IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, THE FEDERATION OF AMERICAN HOSPITALS, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS, INC., MEMORIAL COMMUNITY HOSPITAL AND HEALTH SYSTEM, PROVIDENCE HEALTH SYSTEM - SOUTHERN CALIFORNIA d/b/a PROVIDENCE HOLY CROSS MEDICAL CENTER, and BOTHWELL REGIONAL HEALTH CENTER, *Plaintiffs*, v. ALEX M. AZAR II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, *Defendant*.	)	Civil Action No. 1:19-cv-3619-CJN

MEMORANDUM IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes and Regulations

Other Authorities

INTRODUCTION

America's hospitals and health systems are committed to providing patients with the information they need to make informed decisions about their health care. As the Centers for Medicare & Medicaid Services (CMS) itself acknowledges, what patients really want to know is the out-of-pocket amounts they will be expected to pay for their care, understanding that each patient's circumstances will be differently affected by numerous variables in her health insurance coverage. But because of all those variables, even providing out-of-pocket information to patients is challenging. It requires a number of different stakeholders, including commercial health insurers, to work together with hospitals to develop turnkey technology to provide real-time accurate estimates. And while there is no statutory basis for the federal government to require hospital disclosure of out-of-pocket costs, the hospital field has repeatedly urged CMS to bring together on a voluntary basis the various stakeholders needed to allow hospitals to put information regarding out-of-pocket costs into patients' hands.

Instead, mirroring in large part an Executive Order issued on June 24, 2019, CMS published a Final Rule in the Federal Register requiring that hospitals post on the internet a file containing five types of pricing information for all offered items and services, reflecting hospitals' "gross charges," "payer-specific negotiated charges," "discounted cash price," and "de-identified" minimum and maximum negotiated charges. The Final Rule also mandates that hospitals publicly display negotiated charges and certain other information for 300 "shoppable" services (meaning a health care service that can be scheduled by patients in advance). In plain English: the Final Rule requires hospitals to publicize on their website an extensive amount of confidential pricing information reflecting individually negotiated contract terms with all third

party-payers, including all private commercial health insurers, with which the hospital contracts. None of this information will provide patients with their out-of-pocket costs.

The Final Rule is unlawful, several times over. First, it exceeds the agency's statutory authority. CMS asserts that its authority to mandate disclosure of "payer-specific negotiated charges" is derived from a statutory provision that requires hospitals to publish their "*standard charges* for items and services provided by the hospital." 42 U.S.C. § 300gg-18(e) (emphasis added). But to state the obvious, negotiated charges are not "standard charges." They are the opposite of standard, in fact, because they reflect the non-standard amount negotiated privately between a hospital and commercial health insurer.

The Final Rule also runs afoul of the First Amendment, because it mandates speech in a manner that fails to directly advance a substantial government interest, let alone in a narrowly tailored way. Again, Plaintiffs fully endorse the agency's stated goals of providing patients with meaningful information about their costs in order to put them "at the center of their health care." But the Final Rule does not advance those goals; it frustrates them. When a patient chooses a hospital, what she wants to know is her out-of-pocket costs, not an insurer's "negotiated charges." The Court need not take our word for it. That is what CMS itself said in the Proposed Rule. 84 Fed. Reg. 39,398, 39,574 (Aug. 9, 2019) ("we know through our stakeholder engagement and research conducted over the past year that consumers of health care services simply want to know where they can get a needed health care service and what that service will cost them out-of-pocket"). The Final Rule does not deliver on that stated goal, and thus runs afoul of the First Amendment.

Finally, the Final Rule is arbitrary and capricious and lacks any rational basis. The agency's explanation for the Final Rule runs counter to both logic and evidence. In fact, it is

belied by the agency's own research regarding what patients care about most when selecting a hospital: their own out-of-pocket costs. The agency's justification for the Final Rule therefore does not stand up to even the barest of scrutiny. That is the epitome of arbitrary and capricious agency action.

The Final Rule becomes effective on January 1, 2021. But hospitals will need to start devoting substantial planning efforts and resources toward compliance with the Final Rule immediately. The burden on hospitals is certain to be daunting, and the work needed to come into compliance with the Final Rule will have to commence now. In order to minimize the imposition of an unnecessary burden on hospitals—especially smaller and rural hospitals that are already operating with scarce resources and on thin margins—Plaintiffs respectfully request a decision on the merits as soon as practical.

