IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II,
Secretary of Health and Human Services,

Defendant.

Civil Action No. 1:19-cv-03619 (CJN)

BRIEF OF *AMICI CURIAE* THIRTY-SEVEN (37) STATE HOSPITAL ASSOCIATIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Chad I. Golder (Bar ID: 976914)
MUNGER, TOLLES & OLSON LLP
1155 F Street NW, Seventh Floor
Washington, DC 20004-1357
Telphone: (202) 220-1100
Fax: (202) 220-2300

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

FEDERAL STATUTES

FEDERAL REGULATIONS

LEGISLATIVE MATERIALS

OTHER AUTHORITIES

CORPORATE DISCLOSURE STATEMENT

Amici curiae are non-profit organizations. They have no parent corporations and do not issue stock.

INTEREST OF AMICI CURIAE[1]

Amici curiae are Alaska State Hospital & Nursing Home Association, Arizona Hospital and Healthcare Association, the Arkansas Hospital Association, the California Hospital Association, the Connecticut Hospital Association, the District of Columbia Hospital Association, the Georgia Hospital Association, the Healthcare Association of Hawaii, the Illinois Health and Hospital Association, the Iowa Hospital Association, the Kansas Hospital Association, the Kentucky Hospital Association, the Louisiana Hospital Association, the Maine Hospital Association, the Massachusetts Health and Hospital Association, the Mississippi Hospital Association, the Missouri Hospital Association, the Montana Hospital Association, the Nebraska Hospital Association, the Nevada Hospital Association, the New Hampshire Hospital Association, the New Jersey Hospital Association, the New Mexico Hospital Association, the Healthcare Association of New York State, the Greater New York Hospital Association, the North Carolina Healthcare Association, the North Dakota Hospital Association, the Ohio Hospital Association, the Oregon Association of Hospitals and Health Systems, the Hospital and Healthsystem Association of Pennsylvania, the South Carolina Hospital Association, the South Dakota Association of Healthcare Organizations, Tennessee Hospital Association, the Texas Hospital Association, the Washington State Hospital Association, the West Virginia Hospital Association, the Wisconsin Hospital Association; thirty-seven (37) state and regional hospital associations that represent thousands of hospitals and health systems.[2]

[1] In accordance with Federal Rule of Appellate Procedure 29(a)(4)(E), *amici* certify that (1) this brief was authored entirely by counsel for *amici curiae* and not by counsel for any party, in whole or part; (2) no party or counsel for any party contributed money to fund preparing or submitting this brief; and (3) apart from *amici curiae* and their counsel, no other person contributed money to fund preparing or submitting this brief.

[2] The individual associations are described in Appendix A.

It is no exaggeration to say that *amici*'s member hospitals will be *most* directly impacted by the Department of Health and Human Services' (HHS) Final Rule, entitled "Price Transparency Requirements for Hospitals to Make Standard Charges Public."[3] *Amici*'s members provide care to patients, negotiate complex contracts with insurers, mail out the bills, and will be the hospitals that are required to disclose millions of lines of data under the regulation at issue here. As such, *amici* and their members have the strongest possible interest in how HHS regulates the disclosure of privately negotiated contracts in this Final Rule. They respectfully submit this brief to provide the Court with information directly relevant to its consideration of the parties' summary judgment motions.

INTRODUCTION

Amici are thirty-seven (37) state and regional hospital associations. Their member hospitals know better than anyone how important it is for patients to make informed health care choices. For that reason, *amici* strongly support price transparency. In that respect, *amici* share the broad goals described in the challenged Final Rule. Like HHS, *amici* "believe that transparency in healthcare pricing is critical to enabling patients to become active consumers so that they can lead the drive towards value."[4]

But HHS has chosen to achieve these laudable goals in unlawful ways. And to make matters worse, HHS's Final Rule will impose severe burdens on hospitals and health systems across the United States without a corresponding benefit to consumers. Indeed, *amici*'s member hospitals are experiencing those burdens right now, as they spend hundreds of thousands of dollars and hundreds of staff-hours to comply with a rule that far exceeds HHS's statutory authority and

[3] 84 Fed. Reg. 65,524-01 (Nov. 27, 2019).

[4] *Id*. at 65,526.

still does not advance the ultimate goal of price transparency—to allow consumers to determine their out-of-pocket payment obligations for health care services.

Plaintiffs have persuasively explained to this Court why the Final Rule is "unlawful, several times over."[5] Rather than repeating those compelling arguments, *amici* seek to provide this Court with additional background information about how hospital charges and reimbursement work in the real world. This brief describes the history of hospital charging in the United States and how we have ended up where we are today—a system in which hospitals maintain a list of standard charges (*i.e.*, the "chargemaster" list), which is used as the starting point for individualized negotiations with private insurers. The result of these complex, ongoing negotiations is a myriad of discounts and deviations from the "chargemaster's" standard pricing list. Today, hospitals typically have contracts with dozens of private insurers, covering multiple types of plans, each of which has different payment rates and reimbursement methodologies. None of these charges—which are discounted from the "chargemaster" starting point—can be reasonably described as "standard," as the governing statute provides.[6] Nor can the required disclosure of many different payer- and plan-specific charges be reasonably described as "*a* list" within the meaning of that statute.[7] Quite the contrary, publishing the innumerable variations in separately-negotiated rates across hospitals and insurers will yield an unintelligible mish-mash that no patient, doctor, hospital administrator, or legislator would ever call "*a* list."

Given the sheer amount of information that hospitals must disclose, it is obvious that the Final Rule will inflict immense burdens on hospitals. This brief also provides the Court with

[5] Memorandum in Support of Plaintiffs' Motion for Summary Judgment at 2 (Dec. 9, 2019), ECF No. 13-1.

[6] *See* 42 U.S.C. § 300gg-18(e).

