UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, et al.,	
Plaintiffs,	CA No. 19-3619 (CJN)
v.	
ALEX M. AZAR, II,	Washington, D.C. Thursday, May 7, 2020 2:00 p.m.
Defendant.	

TRANSCRIPT OF MOTIONS HEARING
(VIA VIDEO TELECONFERENCE)
BEFORE THE HONORABLE CARL J. NICHOLS
UNITED STATES DISTRICT JUDGE

APPEARANCES:

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P R O C E E D I N G S

THE DEPUTY CLERK: Civil action 19-3619, American Hospital Association, et al., versus Azar.

Counsel, please identify yourselves for the record.

MS. STETSON: Good afternoon, Your Honor.

This is Cate Stetson representing the plaintiffs.

THE COURT: Ms. Stetson, good afternoon.

MR. BAER: Good afternoon, Your Honor. This is Michael Baer from the Department of Justice on behalf of the Secretary. I'm joined at my virtual counsel table with my colleague, Eric Beckenhauer.

THE COURT: Good afternoon.

Will you be taking the lead, Mr. Baer?

MR. BAER: I will.

THE COURT: So, obviously -- is there anyone else on the line? Sorry. This is a little different than typical in-court argument, and obviously I'm very cognizant of the odd situation that we find ourselves in. So I thought laying out just a couple of very brief ground rules, it will be helpful.

In many ways, this is easier than a teleconference because I can see whoever's speaking, but if you could just introduce yourself again when you go ahead and speak, that would be helpful. Obviously, I appreciate that there may be technological issues: Somebody may get dropped, or we may not be able to hear someone. If that's the case, we can just pause and wait for

everyone to reconvene. I will ask that everyone who is not speaking at a particular time, and I really think that means that will be one advocate who is unmuted and then me, and if everyone else can mute, then we'll just be very clear about when we can move on to the next advocate. All pretty basic stuff.

In terms of an argument today, of course I've reviewed all of the materials: the briefs, the amicus briefs, a fair amount of the administrative record, including the proposed and final rules. I think this is going to be the most efficient way, at least for me, to proceed, which is I would like to hear Ms. Stetson first.

Ms. Stetson, I would like you to cover all of your arguments in roughly a half an hour. I don't have any hard-and-fast rules, but that seems likely sufficient. And then if the government could then be prepared to respond in, call it 30 minutes as well, then, Ms. Stetson, you'll have some time for rebuttal. You don't have to reserve time. We'll figure it out. We can call it 10 minutes now, but it doesn't have to be set in stone now; and if the government would like, I'd be happy to give you surrebuttal. So, other than that, I have no ground rules.

Ms. Stetson, I would treat this as a typical oral argument, just done by video teleconference and with those general constraints.

MS. STETSON: Understood, Your Honor. Thank you.

Shall I dive in?

THE COURT: You may.

MS. STETSON: Okay. Thank you. And thank you, and I also want to thank Ms. White and the other folks in the courtroom for gathering today. I know these are surreal circumstances, and we appreciate it.

So just to set the table a little bit on why we're here, a federal statute requires hospitals to publicly disclose a list of their standard charges for items and services provided by the hospital including for diagnosis-related groups established under the Medicare Act.

The Final Rule under challenge interprets that statutory requirement of "a list of standard charges" to mean hundreds of lists of all third-party payers' negotiated payment rates, a list of maximum payment rates, a list of minimum payment rates, a list of gross charges, and a list of cash discount payment rates for every item on a chargemaster list that CMS understands can run tens of thousands of lines long.

There is simply no way, under any mode of analysis, that that statute can give rise to that requirement. And I want to start by talking about standard charges, but I do want to then pay some attention to the phrase that had kind of a cameo role below but has now been elevated I think to a centerpiece of the government's argument, and that's this "including for diagnosis-related groups" phrase.

But just to start with the standard charges, and not to put too fine a point on it, but standard charges are standard charges. And just to break those two things out, we already know what charges are because CMS, though the Medicare Provider Reimbursement Manual, tells us exactly what they are, and they are the chargemaster charges that are contained on every hospital's master list of regular charges.

So if you look at Section 2202.4 of the Provider Reimbursement Manual, what you'll find is the definition of "charges," and what it says is, "Charges refer to the regular rates established by the provider for services rendered both to beneficiaries," and that's Medicare beneficiaries, "and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients."

So that's what "charges" means. And more to the point of this particular statutory provision, for the last several years, ever since this was issued in 2010, CMS has interpreted "standard charges" exactly as we say it should be interpreted and, of course, as the Provider Reimbursement Manual says, which is if you look at the their statements in 2014 in the Federal Register, they reiterate that "Our guidelines for implementing Section 2718(e) of the Public Health Service Act are that the hospitals either make public a list of their standard charges, whether that be the chargemaster itself or in another form of

their choice, or their policies for allowing the public to view a list of those charges in response to an inquiry." That was 2014.

2018, CMS updates that slightly to say we're requiring hospitals to make available a list of their current standard charges via the Internet in a machine-readable format and again in the form of the chargemaster itself, that master list of charges, or another form of the hospital's choice.

So that is how CMS, both in the Provider Reimbursement Manual and for the last several years, has consistently understood that simple and modest directive: a list of the hospital standard charges.

What we now encountered, starting in the middle of last year with the Proposed Rule, is a transmutation from standard charges to what the CMS calls a second type of standard charges, and those are what they can at least say are payer-specific negotiated charges. That is what they are now expanding "standard charges" to.

Negotiated charges with respect to a particular group of people are not standard charges. And maybe the best way to understand this is to look at the perspective of the two entities that are involved in any of these transactions.

The hospital is the one who is implementing these standard charges, the chargemaster list, and those standard charges, as you can tell from that Provider Reimbursement Manual, those are

a constant. Those are articulated in every single bill the hospital sends out, no matter to what payer, no matter whether to Medicare or to a private third-party payer, precisely because that's what CMS tells it it must do. So the output from the hospital are the standard charges.

What comes back in to the hospital by way of payment can be very, very different depending on the insurer and the particular plan that that particular enrollee has with that insurer, and that second thing, those insurers and those plans, are the level of detail that CMS now wants to introduce into what the statute says are standard charges.

But there is nothing standard about those at all, of course. They're actually quite specific, as the Cleveland Clinic said, and you can find this in the joint appendix. Cleveland Clinic makes the point that across its system it has 3,000 different contracts with different payers and different groups within those payers, and all of those contracts have different payment rates and methodologies and groupings and methods for paying for items, services, or groups of items or services.

THE COURT: Wouldn't you agree -- sorry to interrupt you, but talking about the chargemaster -- I'll put it this way, "amounts," just to not use a loaded term. Is it correct that something like 10 percent or fewer items or services nationwide are paid for at the chargemaster amount?

MS. STETSON: I think at a basic level that is

correct. But I wouldn't take from that what the government extrapolates from that, which is if that few percentage are paid from the regular charged amount, the standard charge, it can't be a standard charge, because the government itself, both in prior final rules and in this one, has emphasized how important that chargemaster is.

Even in this Final Rule, the government says the chargemaster is the baseline from which those other more particularized payer-specific and privately negotiated charges are negotiated. That's essentially the starting point.

THE COURT: How do you define -- and I know you started here, and I had not seen this as highlighted in your briefs, I think. How do you define what a charge is? Is the charge the amount that the hospital bills and expects to be paid by the third-party payer in the example of a third-party payer situation, or is it an amount that the hospital tells the third-party payer is its chargemaster rate even though everyone in the transaction understands that that is not the amount that's being billed in the traditional sense nor the amount that will be paid?

MS. STETSON: Judge Nichols, I think it's actually somewhere in between. I think it is not the amount that the hospital normally bills and expects to be paid, nor is it an amount that is simply a rate on the chargemaster sheet. It is the charge that the hospital -- it's the hospital's output,

what charge shows up on any hospital bill.

But what comes back in, as I said, are those individualized payment rates depending on what's been negotiated with that particular payer with respect to that particular level of plan and with respect to that particular enrollee. So I think part of this -- and this is very well highlighted, I think, in the amicus brief that the 37 state hospital associations filed, has some very good background information about how we got to where we are.

And part of the background of that, including some helpful congressional testimony from someone who, if I remember correctly, was at CMS at the time that the prospective payment system was designed, part of the problem is that, because of a huge convergence of different forces -- market forces, insurance and so forth -- the hospital chargemaster charges have, over time, developed into something that is the reference charge, the regular charge for all other payers, but, as you pointed out, used as a final charge that I think is a creature of this incredibly complicated, incredibly difficult sort of multi-facetted payer world that the hospitals are forced to exist in.

THE COURT: The reason I ask -- sorry to interrupt -- is obviously the parties spent a lot of time defining or attempting to define what it means for something to be standard, and I want to understand whether there's an agreed-upon definition as between the parties or not about what a change

is in this context.

MS. STETSON: Well, I think Mr. Baer will have a difficult time saying that a charge here is anything different than the charge as defined by the CMS Provider Reimbursement Manual. I think what the agency said below is it made reference to the reimbursement manual in one page of its Final Rule, and what it said is, yes, that defines "charges," but here we're talking about standard charges, and that means we don't need to look as closely to the reimbursement manual.

The problem with that is that the reimbursement manual actually supplies the answer to that as well, because the quote I read you earlier from the manual says charges refer to the regular rates established by the hospital and that are billed uniformly across all participants, whether Medicare or other.

