 U.S.C. § 18031(e)(3)(A)(vii) and 42 U.S.C. § 1320a-7h). The Government does not argue otherwise. "[Courts] do not lightly assume that Congress has omitted from its adopted text requirements that it nonetheless intends to apply, and [their] reluctance is even greater when Congress has shown elsewhere in the same statute that it knows how to make such a requirement manifest." *Jama v. Immigration & Customs Enf't*, 543 U.S. 335, 341 (2005).

* * *

We end where we began, with the plain language of the statute. Section 2718(e) requires disclosure only of "standard charges." That term must mean that there are some *non*-standard charges hospitals need not disclose. But CMS proposes to require hospitals to disclose their gross charges, cash discount charges,[11] payer-specific negotiated rates, and de-identified

[10] *See* MedPac, Hospital Acute Inpatient Services Payment System (Oct. 2019), *available at* https://tinyurl.com/tjx3mqb.

[11] "Cash" or "cash discount" includes cash and other self-pay equivalents. *See* 84 Fed. Reg. at 65,553 ("[W]e are finalizing a definition of cash discounted price to mean the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.").

minimum and maximum payer-specific negotiated rates. What is left? The Government's capacious interpretation of Section 2718(e) purports to morph the term "standard charges" into "all charges." But "standard" does not mean "all." Certainly Congress did not mean to impose such a burdensome requirement so opaquely. Rather, Congress said what it meant. Hospitals must disclose their "standard"—customary and regular—charges. Because the Final Rule requires disclosure of not only a hospital's "standard charges," but also commercially sensitive negotiated prices, the Final Rule exceeds the unambiguous limits set by Congress in Section 2718(e). CMS simply "may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'" *FDA v. Brown & Williamson Tobacco Corp*., 529 U.S. 120, 125 (2000) (quoting *ETSI Pipeline Project v. Missouri*, 484 U.S. 495, 517 (1988)).

B. CMS's Interpretation Of "Standard Charges" Is Not Entitled To Deference, And In Any Event, Far Exceeds The Scope Of Any Ambiguity.

The Government argues that the agency's interpretation of "standard charges" to mean "non-standard charges" is entitled to *Chevron* deference. Wrong, for two reasons.

First, *Chevron* deference is inappropriate here because the statutory interpretation endorsed by the Government is wholly grounded in the Executive Order, not the agency's own independent decision-making. To be clear: The problem is not just that the executive branch sought price transparency in the abstract, as the Government suggests. Gov. Br. 22. The problem is that the Executive Order prescribed the very definition of "standard charges" that the agency adopted in the Final Rule.[12]

[12] *Compare, e.g.*, 84 Fed. Reg. at 65,542, *with* Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First (June 24, 2019), *available at* https://tinyurl.com/y433hmhn.

Chevron is rooted in the presumption that agencies may utilize their experience and expertise to fill legislative gaps. *See City of Arlington v. FCC*, 569 U.S. 290, 296 (2013). And *Chevron* deference, when it happens at all, is triggered when an agency exercises discretion under a congressional delegation of authority. "*Chevron* is rooted in a background presumption of congressional intent: namely, that Congress, when it left ambiguity in a statute administered by an agency, understood that the ambiguity would be resolved, first and foremost, *by the agency*." *Id.* (internal quotation marks omitted) (emphasis added). Indeed, "practical *agency* expertise is one of the principal justifications behind *Chevron* deference." *Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 651–52 (1990) (emphasis added). "The fair measure of deference to an agency administering its own statute has been understood to vary with circumstances, and courts have looked to the degree of the *agency's* care, its consistency, formality, and *relative expertness*, and to the persuasiveness of the agency's position." *United States v. Mead Corp.*, 533 U.S. 218, 228 (2001) (footnotes omitted and emphases added). An agency's interpretation of a statute is not entitled to deference when it flows from an Executive Order.

To hold otherwise would be a shocking expansion of *Chevron* deference (in an era where *Chevron* deference may be shrinking, no less), and would conflict with the "background presumption" that Congress expects *expert agencies* to fill legislative gaps. Nothing in the long history of *Chevron* deference would have put Congress on notice that legislative gaps might be filled through Executive Orders, or that a governmental actor without any expertise in such a complex regulatory area would receive deference in his interpretation of statutes. If Congress were deemed to have ceded its legislative power in such a way, that would amplify the serious separation of powers concerns already surrounding *Chevron*. *See, e.g.*, *Guitierrez-Brizuela v.*

Lynch, 834 F.3d 1142, 1149 (10th Cir. 2016) (Gorsuch, J. concurring) (calling the separation of powers concerns surrounding *Chevron* "an elephant in the room"); *see also* John C. Eastman, *The President's Pen and the Bureaucrat's Fiefdom*, 40 Harv. J. L. & Pub. Pol'y 639, 661–662 (2017) (criticizing the Obama administration's use of executive orders to make specific policies as "simply negat[ing] that most basic of separation of powers principles").

Second, even assuming the foregoing hurdle could be overcome and *Chevron* was deemed to apply, the agency's interpretation fails both steps. The plain language of the statute defeats the Government's argument under *Chevron* Step One; "standard charges" means "standard charges," full stop. *See supra* pp. 2–10. Even under the more deferential standard espoused in *Chevron* Step Two, the agency's expansive interpretation of "standard charges" exceeds the reasonable scope of any fathomable ambiguity in Section 2718(e). Whatever "standard charges" means, it cannot mean "*all* charges," which is essentially what the Government argues.

C. The Statute Does Not Authorize Penalties.

As Plaintiffs explained in their opening brief, CMS also lacks the statutory authority to impose penalties for violations of the Final Rule. The statutory provision authorizing penalties, when viewed in context, does not apply to the disclosure requirement at issue. Pls.' Br. at 16–19.

