NO DATE FOR ORAL ARGUMENT HAS BEEN SET

No. 20-5193

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

AMERICAN HOSPITAL ASSOCIATION; ASSOCIATION OF AMERICAN MEDICAL COLLEGES; FEDERATION OF AMERICAN HOSPITALS; NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS; MEMORIAL COMMUNITY HOSPITAL AND HEALTH SYSTEM; PROVIDENCE HEALTH SYSTEM - SOUTHERN CALIFORNIA, d/b/a PROVIDENCE HOLY CROSS MEDICAL CENTER; BOTHWELL REGIONAL HEALTH CENTER,

Plaintiffs-Appellants,

v.

ALEX M. AZAR, III, in his official capacity as Secretary of Health and Human Services,

Defendant-Appellee.

On Appeal from the United States District Court
for the District of Columbia, No. 19-cv-03619

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLANTS AND REVERSAL

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July 24, 2020

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Parties and Amici Curiae. All parties, intervenors, and *amici curiae* appearing before this Court are listed in the Brief of Appellants, and in the Brief of Forty State Hospital Associations as *Amicus Curiae* in Support of Appellants, except for the Chamber of Commerce of the United States of America, which is also *amicus curiae* in support of Appellants.

Rulings Under Review. An accurate reference to the rulings at issue appears in the Brief of Appellants.

Related Cases. As stated in the Brief of Appellants, this case has not previously come before this Court or any other, and there are no related cases within the meaning of D.C. Circuit Rule 28(a)(1)(C).

Dated: July 24, 2020

CERTIFICATE PURSUANT TO CIRCUIT RULE 29(D)

In accordance with Circuit Rule 29(d), undersigned counsel for the Chamber of Commerce of the United States of America (the "Chamber") represent that the other *amici curiae* supporting Appellants of which we are aware are Forty State Hospital Associations, who are enumerated in the brief as *amici curiae* that those associations have filed, and the Healthcare Financial Management Association.

After consulting with counsel for other *amici*, counsel for the Chamber understand that the brief of the State Hospital Associations focuses on providing factual background as to how hospital charges and reimbursement operate, as well on the burdens imposed on hospitals by the challenged rule. Counsel for the Chamber expect that the brief of the Healthcare Financial Management Administration will address different issues than the brief of the Chamber, as well as different aspects of common issues, from that association's distinct perspective.

A separate brief by the Chamber is necessary because it brings a broad perspective on behalf of its members, which include not only hospitals and health insurers, but also businesses across every sector of the nation's economy. The Chamber represents both hospitals and

health insurers that will be affected by the challenged regulation. Neither hospitals, insurers, nor consumers will benefit from the regulation, as the rule will only serve to sow confusion by forcing hospitals to disseminate misleading information. More broadly, the Chamber has an interest, on behalf of its members in all industries, in advocating against governmental regulations that compel misleading, burdensome speech in violation of the First Amendment—particularly in cases, like this one, where an agency's expansive construction of its statutory authority raises First Amendment concerns. Counsel for the Chamber anticipate that the Chamber is the only *amicus* that will address Appellants' First Amendment argument.

CORPORATE DISCLOSURE STATEMENT

The Chamber of Commerce of the United States of America is a non-profit, tax-exempt organization incorporated in the District of Columbia. The Chamber has no parent company, and no publicly held company has 10% or greater ownership in the Chamber.

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GLOSSARY

A	Appendix
CMS	Centers for Medicare and Medicaid Services
DRG	Diagnosis-Related Group
FTC	Federal Trade Commission
HHS	Department of Health and Human Services
NIFLA	*Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018)
The Secretary	Secretary of Health and Human Services

STATEMENT OF IDENTIFICATION OF AMICUS CURIAE, ITS INTEREST IN THIS CASE, AND ITS AUTHORITY TO FILE

The Chamber is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than 3 million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files amicus curiae briefs in cases that raise issues of concern to the nation's business community.

This is such a case because, in the Chamber's view, the Department of Health and Human Services (HHS) has misinterpreted a federal statute to impose a disclosure obligation on private parties that is far more wide-ranging and onerous than what Congress intended and that would provide consumers with misleading information. The Chamber and its members have an interest in ensuring that agencies adhere to the limits of their statutory authority and that agencies do not violate First Amendment principles by compelling speech that would only serve to confuse the public.

Counsel for all parties to this appeal have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no one other than *amicus*, its members, or its counsel contributed money that was intended to fund the preparation or submission of this brief.