[7] *Id*. (emphasis added).

critical information about these burdens. One *amicus* captured it well during the rulemaking process:

> Contrary to CMS's assumption that the requested data and information is already stored in hospital chargemasters and could be easily produced, compiling this information would require a *significant* manual effort.… *Hospitals would need to iterate literally thousands of different service bundle and other code combinations in order to develop the proposed data*. This would require hospitals to commit hundreds of staff hours across administration, finance, managed care, patient accounts, public relations, and information technology departments to compile the information.[8]

The enormity of this regulatory burden is significant in its own right. But it also demonstrates just how far HHS has stretched the statutory language to achieve its policy preferences. The statutory terms "standard charge" and "a list" cannot bear the burdens that HHS seeks to place on hospitals. And HHS's attempt to use the statutory phrase "diagnosis-related groups established under section 1395ww(d)(4) of this title"[9] to justify these massive burdens is an even thinner reed on which to rest such a sprawling, costly regulatory regime. If Congress wanted to require hospitals to disclose hundreds of thousands of lines of privately-negotiated data at a price tag of many millions of dollars across the American hospital system, it surely would have used more direct language. It did not—and HHS now grasps at straws to find statutory authority for its sweeping disclosure requirements.

In the past, the D.C. Circuit has enjoined an agency's attempt to hide a regulatory elephant in a statutory mousehole based on an *amicus* brief explaining regulatory costs and burdens.[10]

---

[8] Greater New York Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3206) (Sept. 27, 2019) at 5-6, https://www.regulations.gov/document?D=CMS-2019-0109-3206 (emphasis in original).

[9] 42 U.S.C. § 300gg-18(e).

[10] *See NACS v. Board of Governors of Federal Reserve System*, 746 F.3d 474, 494 (D.C. Cir. 2014) ("[W]e think it quite implausible that Congress engaged in a high-stakes game of hide-and-seek with the Board, writing a provision that seems to require one thing but embedding a substantially

Amici respectfully submit that this Court should do the same here. The information below regarding the real-world operation of hospital charging practices and the costs that the Final Rule will impose on hospitals reveals a different—but equally unlawful—pachyderm.

Accordingly, *amici* respectfully request that the Court grant summary judgment in plaintiffs' favor, declare the Final Rule invalid, and permanently enjoin it.

I. HHS'S DEFINITIONS OF "STANDARD CHARGE" AND "A LIST" CANNOT BE RECONCILED WITH HOW HOSPITALS OPERATE IN THE REAL WORLD

To understand why the Final Rule's disclosure requirements exceed HHS's authority under 42 U.S.C. § 300gg-18(e), it is necessary to understand (1) the history of hospital charges in the United States; (2) the central role that the "chargemaster" list has played throughout the past 100 years and continues to play today; and (3) the innumerable variations in payment rates that hospitals negotiate with private insurers. With this background in mind, it quickly becomes clear that a hospital's "chargemaster" (or a particular hospital's equivalent) is the *only* realistic list of its "standard charges," and that the Final Rule's definition of "*a* list" (emphasis added) shatters that singular statutory term into hundreds of different lists.

---

different *and, according to financial services* amici, *much more costly requirement* in the statute's definitions section. *See Whitman v. American Trucking Associations*, 531 U.S. 457, 468 (2001) ("Congress ... does not ... hide elephants in mouseholes.")" (emphasis added)); *see* Brief of Amici Curiae at *31, No. 13-5270 (D.C. Cir. Oct. 21, 2013), 2013 WL 5720157 ("Developing and implementing the solutions necessary to satisfy the court's decision would raise a long list of complex and costly challenges. Moreover, any such change would likely require years to develop and implement - again, at considerable cost, none of which would be recoverable under the district court's construction of the statute.… The point of enumerating the likely impacts of the district court's decision on the debit-card payments industry is not to persuade this Court that any particular rule is good policy. Rather, the point is that Congress could not have contemplated rules that would deprive issuers of their basic transaction costs and a reasonable return and that simultaneously impose on issuers costly and impractical burdens, thereby depriving consumers of accessible and effective debit-card usage.").

Early American Hospital Payment and the Advent of Private Insurance. For much of American history, private insurance did not pay for hospital services. In fact, before World War II, "most hospital care was either free or very inexpensive."[11] In the 19th and early 20th centuries, hospitals "were primarily philanthropic organizations" that "hous[ed] the poor and insane who were sick."[12]

This began to change in the 1920s. At that time, "the ability of hospitals to improve the health status of patients increased dramatically."[13] As a result, "[f]or the first time, rich and poor Americans sought out hospital care when they became seriously ill."[14]

As demand for hospital services increased in the 1920s, hospitals began to charge patients for care. In addition, developments in medical science provided physicians with "a wider range of services to provide to hospitalized patients." New drugs and equipment—including anesthesia and antibiotics—were now available, and "more highly trained personnel" were needed to provide these services.[15] Together, these increases in cost and demand led to an entirely new model for hospital charges.

As hospitals began to charge patients for their services, they developed a so-called "chargemaster" list. A "chargemaster" is "a lengthy list of the hospital's prices for every single procedure performed in the hospital and for every supply item used during those procedures."[16]

---

[11] A Review of Hospital Billing and Collections Practices: Hearing Before the Subcomm. On Oversight and Investigations of the H. Comm. on Energy and Commerce, 108th Cong. (2004) (Statement of Dr. Gerard Anderson) ("Anderson Testimony").

[12] *Id*.

[13] *Id*.

[14] *Id.*

[15] *Id*.

[16] Uwe E. Reinhardt, *the Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy*, 25 Health Affairs 57, 58 (2006); *see* Christopher P. Tomkins et al., *The Precarious Pricing System*

"Initially there were only a few items on the list."[17] Over time, that list grew to reflect the many different types of services, products, medicines, and devices provided during the course of a hospital stay. By 1960, "the typical hospital had established a list of prices for approximately 5,000 separate items."[18] Today, as the Final Rule observed, the chargemaster list "can include tens of thousands of line items, depending on the type of facility."[19]

Shortly after hospitals began developing their "chargemaster" lists in the 1920s, the Great Depression began to make it "difficult for hospitals to get paid for services."[20] In response, the modern health insurance system emerged. "Blue Cross was formed in 1932 under the auspices of the American Hospital Association (AHA), and Blue Shield was established by medical societies in 1939."[21] Insurance programs like these "proliferated," with insurers paying hospitals based upon the "chargemaster" list.[22] This private insurance system accelerated after World War II,

---

for Hospital Services 25 Health Affairs 45, 48 (2006) ("Each hospital maintains a file system known as the chargemaster, which contains all billable procedure codes performed at the hospital, along with descriptions of those codes and the hospitals' own list prices."); *see also DiCarlo v. St. Mary Hosp*., 530 F.3d 255, 263, 264 (3d Cir. 2008) ("St. Mary's has a uniform set of charges (casually known as the 'Chargemaster') that it applies to all patients, without regard to whether the patient is insured, uninsured, or a government program beneficiary.… The Court finds that in the context of this case, the price term was not in fact open, and that 'all charges' unambiguously can only refer to St. Mary's uniform charges set forth in its Chargemaster."); *Maldonado v. Ochsner Clinic Foundation,* 493 F.3d 521, 523 n.1 (5th Cir. 2007) ("The 'chargemaster' is an exhaustive and detailed price list for each of the thousands of services and items provided by Ochsner [hospital]."); *Vencor, Inc. v. Webb*, 33 F.3d 840, 842 (7th Cir. 1994) ("Vencor also used a 'chargemaster' which contained standardized charges and terminology for the various procedures Vencor hospitals followed.").