FACTUAL BACKGROUND

Statutory Background

The Patient Protection and Affordable Care of 2010, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, added Section 2718(e) to the Public Health Service Act, which is codified at 42 U.S.C. § 300gg-18(e). That statutory authority provides:

> 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.

Id. (emphasis added).

The Basis for Hospital Charges

Since the "mid-20th century," hospitals have used "chargemasters," "a comprehensive list of a hospital's products, procedures and services," as the "backbone" for their revenue-management purposes. *See generally What is a Chargemaster, and What do Hospital Administrators Need to Know about It?*, The George Washington University School of Business (2019).[1] The chargemaster is a critical administrative tool that hospitals employ for revenue-management and other purposes, which sets the baseline charges for the specific healthcare services offered by a particular hospital. 84 Fed. Reg. 65,533. *See also, e.g.*, *Webster Cty. Mem'l Hosp., Inc. v. United Mine Workers of Am. Welfare & Ret. Fund of 1950*, 536 F.2d 419, 419–20 (D.C. Cir. 1976) (per curiam); *Lefler v. United Healthcare of Utah, Inc.*, 72 F. App'x 818, 821 (10th Cir. 2003). Hospitals publicly post chargemasters on their websites, pursuant to Section 2718(e). "Chargemasters can include tens of thousands of line items, depending on the type of facility, and can be maintained in spreadsheet or database formats." 84 Fed. Reg. 65,533.

Separate and apart from the chargemaster, commercial health insurers typically negotiate discounts or alternative payment arrangements with hospitals. 84 Fed. Reg. 65,533. These discounts are negotiated at arms' length between either an individual hospital or a broader hospital system and each specific insurer. The negotiated rates typically vary not only by insurer, but also among plans offered by a single insurer. Thus, hospitals will typically have hundreds of contracts and/or rate sheets covering a number of insurers and each of their various insurance plans. 84 Fed. Reg. 65,551 ("we recognize that some hospitals may have negotiated charges with many payers representing hundreds of plans"). The payment arrangements negotiated with insurers can take many forms: some are based on a percentage of the

[1] *Available at* https://bit.ly/33SselJ.

chargemaster charge; others are based on a per diem rate; and still others are a flat dollar amount per service, billing code, or other specified metric. *See* 84 Fed. Reg. 65,533. Some payers may negotiate bundled payment arrangements, where a single payment is made for multiple services furnished by multiple providers during an episode of care. *Id*. Some contracts reflect value based arrangements whereby hospitals agree to take financial risk for meeting certain performance standards for patient care; these seek to improve access to care, quality of care and patient health outcomes while reducing costs.

The insurer-negotiated rate does not tell you anything about how much a patient covered by that insurance plan would pay out of pocket. Patients' out-of-pocket costs are typically dictated by a variety of factors largely tied to their own contractual relationships with their insurers, including (i) the scope of the patient's coverage (e.g., does the plan provide mental health benefits); (ii) the amount of the patient's coinsurance or co-payment; (iii) the amount of the patient's and family's annual deductible, and whether either has been reached; and (iv) the network status of the hospital (i.e., whether the hospital is in- or out-of-network of providers the patient has selected). *See* 84 Fed. Reg. 65,528. A patient's costs also will depend on whether the patient has acted in compliance with insurer-mandated requirements, such as obtaining pre-authorization for specified procedures or medical necessity. Each of these factors alone can have a huge impact on what a patient ultimately will pay out of pocket; but together, these individualized factors, many of which evolve over the course of a coverage year, make it impossible for the insurer-specific negotiated rate to tell a patient anything about her own out-of-pocket costs for any particular service at any particular time.

Some patients do not have health insurance, or choose not to use their insurance coverage in connection with a hospital visit. Those patients are eligible for free or reduced cost care if

they meet financial criteria established by the hospital. The criteria are typically linked to the federal poverty level but may consider other facts and circumstances, such as the amount a patient has spent on health care over the preceding year regardless of income level. For patients who do not meet the criteria, the hospital typically negotiates directly with them for payment and may offer discounts or other abatement based on a number of criteria, including the timing of payments and ability to pay. 84 Fed. Reg. 65,552.