SUMMARY OF THE ARGUMENT

Transparency in the cost and quality of health care is a laudable goal. The Chamber strongly supports appropriate efforts to ensure that patients and employers have access to useful information on the cost and quality of health care items and services. For over a decade, the Chamber has advocated for measures that would advance informed consumerism in health care, such as value-based insurance design models. In order for these measures to work, employers and consumers need better information on the price and quality of their health care choices.

But a consumer's access to cost and quality information is only as useful as the information provided. HHS's price transparency rule does not require hospitals to disclose the out-of-pocket amounts that individual health care consumers would pay, but rather mandates that

hospitals publish a vast array of data, including the payer-specific rates for items and services that hospitals have negotiated with third-party insurers.[1] But consumers don't have an interest in learning the precise details of other parties' contractual relationships. Their interest lies instead in learning their own financial exposure for a service or treatment, in the form of a co-pay or a deductible. The price transparency rule does not advance that interest. To the contrary, publishing this information will only lead to greater consumer confusion.

Congress did not authorize HHS to impose such a burdensome and pointless obligation on hospitals; the statute the agency invokes instead established a much narrower disclosure requirement. In any event, HHS cannot, consistent with the First Amendment, force hospitals to publish information that will only serve to mislead their patients. To achieve meaningful transparency in health care, the agency should focus instead on promoting the consumer-specific private

[1] Medicare and Medicaid Programs: Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65,524 (Nov. 27, 2019).

sector tools that are already available to assist consumers in navigating the health care marketplace.

ARGUMENT

Congress imposed a simple disclosure obligation on hospitals: They must publish "a list" of their "standard charges." 42 U.S.C. § 300gg-18(e). HHS's rule dramatically distorts this obligation. The rule requires hospitals to disclose the payment rates they have privately negotiated, for each of the tens of thousands of medical items and services they provide, with each of the hundreds, or in some instances thousands, of plans with which they have contracts. The rule further requires hospitals to publish this data twice: first in a machine-readable spreadsheet, and then again in a separate list intended for the general public. There is no meaningful sense in which these required disclosures could be described as "a list," in the singular, or in which individually-negotiated payer-specific reimbursement rates could be described as a hospital's "standard charges." Nor does the statute's reference to "standard charges" for Medicare beneficiaries suggest that hospitals must disclose the rates they have negotiated with private insurers.

If there were any doubt as to the meaning of the statute, it should be construed narrowly so as not to impose a more burdensome disclosure obligation than is needed. Congress has shown that it knows how to speak with specificity when it intends to impose an obligation on private parties to publicize confidential commercial information, such as their individually-negotiated contract rates. The statute should also be read narrowly to avoid the First Amendment difficulties that arise from the agency's novel reading.

Indeed, the rule violates the First Amendment's protection of the freedom of speech, no matter whether *Zauderer* or *Central Hudson* applies. The rule imposes severe burdens on hospitals, to no useful purpose: it will only serve to raise prices and to confuse and mislead the public, given that many patients may mistake their insurer's overall reimbursement rate for a given medical service with their individual out-of-pocket expense for that service.

I. Hospitals Will Face a Severe Burden in Attempting to Comply with the Rule

In 2010, as part of the Affordable Care Act, Congress enacted Section 2718(e) of the Public Health Service Act, which provides that:

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

42 U.S.C. § 300gg-18(e) (emphases added). In its price transparency rule, HHS has transformed the statute into a requirement that hospitals disclose every payment rate they have negotiated with any of their commercial payers, for each medical service they provide, and to do so twice: first in a machine-readable file consisting of millions of data points, and second in a "consumer-friendly" list for the general public.

The rule requires hospitals to disclose voluminous data to the public. Hospitals perform a wide variety of medical services for their patients. Given the ever-changing nature of medical practice, those services may be delivered in countless different ways. It is accordingly not unusual for a hospital's chargemaster to include "tens of thousands of line items," as HHS itself acknowledges. 84 Fed. Reg. at 65,533. For

some hospitals, the chargemaster can include as many as 80,000 individual items.[2]

Hospitals already faced a significant burden, then, under the agency's reading of the statute before 2019, when HHS had declared that the disclosure of a hospital's chargemaster file alone would satisfy § 300gg-18(e). Under the new rule, however, hospitals must now also publish—for each of the tens of thousands of individual lines from the chargemaster file—data as to the rate for each item or service the hospital has negotiated with each of its third-party payers, as well as its minimum, maximum, and cash discount prices. This dramatically expands the burden on hospitals. Hospitals negotiate contracts with dozens, or even hundreds, of third-party payers to cover beneficiaries under Medicare Advantage, Medicaid managed care plans, or the commercial marketplace. Each of those payers may offer multiple plans, with differing benefit designs, resulting in thousands of separate plan designs.[3] By requiring the reporting of pricing data for tens of

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[2] *See, e.g.*, comment of Christus Health, A268 (80,000 items); comment of Cleveland Clinic, A271 (over 70,000 items); comment of Billings Clinic, A211 (over 45,000 items).