[17] Anderson Testimony.

[18] *Id*.

[19] 84 Fed. Reg. at 65,533.

[20] Tomkins et al, *The Precarious Pricing System* at 46.

[21] *Id*.

[22] Anderson Testimony.

particularly as Congress made health insurance tax exempt.[23] By 1948, for example, Blue Cross and Blue Shield accounted for approximately 9 percent of total hospital expenses; by 1958, those insurers accounted for 27 percent of total hospital expenses, and "nearly one-third of the U.S. population was enrolled in Blue Cross."[24]

In these early years of health insurance, hospital charges were based on the cost of providing services plus a small (*i.e.*, less than 10%) allowance.[25] In other words, the "chargemaster" list, which largely tracked the cost of services, dictated an insurer's cost of care. Critically, during this period, "[t]here were no discounts; everyone paid the same rates."[26]

Medicare and the DRG. The next several decades experienced important changes with the enactment of Medicare and Medicaid.[27] For the most part, however, those changes are less relevant to the Final Rule's unlawful disclosure requirements. In the interest of simplifying an already-complex subject, they need not be addressed here. That said, the one feature of Medicare that is relevant to the Final Rule and the text of Section 300gg-18(e) is how Medicare reimburses hospitals—especially given the government's misplaced emphasis on statutory language referencing diagnosis-related groups (DRGs).[28]

---

[23] *Id.*

[24] Tomkins et al, *The Precarious Pricing System* at 46.

[25] Anderson Testimony.

[26] *Id*.

[27] *See generally* Anderson Testimony; Uwe E. Reinhardt, *the Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy* at 59-61; *see also* Centers for Medicare & Medicaid Services, *Acute Inpatient PPS*, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/-AcuteInpatientPPS/index.html.

[28] *See* Memorandum in Support of Defendant's Motion for Summary Judgment and in Opposition to Plaintiffs' Motion for Summary Judgment at 10 (Feb. 4, 2020), ECF No. 20.

The DRG is at the heart of how Medicare pays hospitals. Specifically, "Medicare uses what is known as the 'case base' system for paying hospitals for inpatient care, which means that hospitals receive one single payment for an entire inpatient episode of a given type. To implement this system, Medicare categorizes all hospital inpatient care into [761] distinct 'medical-severity adjusted, diagnosis-related groupings,' known in the trade as MS-DRGs."[29] Once grouped, "Medicare pays hospitals one single, bundled payment to cover the cost of all the supplies and services that a hospital with average efficiency would use in managing that particular case."[30] Significantly, the Medicare payment system is "fully transparent."[31] Indeed, this year's list of DRG reimbursement rates can be found in the Federal Register at 84 Fed. Reg. 42,044.

As such, HHS's expansive reading of Section 300gg-18(e) is incorrect. There is *no indication whatsoever* in Section 300gg-18(e) that, by referring to DRGs "established under section 1395ww(d)(4) of this title," Congress *also* intended to require hospitals to publish dozens of individually-negotiated lists of what private insurers may pay for DRGs. This single statutory phrase—which expressly refers to Medicare (and *not* private-insurer) DRGs—cannot bear the enormous regulatory weight that HHS now places on it. In fact, HHS's *own* regulations and standard forms demonstrate that HHS itself views the "chargemaster" rate as the standard charge

[29] Uwe E. Reinhardt, *How Medicare Sets Hospital Prices: A Primer*, N.Y. Times Economix Blog (Nov. 26, 2010, 6:00 AM), http://economix.blogs.nytimes.com/2010/11/26/how-medicare-sets-hospital-prices-a-primer/; *see* Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Mar. 2019), http://www.medpac.gov/docs/default-source/reports/-mar19_medpac_entirereport_sec.pdf ("To set inpatient payment rates, CMS uses a clinical categorization system called Medicare severity–diagnosis related groups (MS–DRGs). The MS–DRG system classifies each patient case into 1 of 761 groups, which reflect similar principal diagnoses, procedures, and severity levels.").

[30] Uwe E. Reinhardt, *How Medicare Sets Hospital Prices: A Primer*.

[31] *Id*.

when the agency receives claims.[32] As such, HHS cannot now use this narrow statutory phrase in Section 300gg-18(e) as the basis for requiring hospitals to publish enormous amounts of additional information. *See Whitman*, 531 U.S. at 468 ("Congress ... does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions--it does not, one might say, hide elephants in mouseholes.").[33]

Growth of Payer-Negotiated Hospital Charges. The next major relevant change in the hospital payment system occurred in the 1980s and 1990s. Managed care plans began to increase in popularity and "wanted discounts off of charges in return for placing the hospital in their network."[34] These managed care plans began to "negotiate with hospitals" over pricing and payments.[35] These plans had distinct advantages through their volume, and their negotiating clout

[32] *See* 42 C.F.R. 424.32(b) ("The prescribed forms for claims are the following…. CMS-1450 - Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)); CMS-1450, *available at* https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/-PRA-Listing-Items/CMS-1450 (Entry 47 requiring hospitals to include total charges, *i.e.*, the "chargemaster" rate, when it submits Medicare claims); Indiana Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-0002) (Sept. 26, 2019) at 2, ("While it is true that some payers negotiate and pay on a packaged basis, the hospitals do not bill those payers any differently than they bill all other payers or self-insured individuals. In fact, it would be illegal to do so. There is no such thing as a 'negotiated charge'. Hospitals do not maintain information within their billing systems to be able to provide information on negotiated payments at a chargemaster or service level basis.").