So what you can tell from that is, because the statute says "standard charges" and charges are defined as regular rates, I suppose the statute could have said "standard regular rates;" it could have said "regular rates." But everybody understands what those are because, in fact, the chargemaster rates, in a whole host of other minor regulations not important here, the chargemaster rates are the linchpin for all sorts of cost and charge determinations that hospitals have to submit to CMS in order to get paid and in order to get paid certain other things like outlier payments and the like.

So I think it's difficult for the government to recede from

acknowledging that a charge is the regular rate, and I think it's equally difficult for the government to back away from saying the regular rate is the chargemaster charge. And I think that's why -- just to pivot, if I could, over to this "including for diagnosis-related groups" phrase, I think that is why the government now puts so much truck in that, because when you look at just a list of standard charges alone, that seems pretty straightforward. And we haven't even talked about "a list," of course. These are many, many dozens or hundreds of lists.

So what the government has done in its briefing -- and as I mentioned, this was sort of floated on one page of the Final Rule below, but in its briefing what it says is, no, no, because this statute talks about "including for diagnosis-related groups," that necessarily means that because diagnosis-related groups aren't themselves separately called out in the master list of charges, those diagnosis-related groups must include DRG.

It's not just established under Medicare, by the way. That's not the whole government's theory. It must include groupings of items and services including those paid for by all private payers. And that, in turn, backs them all the way into all private payers' rates for all items and services including for any proprietary groupings of items and services that that particular payer sets forth.

There are a number of different ways -- and, you know, the government kind of calls us out in its final reply for pointing

this out. There are any number of ways that you can interpret that phrase, but the one thing that's pretty clear is that you cannot take that phrase and kind of manhandle it into a blanket permission to require hospitals to do something that, by the way, no other state, in all of their state-transparency programs, no other state has required a hospital to do this.

So that phrase, I think, put very simply cannot -- to overuse a phrase, cannot bear the weight that the government puts on it. "Including for diagnosis-related groups" just means chargemaster charges including for those groups of items and services. The way that a lot of hospitals have interpreted that, they've included the chargemaster list, that list of standard charges, and at the end they've taken every Medicare-specified DRG, diagnosis-related groups established under the Medicare Act, and they have amalgamated, essentially, all of the standard charges that go into that DRG.

And that, by the way, just to harken back to something I said before, even those standard charges show up on any hospital bill involving a diagnosis-related group. Those charges are broken out in addition to the DRG code.

So it's not entirely surprising that a simple directive from Congress that says a list of standard charges for items and services, including groups of items and services established under Medicare, would contemplate that kind of summation of standard charges for items and services.

But I think as far as the text is concerned, I think that is -- the government's argument about including for DRGs is a far, far cry from being able to read in the kind of deep ambiguity into that text that the government suggests.

THE COURT: I have a few questions, but I did want to note that we seem to be getting some feedback.

Ms. White, I don't know if you're hearing that as well. And it's not particularly bothering me, I'm able to concentrate, but I know that can often be distracting for advocates. So I don't know if everyone is also hearing that or if there's anything that can be done to try to eliminate it.

THE DEPUTY CLERK: No, Your Honor. I do hear it.

Is everyone muted besides you and the current speaker?

THE COURT: Am I able to tell that? I can't recall if I'm able to do that on here.

THE DEPUTY CLERK: No, I'm asking everyone if they've muted themselves if they're not speaking.

THE COURT: Sounds likely. So my apologies in case this gets a little bit distracting.

So, Ms. Stetson, is there any relevance, in your view, to Congress's use of two verbs in the statute? It says not just that the hospital shall make public a list of standard charges, but actually shall establish, which suggests to me that whatever it is that shall be published is something that did not previously exist or might not have previously existed.

Obviously, though, I'll ask the government for its view. I don't think the government focuses much on the fact that there are two verbs in the statute rather than one, but, in your view, is there any relevance to the fact that Congress required both the establishment and the publication of the relevant list?

MS. STETSON: No. I don't think that -- I don't think that the fact that there are two verbs operating in that statute changes the scope of the statute. I think probably -- who knows? We can all speculate about what Congress was thinking. But one of the things that was true, and certainly was true ten years ago, is that when we talk about a chargemaster, that master list of charges, those are not uniform from hospital to hospital. As I understand it, there are actually different software systems; there are actually different providers of those systems that create those master charge lists for each hospital.

So it's possible to imagine -- and maybe this is why that qualifier is in there, too, two qualifiers: "and update" and then "in accordance with guidelines developed by the Secretary." Maybe that's why the Secretary, in 2014 and 2018, when they made the point in the Federal Register notices that the form could be in the form of the chargemaster or another form that the hospital desires, it's possible to see someone taking the chargemaster information that they have and creating a different form of list. That would be establishing the list and publicly

disclosing it.

So it probably is just designed to give a little bit of leeway to the fact that not all master lists of charges look exactly the same. And Congress wasn't requiring uniformity across the fees, and in fact the Secretary, in 2014 and 2018, wasn't requiring uniformity across the fees.

THE COURT: If I were to conclude that this provision is ambiguous -- I understand that there are questions about whether the agency's interpretation is nevertheless reasonable, but just hypothetically, if I were to conclude that the provision is ambiguous, is it your view that the requirement to publish discounted cash prices would be an unreasonable interpretation of an ambiguous statute? Again, assuming the statute is ambiguous.

MS. STETSON: Assuming it's ambiguous -- and just to take the first view from the top, we would say and we argue in our brief it's certainly unreasonable, even under a *Chevron* deference regime where you're at step two, to interpret a list of standard charges to mean maximum negotiated, minimum negotiated, and all of hundreds of payer-negotiated rates, to set that aside.

On the cash discount rate, I think it is candidly a closer question, but I think you still run into the same kind of cognitive dissonance that you have with what those standard rates are. And this is where I think a lot of the declarations

that were filed in support of our summary judgment motion, a lot of the comments that you saw on the joint appendix are useful here because they explain -- you know, as with a few other elements of this, it's just not as straightforward as CMS, I think, would prefer it to be. There is no -- in almost all circumstances, there's no standard cash discount rate.

In fact, what hospitals have told CMS and have told you in their declarations is, if we were to post a cash discount rate, that gives the impression to, say, a poor, uninsured payer, that there are no other discounts available when in fact there are all sorts of combinations and permutations of discounts. There are prompt-pay discounts for cash payers. There are cash discounts just based on someone's sheer need: If someone walks into the hospital and simply cannot pay, that cash discount is going to be steep.

THE COURT: But nothing in the rule would prohibit a hospital from saying those things. In fact, nothing in the rule prohibits hospitals from otherwise explaining what it is that they're required by the rule to publish. Correct?

MS. STETSON: I think that's right, but I think it's also a little bit of a -- it's built on a foundation that's not quite right, which is if this speech is unlawful -- before we even get to kind of First Amendment considerations, if this speech is not permissible in terms of what the Secretary can require under his authority, the fact that we could further

caveat that to further explain it doesn't rescue it from unlawfulness; it just means we have to say more. But, you're right. It's possible to put all sorts of additional speech around it, but that's doesn't cure the underlying unlawfulness.

THE COURT: I was in some respects -- and I get that point. I was to some extent pivoting a little bit to the First Amendment claim, so if you wouldn't mind going there and giving me your best argument on the First Amendment.

MS. STETSON: Sure. I'd actually like to start, before we get into kind of the commercial speech, *Zauderer*, *Central Hudson* rubric, I want to start by pointing out something that may have gotten lost in the briefing, which is the government, at around the same time they published this Final Rule, it published a proposed rule pertaining to disclosures that the government plans to require of insurers.

And I want to call your attention to that because I think both with respect to First Amendment and just with respect to common sense, I think what the government is proposing at least in part in that proposed rule is important to look at, and this is 84 Federal Register 65464. There's two kinds --

THE COURT: Ms. Stetson, is that the so-called "Transparency in Coverage" rule?

MS. STETSON: Yes. That is. That is.

So there are two parts of it. One of the parts, of course, is essentially the mirror image of this rule, which is insurers

are required to disclose all of their negotiated rates. My clients have the same problem with that requirement as they do in our own disclosure rule. But there's a different independent component of that rule that I want to draw your attention to, and that's the first part of it.

The first part of the insurer disclosure rule essentially says, insurers shall be required to disclose, upon a request of one of their enrollees or participants with respect to a particular provider in service or item that person's cost-sharing liability -- and that means things like do they have to pay up to their deductible; how much is left; coinsurance requirements; what is the accumulated amount of that person's liability both in terms of how many, for example, treatments they have left and how much money they have left in their deductible; the negotiated rate for that particular item of service, with one exception that I think is important, the out-of-network allowed amount; the list of contents for a service; and the prerequisites to coverage like prior authorization or step therapy or so forth.

That basket of disclosures, which is all designed to be disclosed to a participant on that participant's request when a participant comes and says: I've been referred for a knee replacement; these are the two providers; can you walk me through what my options are? That gives that patient everything that we've been talking about that the hospitals can't give them

up to and including the negotiated rate that the hospitals are being forced to disclose.

And the reason I wanted to front-load that is -- there are a couple, really, but one of them is, when we talk about fit and we talk about undue burden, even if you take it at the basic *Zauderer* level, what you have in that proposed requirement is exactly the kind of fit with a much more minimal burden on all concerned, frankly, than what is being proposed here.