[3] *See, e.g.*, comment of Cleveland Clinic, A271 ("3,000 contracted rate schedules across the Cleveland Clinic health system"); comment of

thousands of items and services, in five different forms and under two different formats, for each of the hospital's dozens, hundreds, or thousands of contracted plans and for each of the hospital's locations, HHS's rule forces hospitals to publish and to maintain a database consisting of millions of data points.

This monumental effort is further complicated by the fact that hospitals and insurers are moving away from the fee-for-service model for health care payments and toward alternative payment models, such as shared-savings models, shared-risk contracts, bundled payments, or capitated payments. These alternative payment models are a growing feature of the health care marketplace; as of 2017, approximately 34% of all health care payments were made on the basis of such models. *See* Health Care Payment Learning & Action Network, *APM Measurement: Progress of Alternative Payment Models* 3 (2018), hcp-lan.org/workproducts/apm-discussion-2018.pdf. That trend will continue to grow in the coming years. *Id.* at 12.

Providence St. Joseph Health, A454 ("up to 1,000 different payers"); comment of Baylor Scott & White Health, A204 ("thousands of contracts across payers and contracted providers"); comment of Texas Hospital Ass'n, A502 ("more than 3,000 contracts with health plans, multiplied by the dozens of plan designs within those contracts").

HHS's rule will burden hospitals that are paid through these alternative payment models, for no useful purpose. In issuing the rule, the agency acknowledged that "negotiated contracts often include methodologies that would apply to payment rates, often leading to payments to hospitals that are different than the base rates negotiated with insurers for hospital items and services." 84 Fed. Reg. at 65,551. The agency suggested that hospitals nonetheless could satisfy the rule by reporting their "base rates" for services and disregarding the upward or downward adjustments that might apply under a particular contract's value metrics. *Id.* This ignores the reality that, in many cases, the hospital's contracts do not specify a single "base rate" for a medical service, but instead describe a complex formula that will determine the payment rate.[4] The rule effectively requires hospitals to separately perform these calculations for each of the tens of thousands of items on their chargemaster in order to publish even what the agency

[4] *See, e.g.,* comment of Hospital + Healthsystem Association of Pennsylvania, A357 ("[T]his process often includes a series of internal steps and algorithms where multiple systems within the hospital are interfacing and doing calculations 'behind the scenes' …. There is much greater complexity and work involved to produce these rates in the format CMS is mandating than simply defining a few key parameters and printing an Excel spreadsheet.").

calls their "base rates." And those "base rates," in any event, do not bear any simple relationship to the actual amount that the insurer pays to the hospital. The rule does not serve the agency's stated purpose of "providing consumers with factual price information," 84 Fed. Reg. at 65,545, by requiring hospitals to publish arbitrary figures that are only one component of the actual amount that the hospital is reimbursed.

Hospitals will be burdened with these obligations to no useful end. The end result of all of the millions of computations that HHS will now require a hospital to perform will be the disclosure of all negotiated rates between an individual hospital and a specific third-party payer under a particular plan for a discrete medical service or item. But for the vast majority of patients, this will not provide them with any meaningful information at all. Approximately 90 percent of hospital patients have third-party coverage. *See* 84 Fed. Reg. at 65,542. The primary interest for these patients, of course, is to determine "what [a] service will cost them out-of-pocket," as HHS acknowledged when it proposed its rule. 84 Fed. Reg. 39,398, 39,574 (Aug. 9, 2019). But publishing the rates that hospitals and insurers negotiate will not assist patients with that determination; the net out-of-pocket costs for

the patient will instead turn on the specific terms of the patient's coverage, "such as the amount of cost-sharing, the network status of the healthcare provider, how much of a deductible has been paid to date, and other information." 84 Fed. Reg. at 65,528.

Moreover, it will be difficult for patients to identify the appropriate negotiated rate to begin with. To do so, patients will have to know what particular service will be performed or item provided, their specific product type out of many, as well as the corresponding code that reflects that service or item. It is often difficult for patients to ascertain the appropriate code in advance—for example, there are multiple codes for a simple office visit, based on the amount of time the provider spends with the patient. For more advanced care, there is significant variability in care complexity, which also affects which codes are billed. A patient may receive ancillary services, which increase the total cost of treatment.