[33] There is an easy explanation for why Section 300gg-18(e) specifically refers to "diagnosis-related groups established under section 1395ww(d)(4) of this title." That language was included to ensure that hospitals *still* made information about DRGs publicly available under the already-transparent system of Medicare payments, and that the new provisions for disclosure in Section 300gg-18(e) were not misread as superseding previous transparency efforts.

[34] Anderson Testimony.

[35] *Id*.

increased.[36] Consequently, managed care plans were able to "successfully negotiate[] sizeable discounts with hospitals."[37] Other private insurers, which competed with managed care plans, quickly caught up. "Soon commercial insurers asked for similar discounts"[38]—and they received them.

By the end of the 20th century, nearly all private insurers and managed care plans negotiated payment contracts directly with hospitals. Hospitals now separately negotiate their charges with each insurance company, often across a variety of product lines. This means that a single hospital typically has a wide variety of reimbursement structures depending on the number of insurers with which it contracts and the type of contracts it negotiates. And even with a single insurer, a hospital often has multiple contracts because of the variety of plans offered by the insurer.

The experience of *amici*'s member-hospitals reflects this reality. In connection with this brief, *amici* surveyed their members about how many charge-related contracts they have with insurers and how they negotiate with private insurers. The following responses reveal just some of the complexity and variability of modern hospital charges:

---

[36] Tomkins et al, *The Precarious Pricing System* at 47; *see* Anderson Testimony ("Managed care expanded rapidly using their market power to negotiate discounts off of charges with hospitals."); *see* Michael E. Porter and Elizabeth Olmstead Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* 37-38 (2006)("In the early 1990s, large employers and large health plans increased their bargaining power by structuring subscriber benefits to include *only* the providers with which the payer had contracted. Health plans then contracted only with those providers that agreed to discounted prices for the group. This triggered competition among hospitals and hospital systems to be included in health plan networks, with the primary method of competition being to offer deep discounts to payers and employers that had large overall patient populations.").

[37] Anderson Testimony.

[38] Anderson Testimony.

- One Ohio hospital responded: "In total, our organization has over 74 contracts it negotiates with the various payors, including commercial plans, Medicaid managed care plans, Medicare Advantage plans, Affordable Care Act Marketplace Eligible Plans, and other niche products. Most contracts are negotiated for a three (3) year period. Contracts are staged so there is no more than one (1) major payor agreement being negotiated at any one time so we do not put too much risk onto the organization at any one time. Most negotiations take between six (6) and twelve (12) months to negotiate both language and rates."
- One New York hospital stated: "We have 200 contracts when we consider product lines and payer organizations. On average, the time to negotiate our contracts is 4 to 6 months. It is fair to say that an additional ten to twelve individuals are engaged in one way or another with negotiations [at any given time]."
- An Oregon hospital explained: "We have about 16 contracts that cover approximately 30 lines of business, resulting in over 200 'contracts' in our system. Contracts are not negotiated on a routine cycle. Many contracts are evergreen and roll over from year to year. A negotiation would routinely take three to six months from start to finish depending on the complexity of the rates."
- A Washington, D.C. hospital answered: "We have approximately 35 contract/products for the facility and approximately 40 different contracts on the professional side. Our organization negotiates with most insurers every three (3) years. It takes six (6) to twelve (12) months to complete negotiations."

- A Kansas hospital stated: " We have 50+ payers and 130+ products. We meet with our major payers 2 to 3 times a year. On average contracts are redone/renegotiated every 3 to 5 years period. Contract negotiations usually take 3 to 9 months for completion."
- The North Carolina Healthcare Association provided aggregate responses for its many hospitals. It explained: "Our largest health systems have several hundred payer contracts representing over 50+ payors with multiple product lines. Negotiation of the actual contract documents, including rate schedules, may take several months to several years depending on the scope and complexity of the contract and the size of the hospital. Negotiation with insurers is a continuous ongoing effort. Negotiation involves much more than just the actual contract document. Insurers may publish changes to policies, procedures and protocols on a monthly basis. Each of the changes requires a review by managed care professionals, legal and operational staff. Often a financial impact analysis is required. The policy negotiations may last several months or may last years. They may involve having to go to arbitration or litigation. Providers may make changes to their charges or may provide new services at new locations. Each of these types of changes require additional negotiations with the insurers.

Taken together, these survey responses indicate that HHS got at least one thing right in the Final Rule (even as its definitions of "standard charge" and "a list" widely miss the mark). The Final Rule correctly recognizes that "some hospitals may have negotiated charges with many payers representing *hundreds* of plans."[39]

[39] 84 Fed. Reg. at 65,551 (emphasis added); *see* Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 Hous. J. Health L. & Policy 11, 23 (2014) ("In sum, any given hospital has dozens of price lists for dozens of payers, each of whom may pay on a different basis.").

Despite this variability in payment structures, the "chargemaster" list remains the central component of the hospital charging system. A century or so after it was first developed, the "chargemaster" remains a hospital's *only* universal list of charges for services. With the exception of Medicare and Medicaid, which have their own cost and price databases, a hospital's "chargemaster" list still "drives price for most healthcare consumers."[40] "[F]or most insurance companies, the price is simply a 'discounted' chargemaster price."[41] Indeed, even the strongest proponents for hospital price transparency acknowledge that the "chargemaster" list is *the* starting point for a hospital's interactions with its dozens of contracting insurers. As one commentator put it: the "chargemaster serves as an anchor in negotiations with health plans over prices."[42] Or, as one district court in Vermont explained. "[m]ost hospitals have a 'chargemaster,' an itemized list of prices, similar to a restaurant menu," which serves as a "starting point for ensuing closed-door bargaining with different commercial insurers."[43]

The history of hospital pricing described above undercuts the Final Rule's attempts to (1) require hospitals to publish multiple "lists" of payer-specific negotiated charges; and (2) subdivide the statutory term "standard charge" into more than one "standard charge." As to the statutory phrase "*a* list," the real-world operation of hospital pricing makes plain that hospitals across America have *many different* lists of charges. Those many lists exist for each insurer, depending on the outcome of months-long individualized negotiations between hospital staff and insurance

[40] John T. McLean & Vinay Datar, *Mastering the Chargemaster, Minimizing Price-Gouging and Exposing the Structural Flaws in the Healthcare Market*, 9 J. of Envtl. & Pub. Health L. 1, 5 (2014).