The June 24, 2019 Executive Order

On June 24, 2019, the President issued an Executive Order entitled *Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First* (June 24, 2019), *available at* https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/.

The Executive Order stated as follows: "Within 60 days of the date of this order, the Secretary of Health and Human Services shall propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients' decision making and allow patients to compare prices across hospitals." *Id.* § 3.

The Proposed Rule

In August 2019, CMS published its annual proposed rule detailing changes to hospital outpatient payments under Medicare for calendar year (CY) 2020. 84 Fed. Reg. 39,398 (Aug. 9, 2019) (the Proposed Rule). The Proposed Rule included a section entitled: "Proposed Requirements for Hospitals To Make Public a List of Their Standard Charges." 84 Fed. Reg. at

39,571. When announcing the Proposed Rule, CMS issued a press release explaining that the hospital pricing proposals contained in the Proposed Rule were a result of the "recent Executive Order on price and quality transparency." Centers for Medicare & Medicaid Services, *CMS Takes Bold Action to Implement Key Elements of President Trump's Executive Order to Empower Patients with Price Transparency and Increase Competition to Lower Costs for Medicare Beneficiaries* (July 29, 2019), *available at* https://www.cms.gov/newsroom/press-releases/cms-takes-bold-action-implement-key-elements-president-trumps-executive-order-empower-patients-price.

In the Proposed Rule, CMS proposed new regulations that would compel hospitals to disclose additional new pricing information on their websites, in addition to the "gross charge" already reflected on the hospital's publicly available chargemaster. These new pieces of information largely mirrored the Executive Order and included: (i) the hospital's "payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting," with each such list of charges "clearly associated with the name of the third party payer"; and (ii) the hospital's "payer-specific negotiated charges" and certain other information for 300 "shoppable services," which was defined as "a service package that can be scheduled by a health care consumer in advance." 84 Fed. Reg. 39,641–642. CMS cited Section 2718(e) as the statutory basis for its authority to require the disclosure of these additional charges.

In the Preamble to the Proposed Rule, CMS admitted: "We believe that these proposals requiring public release of hospital standard charge information are a necessary and important first step in ensuring transparency in health care prices for consumers, although we recognize that the release of hospital standard charge information is not sufficient by itself to achieve our

ultimate goals for price transparency. For example, we know through our stakeholder engagement and research conducted over the past year that consumers of health care services simply want to know where they can get a needed health care service and what that service will cost them out-of-pocket." 84 Fed. Reg. at 39,574. The agency also admitted: "We recognize that the impact resulting from the release of negotiated rates is largely unknown." *Id.* at 39,580. The Proposed Rule also proposed the imposition of penalties on hospitals that fail to comply with the mandates of the rule, including civil monetary penalties (CMPs) and posting of a notice of imposition of a CMP on the agency's website. 84 Fed. Reg. at 39,592–593.

A number of regulated entities submitted comments in response to the Proposed Rule, including AHA, AAMC, FAH, and NACH on behalf of the hospital field. Among other things, these commenters pointed out that CMS's statutory authority under Section 2718(e) is limited to "standard charges," and that the "payer-specific negotiated charges" identified in the Proposed Rule are anything but "standard." Similarly, the commenters noted that the agency lacks statutory authority to issue CMPs and/or publicly name hospitals that fail to comply with the rule. Commenters also pointed out that compelling disclosure of insurer-negotiated charges would violate the First Amendment because it mandates speech in a manner that fails to directly advance a substantial government interest, let alone in a narrowly tailored way. A number of comments also pointed out that the Proposed Rule if finalized would be arbitrary and capricious, because by the agency's own admission, it fails to achieve its stated goals, instead just constituting a purported "first step" toward increasing transparency.

The Final Rule

CMS ultimately severed the Proposed Rule from the Medicare hospital outpatient CY 2020 rule, and published a stand-alone final rule addressing hospital pricing disclosures in the Federal Register on November 27, 2019. 84 Fed. Reg. 65,524 (Nov. 27, 2019).