The Government agrees that only Section 2718(b)(3) provides CMS with statutory authority to impose penalties for violations of the Final Rule. *See* Gov. Br. at 24–27. That provision states: "The Secretary shall promulgate regulations for enforcing the provisions of *this section* and may provide for appropriate penalties." 42 U.S.C. § 300gg-18(b)(3) (emphasis added). But, as previously explained, Section 2718's drafting history makes clear that Congress did not intend for the enforcement language to apply to subsection (e).

During the complicated legislative process that produced the ACA, more than a few details slipped through the cracks. *See King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) (explaining that the "Affordable Care Act contains more than a few examples of inartful drafting"). Section 2718 is a prime example.

Section 2718(b)(3)'s enforcement provision—allowing enforcement of "the provisions of *this section*"—first appeared in separate bills from the Senate and the House that dealt only with reporting Medical Loss Ratios.[13] *See* S. 1730, 111th Cong. § 2(e) (2009); H.R. 3681, 111th Cong. § 2(e) (2009). Meanwhile, the "standard charges" provision originated as a standalone bill in the Senate without any reference to enforcement or penalties. *See* S. 1796, 111th Cong. § 1502(b) (2009); *see also* S. 2786, 111th Cong. § 2718(c) (2009) (amending this language slightly). This history makes clear that Congress intended to attach penalties to certain reporting requirements—medical loss ratios—and not others—the "standard charges" disclosures considered under Section 2718(e). But when the bills merged, the drafters failed to modify the enforcement provision's "section" language to retain the originally intended structure.[14] And while subsections (c) and (d), which first appeared in the standalone "standard charges" bill, may

[13] "Many insurance companies spend a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing." CMS, *Medical Loss Ratio*, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio. Thus, "[t]he Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio," and insurers must "issue rebates to enrollees if this percentage does not meet minimum standards." *Id.*

[14] CMS argues that Plaintiffs introduced their own scrivener's error when they suggested that Congress could have clarified its intent by updating "section" to "subsection." Gov. Br. at 26. But Plaintiffs did not intend to suggest that substituting that term in the enforcement provision was sufficient alone. Instead, Plaintiffs meant to suggest only that using "subsection" would have clarified Congress's intent not to extend the enforcement provision to the section as a whole.

refer to provisions originally from the Medical Loss Ratio bill, Gov. Br. at 26, it does not follow that Congress thus intended to extend the enforcement provision to subsection (e).

The Government claims that the Court should ignore this history. It argues that it is not "unthinkable" that the enforcement section should apply to subsection (e), Gov. Br. at 25, but as Plaintiffs explained in their opening brief, CMS's construction of Section 2718(b)(3) would lead to the extraordinary result that Congress granted CMS authority to penalize the National Association of Insurance Commissioners (NAIC) for failing to establish definitions under subsection (a). NAIC represents state sovereigns, and it works in partnership with Congress and HHS to implement the ACA. It would, in fact, be "unthinkable" that Congress intended to allow CMS to penalize an entity over which Congress granted the agency no authority. Pls.' Br. at 18–19. "[I]nterpretations of a statute which would produce absurd results are to be avoided if alternative interpretations consistent with legislative purpose are available." *Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564, 575 (1982). The Court should decline to read "this section," a relic of inartful drafting, so broadly.

II. THE FINAL RULE VIOLATES THE FIRST AMENDMENT.

As Plaintiffs explained in their opening brief, the Final Rule is also separately unlawful because it violates the First Amendment. Pls.' Br. at 19–27. "For corporations as for individuals, the choice to speak includes within it the choice of what not to say." *Pac. Gas & Elec. Co. v. Pub. Utils. Comm'n of California.*, 475 U.S. 1, 16 (1986). The Final Rule makes that choice for Plaintiffs, and in so doing, violates the First Amendment. That is true under every potentially applicable standard.

As a compelled speech requirement, the Final Rule is subject to strict scrutiny. *See Riley v. Nat'l Fed'n of the Blind of N.C., Inc.*, 487 U.S. 781, 797–798 (1988). In arguing to the contrary, the Government represents without qualification that "[t]he Supreme Court has defined

'commercial speech' to mean 'expression related solely to the economic interests of the speaker and its audience.'" Gov. Br. at 28 (quoting *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of New York*, 447 U.S. 557, 561 (1980)). Not quite. *Central Hudson* was the first case in which the Court articulated that broad description for commercial speech. In all of the cases cited in support of this "economic interests" definition—and elsewhere in *Central Hudson*—the Court employed a narrower definition: "speech proposing a commercial transaction." *Cent. Hudson*, 447 U.S. at 562 (internal quotation marks and citations omitted). Courts and commentators accordingly agree that "the core notion of commercial speech [is] speech which does no more than propose a commercial transaction," *see, e.g.*, *Bolger v. Youngs Drug Prods. Corp.*, 463 U.S. 60, 66 (1983), but much ink has been spilled over the meaning and application of the Government's preferred definition, *see, e.g.*, *Commodity Trend Serv., Inc. v. Commodity Futures Trading Comm'n*, 149 F.3d 679, 684 (7th Cir. 1998); *see also City of Cincinnati v. Discovery Network, Inc.*, 507 U.S. 410, 422 (1993) (declining to endorse the Government's definition); *Nat'l Ass'n of Manufacturers v. S.E.C.* ("*NAM*"), 800 F.3d 518, 523 n.12 (D.C. Cir. 2015) (same).

But even if the Court accepts the Government's argument that the Rule regulates "commercial speech" (and it should not), it fails *Central Hudson*'s intermediate form of scrutiny, too. *See United States v. Philip Morris USA Inc.*, 855 F.3d 321, 327 (D.C. Cir. 2017) (stating requirements). As for *Zauderer*, that applies to only compelled advertisements and point-of-sale disclosures—the Final Rule is neither, but it also fails under this standard. *See NAM*, 800 F.3d at 522, 524. Because the Final Rule does not survive any of the potentially applicable standards, the Court need not decide which applies. *See id.* at 524.