[41] *Id*. at 12.

[42] Erin C. Fuse Brown, 14 Hous. J. Health L. & Policy at 32.

[43] *O'Connell v. Springfield Hospital, Inc*., No. 5:16-cv-289, 2018 WL 4699312, at *2 (D.Vt. July 17, 2018) (quoting AMA Journal of Ethics, Nov. 2015, Vol. 17, No. 11).

providers. Indeed, as indicated by *amici*'s members and as acknowledged by HHS itself, hospitals have a separate list of bespoke charges for each insurer, and in some cases, several different lists for a single insurer depending on the variety of plans that insurer offers. HHS has nonetheless required hospitals to publish *each and every* list, for *each and every* insurer, for *each and every* plan offered by every insurer, and for *each and every* service provided by the hospital—not to mention various additional lists such as "de-identified minimum and maximum negotiated charges."[44] Given the sheer amount and variety of data involved in real-world hospital pricing, requiring hospitals to publish each of these lists for each insurance payer cannot be reconciled with Section 300gg-18(e)'s use of the singular term "*a* list." *See Hertz Corp. v. Friend*, 559 U.S. 77, 93 (2010) (emphasizing Congress' use of "the singular, not the plural").

In addition, HHS's definition—or really, its multiple definitions—of "standard charge" cannot be squared with on-the-ground realities of contemporary hospital charging practices. Even the Final Rule appears to concede that hospitals use the "chargemaster" as the starting point for negotiations with insurers. Specifically, the Final Rule states that "for the insured population, hospitals charge amounts reflect *discounts to the chargemaster* rates that the hospital has negotiated with third party payers."[45] Commonsense therefore suggests that *the only* conceivable "standard" charge is the "chargemaster," and the many variations of discounted prices are non-standard deviations from that "standard charge." Accordingly, HHS's attempt to fractionate each insurer's negotiated rate into hundreds of different per-insurer "standard charges" does not reflect the real-world way in which hospital pricing works. Congress was well aware of that real-world

[44] 84 Fed. Reg. at 65,567.
[45] 84 Fed. Reg. at 65,537 (emphasis added); *see id*. 65,540 ("Specifically, as hospital executives and others familiar with hospital billing cycles often note, hospitals routinely use gross charges as a starting point for negotiating discounted rates.").

system when it enacted the term "standard charge" in Section 300gg-18(e). HHS cannot creatively redefine that statutory language to conjure its own new reality.

II. HHS'S REDEFINITION OF "STANDARD CHARGE" AND "A LIST" WILL IMPOSE SEVERE BURDENS ON HOSPITALS ACROSS THE UNITED STATES

The Final Rule requires hospitals to disclose gargantuan amounts of pricing information. Not only is this requirement unlawful for the reasons stated above and in plaintiffs' briefing, but it will inflict severe adverse consequences on hospitals and their patients that this Court should bear in mind as it evaluates this case. The reason why the Rule inflicts such severe burdens should come as no surprise. By requiring hospitals to disclose so much disparate information, hospitals will have to devote substantial resources to create and maintain the many new lists required under the Final Rule.

As noted earlier, *amici* support useful transparency in healthcare pricing. But transparency can be accomplished through far less burdensome initiatives that are more meaningful to the consumer. Hospital financial navigators, online tools from hospitals and insurers, and other resources would provide consumers the information they *actually* are looking for: their expected out-of-pocket cost of care for a treatment or procedure. For all the information that the Final Rule requires to be disclosed, it ignores the one thing patients actually want. In that respect, it is as unhelpful as it is unlawful.

HHS was well aware of the unnecessary burdens when it issued its Final Rule. Numerous *amici* identified these burdens during the rulemaking process.[46] But to the extent there is any

[46] *See, e.g.*, California Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3038) (Sept. 27, 2019) at 4, https://www.regulations.gov/document?D=CMS-2019-0109-3038 ("CMS' proposal does not account for the many different payment methodologies that are negotiated between hospitals and payers, such as capitated rates, value-based purchasing payments, shared savings arrangements, etc. For example, a single hospital contracts with many different insurers and individual and group health plans that offer many different benefit packages. The proposed rule does not accurately account for the amount and scope of hospital resources

doubt, *amici*'s survey of member hospitals further elucidates the deleterious impact the Final Rule will have:

- One hospital system in Washington, D.C. and Maryland stated: "We do not have the data in one system in the way it has been requested. We would have to manually pull information or try to build a new tool with algorithms to try and meet the standards.… This will create a substantial amount of staff time to build and maintain." In particular, this hospital system estimated that it would cost more than $500,000 to build a database to track the required information, and it would likely need to hire a consultant to do so. In addition,

---

required to gather the relevant data, to prepare for its electronic availability, to prepare for its display in what the agency describes as a user-friendly platform, and to regularly update that information."); Texas Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-2398) (Sept. 26, 2019) at 4, https://www.regulations.gov/document?D=CMS-2019-0109-2398 ("In addition to THA's legal and public policy concerns, THA has significant operational concerns with this proposal. This proposal, if finalized, would pose excessive burden on hospitals and health systems…. One hospital system alone estimates that it has more than 3,000 contracts with health plans, multiplied by the dozens of benefit plans within those contracts. Thinking about displaying this information is nothing short of mind-boggling.… Cursory math indicates that CMS's proposed mandate would require hospitals to sort, compile and make public millions of lines of data. Moreover, the information CMS intends to make public is not neatly grouped into categories because plans reimburse hospitals based on different formulas. Hospitals may contract with one health plan on a DRG-basis while contracting with another insurer on a per diem basis. Further, quality measures often affect reimbursement for services, which means the negotiated rates are not static figures."); Wisconsin Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3247) (Sept. 27, 2019) at 2, https://www.regulations.gov/document?D=CMS-2019-0109-3247 ("WHA strongly cautions CMS against implementing the one-size-fits-all transparency provisions in the proposed CY2020 OPPS rule. CMS's approach in the proposed rule will add to the burden that already drives up costs and creates obstacles for hospitals trying to deliver nation-leading care. An average size hospital already dedicates 59 full-time-equivalent positions to regulatory compliance, with over one-quarter of those individuals being physicians and nurses. Time spent on red tape and regulatory compliance results in less time with patients, frustration by providers and burnout…. The new regulations would require hospitals to determine negotiated rates for hundreds of different services, with multiple different contracts. In a state like Wisconsin that has a very competitive insurance market, this is even more burdensome as hospitals would have to constantly update data covering hundreds of service items for multiple insurers. On top of that, many insurers offer slightly different products that each may have different negotiated payments to go with them.").

the hospital system believes it will cost more than $300,000 to maintain this database each year, which includes hiring at least three additional staff members.