And I mentioned that with respect to those individual participants' requests, negotiated rates are usually provided. But they're not in some circumstances, and I want to land on this because I think it is a telling contrast with what's required here.

The Department acknowledges in that particular Proposed Rule that if the negotiated rate between the hospital, for example, and the insurer doesn't impact that individual's cost-sharing liability, if there's a flat co-pay or what have you, disclosure of the negotiated rate would not be required if it's not relevant for calculating cost-sharing liability.

So that tells you that in those circumstances we have, the participant and all of the particulars of that plan participant's needs and contributions, that there is this much more tailored, much more appropriately tailored way to give the same information all at the same time to that participant that we're talking about.

And I want to be clear that my clients are highly supportive not just of that, but as we've said in our briefs, no one is against the basic principle of transparency of pricing. The problem that we have here is that this is not price transparency; this is disclosure of privately negotiated insurance rates, tens of thousands of them. So I wanted to start with that separate rule because I think it is very telling with respect to the First Amendment issue.

On the First Amendment, I'll run through the listings briefly. The first hurdle I think is one that you needn't spend a lot of time on, just because I think the answers get you to our requested relief no matter where you land, but I think there's an open question both under the D.C. Circuit's precedents and elsewhere about whether this type of disclosure really even is commercial speech. One of the most recent decisions we've had from the D.C. Circuit says it is much easier to explain what commercial speech isn't than what it is.

THE COURT: Is that because the publication of prices is not speech, or because it's not commercial speech?

MS. STETSON: Because it's not commercial speech, I would say. You know, the classic commercial speech, if you go all the way back to *Virginia Board of Pharmacy* or *Central Hudson*, is speech that is proposing a transaction. But as I said, you can pause there, and that's an interesting academic question, but if you take it to the next level and you ask, all right,

assuming this is commercial speech, what level of scrutiny should this get, I would refer you back to that same case I just mentioned, which is the D.C. Circuit's decision in *National Association of Manufacturers.* That decision came out, I think, in 2016 or 2017.

So it had the benefit, among other things, of an *en banc* decision from the D.C. Circuit a couple years earlier in the *AMI* case. And what *National Association of Manufacturers* said is, one thing that's clear both from *AMI*, from *Zauderer*, from *Milavetz* which the government cites, from *Hurley*, from a number of statements, is that *Zauderer* applies in the context of essentially point-of-sale communications: advertising, or as in *AMI*, the labeling on a package. *Zauderer* does not apply simply to every compelled disclosure.

And as you can imagine and I think Your Honor probably knows, there's some discomfort on the Supreme Court even with the idea that a separate standard applies at all to any kind of compelled disclosure. I think there's tolerance for the idea that if it's compelled to dispel confusion, it's appropriate; but where it's simply a compelled disclosure, it's not entitled to any lesser commercial speech protection than if it was a restricted disclosure.

So, in our view, the D.C. Circuit's current statement of the law on *Zauderer* is that it applies to point of sale or advertisement, and those are neither of these.

Under *Central Hudson*, of course, one of the things that you have to establish is that the disclosure requirement directly and materially advances the interest that the government's talking about. And here I would say at best you have what I would call an indirect and marginal impact on what the government is talking about, and that's why I sort of started with where I did with respect to the insurance coverage disclosure rule.

That is a direct and material advancement of exactly what the government's talking about, which is how do I get the most information relevant to a person's out-of-pocket costs to them in the most efficient way possible? And that way, of course, is by someone going to her insurer and saying, tell me what my options are and tell me what it's going to cost me.

So under the *Central Hudson* analysis, you have a highly indirect and quite marginal impact on that same thing because, of course, all that the hospitals would be compelled to disclose -- and say "all" in air quotes -- are hundreds and -- potentially hundreds of millions of lines of insured negotiated payment rates which a patient would then have to reverse-engineer with consulting her own insurer and her own plan in order to figure out what her out-of-pocket obligations are.

That seems like a long way around when you can simply achieve the same result by implementing the first component of the insurance disclosure rule, that patient-focused,

out-of-pocket disclosure rule.

The issue with *Zauderer*, to drop down to the *Zauderer* analysis, what you set aside at that point, you still need a substantial government interest. But under *Zauderer*, one of the things that was made clear by now-Justice Kavanaugh's concurring opinion in *AMI* is that you don't get some kind of rational-basis free pass which you get to *Zauderer*. It is still a rigorous inquiry.

There are things that are satisfied in terms of fit just because of the nature of the inquiry that you're at at that point. But one thing that's very clear, including something the Supreme Court said last year I think in the *NIFLA* case, is one of the things you look at even in a *Zauderer* inquiry is, is this rule unduly burdensome?

And it should be clear from Your Honor's review of the joint appendix and from the briefs and from the amicus briefs submitted by not just the state associations but by the Chamber of Commerce, that what the government thinks will be the commitment from these hospitals compared to what that commitment actually is, is orders of magnitude different.

If you look at some of the comments in the proposed rulemaking, they include things like "the government's estimate is grossly understated," "simply laughable," "woefully inaccurate," "vastly understated." And I'll go back to the example I gave with the Cleveland Clinic.

So Cleveland Clinic is that system that has 3,000 contracts. It's got a chargemaster of 110,000 items. So you are talking about, with a list of items and services, tens of millions of lines of data, all of which is in the possession of all of those various insurers, but very little of which in the first instance is in the possession of the hospital, precisely because the hospital, as we were saying earlier, doesn't generate bills based on those individualized amounts. The hospital always bills the same thing.

So the idea that the hospital can spend 12 hours just gathering this information and sending it out to the world is a complete and total fiction. And I would emphasize that, now more than ever -- you may have seen the news, as I did, two days ago that the American Hospital Association has reported that COVID itself will cost hospitals by mid-June -- so for half a year -- $200 billion.

And I think before the government seeks to impose an absurdly burdensome and very round-about requirement on the hospitals when it understands, through appending rulemaking, that it could do the same thing much more quickly, efficiently, and effectively using a different disclosure requirement that is personalized to a particular patient and provider and treatment, I think even under *Zauderer* this is not a close call.

THE COURT: Could you say a brief piece on the enforcement penalty argument? I suppose -- would you walk

me through your argument there?

MS. STETSON: Sure. So on the penalties I think -- first thing that I would point out is something that presumably -- which struck me at least as odd about the statute, which is you have a statute where this particular requirement, this standard master charges requirement, is subsection (e). The penalties requirement is baked into a subprovision of subsection (b), and there I think lies in the problem.

As we explain in our brief in some detail, one of the things that happens during this massive sort of sausage-making process is that those subsections having to do with rebating now and certain health insurer coverage showing got amalgamated in with other requirements including things demanded of the National Association of Insurance Commissioners, including this particular standard hospital charge list requirement.

And one of the things that I think happened is that penalties requirement that was baked into the rebate and the sort of ratio requirements of the first part of that statute, the provision, got essentially assigned to the whole section, because that's what it says. But both structurally and just logically, it doesn't make any sense.

We pointed out in our brief, among other things, that if you take that at face value, it would mean that CMS has the authority to punish the National Association of Insurance Commissioners for not doing its job, which is of course absurd.

The government's response to that is, well, we wouldn't do that. But that's not an entirely satisfying response.

Just because they would opt not to enforce doesn't go to the statutory question here, which is can you read that statute really to suggest that they could enforce against their partner in this kind of effort. But they both, because of the placement of BME and because of the history that we've set out in the briefs, I think it's clear that there were not penalties associated with this simple requirement of publishing a list of the hospital standard charges.

THE COURT: Thank you. I understand there are other issues in the case, but I think it would be helpful for me to turn to the government, let the government both respond to you and make whatever arguments it would like affirmatively, and then of course you'll have an opportunity to respond. So thank you, Ms. Stetson.

Mr. Baer, you'll have roughly half an hour, but whatever makes the most sense.

MR. BAER: Thank you very much, Your Honor. Again, Michael Baer from the Department of Justice on behalf of the Secretary.

Your Honor, patients deserve to know how much it's going to cost when they get hospital care, and they deserve to know it before they open a medical bill and, indeed, before they choose where they want to receive that care. That basic fundamental

transparency is not only a key feature of almost every market that we can think of in this country, it's a foundation of competition. It forces providers to be better, and it allows consumers to make more informed choices.

Congress, in enacting Section 2718 of the Public Health Service Act, brought some of that basic transparency to the market for healthcare services. HHS's Price Transparency Rule furthers that purpose, and it does so in a manner that is statutorily and constitutionally permissible.

I want to start with the statutory argument, and before I dive in there, I do want to note -- and Your Honor I think recognized this in the back-and-forth with plaintiffs' counsel -- that the focus of the statutory discussion has sort of shifted over the course of the briefing of argument with "charges," to my knowledge, not meaningfully appearing in plaintiffs' opening brief, to then in a footnote at page 3 in their reply brief being defined as the amount demanded for an item or service. And to Your Honor's question, I think the government agrees that that's the charges or amount demanded for an item or service.

And now it becomes sort of the linchpin of plaintiffs' argument in this oral argument that, well, standard charges have to mean chargemaster rates because "charges" only has one meaning, and I think just the plain meaning that the plaintiffs pointed to in their opposition and reply brief forecloses that.