The Final Rule mandates public disclosure of the two types of charges previously identified in the Proposed Rule (gross charges and payer-specific negotiated charges), plus three additional types of information: "discounted cash price," the "de-identified minimum negotiated charge," and the "de-identified maximum negotiated charge." *Id*. at 65,560. The Final Rule also required display in a "consumer-friendly manner" of payer-specific negotiated charges, discounted cash prices, and de-identified minimum and maximum negotiated charges for the 300 "shoppable" services identified in the Proposed Rule. *Id*. at 65,564.

In response to public comments, CMS "agree[d] with commenters who indicated that disclosure of hospital charge information alone may be insufficient or does not go far enough for consumers to know their out-of-pocket costs in advance of receiving healthcare service." 84 Fed. Reg. 65,528. The agency also admitted that "[n]ecessary data to make out-of-pocket price comparisons depends on an individual's circumstances." *Id*. And it acknowledged that patients with insurance coverage wanting to know their out-of-pocket costs would also need "additional individual benefit-specific information 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." *Id.*

CMS explained that the "discounted cash price" would be defined as "the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service." 84 Fed. Reg. 65,553. However, the agency "recognized that many hospitals have not determined or

maintain [sic], a standard cash discount that would apply uniformly to all self-pay consumers for each of the items and services provided by the hospital or for service packages, unlike they do for negotiated charges." *Id.* The agency also clarified that the term "discounted cash price" would reflect "the discounted rate published by the hospital, unrelated to any charity care or bill forgiveness that a hospital may choose or be required to apply to a particular individual's bill." *Id*. CMS went on to note: "Hospitals that do not offer self-pay discounts may display the hospital's undiscounted gross charges as found in the hospital chargemaster." *Id.*

Like the Proposed Rule, the Final Rule also imposed penalties on hospitals that fail to comply with the mandates of the rule, including CMPs and posting of a notice of imposition of a CMP on the agency's website. 84 Fed. Reg. 65,586.

ARGUMENT

Administrative agencies are bound by several key guiding legal principles. Agencies must act in accordance with their statutory mandate and the authority granted to them by Congress. *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 315–316 (2014); *see also*, *e.g.*, *Bennett v. Donovan*, 4 F. Supp. 3d 5, 13 (D.D.C. 2013). They also must operate within the confines of the United States Constitution, including the First Amendment's restrictions on governmental efforts to regulate free speech. *See, e.g.*, *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 516 (2009). And agencies must refrain from taking action that is arbitrary, capricious, and without rational basis. *See, e.g.*, *Fox v. Clinton*, 684 F.3d 67, 80 (D.C. Cir. 2012). The Final Rule fails all of these tests.

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

"Under our system of government, Congress makes laws and the President, acting at times through agencies . . . 'faithfully execute[s]' them." *Utility Air*, 573 U.S. at 327 (citing U.S. Const., art. II, § 3). In keeping with this basic constitutional principle, federal agencies may

promulgate rules only to the extent authorized to do so by Congress. "It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress," *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988), because "an agency's power is no greater than that delegated to it by Congress." *Lyng v. Payne*, 476 U.S. 926, 937 (1986). Federal agencies similarly lack the authority to override Congress's clear commands. *See Utility Air*, 573 U.S. at 325 ("An agency has no power to 'tailor' legislation to bureaucratic policy goals by rewriting unambiguous statutory terms.").

CMS relies on Section 2718(e) as the basis for its statutory authority to promulgate the Final Rule. 84 Fed. Reg. 65,524. But Section 2718(e) mandates disclosure of "*a list* of the hospital's *standard charges* for items and services provided by the hospital." 42 U.S.C. § 300gg-18(e) (emphases added). It does not permit CMS to mandate disclosure of multiple non-standard charges of the sort contemplated by the Final Rule. The Final Rule thus exceeds the agency's statutory bounds in numerous ways: It purports to invert the meaning of the clear phrase "standard charges," and it imposes penalties not contemplated by Congress. For all of these reasons, it is unlawful and should be vacated.

A. "Standard Charges" Are Not "Insurer-Specific Negotiated Charges."

The statutory language "standard charges" does not allow the agency to mandate disclosure of insurer-specific negotiated charges, a "de-identified minimum" negotiated charge, or a "de-identified maximum" negotiated charge. We must first start, as always, with the plain language of the statute.