- An urban hospital in Illinois responded: "[T]he burden of complying with this rule is significant." This hospital stated that it will need to spend at least $214,000 to get a system up and running, and it "will require us to divert several FTE's for several months to meet this requirement." In particular, the hospital explained, "[t]his will impact not just staff directly involved with pricing, but also our communications staff who need to assist posting the data on line in a readable format and with scripting responses for speaking with patients about this data." In short, this Illinois hospital has concluded that the Final Rule will "diver[t] attention away from focusing on the patient experience," and prevent it from "being able to focus more on meeting the individual needs of the community and our patients."
- A Kansas hospital explained that "gathering the data required by the new HHS price transparency rule will be extremely time consuming and taxing on facilities who already have limited resources for day to day operations." Specifically, "[a]ll information required under the new HHS price transparency rule must be compiled 'manually' using a combination of both facility and professional historical claims data, definitions of shoppable services defined by HHS, charge master files and current contract/reimbursement documents for all 34 product lines across all plans (therefore, up to 34 unique negotiated rates for EACH of our thousands of services)." This Kansas hospital estimates that the cost of compliance will exceed $100,000, which will "delay the purchase of new, high tech equipment" for patient care.

- One California hospital system stated "we manage a multitude of payer contracts with multiple product lines and reimbursement schedules (inpatient and outpatient) for Commercial PPO and HMO, Medicare Advantage, transplant, behavioral health and acute care services, which equates to hundreds of different fee schedules across the system."
- One Ohio hospital system stated that "based on the analysis to produce and update the data, potential use of outside vendors, and increased support staff, the cost could be as high as $2,000,000 annually." Its explanation for these high costs captures both the scope of the burdens of the Final Rule and the unreasonableness of HHS' statutory definitions. This system "estimates that we have 3,000 contracted rate schedules across the system. Further, our chargemaster reflects over 70,000 lines – just for technical (hospital inpatient and outpatient) charges. Thus, the number of data points that would need to be posted would exceed 210 million just for hospital services. This number does not include professional fees, most drugs and some supplies. Adding those components would increase the number of data points exponentially – potentially adding an estimated 40,000 lines, at least."
- A Washington State hospital called the burdens "a nightmare." The administrator for this hospital stated: "I don't have the resources to do it, I don't have the staff, and I know it can't all be done by me. The time estimate by HHS is absurd. I've already spent more time learning about what we need to do than their estimate." This Washington hospital anticipates having to hire an outside consultant, which will cost more than $100,000, to assist with initial compliance, and then a full-time employee to keep up with regulatory requirements. As a result, this hospital explained, "we will be slashing staff until we can get into the black. It's the last thing we want to do, but we aren't really left with many options."

As this Court evaluates plaintiffs' legal arguments, it should take into account these consequences. The massive burdens that the Final Rule imposes on hospitals across the United States cast even further doubt on the agency's expansive interpretation of "standard charge" and "a list." *Cf. Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015) (consideration of cost is relevant to the reasonableness of an agency's statutory interpretation). As explained above, *amici* do not believe that Congress intended to impose such a burdensome disclosure regime. It certainly did not intend to do so via the narrow statutory phrase "diagnosis-related groups established under section 13954746ww(d)(4) of this title," as HHS repeatedly (and wrongly) insists in its brief.[47]

CONCLUSION

For the foregoing reasons and those stated in plaintiffs' filings, this Court should grant summary judgment in favor of plaintiffs.

Dated: February 28, 2020

/s/ Chad I. Golder

Chad I. Golder
MUNGER, TOLLES & OLSON LLP
1155 F Street NW, Seventh Floor
Washington, DC 20004-1357
Telphone: (202) 220-1100
Fax: (202) 220-2300

Counsel for Amici Curiae

[47] *See NACS v. Board of Governors of Federal Reserve System*, 746 F.3d 474, 494 (D.C. Cir. 2014) ("[W]e think it quite implausible that Congress engaged in a high-stakes game of hide-and-seek with the Board, writing a provision that seems to require one thing but embedding a substantially different *and, according to financial services* amici*, much more costly requirement* in the statute's definitions section." (emphasis added)).

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing complies with Local Civil Rule 7(o)(4) and does not exceed 25 pages.

Dated: February 28, 2020

/s/ Chad I. Golder
Chad I. Golder

CERTIFICATE OF SERVICE

I hereby certify that on February 28, 2020, I caused a true and correct copy of the foregoing to be served on all counsel of record through the Court's CM/ECF system.

Dated: February 28, 2020

/s/ Chad I. Golder
Chad I. Golder

APPENDIX A

DESCRIPTION AND INTERESTS OF INDIVIDUAL *AMICI*

The Alaska State Hospital & Nursing Home Association (ASHNHA) is a non-profit trade association established in 1953. We represent more than 65 hospitals, nursing homes, and other healthcare organizations who employ over 10,000 Alaskans. Our membership spans geographically from PeaceHealth Ketchikan Medical Center to Samuel Simmonds Memorial Hospital in Utqiagvik.

Arizona Hospital and Healthcare Association (AzHHA) is Arizona's largest statewide trade association for hospitals, health systems, and affiliated healthcare organizations. Its hospital members are united with the common goal of improving healthcare delivery in Arizona. AzHHA is a powerful advocate for issues that impact the quality, affordability, and accessibility of healthcare for the patients, people, and communities of Arizona. AzHHA's long-term vision is simply stated, but difficult to achieve: to make Arizona the healthiest state in the nation. AzHHA files this brief as amicus curiae in furtherance of its goal and vision, and because it is uniquely situated to provide information on the severe burden this rule imposes on hospitals.

The Arkansas Hospital Association (ArHA) is a trade association representing over 100 hospitals and related institutions and the more than 41,000 dedicated individuals serving patients within these organizations. For 90 years, ArHA has supported its members in the delivery of high quality, efficient, and accessible health care throughout Arkansas. As the state's most trusted authority on health care, ArHA is committed to improving the health system to enhance individual patient care and safeguard the well-being of Arkansas hospitals and the communities they serve.