If I negotiate with a contractor and say, all right, it's going to be $10,000 to do a repair of my kitchen, and the contractor comes back and says, yes, it's going to be $10,000; that's how much you're going to have to pay me, but just so you know, I like to add a zero at the end of all of my invoices, so when you see that, just be prepared, but you know you only have to pay me $10,000.

If I was telling my friends about that conversation, I would say, well, you know, my contractor's charging me $10,000 for this. I wouldn't inflate it by a factor of 10 just because of the quirk of the contractor's billing. And I think another reason why "charges" has to mean more than just sort of a set rate, which, to be clear, is what plaintiffs' definition would mean, that there was only one definition of "charge" that plaintiffs have in mind.

Plaintiffs cite from the Christensen article from the Administrative Record, and there that article says expressly, for purposes of that academic analysis, there is only one charge. All payers are charged, you know, the same charge, and then everything else is sort of a question of payment.

But if that's what Congress thought, if Congress really thought that "charge" had one meaning and, as Ms. Stetson suggests, Congress just wanted to use the sort of technical meaning of "charge" as it's used in the CMS provider manual, then Congress would have said "charge." It wouldn't have added

the modifier "standard" to the term.

In order for "standard" to be doing any work, "charge" has to have the meaning that plaintiffs' own dictionary definitions would suggest, which is the amount demanded for a particular service. So with that sort of foundational point out of the way for the moment, I do want --

THE COURT: Let me pause you, though, just to make sure that I understand. Your position, then, is that the word "charge" in this statute has to mean something different than in the provider manual and that it has to have its ordinary dictionary meaning, I take it, but different from that provider manual definition. And just to be very specific about this market, it is, in the context of Hospital A and Insurance Company B for Service C, the charge is the amount, I take it, that the hospital expects to be paid by the third party, by the insurer, for that service.

MR. BAER: Yes. And I would say the amount that they expect to be paid is the same as the amount that they're demanding to be paid. So whether you phrase it as an expectation or demand, yeah.

THE COURT: What about plaintiffs' argument here that relies on the Provider Reimbursement Manual?

MR. BAER: So the agency dealt with this in the rule's preamble. It noted that this meaning of "charge" exists, and it actually notes that in the provider manual. It says charges

should be listed at the gross rate, which is how you get to the term "gross charges" in the course of the rule.

In other words, I think even in the provider manual, because "charges" are identified as being listed at the gross rate, there's a sense that you could have sort of different rates within a concept of "charges," and the CMS provider manual is choosing one uniform definition for administrative simplicity.

I think Ms. Stetson talked about how this definition of "charge" is used as a result of Medicare's complicated scheme of regulations and reimbursements and outlier payments, and so I think it makes perfect sense for Medicare to have that more technical definition of "charge."

But as the agency noted in the rule's preamble, surely if Congress had wanted to just adopt that, it would have referenced either the fact that Medicare uses that term, or it just would have used the word "charge." It wouldn't have modified it with anything like "standard."

So I think there's both textual reasons based on the structure of the statute and how Medicare regulations are structured, but also just sort of common-sense intuition here, that if we're talking about standard charges, as plaintiffs acknowledge, there has to be some universe of nonstandard charges, which means "charges" has to have more than just one meaning. And I sort of understood until maybe the opposition reply brief, or possibly till argument, that the parties were

in agreement on that point.

THE COURT: So to stick with points that were maybe less developed in the briefs, although this one is more from me than anyone else, in your view does the verb "establish" when paired with "and make public" matter at all to your argument?

MR. BAER: Yes, Your Honor. And I think the way in which it most helpfully illustrates our argument is to make clear that Congress meant something other than just chargemaster rates. And I think this sort of core statutory interpretation division here between the parties is plaintiffs think that "standard charges" means only and exclusively chargemaster rates, and the government thinks that it's a broader term that includes sort of the most important point here, is negotiated rates, that those are the principal set, in fact, of standard charges that hospitals levy.

And so I think, as we note in our brief, if Congress had wanted to just have chargemaster rates be what hospitals published, it could have used that term, and I think the point Your Honor made about the verb "established" reinforces that point. If the chargemaster rates are something that hospitals have already had for decades and the rule's preamble makes clear that these are universal to each hospital, then there wouldn't be a need for the hospital to establish that list in any meaningful way.

So I do think the text of the statute in using "establish"

suggests that Congress didn't mean for something that wasn't already preexisting, that could just be uploaded in a matter of seconds to be the object of its disclosure requirement, and I think the rule reflects that fact.

THE COURT: But on the question of -- and I appreciate that. To go back to where you were before on the question of standard charges, at least as it relates to negotiated charges, it seems to me that, at least in certain hospital contexts including the one that Ms. Stetson referenced before, the Cleveland Clinic or some other systems, that at least in theory one could have, for any particular item or service, a large number of charges that would have to be required because the hospital or hospital system has negotiated with both a large number of payers who themselves have differently situated patients and plans.

So at least, hypothetically, a hospital for a particular item or particular service might be required by this rule to publish a large number of amounts as standard charges, and it seems at least potentially counterintuitive that you could have a large number of charges for the same item or service all considered standard.

MR. BAER: So, Your Honor, at bottom I agree with your characterization that there could be a large number of standard charges under this rule for a particular item or service. I think the reason why that sounds, you know, maybe

initially counterintuitive is that there just is not another market that looks like the market for hospital services.

As Your Honor noted in the back-and-forth with Ms. Stetson earlier, roughly 90 percent of patients are going to face a negotiated rate when they receive care from a hospital. And so to say that you would write off from the outset 90 percent of paying patients in conceiving of what a standard charge means, that seems totally atextual to me.

What the agency's explanation in the rule does is it sort of walks through this point and says, well, all right, the first thing you have to figure out is, you know, how does this market structure charge for different kinds of groups? And there are self-pay patients, and then there are patients covered by, you know, third-party payers, by insurance companies, essentially.

And so if you start from that premise, then, okay, there's a set of rates, you know, perhaps a chargemaster rate or a standardized discounted cash price that applies to the self-pay patients, but then when you start to look at the lion's share of the patients, those with coverage, there needs to be some way to identify what the standard charge is.

And the best way -- and candidly, Your Honor, I think the only way that anyone in this case has suggested to define a standard charge that actually applies to those patients is to just look at them, sort of group of patient by group of patient, look at the rates that have been set in advance for a defined

group of patients, and that may mean that you have a number of different charges because the way this market is structured results in a bunch of different insurance companies negotiating with hospitals. But that fact is sort of downstream from the initial point, which is that the term has to capture, in some meaningful way, this lion's share of patients.

And the only other quick point I would note on this, Your Honor, to the question about, well, you know, are you going to have 3,000 different charges along the lines of the Cleveland Clinic, there's a distinction between the number of charges for an item or service and the number of different contracts or rate plans at issue. In other words, a hospital could have a thousand different contracts with insurers, and yet those contracts for a particular item all have, you know, only ten different charges. So it's quite possible that you're actually dealing with a smaller number of charges just across a larger number of plans.

THE COURT: It seems to me that both are possible and that in the context where, even if you have a huge number of payers with a large number of plans where the hypothetical possibility was 3,000 different charge amounts but you actually only land on 10, the hospital still has to disclose for each of the 10 which of the very many payers is in the bucket that you're talking about.

And so while there may only be ten dollar amounts, you

still have, right, a bunch of iterations that is, you know, dollar amount A applies to both Aetna and United Healthcare and Cigna, dollar amount B applies to 78 insurers, and dollar amount C applies to something else.

So I get your point that there are potentially going to be overlapping amounts where different insurance companies have negotiated the same charge with a hospital, but it's not as if the rule requires just the charge amount. It requires the charge amount and the payer's name. Correct?

MR. BAER: Absolutely, Your Honor. And it does that again -- this is sort of downstream of the structure of the market. It does that because, for each patient, the charge that you're going to face depends on that information that's going to be displayed. The charge that the hospital levies for my care when I go to a hospital will depend on the rate that my insurance company has negotiated with that hospital, and that rate is set from the moment I walk in the door.

Plaintiffs, in their briefs, try and analogize this to other contexts where we think of one-off negotiations as being nonstandard, like if you're negotiating for a lower price from a restaurant for a particular catered event or if you're negotiating with an automaker. But there you're talking about direct consumer-to-supplier negotiations in the context of a one-off transaction.

If I am similarly situated when I walk through a hospital's

doors to everyone else on my insurance plan in terms of the standard charges that are going to apply to me and like the 90 percent of patients that receive hospital care who have third-party payer coverage, that same structure applies to all of us I think is the best reading of the statute and, at a minimum, certainly a reasonable reading of the statute to define standard charges in a way that has some direct meaning for that large category of patients.

THE COURT: I note in this argument -- and I apologize for interrupting, awkwardly, I suppose, on the video -- but at least as it relates to the statutory interpretation *Chevron* question, don't the maximum and minimum -- I forget the term of art -- the de-identified maximum and minimum charges, at least for statutory interpretation purposes, don't they stand or fall with the payer-negotiated rate definition? Is there any argument that those are somehow more standard than all of the other payer-negotiated rates?

MR. BAER: No, Your Honor. I agree that if you're thinking about just the definition of "standard charges," they also certainly rise or fall. I think the only way in which you would get to a different result is if somehow the number of standard charges was the point that was giving Your Honor particular pause, then de-identified minimum and maximum is just a smaller number of lines in the spreadsheet. But I think otherwise, yes, they are -- as we describe them in the brief,

that's essentially a data display requirement, that if all payer-specific negotiated rates are going to be published, then it's helpful for consumers to see the minimum and maximum range, essentially, that they would be subject to from that particular hospital.