"Standard charges" means "standard charges." "Standard" means usual, common, or customary, especially for purposes of comparison. *See* Dictionary.com (2019) ("serving as a basis of weight, measure, value, comparison, or judgment"); Merriam-Webster (2019) ("regularly and widely used, available, or supplied"); Oxford English Dictionary (2019)

("[h]aving the prescribed or normal size, amount, power, degree of quality, etc."); *see also Black's Law Dictionary* (11th ed. 2019) ("A model accepted as correct by custom, consent, or authority"). "Standard," by contrast, does *not* mean individualized, tailored, or bespoke.

For that reason, the term "standard charges" has a longstanding and clear meaning in the hospital services context. "Standard charges" are commonly understood to mean a hospital's usual or customary chargemaster charges, in contrast to plan-specific "negotiated" rates that necessarily vary from plan to plan and insurer to insurer. *See, e.g.*, *Webster Cty. Mem'l Hosp., Inc. v. United Mine Workers of Am. Welfare & Ret. Fund of 1950*, 536 F.2d 419, 419–20 (D.C. Cir. 1976) (per curiam) (explaining that "negotiated" contract rates reflected "the difference, if any, between" a plan-specific "figure and the Hospital's standard charge"); *Lefler v. United Healthcare of Utah, Inc.*, 72 F. App'x 818, 821 (10th Cir. 2003) (contrasting hospitals' "standard charges" with charges that are "discounted in accordance with individual contracts negotiated between payors and service provider"); *NorthBay Healthcare Grp., Inc. v. Kaiser Found. Health Plan, Inc.*, No. 17-CV-05005-LB, 2017 WL 6059299, at *2 (N.D. Cal. Dec. 7, 2017) (distinguishing the " 'charge master rate' (the standard rate a hospital charges for the services it provides)" from plan-specific negotiated rated based on "a standardized percentage" rather than the "full charge-master rate"); *Brown v. Blue Cross & Blue Shield of Mich., Inc.,* 167 F.R.D. 40, 41 (E.D. Mich. 1996) (defining a "hospital's standard charge" as "the customary rate" as opposed to a plan-negotiated "discounted charge"). Congress is presumed to have been aware of this long-standing meaning when it chose the phrase "standard charges." *See Morissette v. United States*, 342 U.S. 246, 263 (1952) (when "Congress borrows terms of art," "absence of contrary direction may be taken as satisfaction with widely accepted definitions, not as a departure from them").

Indeed, for the first eight years Section 2718(e) was in effect, CMS itself appears to have recognized the established meaning of "standard charges." *See, e.g.*, 83 Fed. Reg. 41,144 (Aug. 17, 2018) (explaining that CMS did not then require "that any information be published in a payer-specific manner" and reiterating the agency's prior reading of Section 2718(e) "that hospitals are required to either make public a list of *their standard charges (whether that be the chargemaster itself or in another form of their choice)* or their policies for allowing the public to view a list of those charges in response to an inquiry" (emphasis added)). And yet CMS now interprets the statutory phrase "standard charges" to mean charges that are "standard for different identifiable groups of people." 84 Fed. Reg. 65,539. To be clear: When CMS describes something as "standard for different identifiable groups of people," it is referring to people covered under different insurance plans.[2] That is not "standard." That is "*tailored* to different identifiable groups of people." An agency cannot purport to reverse the plain meaning of statutory language by engaging in creative definitions of otherwise clear terms, such that black means white and yes means no. Words have objective meanings. "Standard" as used by Congress cannot be defined by the agency to mean "non-standard."

The statute's context, purpose, and history bolster this plain meaning of the phrase. Recognizing the additional costs of gathering, assembling, and disseminating pricing information, as well as the sensitivity of the underlying data, Congress did not require all pricing information to be disclosed but instead struck a deliberate balance: Only "standard charges" must be publicly disclosed. Congress further cemented its decision to require the disclosure of *only* this single set of data by requiring disclosure of "*a list*" of those charges. *See* 42 U.S.C. §

[2] *See also* 84 Fed. Reg. 65,542 ("a type of 'standard charge' is the 'payer-specific negotiated charge' that would be defined as the charge (or rate) that a hospital has negotiated with a third party payer for an item or service.").