Additionally, the publicly posted rates may be incomplete and misleading. The rule requires a hospital to display payer-specific negotiated rates for services performed by practitioners who are employed by the hospital and subject to the contractual agreement with

the insurer. However, these negotiated rates do not apply when services are performed by practitioners with independent billing arrangements who are not bound by the hospital's contract with the insurer. *See* 84 Fed. Reg. at 65,534–65,535. In these cases, the publicly posted negotiated rates between a hospital and an insurer will not provide an accurate assessment. For all of these reasons, the rule does not assist patients in determining their individual out-of-pocket costs and, to the contrary, is likely to lead to greater confusion regarding their financial liability for hospital services.

II. HHS Lacks the Statutory Authority to Impose this Burden on Hospitals

Section 300gg-18(e) requires a hospital to disclose "a list" of its "standard charges" for the items and services that it provides, and nothing more. The statute does not empower HHS to require hospitals to disclose multiple lists, matrices, or databases of the reimbursement rates that have been discretely negotiated with each of the various insurers with which the hospital has contracted. The rule is therefore unlawful because it violates the "core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regulatory Grp. v. EPA*, 573

U.S. 302, 328 (2014). The words of a statute generally must be given their ordinary meaning, and an agency cannot assume ambiguity for the convenience of giving itself authority to achieve a policy goal. *See Gross v. FBL Fin. Servs.*, 557 U.S. 167, 175 (2009) ("Statutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.") (quoting *Engine Mfrs. Ass'n v. S. Coast Air Quality Mgmt. Dist.*, 541 U.S. 246, 252 (2004)). The rule cannot be squared with the ordinary meaning of the terms "list" and "standard charges," and it should accordingly be set aside.

A. The Rule Requires the Disclosure of Far More than "A List" of the Hospital's "Standard Charges"

As an initial matter, HHS seeks to require hospitals to disclose far more than "a list" (in the singular) of a hospital's charges. The rule will require each hospital to calculate, and to disclose, reimbursement rates for each of the tens of thousands of items and services the hospital provides, broken down into five different forms (the "gross charge" from the chargemaster, the individually-negotiated reimbursement rate for each of the hospital's contracted plans, the minimum negotiated price, the maximum negotiated price, and the cash discount price), leading to

the disclosure of dozens or hundreds of points of pricing data for a given item or service, depending on how many third-party payers have contracted with the hospital and the number of benefit plans offered by those payers. That information must be separately broken down again for each of a hospital system's locations, to the extent that reimbursement rates vary by location. And this information must be published twice—first, in a machine-readable format and second, for 300 shoppable services, in a separate "consumer-friendly" display subject to its own set of formatting requirements.

This cannot fairly be described as the disclosure of "a list" of standard charges. Hospitals could comply with each of these wide-sweeping disclosure obligations only by publishing multiple databases or matrices of pricing information for all of their contracted plans, consisting of millions of sets of data. But Congress made a deliberate choice to require only the publication of "a list," in the singular, rather than multiple sets of different lists or matrices, and its choice should be respected. *See, e.g., Hertz Corp. v. Friend*, 559 U.S. 77, 93 (2010) (Congress deliberately phrased a statutory term in the singular). *See also* Appellants' Br. 37–40.

What is more, the rule requires hospitals to publish a great deal more data beyond simply the hospital's "standard charges." The district court acknowledged that it was a "close call" whether that term could be read to require the disclosure of individually-negotiated rates, but reasoned that, given the "complex economic relationships" among the various parties in the health care market, no one price would qualify as the "standard" rate of payment. A45. It accordingly concluded that HHS had reasonably construed the statute to require the disclosure of thousands of individually-negotiated rates. A45–46.

The court should have drawn the opposite conclusion. The term "standard," in its adjectival form, means "normal, familiar, or usual." American Heritage Dictionary of the English Language 1703 (5th ed. 2011); *see also Standard*, Merriam-Webster Dictionary Online, merriam-webster.com/dictionary/standard ("regularly and widely used, available, or supplied"). In other words, a hospital's "standard" charges are its normal or usual charges for items or services, before it negotiates *particularized reimbursement* rates with any *one* insurer; they are a hospital's "list prices." These uniform charges serve as the baseline for contractual negotiations between hospitals and payers. The district

court's observation that only about 10% of patients pay the hospital's chargemaster rate, A40, is neither here nor there; payment rates may vary widely for a particular service, but the hospital's standard charge for that service, before a payment rate is negotiated, is the same for all comers.