A. The Final Rule Does Not Survive Strict Or Intermediate Scrutiny.

1. The Government's asserted interests are (1) enabling consumers to make more informed decisions about where to seek care based on price, and (2) lowering healthcare costs for consumers. Even accepting that these interests are "substantial," the Final Rule does not directly advance them. *See Cent. Hudson*, 447 U.S. at 564 ("the restriction must directly advance the state interest involved").

As Plaintiffs have explained, transparency about hospitals' negotiated rates is not the same as transparency about out-of-pocket charges. Pls.' Br. at 21–22. Look no further than CMS's own sources. Although the Government claims that "patients want access to *hospital* pricing information," Gov. Br. at 34 (emphasis added), the study it cites in support of that claim reported that 71% of survey respondents wanted "more transparency about *the true costs*" of services, not the negotiated rates between hospitals and insurers, *see* Jon Bees, *Survey Snapshot: Is Transparency the Answer to Rising Health Care Costs?*, New England Journal of Medicine Catalyst (March 20, 2019), AR 4591, 4595; *id.*, AR 4593 ("most patients are only concerned about their out-of-pocket costs").

CMS's sources also undercut its argument that "price transparency" at the *provider level* "is effective at lowering costs in the market for healthcare." *See* Gov. Br. at 32. The CRS Report it cites found that a "California hospital price transparency initiative" similar to the Final Rule "had *negligible or no observable effect* on hospital prices." Congressional Research Service, Does Price Transparency Improve Market Efficiency? (2008), AR 4780 (emphasis added). Other sources cited in the AR demonstrate that price transparency about *out-of-pocket* costs may help lower healthcare costs. *See* Christopher Whaley, et al., *Association Between Availability of Health Service Prices and Payments for These Services*, JAMA (2014), AR 5680 (explaining that the study showed individuals' "*personalized out-of-pocket costs*" based on their

"insurance design, network, and deductible status" (emphasis added)); *see also* Sze-jung Wu et al., *Price Transparency For MRIs Increased Use of Less Costly Providers and Triggered Provider Competition*, HealthAffairs (Aug. 2014), AR 5625–26, 5629 (explaining that when patients were provided with real-time information about their costs, as determined using insurance pre-authorization information, they chose less costly providers). And even assuming *arguendo* that the Final Rule might save consumers some "time and money," "cheapness alone cannot save an arbitrary agency policy," or an impermissible speech restriction. *Judulang v. Holder*, 565 U.S. 42, 64 (2011). "If it could, flipping coins would be a valid way to determine an alien's eligibility for a waiver [of deportation]," *id.*, or a speaker's right to wear a jacket protesting the draft, *see Cohen v. California*, 403 U.S. 15 (1971).

The one consequence of requiring the disclosure of hospitals' negotiated rates that is assured is that it will threaten open and fair competition. Read in full—not cherry-picked, as the Government prefers—Plaintiffs' declarations make that clear. *E.g.*, Smith Decl. ¶¶ 15–16, Dkt. No. 13-2; Klein Decl. ¶ 11, Dkt. No. 13-8; *see also, e.g.*, AR 445, 4464–65; AR 1769–70 (summarizing reports from the Federal Trade Commission); Paul B. Ginsburg, *Shopping For Price In Medical Care*, MarketWatch (Feb. 6, 2007), AR 5266. Plenty of citations in the AR likewise demonstrate that disclosing negotiated rates will have anti-competitive consequences. *See, e.g.*, AR 1653, 4491. In addition, even if the Final Rule decreases *insurers'* costs, there is no guarantee that it will decrease *patients'* costs. Reducing insurance-based revenues will force hospitals to discontinue other cost-lowering initiatives for patients. *E.g.*, Smith Decl. ¶ 16; Wightman Decl. ¶ 9, Dkt. No. 13-6; *see* AR 4465; *see also* AR 1374. And insurers might decide to keep any cost savings for themselves, a task made easier in a less competitive marketplace. *See Ginsburg*, *supra*, at AR 5267 (noting that insurers may view transparency "only as a public

relations requirement," not "an opportunity to meaningfully increase their value to customers"); *see also* supra n. 13. Because the Final Rule fails to directly advance the Government's asserted interests, it fails both intermediate and strict scrutiny.

2. Turning to the tailoring inquiry, the Government is correct that the First Amendment does not require "the perfect to be the enemy of the good." Gov. Br. at 35. But it does require that the purported "good" survive a tailoring inquiry, and this one does not. *See Philip Morris USA Inc.*, 855 F.3d at 327 (to prove a speech requirement is not "more extensive than is necessary," the Government must show "less restrictive means would fail" (internal quotation marks omitted)); *see also McCullen v. Coakley*, 573 U.S. 464, 467 (2014) ("To meet the narrow tailoring requirement . . . the government must demonstrate that alternative measures that burden substantially less speech would fail to achieve the government's interests.").