THE COURT: So can you answer this question for me, which is, under this rule, what charges need not be published?

MR. BAER: So, Your Honor, under this rule, the principal category of charges that need not be published for all of the bespoke negotiated rates that patients arrive at with hospitals. For instance, the rule explains that the discounted cash price applies to discounts that are sort of universally available, and so discounted cash prices that depend more on a patient's circumstances, those rates need not be published under the rule because those are more tailored.

Similarly, there are lots of instances where a patient who is self-pay may come to a hospital and try to negotiated a different rate based on what they can or can't afford, and all of those sort of one-off negotiated prices would not be published under the rule and wouldn't have to be published.

THE COURT: Does the agency or do you know, at least roughly, what percentage of transactions occur with respect to items or services that would fit within this category of not requiring publication?

MR. BAER: I don't, Your Honor. But I would just

note, I would think it actually is a mark in favor of the rule. There's a fairly narrow category of rates that are not standard. I think in most contexts we think that rates tend to be more standardized and that we would also think that when Congress required the publication of standard charges, it wanted to put out information that was useful to patients.

And so the upshot of the agency's definition of standard charges is that you have a rate that most patients are going to be able to look at, and that's the rate that's going to apply to them. That's, I think, the net benefit of the statute.

And I wanted to turn briefly to the question of items and services and service packages and to DRGs.

THE COURT: Yes, please.

MR. BAER: Because even if you disagree with everything that I've just been saying -- again, the two interpretations at issue here are "standard charges" means chargemaster rates, or it means some definition that includes negotiated rates; but the agency's definition is the only one that's even before us on that score. But it cannot mean chargemaster rates for three reasons:

The first is the reason that we've already been discussing, just in terms of why intuitively it wouldn't make sense for Congress to define a rate that only applies really to 10 percent or fewer of patients, but the second comes directly from the statute's text, which is, before requiring the publication of

standard charges, Congress specified that this was for items and services. And Congress gave an example of those kinds of items and services: diagnosis-related groups established under the Medicare Act.

Now, the agency, in going through the relevant statutory definitions in the rule, defines "items and services" before it gets to the definition of "standard charges." And I don't understand plaintiffs to have ever taken issue with at least the high-level agency definition of "items and services" as including service packages. But as the agency notes in the rule, service packages don't appear on hospital chargemasters. Chargemasters are individual items and services.

So if the parties agree that items and services includes service packages, and service packages don't appear on hospital chargemasters, then there is not a rate that plaintiffs have pointed to or that I'm aware of that could count as a standard charge for any kind of service package, whether it's a diagnosis-related group or one of the other kind of service packages that hospitals use.

And if we could talk specifically about the diagnosis-related group aspect part of this, the reason why that so clearly illustrates why plaintiffs' definition isn't viable is because diagnosis-related groups are a way of charging based, unsurprisingly, on a diagnosis as well as other patient characteristics. And, importantly, it's not tied to the number

of items and services that a patient consumes or otherwise receives from a hospital.

So the same patient who's in, let's say, an appendectomy diagnosis-related group would face the same charge regardless of, let's say, the number of bags of IV fluid or particular pain pills or other variables like time spent in a hospital bed. There are sort of outlier cases, but as a general rule, that characterization is true, which means you couldn't have a chargemaster rate for a diagnosis-related group because you'd be trying to set a rate for a not-fixed amount of items and services.

So that alone renders it textually impossible that when Congress included "diagnosis-related group" in Section 2718, it meant for only chargemaster rates to be published. And that's a principal reason why I think the government wins here under step one of *Chevron,* because we have the best reading of the statute and the only reading that sort of makes textual sense of that phrase.

But if we get to *Chevron* step two, I would note that plaintiffs do not really put forward another alternative in between "standard charges" means only chargemaster rates and "standard charges" means the regular rates as the government has defined here. So, regardless of what level of *Chevron* analysis you're looking at, the only alternative on the table is that "standard charges" means only chargemaster rates, and that's

the one category of charge that we know unequivocally Congress couldn't have meant, because the inclusion of diagnosis-related groups forecloses it.

The final point I would note on the statutory interpretation question is there's another text-based reason why the government has the better reading here, and that's the statutory purpose, which here appears in the provision text. Section 2718 is entitled "Bringing Down the Cost of Healthcare Coverage."

And I don't think there's a dispute that publishing standard charges in a way that applies to a larger percentage of patients who had actually faced them -- in other words, in a way not just limited to the 10 percent that might be the benefit under a system where you just publish the chargemaster rate. Publishing that broader set has a much more likely and more direct effect on bringing down the cost of healthcare and healthcare coverage, which is another reason why it's the better reading of the statute.

THE COURT: I want to put a pin there for one second because I think it's a question that I want to get to in connection with the First Amendment question.

MR. BAER: Yes.

THE COURT: But on the *Chevron* point, plaintiffs make some arguments about the fact that this was not just an agency rulemaking arising out of a statute, but was of course following an EO, and the Executive Order does have some

substantive kick to it. So my question is, in your view, could the agency have disregarded the EO and defined "standard charges" to be just chargemaster charges?

MR. BAER: In the Final Rule? Yes. The Executive Order requires the agency to propose a rule with a certain definition of "standard charges." That definition included payer-specific negotiated rates, but the Executive Order didn't require the agency to adopt that rule following notice and comment.

In fact, one of the items that the agency asked for comment on was the standard charges that it has already defined in the Proposed Rule that was just chargemaster and payer-specific negotiated rates. So it asked for comment on that specifically, and it also asked for comment on whether there were other standard charges that should be included.

And, of course, the definition that the agency arrived at, including, among other things, discounted cash prices, is different than the definition that the Executive Order put forward. And as I think we note in the brief, the agency doesn't cite the Executive Order as, you know, a sort of authoritative basis for setting the definition here once it had arrived at the Final Rule. So I just don't see how the Executive Order could change the *Chevron* analysis.

And I would note that that's the only argument that plaintiffs raise as to why sort of the *Chevron* framework

shouldn't apply here. In other words, they don't contest that if Your Honor finds this to be an ambiguous provision, this would be the normal sort of case where HHS had interpretive authority under -- I believe it's Section 300gg-92 of Title 42, which is the rulemaking authority for the PHS Act. And if the agency is acting pursuant to that authority, then it has the normal *Chevron* ability to interpret ambiguous terms.

THE COURT: Right. I'm not in a particularly good position to question the overall applicability of *Chevron* in agency interpretations of their own statutes. That's for people above my pay grade, so to speak.

Can we now go to the First Amendment question?

MR. BAER: Yes, Your Honor.

THE COURT: I want to get some clarity around -- and maybe the easiest question is if you could just articulate as clearly as possible what specifically the governmental interest in this rule is or that the rule is designed to empower.

MR. BAER: Yes, Your Honor. There are two interests, and they come directly from the text of the rule's preamble. The rule identifies the two substantial interests as, first, providing consumers with factual information about the cost of healthcare, and second, as lowering the cost of healthcare coverage.

THE COURT: So as to the first, if that were sufficient, wouldn't that mean, essentially, that any disclosure

regime would pass First Amendment muster because that interest would always be linked, or linked enough, to the disclosure?

MR. BAER: So a couple things on that, Your Honor. First, I don't mean to suggest that a disclosure of any information is automatically sufficient to clear the interest hurdle of the First Amendment, but I do think factual pricing information about the costs of healthcare is, of course, sufficient to clear that hurdle given that I don't take there to be any disagreement about the opacity of the market for healthcare services and frankly the demand on the part of patients to know how much their care is going to cost. The agency found overwhelming interest in that information in the rule's comments.

But I would also note, Your Honor, that the *en banc* court in *AMI* sort of took that same premise that frankly came to the conclusion that, actually, yes, most disclosure requirements will pass scrutiny under *Zauderer* because they have a self-evident tendency to promote the disclosure of the information that was sought to be released.

And so I don't think Your Honor needs to endorse that more robust version in order to rule for the government here given how undisputably important pricing information about healthcare is and accurate information about healthcare pricing, but I think under *AMI* almost -- in other words, under *AMI*, a disclosure requirement that was less effective than this one I think would

still pass muster under *Zauderer.*

And a principal reason for that, Your Honor, shifting out to that question of the application of *Zauderer*, *Zauderer* applies to the disclosure of purely factual and noncontroversial information and permits the government to require those disclosures as long as they're not unjustified and unduly burdensome in a manner that chills commercial speech.

So taking the first part of that, of purely factual and noncontroversial, I find it hard to believe that accurate pricing information could ever be considered nonfactual or even controversial, at least within how those terms have been used in applying *Zauderer.* This is a core, fact-based disclosure requirement.

And I take plaintiffs' only real challenge to those threshold requirements to be their claim that, well, this is misleading because some consumers might be confused by that. But as an initial matter, when it comes to First Amendment law, the Court -- and it says this in *Central Hudson* -- has consistently found that disclosing more factual information is generally less likely to be misleading.

I would also note that it's interesting that plaintiffs don't seem to take issue with disclosing chargemaster rates, which, although we certainly wouldn't think that disclosure of chargemaster rates is misleading, there's no question that the disclosure of payer-specific negotiated rates is more relevant

to more people than chargemaster rates is. So there's sort of some, I think, selective outrage or application going on there.