The payer-specific rates that a hospital negotiates on an individual basis with *each* of the dozens or hundreds of payers with which it contracts cannot be described as the hospital's "standard" charges that serve as a baseline for *all* payers. Individually-negotiated, insurer-specific charges are the *opposite* of "standard" charges:

> [T]he terms "standard agreement" or "standard contract," as referenced by other courts, invariably denote a "normal" or "typical" agreement between parties in a given contractual situation, often in conformance with one party's boilerplate form of terms and conditions, rather than a single, particularized agreement between two named signatories.

Flynn v. S. Seamless Floors, Inc., 460 F. Supp. 2d 46, 52–53 (D.D.C. 2006) (collecting authorities). A hospital's "standard" charges, then, are the "normal" or "typical" charges that it holds out as a matter of course to *all* parties. HHS misreads the statute to authorize it instead to compel hospitals to disclose reimbursement rates negotiated in "particularized agreements." *Id.*

The "ordinary meaning," *Gross*, 557 U.S. at 175, of the term "standard" cannot bear the meaning that HHS ascribes to it. If Congress had intended to require hospitals to disclose the individualized reimbursement rates that hospitals and insurers arrive upon after particularized negotiations, it would have said so. But far from compelling the disclosure of the hospital's "rates" or "charges" more broadly, Congress chose to qualify the disclosure obligation so as to require only the disclosure of "*standard* charges." HHS is not at liberty to take a red pen to strike that qualifying term from the statute. Instead, it, like this Court, is "obliged to give effect, if possible, to every word Congress used." *Nat'l Ass'n of Mfrs. v. Dep't of Def.*, 138 S. Ct. 617, 632 (2018) (internal quotation marks omitted).

B. The Statute's Reference to "Diagnosis-Related Groups" Does Not Expand Hospitals' Disclosure Obligations

Section 300gg-18(e) requires hospitals to disclose their standard charges "for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title," *i.e.*, the provision governing the calculation of payments for inpatient care to Medicare beneficiaries under the Inpatient Prospective

Payment System, 42 U.S.C. § 1395ww(d)(4). HHS contends that this phrase shows that Congress understood "standard charges" to encompass all negotiated rates for Medicare and privately insured patients. *See* 84 Fed. Reg. at 65,534.

As an initial matter, Congress's reference to standard charges for "diagnosis-related groups established under section 1395ww(d)(4) of this title" describes charges for Medicare patients, not commercially insured patients whose insurance companies may choose to use a payment system based on diagnosis-related groups. Medicare beneficiaries are the only patients for whom "diagnosis-related groups [were] established under section 1395ww(d)(4) of this title." 42 U.S.C. § 300gg-18(e). Nothing in this phrase suggests that Congress was referring to charges for non-Medicare patients whose commercial insurance payments are somehow based on diagnosis-related groups.

HHS takes this phrase even further, claiming that it indicates that Congress intended for "standard charges" to sweep in negotiated rates for *all* insured patients, regardless of the insurer's payment methodology. It claimed below that "because charges for DRGs … 'are determined as a result of negotiations with third party payers,'

'standard charges' must encompass negotiated rates." Gov't Reply 7, Dist. Ct. Dkt. No. 30 (quoting 84 Fed. Reg. at 65,539). But as the government acknowledged, HHS does not negotiate Medicare's reimbursement rates; the agency instead sets forth a formula in annual rulemakings that governs inpatient reimbursement, on a take-it-or-leave-it basis, for each hospital that participates in Medicare. *See* 84 Fed. Reg. 42,044 (Aug. 16, 2019) (setting Inpatient Prospective Payment System rates, including relative weights for diagnosis-related groups, for 2020); *see also* Gov't Reply 10, Dist. Ct. Dkt. No. 30 ("Medicare's reimbursement rates for DRGs are dictated by Medicare; they are not set or negotiated by hospitals.").

There is no reason to believe that Congress, by referring to Medicare's payment system, meant to require the disclosure of privately-negotiated reimbursement rates. If Congress had intended to require the disclosure of those rates, it could easily have said so directly. *See Landgraf v. USI Film Prods.*, 511 U.S. 244, 262 (1994) ("petitioner's statutory argument would require us to assume that Congress chose a surprisingly indirect route to convey an important and

easily expressed message"); *see also Cty. of Maui v. Haw. Wildlife Fund*, 140 S. Ct. 1462, 1474 (2020).