Perplexingly, the Government contends on page 37 that it has not "identified a narrower alternative" to the Final Rule after admitting on page 8 that, on the same day it published the Final Rule, CMS extended the comment period on a Notice of Proposed Rulemaking proposing a narrower alternative. *See* Transparency in Coverage, 85 Fed. Reg. 276 (proposed Jan. 3, 2020); Transparency in Coverage, 84 Fed. Reg. 65,464 (proposed Nov. 27, 2019). This rule would require "group health plans and health insurance issuers" to disclose information related to an "individual's out-of-pocket expenses." 84 Fed. Reg. at 65,464. That is essentially what Plaintiffs have called for all along. *See, e.g.*, Pls.' Br. 1–2, 21; AR 2553 (AHA comment letter explaining that CMS should work with health plans and other stakeholders to identify mechanisms that will actually allow for the disclosure of out-of-pocket costs to patients); AR 2347 (AAMC comment letter explaining that it is "imperative that CMS engage insurers, who are better positioned to have accurate information about beneficiaries' out-of-pocket

estimates")[15]; *see also, e.g.*, AR 614 (Provider Roundtable comment letter explaining that "insurers are best equipped to handle questions and information regarding what a person's individual out-of-pocket-costs will be for the services in question"); AHA Comment Letter on Transparency in Coverage (CMS-9915-P) (Jan. 28, 2020) (explaining that insurers should not be required to disclose negotiated rates, because such disclosures will not help patients estimate out-of-pocket costs).[16] The new insurer-focused rulemaking also aims to require the disclosure of out-of-pocket costs, which is the (purported) motivation behind the Final Rule at issue here. *See, e.g.*, 84 Fed. Reg. at 65,543 ("When a consumer has access to payer-specific negotiated charge information . . . in combination with additional information from payers, it can help him or her determine potential out-of-pocket cost.").

Separately mandating an out-of-pocket-cost disclosure regime serves CMS's (and consumers') interests without impinging on Plaintiffs'. Allowing patients to determine their actual costs in real time will better inform treatment decisions and permit them to select lower-cost healthcare options. *See* Wu, *supra*, at AR 5625–25, 5629. The agency does not and cannot dispute that negotiated rates do not reflect most patients' out-of-pocket costs—as it acknowledged in the Proposed Rule, over 90% of people "rely on a third-party payer to cover a portion or all of their cost of health care items and services." 84 Fed. Reg. at 39,579. As for high-deductible plans, the Government claims that those patients "*may* be able to determine the full cost of a service just by looking at" the hospital's negotiated rate, Gov. Br. at 35 (emphasis added), but whether that is so necessarily depends on *how much of the deductible* they have already paid. In other words, even patients with high deductibles must consult *both* the applicable negotiated rate *and* their insurance plan *and* do the math to obtain their out-of-pocket

[15] The full text of this comment is available at https://tinyurl.com/ttfb7zy.
[16] *Available at* https://tinyurl.com/sys3s8e.

rate. CMS offers no explanation of why this group of patients will be better off with a rule requiring a hospital to disclose a negotiated rate than one that requires an insurer simply to disclose an out-of-pocket cost.

Requiring insurers to publish out-of-pocket rates would also prevent hospitals from having to choose between defending a breach-of-contract lawsuit for disclosing confidential information or paying a civil penalty for noncompliance with the Final Rule. *See* Wightman Decl. ¶ 8; *see, e.g.*, AR 1933, 2110, 2433–34.[17] Although *amici* for the Government argue that this information is not confidential because patients will see it eventually on their individual explanation of benefits (EOB), that misses the point. *See* Br. of PatientRightsAdvocate.Org, *et al.*, at 18–20, Dkt. No. 23-1 (Feb. 13, 2010); *see also* Gov. Br. at 20–21 (making a similar argument in connection with the statutory argument). An *insurer* is not prohibited from disclosing this information to its customers, but a *hospital* may be prohibited by contract from disclosing this information to the insurer's competitors. *See* Orlowski Decl. ¶ 10, Dkt. No. 13-3; Wightman Decl. ¶ 8; *see, e.g.*, AR 2521, 3677, 4063, 4575.

Moreover, a compilation of data—such as the entire list of a hospital's negotiated charges with all insurers—may be commercially sensitive and deserving of protection even if individual pieces of that data are disclosed to individual people, as is the case with the single price for a single service negotiated with a single insurer that is reflected on a patient's EOB. *See AirFacts, Inc. v. de Amezaga*, 909 F.3d 84, 96 (4th Cir. 2018) ("The fact that individual pieces of

[17] The agency's response to this concern in the Final Rule is no response at all: "[I]t is our understanding that such contracts typically include exceptions where a particular disclosure is required by Federal law." 84 Fed. Reg. at 65,544. The Government does not cite any evidence in support of its purported "understanding," but in any event, the question is whether a different, more tailored disclosure regime would better advance the Government's goals, not whether a technicality might provide Plaintiffs a defense in a breach-of-contract lawsuit based on an overly broad disclosure requirement.

information claimed to be confidential are available to the general public does not defeat a claim of confidentiality if the value of the information stems from its compilation or collection in a single place or in a particular form which is of value." (quoting *Mettler–Toledo, Inc. v. Acker*, 908 F. Supp. 240, 247 (M.D. Pa. 1995)). As the Government has recognized in other contexts, disclosing data piecemeal does not carry the same risks as disclosing an entire "mosaic that, when viewed as a whole, would reveal confidential" information. *See Shapiro v. U.S. Dep't of Justice*, 239 F. Supp. 3d 100, 115 (D.D.C. 2017) (Freedom of Information Act); *see also, e.g.*, Restatement (Third) of Unfair Competition § 39 (1995) (explaining that "it is the secrecy of the claimed trade secret as a whole that is determinative").