But much more fundamentally, I think the reason why disclosure isn't misleading is because it's so significantly better than the information that's available to patients under the status quo. We note the sort of core options that a lot of patients have today including Google or going to crowdsourcing websites or finding other ways of trying to track down how much a procedure is going to cost.

And I thought it was telling that Ms. Stetson began her presentation on the First Amendment by comparing what happens under this rule to the Transparency in Coverage Rule because I thought that echoed a theme from the briefs, which was to compare and contrast the Price Transparency Rule, this rule, with some sort of idealized version of perfect information or transparency as opposed to what I think should actually be the baseline here, which is does this make the market for healthcare services better? Does it make patients more informed? Does it lower healthcare cost?

THE COURT: So on that question -- right. Okay. So you're about to get there, which is my next question, which is, so on the second government interest that you identify, which is the lowering of healthcare costs, what's the evidence that you have that this rule will --

MR. BAER: So, Your Honor, we set this out first

in our opening brief. We sort of set out three categories of evidence. And I think walking through this here, the agency basically relies on -- and I think the most empirical evidence is sort of two principal buckets.

The first is general economic theory about price transparency, and here there are -- you know, there's the CRS report that documents price transparency initiatives in a number of different industries and concludes that price transparency efforts generally tend to reduce costs by promoting competition, but then there are a series of articles in the administrative record that apply this specifically in the context of healthcare and of hospital services.

So, for instance, there are several articles that deal with medical imaging services. I think the Zach Brown articles which are at, I think, 4926 of the administrative record and right around 5000 of the administrative record, those do a great job of walking through how similar price transparency efforts in New Hampshire, where payer-specific negotiated rates were disclosed, led to real cost savings on medical imaging procedures.

So, in particular, for patients with deductibles, those patients could save an average of $200, or roughly 36 percent, for their services, for medical imaging services. And across the board, patients save, I think, roughly 5 percent on medical imaging services.

There are then other studies that look at -- and these

are in particular the Lieber article and the Whaley study that look at different corporate price transparency efforts. So that gave patients access to tools and tracked how they used the tools to search for prices, to search for lower prices and compare costs, and each of those articles also concluded that price transparency efforts brought down costs. And those effects were particularly pronounced in a context of what the rule calls "shoppable services."

So, in other words, in dealing with services that a patient can schedule in advance, it makes sense that the patient's going to be able to sort of, in that context, take time, look at different prices, and arrive at what is the best option and the most affordable.

The one thing I would note in particular about the Brown article -- sorry to jump back to that for a second -- is it helpfully lays out two different mechanisms as to why the rule will lower costs.

The first is sort of the demand side of things, and here the intuition is simple: If I'm the patient and I'm looking at different prices, I'm going to choose the lower-cost option. So that means I'm spending less. And then if you're looking sort of systemwide, people are spending less overall.

But the other mechanism it identifies is what it refers to as the supply-side mechanism. In other words, once hospitals know that patients can be engaged in that kind of comparison,

that forces them to be more sensitive about the prices that they charge and the rates they negotiate with insurance companies.

The article modeled and found evidence of both of those effects at play in New Hampshire in the context of the market for medical imaging services, and I think that's a pretty robust reason to think that this rule is going to have effect both on how patients use the tools that the rule will allow to come into existence and in terms of how hospitals will react to those tools.

So, Your Honor, if we were -- you know, before we started talking in the weeds about these substantial interests, we were at the sort of *Zauderer* stage of the inquiry of unjustified and unduly burdensome I think is where we come to because we've sort of been through the factual and noncontroversial.

The one thing I would note in terms of whether a restriction on speech is unjustified or unduly burdensome is it's not a question of whether it's unjustified in the abstract or burdensome in the way that the APA might require courts to investigate. The burden in a First Amendment case is, of course, the burden on speech.

So even if one -- we'll sort of -- we can get to it in a minute if Your Honor would like, the Transparency in Coverage Rule, but the thing I would just note at the outset is that when Ms. Stetson is pointing to that as an alternative, there's no suggestion that there is a different burden on speech between the rule that HHS promulgated here and the rule that's under

consideration there. In fact, plaintiffs concede in their opposition to our reply brief that the rule doesn't chill commercial speech.

So if the rule doesn't chill commercial speech, it almost *a fortiori* can't be unjustified and unduly burdensome with respect to its effect on speech. So the sort of cost burdens, the notion that this is somehow going to cripple hospitals, that may be relevant under the arbitrary and capricious analysis, and we can turn to that in just a moment, but under *Zauderer*, in terms of assessing the burden on speech, that's not the inquiry for the Court to engage in.

THE COURT: Is that a relevant inquiry under *Central Hudson*?

MR. BAER: No, Your Honor, because as cases like *McCullen v. Coakley* which plaintiffs cite indicate, the relevant question for intermediate scrutiny is whether there's an alternative that burdens substantially less speech.

So, again, the Court's question of comparing alternatives, which is what I took Ms. Stetson to be doing in bringing up the Transparency in Coverage Rule, that only matters if you're at the *Central Hudson* point of the inquiry. But even there, the difference between alternatives is a question of the burden on speech, not whether the agency has chosen the perfect means of accomplishing a particular goal.

And I would just note briefly, in thinking about the

Price Transparency Rule versus the Transparency in Coverage Rule -- which, as an aside, they are far too similarly named, so I apologize for that.

One thing that you get from the Price Transparency Rule that the Transparency in Coverage proposed rule, which has not yet been promulgated -- you know, who knows what if any changes there will be to what was proposed to be promulgated, but even if it were to be promulgated as proposed, it wouldn't allow patients to compare prices within a hospital.

And so one of the articles in the administrative record, the *Consumer Reports* article on discounted cash prices notes that for patients with high deductibles, it can actually be more affordable to choose a discounted cash price than it can be to go through an insurance company's reimbursement mechanism. So if a patient with a high deductible finds out that it's cheaper to go through a hospital's discounted cash price, that patient could save significant sums of money on care.

But the Transparency in Coverage Rule, because it just regulates insurers rather than providers, wouldn't allow for that same sort of comparative. Having that all together on the same website and the same spreadsheet is a unique benefit to consumers that only comes from this.

THE COURT: Mr. Baer, I don't think you need to spend time on the arbitrary and capricious argument, not because I don't think it's important, but because I think

I have a very good handle on it. But could you respond, I'd say briefly so we have time for Ms. Stetson to do rebuttal and then a surrebuttal for you if you'd like, to talk about the penalties question?

MR. BAER: Yes, Your Honor. And I think the important point to start with here is that the parties agree that, as written, the statute authorizes the imposition of penalties, which means that to get to the conclusion that the Court shouldn't read the statute as written, there has to be an invocation of the scrivener's error doctrine. And I don't see any point in plaintiffs' brief where they cite to or meaningfully attempt to show that they have met the high standard that must be necessary to invalidate a provision of a statute under a scrivener's error theory.

And as an initial matter, the first thing you need in order to invalidate such a provision is sort of a clear, instant sense that Congress got it wrong. But, of course, here that would mean thinking that Congress chose not to make a disclosure requirement enforceable, a disclosure requirement that, as this very case illustrates, many hospitals don't want to comply with.

And so I think the sort of -- if you're starting from an intuitive look at the statutory structure, it makes sense that Congress would put a new requirement on hospitals and at the same time make that requirement enforceable. Otherwise, you know, hospitals could get away with not publishing the

information that Congress had required patients to now have access to.

But getting into the weeds of it, I think the most compelling argument against plaintiffs' position here is their own theory as to how Congress allegedly screwed this up, right? Because their theory is, look, the ACA, the drafting was complicated, we were putting together a bunch of different positions, and you initially had one bill that dealt with medical loss ratio. That bill became what are now subsections (a) and (b) of Section 2718.

Then you had other provisions, including the standard charges provision, which are now subsections (c), (d), and (e). And when Congress fused those all together, it just didn't pay attention to how those provisions would interact, and so it forgot that in subsection (b) it used the term "section" when describing the scope of the penalties authority when it meant something else.

As a brief aside, in their opening briefs, plaintiffs suggest that something else is "subsection," but we note that "subsection" wouldn't have corrected the error as plaintiffs see it, because then the penalties wouldn't apply to subsection (a) of 2718; it just would have applied to subsection (b). And both parties agree that that is not what Congress intended.

But setting aside that more minor point, in subsections (c) and (d) of the statute, 2718(c) and (d) each reference

subsection (a) or subsection (b). In other words, Congress paid attention to how those subsections interact with the medical-loss ratio provisions. And so it's not just that Congress had to be careless under plaintiffs' reading, but that Congress had to be selectively careless, that it paid attention to how (c) and (d) interact with (a) and (b) but not how (b) interacts with subsection (e).

And so with apologies for getting a little too alphabetical there, Your Honor, I think that fact all but defeats the scrivener's error argument. It's just not plausible that Congress was careless in that particular way. And even if it was theoretically possible, plaintiffs haven't come close to the showing that would be necessary to invalidate the enforcement provision as applied to subsection (e) on a theory of scrivener's error.

THE COURT: Thank you.

Ms. Stetson -- I'll let you mute, Mr. Baer, and Ms. Stetson, you can unmute. I'm happy to hear any and all things you would like in rebuttal. I would like you to address at some point -- you can start with it or do it as you see fit, but my question is, in your view, what does the statute require to be published with respect to DRGs?