The California Hospital Association (CHA) is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the general acute care and psychiatric acute patient beds in California. CHA's members include all types of hospitals and health systems: non-profit; children's hospitals; those owned by various public entities, including cities/counties, local health care districts, the University of California, and the Department of Veterans Affairs; as well as investor-owned. The vision of CHA is an "optimally healthy society," and its goal is for every Californian to have equitable access to affordable, safe, high-quality, medically necessary health care. To help achieve this goal, CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals, health care systems, and other health care providers can offer high-quality patient care. CHA promotes its objectives, in part, by participating as *amicus curiae* in important cases like this one.

The Connecticut Hospital Association (CHA) in a not-for-profit membership organization that represents hospitals and health-related organizations. With more than 140 members, CHA's mission is to advance the health of individuals and communities by leading, representing, and serving hospitals and healthcare providers across the continuum of care that are accountable to the community and committed to health improvement.

The District of Columbia Hospital Association (DCHA) is a trade association representing 13 hospitals and the more than 27,000 individuals employed by these facilities in the District of Columbia. DCHA is the unifying voice for its members and works to advance health policy to strengthen the District's world-class health care system to ensure that it is equitable and accessible to all.

The Georgia Hospital Association is a non-profit trade association made up of member hospitals and individuals in administrative and decision-making positions within those institutions. Founded in 1929, the Association serves 161 hospitals and health systems in Georgia. Its purpose is to promote the health and welfare of the public through the development of better hospital care for all of Georgia's citizens. The Association represents its members in legislative matters, as well as in filing *amicus curiae* briefs on matters of great gravity and importance to both the public and to health care providers serving Georgia citizens.

The Healthcare Association of Hawaii (HAH), established in 1939, is a trade association which serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the healthcare continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate affordable, high quality care to all of Hawaii's resident and visitors, our members contribute significantly to Hawaii's economy by employing over 30,000 people statewide. HAH promotes its objectives through a variety of means, including participating as amicus curiae in matters of importance such as this.

The Illinois Health and Hospital Association (IHA) is a statewide not-for-profit association with a membership of over 200 hospitals and nearly 50 health systems. For over 90 years, the IHA has served as a representative and advocate for its members, addressing the social, economic, political, and legal issues affecting the delivery of high-quality health care in Illinois. As the representative of virtually every hospital in the state, the IHA has a profound interest in this case. The IHA respectfully offers this *amicus curiae* brief in hopes of providing information not

addressed by the litigants that will help the Court evaluate the litigants' arguments more thoroughly.

The Iowa Hospital Association (IHA) is a voluntary, not-for-profit membership organization representing all of Iowa's 118 community hospitals, including 82 critical access hospitals. IHA's mission is to support Iowa hospitals in achieving their mission and goals by advocating for member interests at the state and national level, and providing members with valuable education and information resources.

The Kansas Hospital Association (KHA) is a not-for-profit voluntary state organization located in Topeka, Kansas that represents and serves 127 community hospitals, including 85 Critical Access Hospitals. Its mission is to provide education and information and be the leading advocate for its members on the state and national level.

The Kentucky Hospital Association (KHA) is a non-profit state association of hospitals, related health care organizations, and integrated health care systems statewide. Membership in KHA is voluntary, and its member entities include 120 hospitals in the Commonwealth of Kentucky. KHA engages in advocacy and representation efforts on behalf of their member hospitals that promote safety, quality, and efficiency in health care. The mission of KHA is to be the leading voice for Kentucky health systems in improving the health of our communities.

The Louisiana Hospital Association (LHA) is a non-profit organization founded in 1926 and incorporated in 1966 for the purpose of promoting the public welfare of the State of Louisiana. The Association's membership is composed of over 150 member institutions, with more than a thousand individual members. Membership consists of hospitals of all kinds, including public, private, non-profit, for-profit, federal, municipal, hospital service district, religious, general, specialty, acute-care, psychiatric, and rehabilitation classifications.

The Maine Hospital Association (MHA) represents all 36 community-governed hospitals in Maine including 33 non-profit general acute-care hospitals, two private psychiatric hospitals, and one acute rehabilitation hospital. In addition to acute care hospital facilities, it also represents 11 home health agencies, 18 skilled nursing facilities, 19 nursing facilities, 12 residential care facilities, and more than 300 physician practices. Its acute-care hospitals are non-profit, community-governed organizations with more than 800 volunteer community leaders serving on the boards of Maine's hospitals. Maine is one of only a handful of states in which all of its acute-care hospitals are non-profit.

The Massachusetts Health and Hospital Association (MHA) is a voluntary, not-for-profit organization composed of hospitals and health systems, related providers, and other members with a common interest in promoting the good health of the people of the Commonwealth of Massachusetts. Through leadership in public advocacy, education, and information, MHA represents and advocates for the collective interests of hospitals and health care providers, and it supports their efforts to provide high-quality, cost-effective, and accessible care.

The Mississippi Hospital Association (MHA) is a statewide trade association which serves the public by assisting its Members in the promotion of excellence in health through education, public information, advocacy, and service.

The Missouri Hospital Association (MHA) members include every acute-care hospital in the state, as well as most of the federal and state hospitals and rehabilitation and psychiatric care facilities. MHA actively serves its members' needs through representation and advocacy on behalf of its members, continuing education programs on current health care topics, and education of the public and media as well as legislative representatives about health care issues.

The Montana Hospital Association (MHA) is the principal advocate for the state's health care providers and the communities they serve. MHA's diverse membership includes organizations that provide hospital, nursing home, physician, home health, hospice and other health services. The MHA Board serves voluntarily as Trustees of the not-for- profit organization and determines the association's public policy agenda based on input from member representatives through MHA councils, committees and task forces.

The Nebraska Hospital Association (NHA) is a statewide trade association representing Nebraska's hospitals and health systems since 1927. The hospital and health system field is the only sector of Nebraska's economy that touches every citizen and business of Nebraska. Not only do hospitals support a healthy Nebraska and provide essential health care services, they are also among the largest employers and economic drivers in most regions of the state. Hospitals and health care are the foundation upon which communities in Nebraska are built.