The Final Rule also fails the tailoring inquiry because it is unduly burdensome. CMS grossly underestimates the burden the Final Rule will impose on hospitals. It will require hospitals to collate massive amounts of data, and publish and update multiple lists and matrices. As the State Hospital Associations' brief explains, the total dollar cost of compliance for some hospitals "could be as high as $2,000,000 annually." Br. of *Amici Curiae* Thirty-Seven (37) State Hosp. Ass'ns In Support Of Pls.' Mot. For Summ. J. 20, Dkt. No. 25-1 (Feb. 28, 2020); *see also* AR 1534 (comment from Cleveland Clinic explaining that complying with an earlier, less involved requirement took "[a] multi-departmental team . . . approximately 4 months"). Furthermore, in resting on raw numbers alone, the Government overlooks the *relative* cost of compliance: Hospitals do not have infinite budgets, and a rule that requires a hospital to take drastic steps to pay the compliance bill—like "slashing staff," "delay[ing] the purchase of new, high tech equipment for patient care," or otherwise diverting "attention away from focusing on the patient experience"—is costly indeed. State Hosp. Ass'ns Br. at 18–20 (internal quotation marks omitted); *see* AR 1375–76; *see also* AR 368 (comment from HomeTown Health LLC,

explaining that this added burden may force rural hospitals to close). That the Final Rule simply requires "information gathering" does not change this reality. For those hospitals that do not have ready access to negotiated rate information, gathering historical data on the patients a hospital has seen, the services rendered, the charges imposed, and the amount collected is still a monumental task. *See, e.g.*, Kaufman Decl. ¶¶ 14–16, Dkt. No. 13-4; *see* AR 788; *see also* AR 644 (comment from Integrated Revenue Integrity listing steps required to comply with this burden). This is not narrow tailoring.

B. *Zauderer* Does Not Apply, But The Rule Fails Even That Framework.

Contrary to the Government's claim, *Zauderer* does not apply to this case. But even if it did, the result would be the same: The Final Rule runs afoul of the First Amendment.

1. *Zauderer* informs the "application" of *Central Hudson* in "specific circumstances." *See Am. Meat Inst. v. U.S. Dep't of Agric.* ("*AMI*"), 760 F.3d 18, 26–27 (D.C. Cir. 2014) (en banc). As always, the Government must identify a substantial interest in regulating the speech in question. *See id.* But if the required speech is connected to advertising or a point-of-sale label and conveys "purely factual and uncontroversial information," "absent a showing that the disclosure is unduly burdensome," the Government generally need not do more to demonstrate a "reasonable fit . . . between means and ends." *Id.* (internal quotation marks omitted).

Although the Government claims that *Zauderer* applies to all "compelled commercial disclosures," Gov. Br. at 28, that is not the law of this Circuit or the Supreme Court. As Plaintiffs explained, "by its own terms, *Zauderer* applies only in the context of commercial 'advertising.'" Pls.' Br. at 26; *see Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626, 651 (1985) ("[W]e hold that an *advertiser's rights* are adequately protected as long as [such] disclosure requirements are reasonably related to the State's interest in preventing deception of consumers." (emphasis added)). *AMI* simply determined that "[t]he

language with which *Zauderer* justified its approach" to advertisements *also* "appl[ied]" to a "country-of-origin labeling scheme." 760 F.3d at 22–23. But neither *AMI* nor any other D.C. Circuit or Supreme Court case has held, as the Government intimates, that *Zauderer* applies to all disclosure regimes, or even all disclosure regimes that serve "economic or [consumer] protection benefits." *See* Gov. Br. at 29 (alternation in original) (quoting *NAM*, 800 F.3d at 522).

In fact, *NAM* held the precise opposite: "*Zauderer*, as now interpreted in *AMI*," does not reach "compelled disclosures that are unconnected to advertising or product labeling at the point of sale." 800 F.3d at 522; *see id.* at 524. That is wholly consistent with *AMI*. *See* 760 F.3d at 22–23. Because the compelled conflict-minerals disclosures at issue in *NAM* were neither advertising disclosures nor point-of-sale labels, the court held that even if they qualified as "commercial speech," *Zauderer* did not apply. *NAM*, 800 F.3d at 521–522. And because those disclosure requirements could not survive "even *Central Hudson*'s intermediate standard," the court declined to determine "whether strict scrutiny or the *Central Hudson* test for commercial speech applies." In the alternative, the court held, the challenged statute and regulations could not survive even under *Zauderer*. *Id.* at 524.

Perhaps in recognition that none of its sources support the claim that *Zauderer* applies to *all* compelled commercial disclosures, the Government tries to pivot by arguing that it applies to compelled commercial disclosures "about the terms under which . . . services will be available." Gov. Br. at 28 (quoting *Nat'l Inst. of Family & Life Advocates* ("*NIFLA*") *v. Becerra*, 138 S. Ct. 2361, 2372 (2018)). But this effort fares no better because that description decidedly does not "sum[] up this case." *See id.* "The terms under which services will be available" is just another way of saying "advertisement." Look no further than the original quote: "The State has attempted only to prescribe what shall be orthodox in *commercial advertising*, and its

prescription has taken the form of a requirement that appellant *include in his advertising* purely factual and uncontroversial information about the terms under which *his services will be available*." *Zauderer*, 471 U.S. at 651 (emphases added); *see also NIFLA*, 138 S. Ct. at 2372 (citing *Hurley*, which likewise explained that *Zauderer* is limited to "commercial advertising"). The price disclosures at issue here are not advertisements, and the Government does not claim otherwise. *See Advertisement*, Black's Law Dictionary (11th ed. 2019) ("A commercial solicitation; an item of published or transmitted matter made with the intention of attracting clients or customers."); *see* Gov. Br. at 28.

Zauderer does not apply for yet another reason: *Partial* disclosures are not purely factual. Pls.' Br. at 26 (citing *AMI*, 760 F.3d at 27). The entire premise of *Zauderer* is that the Government may mandate certain disclosures that will lessen consumer confusion, *see* 471 U.S. at 651, but partial disclosures will increase it. The Government's retort that hospitals can always provide more information if they see fit is no solution; the whole point is that the majority of hospitals *do not have and cannot easily obtain* information about a patient's insurer-determined out-of-pocket cost for a particular service.[18] Hospitals are not being "paternalistic"; they simply are unable to provide complete, accurate information as contemplated by *Zauderer*. *Contra* PatientRightsAdvocate.Org Br. at 24. Imagine a consumer asks "How much will this shirt cost?" and the distributor answers, "I charge the shopkeeper $10." If the consumer relies on that disclosure and budgets $10 for the shirt, only to find out that the shopkeeper actually charges $12 to account for her overhead, the partial disclosure of information harms the consumer. *See* 84 Fed. Reg. at 65,547 (acknowledging but not responding to this "reliance" risk).