300gg-18(e) (emphasis added). That is, "a list," singular. Had Congress intended for every hospital in America to release not a comprehensive list of baseline charges, but also a huge compendium of payer-specific lists reflecting individually negotiated charges across all commercial health insurance plans, plus a list of de-identified maximum negotiated charges, plus a list of de-identified minimum negotiated charges, plus a list of discounted cash charges, it "would have used the plural." *U.S. v. Hayes*, 555 U.S. 415, 421 & n.4 (2009).

And Congress knows how to specify the disclosure of payer-specific information when it wants to, as Section 1311(e)(3) of the Affordable Care Act itself confirms. *See* Pub. L. No. 111-148, § 1311(e)(3), 124 Stat. 119, 900, codified at 48 U.S.C. § 18031(e)(3)(A)(vii) (requiring that health plans seeking certification on a covered exchange provide, among other things, "[i]nformation on cost-sharing and payments with respect to any out-of-network coverage"); *see also, e.g.*, 42 U.S.C.A. § 1320a-7h (requiring specific disclosures and publication of manufacturer payments to physicians).

CMS presumably will resort to the standard handbook of government responses to a straightforward question of statutory interpretation, and Chapter 1 of that handbook is to invoke *Chevron* deference. But there is no deference due CMS on the statutory interpretation issue presented here. The Final Rule—and its critical assumption regarding the meaning of the statutory phrase "standard charges"—flow not from the agency's reasoned judgment, but directly from the mandate of the Executive Order,[3] which is owed no deference on its interpretation of statutory provisions delegating power to a federal agency.

[3] *See* June 24, 2019 Executive Order ("[HHS] shall propose a regulation, consistent with applicable law, to require hospitals to post standard charge information, *including charges and information based on negotiated rates and for common or shoppable items and services*") (emphasis added), *available at* https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/.

But even assuming that were not the case, and even assuming for the sake of argument that the term "standard charges" were deemed to be ambiguous, the expansive disclosure regime that CMS has tried to institute far exceeds the reasonable scope of any such ambiguity. As courts have repeatedly recognized, negotiated-rates data are commercially sensitive information normally shielded from disclosure by numerous legal protections. *See, e.g.*, *West Penn Allegheny Health Sys., Inc. v. UPMC*, 2013 WL 121441532 (W.D. Pa. Sept. 16, 2013) (trade-secrets protection); *Medical Ctr. at Elizabeth Place, LLC v. Premier Health Partners*, 294 F.R.D. 87 (S.D. Ohio 2013) (discovery protections); 73 Fed. Reg. 30,664-01, 30,675–75 (May 28, 2008) (FOIA Exemption 4). There is nothing in Section 2718(e) that even hints that Congress would have indirectly permitted such a radical disruption to these longstanding protections. CMS's mandate that all American hospitals must now make public extensive, plan-specific negotiated rates that had previously been viewed (correctly) as highly confidential and competitively sensitive information wipes away all those protections in one fell swoop. It mandates a category of disclosures that, as the very existence of the Final Rule itself confirms, Congress chose not to require. Even if there were some play in Section 2718(e)'s joints, Congress's modest instruction cannot bear that weight.

Because the Final Rule requires disclosure of not only a hospital's "standard charges" but also insurer-specific negotiated charges, the Final Rule exceeds the unambiguous limits Congress placed on the narrow authority granted in Section 2718(e). No matter what CMS represents that it seeks to address, the agency simply "may not exercise its authority in a manner that is inconsistent with the administrative structure that Congress enacted into law." *Merck & Co. v. United States Dep't of Health & Human Servs.*, 385 F. Supp. 3d 81, 92 (D.D.C. 2019) (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 125 (2000)). This is especially true

because the mandated disclosures "invariably raise First Amendment issues," as explained below, and therefore must be read narrowly. *See Motion Picture Ass'n of Am., Inc. v. FCC*, 309 F.3d 796, 805 (D.C. Cir. 2002); *see also Nat'l Cable Television Ass'n v. United States*, 415 U.S. 336, 342 (1974) (instructing that delegations to agency should be read "narrowly to avoid constitutional problems").