The Nevada Hospital Association (NHA) represents all of Nevada's acute care hospitals along with psychiatric, rehabilitation, and other specialty hospitals, as well as health-related agencies and organizations throughout the state. Formally established in 1960, the NHA serves as an advocate for its members to lead in the provision of high quality, affordable and accessible healthcare services, resulting in healthier Nevada communities.

The New Hampshire Hospital Association (NHHA) is the leading and respected voice for hospitals and health care delivery systems in New Hampshire, working together to deliver compassionate, accessible, high-quality, and financially sustainable health care to the patients and communities served by its member hospitals. NHHA represents 31 member hospitals, including a large academic medical center, 13 critical access hospitals, two specialty rehabilitation hospitals, one state psychiatric hospital, one private behavioral health hospital, and one VA Medical Center.

The New Jersey Hospital Association (NJHA) has served as New Jersey's premier health care association since its inception in 1918. NJHA currently has members across the health care continuum including hospitals, health systems, nursing homes, home health, hospice, and assisted living, all of which unite through NJHA to promote their common interests in providing quality, accessible and affordable health care in New Jersey. In furtherance of this mission, NJHA undertakes research and health care policy development initiatives, fosters public understanding of health care issues, and implements pilot programs designed to improve clinical outcomes and enhance patient safety. NJHA regularly appears before all three branches of government to provide the judiciary and elected and appointed decision makers with its expertise and viewpoint on issues and controversies involving hospitals and health systems.

The New Mexico Hospital Association (NMHA) is the trade association for acute-care hospitals in New Mexico. It advocates for the interests of its members at the state and federal level in the legislative and regulatory arenas. The NMHA represents 45 not-for-profit, investor-owned, and governmental hospitals and health systems from around the state.

The Healthcare Association of New York State (HANYS) is New York's statewide hospital and health system association representing over 500 not-for-profit and public hospitals and hospital based skilled nursing facilities, home health agencies, and hospices. HANYS' members range from rural Critical Access Hospitals to large, urban Academic Medical Centers and other Medicaid and safety net providers. HANYS seeks to advance the health of individuals and communities by providing leadership, representation, and service to health providers and systems across the entire continuum of care.

The Greater New York Hospital Association (GNYHA) is a Section 501(c)(6) organization that represents the interests of nearly 150 hospitals located throughout New York State, New Jersey, Connecticut, and Rhode Island, all of which are not-for-profit, charitable organizations or publicly-sponsored institutions. GNYHA

engages in advocacy, education, research, and extensive analysis of health care finance and reimbursement policy.

The North Carolina Healthcare Association (NCHA) is a statewide trade association representing 136 hospitals and health systems in North Carolina, with the mission of uniting hospitals, health systems, and care providers for healthier communities. NCHA is an advocate before the legislative bodies, the courts, and administrative agencies on issues of interest to hospitals and health systems and the patients they serve.

The North Dakota Hospital Association (NDHA) has been representing hospitals and health-related member organizations for over 80 years. The NDHA is a voluntary, not-for-profit organization comprised of hospitals and health systems, related organizations, and other members with a common interest in promoting the health of the people of North Dakota.

The Ohio Hospital Association (OHA) is a private non-profit trade association established in 1915 as the first state-level hospital association in the United States. For decades the OHA has provided a forum for hospitals to come together to pursue health care policy and quality improvement opportunities in the best interest of hospitals and their communities. The OHA is comprised of 236 hospitals and 14 health systems, all located in Ohio, and works with its member hospitals across the state to improve the quality, safety, and affordability of health care for all Ohioans. The OHA's mission is to collaborate with member hospitals and health systems to ensure a healthy Ohio.

The Oregon Association of Hospitals and Health Systems (OAHHS), founded in 1934, is a statewide, non-profit trade association that works closely with local and national government leaders, business and citizen coalitions, and other professional health care organizations to enhance and promote community health and to continue improving Oregon's innovative health care community. Representing all 62 hospitals in Oregon, OAHHS provides leadership in health policy, advocacy, and comprehensive member services that strengthen the quality, viability, and capacity of Oregon hospitals to best serve their communities.

The Hospital and Healthsystem Association of Pennsylvania (HAP) is a statewide membership services organization that advocates for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve.

The South Carolina Hospital Association is a private, not-for-profit organization founded in 1921 to serve as the collective voice of the state's hospital community. Today, it comprises approximately 100 member hospitals and health systems and 900 personal members. It advocates for sound healthcare policies and legislation, facilitates collaboration to tackle problems that none of us could solve alone, finds and shares innovations and best practices, and provides data, education and business solutions to help its members better serve their patients and communities.

The South Dakota Association of Healthcare Organizations (SDAHO) is the professional/trade association representing and serving health care organizations across the state in advancing healthy communities. The association has a not-for-profit mission and is funded principally through membership dues. Membership spans various types of category, geographic location, size and complexity of services and includes 54 hospitals, 3 health care systems, 32 nursing facilities, home health agencies, assisted living centers, and hospice organizations.

Tennessee Hospital Association (THA) was established in 1938 as a not-for-profit membership association to serve as an advocate for hospitals, health systems, and other health care organizations and the patients they serve. The Association also provides education and information for its members, and informs the public about hospitals and health care issues at the state and national levels.

The Texas Hospital Association (THA) is a non-profit trade association representing Texas hospitals. THA advocates for legislative, regulatory, and judicial means to obtain accessible, cost-effective, high-quality health care. THA opposes reductions to 340B Program reimbursement that increase costs for uninsured or low-income patients and reduce hospitals' ability to provide expanded services to patients.

The Washington State Hospital Association (WSHA) is a non-profit membership organization that represents 107 member hospitals. WSHA works to improve the health of the people of the State by advocating on matters affecting the delivery, quality, accessibility, affordability, and continuity of health care.

The West Virginia Hospital Association (WVHA) is a not-for-profit statewide organization representing 63 hospitals and health systems across the continuum of care. The WVHA supports its members in achieving a strong, healthy West Virginia by providing leadership in health care advocacy, education, information, and technical assistance, and by being a catalyst for effective change through collaboration, consensus building, and a focus on desired outcomes.

The Wisconsin Hospital Association (WHA) is a statewide non-profit association with a membership of more than 130 Wisconsin hospitals and health systems. For 100 years, the Wisconsin Hospital Association has advocated for the ability of its members to lead in the provision of high-quality, affordable, and accessible health care services, resulting in healthier Wisconsin communities.