C. Congress Speaks Clearly When It Intends to Impose a Disclosure Obligation on Private Parties

The plain language of section 300gg-18(e) limits hospitals' disclosure obligations to "a list" of their "standard charges." That plain language cannot be stretched beyond recognition to require hospitals also to disclose payment rates that, as they are individually-negotiated, are anything but "standard." Congress knows how to speak directly when it intends to require private parties to disclose commercially confidential data, such as the discrete payment rates that they have privately negotiated with particular counterparties.

For example, in the Protecting Access to Medicare Act, Congress required certain laboratories to report "private payor" data to HHS on a regular basis. 42 U.S.C. § 1395m-1(a); *see Am. Clinical Lab. Ass'n v. Azar*, 931 F.3d 1195, 1199 (D.C. Cir. 2019). Congress specified that the required report must include "[t]he payment rate … that was paid by each private payor for the test during the [reporting] period." 42 U.S.C. § 1395m-1(a)(3)(A)(i). At the same time, Congress recognized the sensitive nature of this data and prohibited HHS from disclosing the

information reported to it "in a form that discloses the identity of a specific payor or laboratory, or prices charged or payment made to any such laboratory." *Id.* § 1395m-1(a)(10). Congress accordingly understood its need to speak with specificity when it sought to require private entities to disclose the results of their confidential contractual negotiations. *See also* 42 U.S.C. § 1320b-23(c) (provision enacted as part of the Affordable Care Act that protects the confidentiality of pricing information reported by pharmacy benefit managers); Appellant's Br. 34. In contrast to these statutes, however, Section 300gg-18(e) does not contain any indication that Congress sought to compel hospitals to disclose contractual reimbursement rates for medical services or to mandate that those rates be made available to the general public.

Indeed, Congress knows that it must speak with precision if it intends to impose such an obligation, given that the compulsion of speech inevitably raises First Amendment concerns and courts must interpret statutes to avoid constitutional difficulties. *See, e.g., Clark v. Martinez*, 543 U.S. 371, 381 (2005). Congress's carefully-worded decision to require hospitals to publish a list of their standard charges

must be read, then, not to impose a very different obligation to disclose negotiated payment rates.

III. The Rule Compels the Disclosure of Misleading Information, in Violation of the First Amendment

"[I]n the context of protected speech, … the First Amendment guarantees 'freedom of speech,' a term necessarily comprising the decision of both what to say and what not to say." *Riley v. Nat'l Fed'n of the Blind of N.C.*, 487 U.S. 781, 796–97 (1988) (emphasis omitted). HHS's price disclosure rule delineates what hospitals must say with regard to their private contract rates. Varying degrees of scrutiny may apply to governmental regulations that compel speech in the commercial arena. The district court reasoned that this case was governed by the more lenient standard for certain commercial speech regulations announced in *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985). A55. This was error; the price disclosure rule goes well beyond a simple requirement to disclose truthful, non-misleading information in commercial advertising, and it is both unduly burdensome and unjustified. At a minimum, the more searching standard of intermediate scrutiny described in *Central Hudson Gas & Electric Corporation v. Public Service Commission of*

New York, 447 U.S. 557 (1980), applies instead. In truth, though, it is merely an academic point as to which test governs here, as the price disclosure rule cannot survive under either standard.

A. The Rule Fails Under *Zauderer*

In *Zauderer*, the Supreme Court carved out a narrow category of commercial speech regulations that it would review under a relaxed standard. This deferential standard applies only when compelled speech is "limited to 'purely factual and uncontroversial information about the terms under which … services will be available,'" and it requires the government to show that the compelled speech is not "unjustified or unduly burdensome." *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2372 (2018) ("*NIFLA*") (quoting *Zauderer*, 471 U.S. at 651). Neither condition is satisfied here.

HHS's disclosure requirements are not "limited to purely factual and uncontroversial information about the terms under which services will be available." *Id.* Compelled speech that risks confusing and misleading consumers, and that is "subject to misinterpretation by consumers," is hardly uncontroversial. *R.J. Reynolds Tobacco Co. v. FDA*, 696 F.3d 1205, 1217 (D.C. Cir. 2012), *overruled on other grounds*

by Am. Meat Inst. v. U.S. Dep't of Agric., 760 F.3d 18, 22 (D.C. Cir. 2014) (en banc). The rates that hospitals will be required to disclose will be incomplete and misleading, given that they bear no simple relationship to a patient's true financial exposure. As HHS has acknowledged, patients' primary interest is in learning "what [a] service will cost them out-of-pocket." 84 Fed. Reg. at 39,574. For patients, that is the critical "term[] under which … services will be available." *NIFLA*,138 S. Ct. at 2372 (quoting *Zauderer*, 471 U.S. at 651). But the publication of the rates that insurers privately agree to pay a hospital will not assist patients with that determination; the net out-of-pocket costs for the patient will instead turn on the specific terms of the patient's coverage, "such as the amount of cost-sharing, the network status of the healthcare provider, how much of a deductible has been paid to date, and other information." 84 Fed. Reg. at 65,528. Moreover, it will be difficult for the patient even to identify the insurer's negotiated rate, given that the patient must accurately predict in advance which codes will apply to her visit. Adding to the uncertainty, the publication of reimbursement rates for hospital-provided services will not include the rates paid for services rendered by providers not

bound by the hospital contract, such as services performed by practitioners with independent billing arrangements. *See* 84 Fed. Reg. at 65,534–65,535.