MS. STETSON: I think in our view -- I'd like to start otherwise with the text of the statute, and that's as good a place to start as any. I think what the statute requires

is what the statute sets forth, which is standard charges including for DRG. And I think I mentioned in my first outing here that our interpretation of that is, just as a hospital is required to publish standard charges for items and services, it's also required to post standard charges for groups of items and services.

Now, Mr. Baer made the point that, depending on a particular patient, there may be different groups of items and services within a particular DRG. Somebody might need three doses of ibuprofen; another person needs two. I think the way that a lot of hospitals have chosen to think about that is by averaging what their standard charges are for the groupings of items and services across DRGs.

The other way to look at what standard charges, including for DRGs is, is just a reminder that in other places in the Medicare statute and regulations, the payments that Medicare that are not negotiated in the least, the payments that Medicare imposes for DRGs are published. So whether you look at it as a grouping of standard charges or you look at it as the reminder that the payment rates for DRGs are published, I think those are the two most reasonable interpretations of that phrase.

What is not a reasonable interpretation of that phrase is some kind of a sort of Rube Goldberg extrapolation from the mention of DRGs to the presence of hundreds of privately negotiated third-party payer rates.

But I want to go back to the whole text for a minute because I found it telling that Mr. Baer omitted something in his discussion. He talked about the title, he talked about standard charges, and he talked about "including for diagnosis-related groups." What he missed was those two words, "a list." And I think that omission is probably understandable because there is simply no way, no way, to characterize what the government is requiring of each and every hospital in the country as being the publication of "a list."

I think the government below, and maybe a little bit in its brief, tries to pass off this idea that it's really -- yes, it may be a massive, massive data set, but it's really just one super big list. But if you look at page 65574 of the Final Rule, you'll see that CMS itself understands exactly what it's doing.

It says, "We clarify that the hospital must identify and clearly associate each set of payer-specific negotiated charges with the name of the third-party payer and plan." This is a point that you made earlier, Judge Nichols.

For example, the hospital's list of payer-specific negotiated charges for Payer X's Silver Plan could be in one tab or column in a spreadsheet titled Payer X Silver Plan, while the list of payer-specific negotiated charges for Payer Y's Gold Plan could be in another tab or column. The propagation from "a list" of standard charges to many dozens or hundreds of

highly particularized charges is where the textual argument falls down, and I think that's why you didn't hear a response on that from Mr. Baer.

With respect to charges themselves, I think what Mr. Baer returned to was something that I mentioned earlier and that was discussed in the preamble, which is this idea that because the Provider Reimbursement Manual just talks about charges and the Final Rule talks about standard charges, I think what Mr. Baer says is that means that there has to be more than one charge; and, accordingly, I guess where the logical leap is, is so there has to be more than one standard charge. There are a couple elements of problem with that.

The first is, as I mentioned earlier, the Provider Reimbursement Manual definition of "charges" specifically says charges are the regular rate. So what you have, if you take that definition and you import it into the statute, is the standard regular rate.

If you take standard charges and you understand, as Your Honor also pointed out, that there may be circumstances where the charges are not standard, that doesn't entitle the government to create hundreds and hundreds of new types of standard charges.

This is not a question about who is paying the most uniform charge among the most people. The question is what is the standardized charge that the hospital is publishing to all

payers, whether it's Medicare or a third-party payer. What is the standardized charge? This isn't a standard as in let's find out how many people are paying the most amount and that will be the charge. That's a concept that was used in the two cases that Mr. Baer cited in his brief or some other definition of "standard charge." It's not what we're talking about here.

So I think what CMS is bounded by, in addition to the statute and to that concept of a list of standard charges, is a couple of different constraints. One of them is just the reality of the hospital charge system, and the other one is that CMS definition of "charges."

Because what I heard Mr. Baer do after pivoting from "standard charges" has to mean that there are different types of charges, therefore there are different types of standard charges, what he ended up saying was something along the lines of it simply doesn't make sense if so few people are subject to the chargemaster charge; we have to find a way to capture the meaning of that along the lines reflecting the lion's share of patients. That's what he said.

I think that is the point at which CMS departs from the statute and starts imposing its own quite different legislative prerogatives on that particular statute. It very well could be that a different legislature could have enacted something that said hospitals must publish all of their negotiated payment rates. You would, by the way, expect to see at least a sentence

of legislative history on that if that were the case, and there is nothing related to legislative history on this particular, very modest directive.

But what you can't do, and I think what CMS is trying so hard to do here, is to solve a problem with a tool that it doesn't have. What CMS is claiming is the authority to impose this massive listing of multiple charges across thousands of contracts by reference to a list of standard charges. And it could be, as I said, that in another universe there might have been a different way to do that, but the government can't take that statutory authority and expand it to this particular set of circumstances.

I think when Your Honor asked the question of Mr. Baer about what charges need not be published, that was quite a telling answer, because what Mr. Baer said was, well, all of those one-off charges, when a patient comes in and negotiates a different discount, when a self-pay patient comes in, for example, all of those what he called one-off charges wouldn't be standard charges. So, basically, standard charges are every single charge except for a few charges that are really unusual.

And you see this in the government's brief as well. If you look at page 12 of their brief, they talk about these groups of patients, and that's their shorthand for this second type of standard charge, these groups of patients that the grouping is based on the patient's diagnosis and other factors such as age.

So the granularity of what the government apparently thinks is a standard charge goes pretty deep, all the way, apparently, to the one-off circumstances that the government is willing to concede are not themselves standard charges. That completely explodes the definition of what it means to be a standard charge, particularly when you couple it with a list of standard charges.

On the First Amendment issue, I would say a couple things. The first is no one -- as I said earlier, no one is disputing, least of all the hospitals that are in the thick of this every day, how important it is that patients understand how much they may have to pay for their services.

The question on which we depart is, is this a constitutionally appropriate method, to force the hospitals to disclose not the out-of-pocket rates, as I said earlier, but the payer-negotiated, privately-negotiated rates that the hospitals have worked out over many months of negotiations with each of these payers, which, by the way, as we say in our brief, is confidential, trade-secret protected information.

It took Mr. Baer awhile to get around to the undue burden point, but I do have to take issue with the idea that the only thing you look at from an undue burden argument is the burden on speech. That's not the way that I understand the undue burden requirements to demand. The undue burden requirement is essentially the *Zauderer* version of the fit requirement.

So what you're asking is, is there a less burdensome way for the government to compel the disclosure of the information it's interested in?

And the reason that I landed so hard on that first component of the insurance coverage rule is not because it is, as Mr. Baer says, some idealized version of what we'd like; it is a very real version of what is possible and efficient and practicable, because the government's already proposed it in another rule.

So it's not a question about whether this also can serve some minor, marginal, indirect benefit. The question with respect to either *Central Hudson* or *Zauderer* is does this rule do anything to directly and materially advance the government's interest in doing what all of us frankly want, which is get patients the information about their out-of-pocket expenses in as efficient and practical a way as possible.

With respect to -- I want to mention one thing, because Mr. Baer mentioned the state of New Hampshire, and I said earlier and CMS has said, and I think it's also in its insurance coverage rule, that states have really been in the forefront of transparency requirements. I think there are over 30 different states that have transparency requirements. New Hampshire is one of them, as Mr. Baer mentioned.

New Hampshire set up its own state department to which payers submit encrypted claims information for the department

to then average and publish across kind of an average list of payers, which I think there are four main payers that it lists with respect to certain items and services. That is a far, far cry from requiring hospitals to publish all of their negotiated rates.

So I think the fact that there is no other state that I have found that comes even close to requiring hospitals to publish privately negotiated, third-party payer rates tells you a great deal about whether this particular regulation is in the right lane or not.

So whether you look at that as a First Amendment issue, how does this directly and materially advance the government's interest, how burdensome is it on hospitals that are crushed under other obligations right now to have to propagate tens of millions of lines of data, whether you look at it under either of those two standards, I think the First Amendment argument gets you to the same place. But, again, one of the things that this Court and other judges are always enjoined to do is to not arrive at a First Amendment argument unless you have to.

So one of the things, I think, to return back to is that question that you mentioned, Your Honor, which is, is this a reasonable interpretation in the end? And back to the statutory interpretation, particularly in light of that nest of First Amendment issues that would await if this interpretation is found to be reasonable, I think that is yet one more thumb on

the scale while you simply cannot say that a list of standard charges can mean in any universe -- *Chevron I*, *II*, or zero -- that a list of standard charges can mean hundreds of lists of privately negotiated charges.

THE COURT: Thank you, Ms. Stetson.

Mr. Baer, happy to hear, frankly, as long as you would like, up to 10 minutes or so.

MR. BAER: Thank you, Your Honor.

THE COURT: No requirement to take 10 minutes.

MR. BAER: Hopefully, we'll keep it under that, especially because I realize I probably ran a little long at the outset. The clock on the microwave that is directly behind the computer here is harder to read than when I was initially setting up my own Rube Goldberg contraption for this argument.

THE COURT: Certainly, I am capable of shortening advocates' time if I deem necessary, and I did not, so it's as much my issue as yours. So don't worry about it. Take the time you need.

MR. BAER: Thank you, Your Honor. I'd like to start with the statutory interpretation question, and I'd like to start sort of very narrowly at the risk of buying more into this replacing all of our weight on DRG point, because I don't think we are, and we'll get into that in a second.