B. The Statute Does Not Authorize Penalties.

CMS also lacks statutory authority to impose penalties for violations of the Final Rule. CMS cited both Section 2718(b)(3) of the Affordable Care Act and Section 1102 of the Social Security Act (SSA) as the basis for its statutory authority to impose penalties. The agency fails to explain how Section 1102 of the SSA could provide CMS with the requisite authority, given that Final Rule extends well beyond CMS's authority over Medicare and Medicaid. So that leaves only Section 2718(b)(3).

That provision states: "The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties." CMS reads the reference to "this section" to include Section 2718(e) in addition to Section 2718(a) and (b). But that reading cannot be squared with the authority Congress actually granted to CMS, as the history of Section 2718's enactment makes clear.

That history shows that the enforcement provision is intended to apply only as to the medical loss ratio (MLR) provisions; the reference to "section" is a scrivener's error that arose when Congress consolidated various provisions into Section 2718 of the ACA. What is now Section 2718(b)(3)'s enforcement provision first appeared in standalone Senate and House Bills, S. 1730[4] and H.R. 3681,[5] each of which was introduced on September 30, 2009. As originally

[4] *Available at* https://bit.ly/2qDGEIB.
[5] *Available at* https://bit.ly/2On85PJ.

proposed, the enforcement provision applied exclusively to the MLR requirements and did not include any reference to hospitals' "standard charges." The "standard charges" provision, instead, first appeared in a separate standalone bill from the Senate Finance Committee, S. 1796,[6] introduced on October 19, 2009 and slightly revised on November 19, 2019, S. Amend. No. 2786.[7] By contrast to the MLR provisions, this "standard charges" provision included no enforcement provision whatsoever for a hospital's failure to make required disclosures—much less any penalty provision. The standalone MLR and "standard charges" provisions were then consolidated as "Section 2718" by a floor amendment from then-Senator Franken on December 4, 2009. *See* 155 Cong. Rec. at S12429.[8] Following further amendment not relevant here, the consolidated Section 2718 was then incorporated into the Senate bill enacted as part of the ACA on December 24, 2009.[9]

The "legislative process" that generated Section 2718, mirroring the ACA's generally, was "extremely intense, lengthy, and complex." *See* Abbe R. Gluck, *Imperfect Statutes, Imperfect Courts: Understanding Congress's Plan in the Era of Unorthodox Lawmaking*, 129 Harv. L. Rev. 62, 96 (2015). Indeed, as previous litigation has confirmed, the "Affordable Care Act contains more than a few examples of inartful drafting." *See, e.g.*, *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) (citing as an example the fact that "the Act creates three separate Section 1563s"). In light of this complicated and fast-moving drafting history, it is clear that Congress intended to limit Section 2718(b)(3) to the MLR provisions only, in keeping with the structure and purpose of the standalone bills—and not also to the separate "standard charges"

[6] *Available at* https://bit.ly/2OMq3Kt.
[7] *Available at* https://bit.ly/34o9TO4.
[8] *Available at* https://bit.ly/2qRbWvx.
[9] *Available at* https://bit.ly/2Dpiowd; *see also* https://bit.ly/33l6XjR (H.R. 3590 – Patient Protection and Affordable Care Act).

provisions—notwithstanding the use of the potentially broader-sounding "section." To be sure, Congress could have further clarified as much by updating the word to be "subsection" in section 2718(b)(3) when the standalone MLR and "standard charges" bills were consolidated. *See, e.g.*, *Koons Buick Pontiac GMC, Inc. v. Nigh*, 543 U.S. 50, 65 (2004) (Stevens, J., concurring) (emphasizing that "a busy Congress is fully capable of enacting a scrivener's error into law"). But "insofar as 'the language of the statute does not make [Congress' intention] *crystal* clear,' " this Court may look "to the 'legislative history' " of Section 2718(b)(3). *Moore v. D.C.*, 907 F.2d 165, 172 (D.C. Cir. 1990) (quoting *Allen v. State Bd. of Elections*, 393 U.S. 544, 570 (1969)). And that history unambiguously demonstrates that Congress did not intend to attach penalties to hospital disclosures contemplated under Section 2718(e).