At best, disclosure of negotiated rates will lead to confusion over a patient's financial obligation. At worst, it may deter patients from obtaining medical care they need, if individuals fail to recognize that their own financial exposure is much lower than the negotiated reimbursement rate that the insurer pays the hospital. As HHS was warned during the rulemaking, "the new system's unexplained and non-individualized list of charges—which will not reflect co-payment rates or discounts available for many indigent patients—may deter patients from accessing the healthcare that they require by providing inaccurate, incomplete, and confusing hospital charges." Comment of Santa Clara Valley Medical Center, A475. HHS's rule thus requires hospitals to make disclosures that are "subject to misinterpretation by consumers," *R.J. Reynolds Tobacco Co.*, 696 F.3d at 1217, and that are "so one-sided or incomplete that they [cannot] qualify as 'factual and uncontroversial,'" *Am. Meat Inst.*, 760 F.3d at 27 (en banc); *see also R.J. Reynolds Tobacco Co.*, 696 F.3d at 1217.

The rule also fails because it imposes a disclosure requirement that is "unjustified or unduly burdensome." *NIFLA*, 138 S. Ct. at 2376–77. As discussed above, the rule imposes onerous obligations to calculate and to disclose negotiated rates for each of a hospital's tens of thousands of medical items and services, across each of the dozens, hundreds, or even thousands of plans with which it may contract, calculated in five different ways and then displayed for the public under two different formats.

The rule imposes these burdens for no useful reason; the disclosures will neither provide patients with useful information nor serve the agency's purpose of lowering heath care costs. HHS posits that the publication of negotiated reimbursement rates would increase competition on the pricing for medical services and, therefore, decrease the price of care. This rationale is not supported in the economic literature, however. Many economists have concluded that the publication of payer-specific negotiated rates would lead to *higher* prices for medical services, because market forces would compel providers to benchmark themselves off the highest reimbursement rates for each item or service.

One example of this phenomenon that is commonly cited in the economic literature involves the Danish government's attempt to regulate concrete prices. In 1993, Denmark required that all ready-mixed concrete contracts be made public, with the hope (as HHS hopes here) that disclosure would stimulate greater competition. "The result was an increase in average prices of 15 to 20% within a year, as the lower prices in the market rose and the higher prices edged up." David Cutler and Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, 364 N. ENG. J. MED. 894, 894–95 (2011). The disclosure obligation changed the behavior of both sellers and purchasers, and sellers became less willing to strike favorable deals with harder-bargaining purchasers when they were aware that the price that they struck would become public. *See* Svend Albaek et al., *Government Assisted Oligopoly Coordination? A Concrete Case*, 45 J. LAW & ECON. 429, 441 (1997).

The Federal Trade Commission has likewise noted its concern that the public disclosure of negotiated rates for medical services "likely would undermine the effectiveness of selective contracting, a key mechanism used by health plans to drive down health care costs and

improve overall value in the delivery of health care services."[5] These disclosures may enable providers to determine whether their reimbursement rates are above or below their competitors' rates, to monitor the service offerings and output of current or potential competitors, and to increase their leverage in future contract negotiations. FTC Letter at 6. As a result, a poorly-designed price transparency rule may "offer little benefit but could pose substantial risk of reducing competition in health care markets." *Id.* at 3 (internal quotation marks omitted). For this reason, both the FTC and the Department of Justice have indicated that the widespread disclosure of hospitals' negotiated reimbursement rates raises antitrust concerns.[6] HHS has thus failed to meet its burden to show that the rule is not "unduly burdensome or unjustified." *NIFLA*, 138 S. Ct. at 2372 (quoting *Zauderer*, 471 U.S. at 651).

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[5] Letter from Marina Lao, Dir., Office of Policy Planning, FTC, to Rep. Joe Hoppe, Minn. House of Representatives, at 4 (June 29, 2015), https://tinyurl.com/u7fryu8 ("FTC Letter").