But on the language that Ms. Stetson quoted from page 12 of our brief, she said the government's reading has to be wrong

because look at how granularly they are defining the types of standard charges at issue here not just based on the diagnosis, but based on other factors such as age. That's on page 12 of our opening brief. But, Your Honor, that wasn't how we were defining "standard charges." That was during a part of the brief where we're recounting how diagnosis-related groups work. That's how each of the Medicare diagnosis-related groups is structured.

And so what I think that intuition that you just heard from Ms. Stetson, that, well, how can something that granular constitute a standard charge, shows you exactly why, when Congress chose to include Medicare DRGs as among the items and services for which standard charges must be listed, it absolutely was envisioning a version of standard charges that is more granular than just the chargemaster rate.

In other words, all 600 or so MS DRGs, Medicare System DRGs, make those same granular determinations, and yet Congress chose them not just as an example. That is literally the only example in the statute to list the kind of items and services for which hospitals needed to make standard charges public.

And on that point, when Your Honor pressed Ms. Stetson about, well, what does a standard charge for a DRG look like in plaintiffs' world? I'm still not entirely sure I have my head around what the answer is, but as I understood it, it was one of two things:

One was some sort of average across DRG -- for a particular DRG, and I think there is no evidence that when Congress required the publication of standard charges, it required hospitals to calculate some new rate, to essentially invent a rate for the sake of publishing it.

And the second option was, well, maybe it's Medicare reimbursement rates for DRGs. But as Ms. Stetson, I think, noted in the next sentence, those are already public, and Medicare is the entity that publishes that. So those aren't even meaningfully the hospital's charges, and they're certainly not charges established by the hospital, because Medicare is the entity setting those rates.

And so what this gets us back to is, as I noted during my opening presentation, plaintiffs just don't have an answer for how this statute accounts for service packages, whether that's diagnosis-related groups or any other kind of service package that would not be listed on a chargemaster, and you can't square the circle of this statute when you don't have a clear answer as to what Congress meant by including diagnosis-related groups as the one example of items or services.

But stepping back, even though I think, as we put it in our reply, the diagnosis-related groups issue is kind of the nail in the coffin for plaintiffs' interpretation of the statute, it's by no means the linchpin of the government's reading, because the focus of our reading of "standard charges" stems from the

premise that you need to look at different groups of patients in order to figure out what the regular rates are because that's how the hospital market is structured.

And there -- you know, I think Ms. Stetson noted in her reply or in her rebuttal that it would be reasonable for Congress to have used the term "standard charge" to mean a charge that only applied to a small group of patients, you know, let's say 10 percent. And in certain contexts, perhaps that would be true. You know, you could imagine standard charges in some markets applying to a larger set of patients and standard charges applying to a smaller set.

But our point isn't just the absolute number of patients who are ultimately charged the chargemaster rate. It's that the chargemaster rate doesn't meaningfully come into play for the 90 percent of patients with third-party coverage.

So it's not just what a patient ultimately ends up paying; it's a question of can you look at a standard charge and get something useful for the patients for which you are claiming it is standard. And the agency's point was that you need to look at patients based on how they're paying for hospital services before you can figure out what it makes sense to define as the standard rate.

Turning then to the First Amendment point, I want to -- actually, sorry. Before I go to the First Amendment point, I want to just briefly note on the "a list" argument, which

received a little more attention in Ms. Stetson's rebuttal.

First of all, if a hospital wanted to, it could list, with just two columns, all of the standard charges that are required here. So to the extent that a -- so, yes, CMS suggested in the rule that you could do it in a multi-tab spreadsheet. That's just a question of how you display the data. I don't think there's anything inherent in "a list" that would prevent a hospital from, you know, doing this all in just two columns with a lot of different rows.

But more to the point, the Providence chargemaster that we cite, Providence being one of the hospital plaintiffs here, has three tabs on its chargemaster spreadsheet, one for inpatient services, one for pharmaceuticals, and I believe one for outpatient services.

And there's no argument from plaintiffs that a chargemaster is somehow more than a list. How hospitals choose to display that data within an Excel file doesn't change the meaning of "a list" as Congress used in the statute, and we give an example in our reply brief.

If Congress had said that hospitals must publish a list of every rate they have charged and every payment they have accepted from all patients in the previous year, a hospital couldn't avoid the clear import of that requirement just by claiming that "a list" wouldn't allow for it even though that "a list" in those circumstances would clearly have hundreds of

millions more rows and entries than the list that is required here.

But finally, turning to the First Amendment, Ms. Stetson, in talking about burden, started out by contesting the premise that the burden that matters from a First Amendment perspective is just the burden on speech. She reframed the issue as, well, is there a less burdensome way to accomplish the goal?

But I think the assumption that's still lurking there is: less burdensome with respect to what? And, again, all of the First Amendment cases that the parties have cited in the briefs pay attention to the burden on speech, not the burden in collecting the information.

I think the hospitals' argument would be similar here if, rather than a disclosure requirement, a hospital's just required to keep a list of these same charges on hand for the government to inspect when it so chose, sort of like the way OSHA requires recordkeeping in the workplace requirement. They wouldn't have any different argument about the cost or burden on hospitals for collecting that information, yet I think there'd be no argument that that was in any way a burden on speech.

And so if at the end of the day the burden stems from like the collection and colation of the data rather than any burden on their rights as speakers, any limit on commercial speech, then that just reenforces that this isn't a First Amendment question principally; this is a question about whether or not the agency

chose a reasonable means of accomplishing the rule's end.

And I want to close on that point because Ms. Stetson, in her opening presentation, talked about, you know, the comments during the rulemaking period that suggested that the burden here was going to be, you know, massive, undue, the agency totally underestimated it.

Well, Your Honor, the agency significantly revised upwards its estimate of average cost in arriving at the Final Rule and reached an estimate of roughly $12,000 in the first year and $3600 in the second year, which was -- I'm forgetting the exact factor, but an order of magnitude more than the agency had initially estimated. So the agency paid attention to those concerns for hospitals.

And in the briefing, I don't know that the plaintiffs cite any comment in the record that criticizes the ultimate amounts or methodology that the agency used for arriving at the estimate cost, certainly not anything that is significant enough to call into question the overall reasonableness of the agency's assessment. So, in other words, even if the agency got that $12,000 estimate off by a little bit, we're talking about at least a sustained relative ballpark.

And when you're weighing the cost and benefits here, the notion that a $12,000 per hospital cost or maybe slightly more even compares to the access to information that millions and millions of patients would get under the rule, patients, many

of whom have high deductibles such that, until they get their deductible, every payer-specific negotiated charge that they see is likely to be the charge that they'll face, patients who could face differences of thousands or even tens of thousands of dollars for procedures across different healthcare providers, those are the patients who this rule helps. Those patients will, for the first time -- as Ms. Stetson acknowledged, this rule requires significantly more information to be displayed than most other states presently do.

That's an argument in favor of the rule, in favor of the transparency that the rule creates, and is the reason why, at the end of the day, patients here are directly and materially better off. Healthcare costs go down. And this rule, even if it has a significant effect on the healthcare industry from the perspective of patients' welfare, is certainly worth the marginal additional costs that hospitals have to bear.

THE COURT: Thank you, Mr. Baer.

First of all, thank you both for the excellent argument today and in the briefs, which I thought were just terrific. I'm going to take the cross-motions under advisement. I very well understand the effective date of the rule, also the possibility that one or the other of the sides that doesn't like how I come out here might want to go to the Court of Appeals, and so I have no intention of sitting on this. But on the other hand, this is not -- you know, this is not

a simple case.

So my goal is to, of course, write something and to do so relatively quickly. I can't promise any particular deadline, but I certainly understand that this is not a money-damages case that has no particular deadline, but there's a looming effective date. So I will endeavor to get something out very quickly.

Other than saying that, I really am going to take it under advisement. I'm not prepared, because I'm actually not sure, but I'm certainly not prepared to give you any preview of where I think that's going to come out other than to say that I think the parties and the amici all did a terrific job both in the papers and today, and for that I appreciate your efforts very much.

MS. STETSON: Thank you, Your Honor.

MR. BAER: Thank you, Your Honor.

THE COURT: Thank you. And I suppose -- I guess the last thing to say is that if for any reason -- I suppose if something came up today that one or the other of you felt was not fully explored and you decided you wanted to submit something, you know, you can ask, of course, and I'll consider it. But I think more importantly, if anything changes on the regulatory timeline -- I suspect the answer is it's not going to, but if anything does change, I would like to be notified of that immediately, and I think that's really a question or request of you, Mr. Baer.

MR. BAER: Absolutely, Your Honor. If I can verify anything on the regulatory timeline specific to the effective date, or did you have a broader conception?

THE COURT: It's primarily that, but I suppose if there were anything that you felt substantially affected my consideration of the issues. But I was really thinking about the timeline. I am cognizant of the effective date looming. I guess it's a little bit less than seven months from now if I'm counting correctly, maybe it's eight. But in any event, certainly much less than a year from now. That's a relevant date, and I will move quickly. But if that were to change for some reason, please let me know.

MR. BAER: Of course.

THE COURT: Thank you all.

MR. BAER: Thank you, Your Honor.

(Proceedings adjourned at 2:50 p.m.)

CERTIFICATE

I, BRYAN A. WAYNE, Official Court Reporter, certify that the foregoing pages are a correct transcript from the record of proceedings in the above-entitled matter.

Bryan A. Wayne
BRYAN A. WAYNE