[18] Disclosing cash discount rates is fraught with these same risks, though for other reasons. *See infra* pp. 29–30, 33.

This risk is real in the healthcare world. The complexities of insurance plans are legion, and the consequences of releasing partial pricing information shorn of the context provided by an individual's insurance plan are severe. Imagine if a patient interprets the mandatory, negotiated-rate disclosures at issue here to mean that she need only pay $1,000 for a treatment and budgets accordingly, but later discovers that because the treatment is considered experimental, it is not covered by her insurance plan. Thus, the negotiated rate does not apply to her, and she actually owes $10,000. *See R.J. Reynolds Tobacco Co. v. Food & Drug Admin.*, 696 F.3d 1205, 1216 (D.C. Cir. 2012) (a disclosure that is "subject to misinterpretation by consumers" is not "purely factual" under *Zauderer*), *overruled on other grounds by AMI*, 760 F.3d 18.

In any event, Plaintiffs win under *Zauderer*, too. A compelled speech requirement like the Final Rule fails *Zauderer* if it is either "unjustified or unduly burdensome." *See NIFLA*, 138 S. Ct. at 2376–77. The Final Rule is both. It does not remedy the problem it identifies: that patients lack accurate data about *their* out-of-pocket costs. *See supra* pp. 16, 18–19. It imposes a high burden with a limited potential benefit. *See supra* pp. 18–21. And it does so despite the availability of a less-restrictive alternative. *See supra* pp. 18–19.

Although the Government contends that Plaintiffs lose because we cannot "plausibl[y]" demonstrate "the particular harm that matters under *Zauderer*—chilling commercial speech," Gov. Br. 31—that just proves Plaintiffs' points. The Final Rule does not chill commercial speech *because it does not regulate commercial speech*. *See supra* pp. 16–17. And "[r]equiring hospitals to disclose their standard charges does not effectively rule out speech or nullify the message hospitals might otherwise wish to communicate," Gov. Br. 31 (internal quotation marks omitted), *because that is not the kind of disclosure requirement to which Zauderer applies*. *Zauderer* tests whether "compelling the publication of" certain information would literally or

linguistically "fill far more space *than the advertisement itself*," and therefore "chill the publication of protected commercial speech" that the advertiser wants to display. 471 U.S. at 663 (emphasis added); *see Ibanez v. Fla. Dep't of Bus. & Prof'l Regulation*, 512 U.S. 136, 146 (1994) (applying *Zauderer* to invalidate an advertising requirement that was so detailed it "effectively rule[d] out" the ability to include a different, preferred disclosure); *see also Pac. Gas*, 475 U.S. at 15 n.12 (explaining that, under *Zauderer*, the compelled disclosure of messages "biased against or . . . expressly contrary to the corporation's views" also has a chilling effect). In other words, *Zauderer*'s chilling inquiry asks whether a compelled disclosure will crowd out what the advertiser *wants* to say.

Therein lies the problem. Even accepting for the sake of argument that negotiated rates are commercial speech, it cannot be that because hospitals are not interested in disclosing their negotiated rates, the Government can compel the disclosure of those rates because there is no threat that doing so will crowd out, and therefore chill, speech the hospitals are not interested in making. The Government's answer—that hospitals can always *add* to a disclosure they never wanted to make—is no response, at least not within the rubric *Zauderer* set up.

The Government cannot have its cake and eat it too. If, as the Government claims, *Zauderer* applies beyond compelled advertising regulations, then it must also account for burdens beyond the chilling of an advertiser's speech. The Government does not explain what such a test might entail. But at the least, it should account for the fact that the compelled disclosure will unduly burden the speaker in other ways, including by chilling related speech that the speaker wants to engage in—here, the arms'-length negotiations between hospitals and insurers. Because the Final Rule's disclosure mandate threatens to make it impossible to

negotiate rates in the future, it does in fact threaten to chill (allegedly) commercial speech. Even under the Government's flawed reading of *Zauderer*, then, Plaintiffs prevail.

2. The Government *amici*'s litany of First Amendment red herrings (at 21–24) is too long to refute in any detail, but here's the CliffsNotes version of our rebuttal:

Plaintiffs are not looking to "keep patients in the dark about the true costs of their healthcare," PatientRightsAdvocate.Org Br. at 21; they want the Government to adopt a constitutionally permissible rule that provides consumers with accurate information.

Spirit Airlines, like *Zauderer*, involved an *advertising* regulation.

That no one has bothered to challenge the FTC's Funeral Rule on First Amendment grounds does not mean this Final Rule is constitutionally permissible; such an approach to constitutional law would be absurd.

AMI's holding was confined to country-of-origin labels, as evidenced by the opinion's extensive discussion of the history of such regulations, and as *NAM* made plain.

And no, Plaintiffs' approach to the First Amendment is not "highly paternalistic," PatientRightsAdvocate.Org Br. at 24; it is the approach mandated in case after case requiring an adequate means-end connection between the Government's stated interest and the compelled speech requirement.

Because the Final Rule fails any (and every) applicable First Amendment test, it should be vacated and declared invalid.

III. THE FINAL RULE IS ARBITRARY AND CAPRICIOUS.

The Final Rule "runs counter to the evidence before the agency," *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983), and represents an unexplained departure from an existing policy, *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125–26

(2016). It is therefore not "the product of reasoned [decision-making]," and should be set aside. *Fox v. Clinton*, 684 F.3d 67, 74–75 (D.C. Cir. 2012); *see* Pls.' Br. at 27–29.