[6] *See* U.S. Dep't of Justice and FTC, Statements of Antitrust Enforcement Policy and Health Care, at 49–51 (1996), justice.gov/atr/guidelines-and-policy-statements-0.

B. The Rule Is Invalid Under *Central Hudson*

Because the price transparency rule imposes content-based restrictions, it is presumptively unconstitutional, and is subject to strict scrutiny. *See* Appellants' Br. 44–45. At a minimum, the demanding standard of *Central Hudson* applies here. That intermediate scrutiny test requires the government to affirmatively prove that (1) its asserted interest is substantial, (2) the speech restriction directly and materially advances that interest, and (3) the restriction is narrowly tailored. 447 U.S. at 564–65. The price disclosure rule fails both the second and third prongs of this test.

HHS cannot provide affirmative proof that its rule will directly and materially advance the agency's asserted interests. The agency issued the rule with the hope that the disclosure of payer-specific negotiated reimbursement rates will lower health care prices. But it can provide no evidence that the rule actually will have this effect, and the economic literature discussed above provides strong reason to believe that the disclosure of contract prices will result in a "Danish concrete" effect that actually increases prices for medical services. "[T]he government cannot rest on 'speculation or conjecture'" to satisfy

intermediate scrutiny. *Nat'l Ass'n of Mfrs.*, 800 F.3d at 526 (quoting *Edenfield v. Fane*, 507 U.S. 761, 770 (1993)). Instead, it bears the affirmative burden to prove that its regulation of speech will materially advance its asserted interest. HHS is unable to provide such proof; indeed, it acknowledges that "the impact resulting from the release of negotiated rates is largely unknown," 84 Fed. Reg. at 65,542. Hoping for the best is not enough.

Nor is the rule narrowly tailored. The government bears the burden to prove that there is at least a "reasonable fit" between its ends and the means it has chosen to accomplish those ends. *Nicopure Labs, LLC v. FDA*, 944 F.3d 267, 286 (D.C. Cir. 2019). The rule, however, requires the disclosure of a much more extensive range of data than is necessary to serve the agency's asserted interests, and to no useful end. HHS rests its defense of the rule on its assertion that, for those hospital patients who do not rely on insurance coverage but instead are self-paying customers, the rule would, if nothing else, assist these patients in calculating their out-of-pocket costs. *See* 84 Fed. Reg. at 65,553. Even under HHS's own rationale, then, the rule is wildly overbroad, as it requires the disclosure of negotiated rates from thousands of

individualized contracts that would be of no use to these self-pay customers.

Rather than imposing these burdens on hospitals, HHS would have better served its interests if it had instead promoted private-sector solutions for the price transparency issue. "[T]he existence of [these] numerous and obvious less-burdensome alternatives" to the governmental regulation of speech demonstrates that the narrow tailoring requirement is not met. *Fla. Bar v. Went for It, Inc.*, 515 U.S. 618, 632 (1995) (quoting *Cincinnati v. Discovery Network, Inc.*, 507 U.S. 410, 417 n.13 (1993)). The Chamber has consistently promoted efforts by private entities to provide information on health care costs in a manner and format that actually will be of use to the public. For example, the Chamber has promoted the development of insurer cost tools that can (unlike HHS's rule) provide real-time, personalized estimates for patients' out-of-pocket expenses for the most common medical services. Many insurers already provide their policyholders with tools that provide estimates of average in-network and out-of-network costs for medical procedures. These tools commonly provide beneficiaries with comprehensive pricing information for all stages of a

hospital visit, from admission to discharge. Hospitals, as well as insurers, are already pursuing voluntary efforts to provide patients with useful information and to assist patients, through financial counselors, in contacting their insurers to determine their cost-sharing obligations. The Chamber supports these voluntary efforts, which certainly present a less burdensome means to promote the agency's goal of price transparency. The price disclosure rule, then, cannot satisfy the First Amendment, given HHS's failure to pursue this less burdensome path.

CONCLUSION

This Court should reverse the order of the District Court.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE
WITH TYPE-VOLUME LIMITATION

Pursuant to Fed. R. App. P. 32(g), I hereby certify that this brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B) because it contains 6,103 words, excluding the parts exempted by Fed. R. App. P. 32(f) and Cir. R. 32(e)(1). I further certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because the brief was prepared in 14-point Century Schoolbook font using Microsoft Word ProPlus 365.

Dated: July 24, 2020

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CERTIFICATE OF SERVICE

I hereby certify that on July 24, 2020, I electronically filed the foregoing amicus brief with the Clerk of Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system, thereby serving all persons required to be served.

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