The Government complains that Plaintiffs have made similar arguments that the Final Rule violates both the First Amendment and arbitrary and capricious review. *See* Gov. Br. at 40. Last we checked, an agency action can be both illegal and unconstitutional. *See, e.g.*, *Time Warner Entm't Co., L.P. v. F.C.C.*, 240 F.3d 1126, 1128 (D.C. Cir. 2001). The Final Rule is both.

And the Final Rule is indeed arbitrary and capricious for many of the same reasons that it violates the First Amendment.[19] Put simply, the agency's stated explanation for the Final Rule cannot be squared with the evidence before it. CMS seeks to justify the rule based on a desire to better inform patients about their healthcare costs, but it admits that out-of-pocket costs are what patients care about when comparing prices across hospitals, and that these costs vary based on factors unrelated to a hospital's negotiated rates. *See* 84 Fed. Reg. at 65,528 ("Necessary data to make out-of-pocket price comparisons depends on an individual's circumstances," like the outstanding deductible amount); *id.* at 65,559 (acknowledging that disclosing "payer-specific negotiated charges does not in isolation provide a patient with an individualized out-of-pocket estimate"); *see also supra* pp. 18–19. In other words, the agency has admitted that the Final Rule does not further the interests on which it purportedly rests. That is textbook arbitrary and capricious decision-making.

Moreover, although the Final Rule purports to be a "first step" *towards* helping consumers make "more informed decisions about where to seek care based on price," 84 Fed. Reg. at 65,528, because the Final Rule will exacerbate customer confusion, it is actually a step

[19] Because the Government plainly dislikes overlap in legal arguments, Plaintiffs incorporate by reference their First Amendment arguments here as well, *see supra* 14–27.

backward. As explained, for the 90% of patients with insurance, the disclosures mandated by the Final Rule will not provide accurate information about out-of-pocket costs. *See supra* p. 19; 84 Fed. Reg. at 39,579; *see also* Gov. Br. at 33 (acknowledging that the Agency is "uncertain[]" about the effects of the Final Rule).

That leaves the Government with only a small category of individuals potentially benefitted by this Rule—cash (or equivalent) payers. *See supra* n. 11. But requiring hospitals to disclose their "discounted cash price" also risks misleading these patients. Even assuming patients are able to navigate the exceedingly complex disclosure documents, *but see* Ginsburg, *supra*, at AR 5263 ("Efforts to push the publication of hospital charge lists have often been ridiculed on the basis of the challenge for consumers to identify which of the 25,000 services are relevant to them."), for the numerous hospitals with no one-size-fits-all discount, the required disclosures erroneously suggest that no further discount or forgiveness is available, *see* 84 Fed. Reg. at 65,553 (acknowledging these discounts are not standard).

The Government tries to minimize that risk by claiming that hospitals can simply "display . . . other discounts," and so if patients are misled, it is the hospitals' fault, not the Agency's. Gov. Br. at 42. That argument is tautological. As CMS has acknowledged, because these "other discounts" are specific to each individual patient's circumstances, hospitals *cannot* display their *patient-specific* discounts in advance. *See* 84 Fed. Reg. at 65,553 ("[M]any hospitals have not determined or [do not] maintain[] a standard cash discount that would apply uniformly to all self-pay customers . . . . it may be difficult for a hospital to establish and make public a single standardized cash rate for such groups of consumers."). Because hospitals cannot display every patient-specific discount for every service and every item or group of items and services, the public will wrongly believe the non-discounted rate is *the rate*, general language

about additional discounts or forgiveness programs notwithstanding. *See* 16 C.F.R. § 233.3(a) (explaining that "[m]any members of the purchasing public believe that a manufacturer's list price . . . is the price at which an article is generally sold"). Because many hospitals offer situation-specific discounts for patients paying in cash, the cash rates hospitals must disclose under the Final Rule will be artificial; disclosing only those rates may lead patients to delay healthcare services, including for acute needs, based on an inaccurate understanding of what those services will cost and what financial assistance might cover. *See, e.g.*, AR 1498 (comment from American College of Emergency Physicians explaining that these risks are particularly acute in the field of emergency services). The Agency's responses—that it "believe[s]" that because commentators *want* more information they will not find the additional information confusing; that because patients already receive this information after-the-fact in an EOB they will be able to understand and make accurate decisions in advance based on necessarily incomplete disclosures; and that hospitals can always disclose more information—are no responses at all. *See* 84 Fed. Reg. at 65,547.

In sum, CMS identified a problem and a specific tool to fix it. But the agency opted to construct a rule that admittedly does not solve the problem, and potentially creates new problems in the form of *more* patient confusion and a decrease in competition. That is arbitrary and capricious. *See State Farm*, 463 U.S. at 43.

IV. PLAINTIFFS' REQUESTED RELIEF IS APPROPRIATE.

If the Court agrees with Plaintiffs on the merits, it should declare the Final Rule unlawful, set it aside, and enjoin HHS from enforcing, implementing, or taking any other action in reliance on the Final Rule. Such relief is appropriate and well within this Court's authority. And because no provision of the Final Rule can withstand scrutiny, it should be vacated in its entirety.

A. Nationwide Relief Is Proper.

The Government argues that even if the Final Rule exceeds the agency's authority under Section 2718(e) or violates the Constitution, this Court may grant relief to only a subset of Plaintiffs here, while the remaining Plaintiffs and other hospitals across the country must remain subject to an unlawful regulation. Gov. Br. at 43–44. That is just not so. This Court can and should grant nationwide relief through a permanent injunction or vacatur of the Final Rule.

Where an agency action violates the APA, nationwide relief "is compelled by the text of the [statute]." *Earth Island Inst. v. Ruthenbeck*, 490 F.3d 687, 699 (9th Cir. 2007), *rev'd in part on other grounds sub nom. Summers v. Earth Island Inst.*, 555 U.S. 488 (2009); *see also Make the Road New York v. McAleenan*, 405 F. Supp. 3d 1, 66 (D.D.C. 2019) ("Ordinarily, in the wake of an unfavorable judgment from a federal court regarding procedural claims brought under the APA, agency actors willingly refrain from imposing *on anyone* the rule that a federal court has found to be unlawful . . . ."). The APA instructs courts to "hold unlawful and set aside agency action[s] found to be" invalid. 5 U.S.C. § 706(2). Thus, if an agency action violates the APA, "the ordinary result is that the rule[ ] [is] vacated—not that [its] application to the individual petitioners is proscribed." *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998) (quoting *Harmon v. Thornburgh*, 878 F.2d 484, 495 n.21 (D.C. Cir. 1989)). Examples abound. *See, e.g.*, *Guilford College v. Wolf*, No. 1:18-cv-891, 2020 WL 586672, at *11 (M.D.N.C. Feb. 6, 2020) (invalidating an agency policy under the APA "not just for the named Plaintiffs, but for all those subject to its terms"); *Make the Road New York*, 405 F. Supp. 3d at 66–72 (rejecting the government's request for a limited injunction and enjoining enforcement of a DHS policy as against plaintiffs and non-plaintiffs); *Texas v. United States*, 86 F. Supp. 3d 591 (S.D. Tex. 2015) (enjoining implementation of the DAPA program nationwide because it violated the APA), *aff'd,* 809 F.3d 134 (5th Cir. 2015); *see also* Mila Sohoni, *The Lost*

History of the "Universal" Injunction, 133 Harv. L. Rev. 920, 991 n.466 (2020) (APA's "set aside" directive "should be read (as it has long been read by lower courts) as authorizing 'universal vacatur' of agency action—including rules").

To be clear: All of the Plaintiffs have standing here. Every single hospital member of the associational Plaintiffs will be forced to comply with an unlawful rule that will impose a significant burden on them. *See* Smith Decl. ¶¶ 11–12, 19; Orlowski Decl. ¶¶ 10, 13; Kaufman Decl. ¶¶ 10, 14; Tenoever Decl. ¶¶ 12, 14. In light of that, it would be nonsensical to require the association to name all of its members in its declaration. But regardless, nationwide relief fits squarely within the bounds of permissible relief suggested by the Government itself. The Government proposes that the Court may enjoin or vacate the Final Rule as "to the subset of Plaintiffs with standing." Gov. Br. at 43. But the AHA alone—which the Government concedes has associational standing, *id.*—has nearly 5,000 member hospitals located in all 50 states.[20] Fully 80% of the nation's hospitals are represented by the AHA.[21] Practically speaking, even a ruling solely in favor of the AHA and the hospital Plaintiffs alone will warrant a nationwide injunction.

The Government speculates that limiting relief to Plaintiffs will not "lead to 'a flood of duplicative litigation' in this Court." Gov. Br. at 44 (quoting *Nat'l Mining Ass'n*, 145 F.3d at 1409). Really? Under the Government's theory, hospitals *must* bring independent actions to have the Rule invalidated as to them specifically. *Id.* at 43–44. If the Final Rule is invalidated

[20] Plaintiffs need only establish that one of them has standing for the action to proceed. *See Humane Soc'y of the U.S. v. Vilsack*, 797 F.3d 4, 10 (D.C. Cir. 2015) ("Because we find that [one plaintiff] has standing, we need not and do not reach the arguments of the other plaintiffs regarding their standing.").

[21] *See* AHA, *Fast Facts on US Hospitals*, *available at* https://tinyurl.com/r475s43 (identifying 6,146 total U.S. hospitals); AHA, *About the AHA*, https://www.aha.org/about (noting that nearly 5,000 hospitals are AHA members).

only as to Plaintiffs, the Government cannot seriously expect that other hospitals expending scarce resources to comply with an unlawful regulation will sit idly by.

B. Vacatur of the Entire Rule Is Appropriate

According to HHS, it intended the five "standard charges" hospitals must publish under the Final Rule to be severable, and so, the Court should invalidate only the provisions that exceed the agency's authority. Gov. Br. at 44–45 (citing 84 Fed. Reg. at 65,555). But each definition under the Final Rule rises and falls with the parties' merits arguments.

Requiring hospitals to disclose "insurer-specific negotiated charges," "discounted cash prices," "de-identified minimum negotiated charges," or "de-identified maximum negotiated charges" exceeds HHS's authority. *See supra* pp. 2–12; Pls.' Br. at 11–16. "Standard charges" under Section 2718(e) simply does not encompass "negotiated charges" (whether de-identified or not) because such charges necessarily are *non*-standard. Nor can it include "discounted cash prices" because, as HHS admits, many hospitals *have no* standard "one size fits all" discount. *See supra* pp. 29–30; Pls.' Br. at 11–16. More, the same First Amendment concerns that preclude compelled disclosure of insurer-specific negotiated charges apply equally to "de-identified minimum" and "de-identified maximum" negotiated charges, just as they do to each individual charge. Negotiated-charge information is highly confidential and commercially sensitive, and CMS has not shown that a substantial or compelling interest is served by requiring hospitals to disclose this information. *See supra* pp. 15–22; Pls.' Br. at 19–27.

Ultimately, whether the agency intended the definitions of "standard charges" to be severable is inconsequential. Each provision of the Final Rule is independently invalid. Therefore, the Court should vacate the Final Rule in its entirety.

CONCLUSION

For these reasons, Plaintiffs' Motion for Summary Judgment should be granted, Defendant's Cross-Motion for Summary Judgment should be denied, the Final Rule should be vacated and declared invalid, and Defendant should be enjoined from enforcing, implementing, or taking any other action in reliance on the Final Rule.

Respectfully submitted,

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