If Section 2718(b)(3)'s enforcement provision were read to apply beyond the MLR provisions of 2718(a) and (b) that would mean, among other things, that CMS would be claiming the authority to penalize both States and the National Association of Insurance Commissioners (NAIC), in addition to hospitals.[10] *See, e.g.*, 42 U.S.C. § 300gg-18(c) (instructing that "the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2)"). But CMS under neither Section 2718 nor any other provision of the ACA claims such authority over NAIC. For good reason: NAIC, as the representative of separate State sovereigns, is HHS's *partner* in implementing Section 2718, as both Congress and HHS itself have long recognized. *See, e.g.*, Letter from Kathleen Sebelius,

[10] NAIC is the nationwide standard-setting and regulatory organization comprising the chief insurance regulators of the States, District of Columbia, and U.S. territories. *See generally About Us*, National Association of Insurance Commissioners (2019), https://bit.ly/2QSSpW4.

Secretary, U.S. Dep't of Health and Human Servs., to Jane L. Cline, President, NAIC, and Therese M. Vaughn, CEO, NAIC (Apr. 12 2010) ("I am writing this letter to request NAIC's assistance relating to implementation of the provisions in Section 2718 of the PHS Act.").[11] Reading Congress's "section" scrivener's error as capaciously as CMS seeks is thus doubly flawed because that interpretation necessarily arrogates to the agency the power to punish parties over whom Congress has granted CMS no authority. Regardless of any ambiguity in the term "section" in Section 2718(b)(3), this Court should decline to do so.

II. THE FINAL RULE VIOLATES THE FIRST AMENDMENT.

The Final Rule is unlawful for a separate reason as well; it violates the First Amendment, which "prohibits the government from telling people what they must say." *Rumsfeld v. Forum for Academic & Institutional Rights, Inc.,* 547 U.S. 47, 61 (2006). When the Government compels individuals to speak a particular message, that compulsion "alters the content of their speech." *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2365 (2018) (cleaned up). That is no less true in the commercial arena. As the Supreme Court has repeatedly instructed, speaker- and content-based speech mandates that target certain types of speakers or certain types of messages "are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Reed v. Town of Gilbert, Ariz.*, 135 S. Ct. 2218, 2226 (2015); *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 565 (2011) ("heightened judicial scrutiny is warranted" for laws imposing "a specific, content-based burden on protected expression.").

The exact level of scrutiny due Government regulation of speech turns on the nature of the speech in question. While certain disclosure requirements directed at "commercial speech" are subject to an intermediate form of First Amendment scrutiny, the Final Rule here does not

[11] *Available at* https://go.cms.gov/2Ol67iS.

regulate advertising. *Cf. Spirit Airlines, Inc. v. Dep't of Transp.*, 687 F.3d 403, 412 (D.C. Cir. 2012) (explaining that "commercial speech" is speech that does "no more than propose a commercial transaction" (quoting *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council*, 425 U.S. 748, 762 (1976))). It instead imposes an affirmative obligation on hospitals to speak anew. As such, the Final Rule is subject to full—that is "strict"—First Amendment scrutiny. *See Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos.*, 515 U.S. 557, 573 (1995) ("[T]his general rule, that the speaker has the right to tailor the speech, applies not only to expressions of value, opinion, or endorsement, but equally to statements of fact the speaker would rather avoid.").

The Final Rule also fails intermediate scrutiny, which applies at a minimum. *See, e.g.*, *Nat'l Ass'n of Mfrs. v. SEC*, 800 F.3d 518, 524 (D.C. Cir. 2015). To satisfy intermediate scrutiny, the government must affirmatively prove that (1) its asserted interest is substantial, (2) the restriction directly and materially advances that interest, and (3) the restriction is narrowly tailored. *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of New York*, 447 U.S. 557 (1980). CMS cannot prove any of these things.

A. The Rule Does Not Directly Advance a Substantial (Let Alone Compelling) Government Interest.

In promulgating the Final Rule, CMS asserted that "transparency in health care pricing is 'critical to enabling patients to become active consumers so that they can lead the drive towards value.' " 84 Fed. Reg. 65,526. CMS concluded that, because "the information that health care consumers need to make informed decisions based on the prices of health care services is not readily available," hospitals should be required to disclose not only their list of chargemaster charges but also four other insurer-specific amounts: negotiated charges, de-identified maximum

and minimum insurer charges, and discounted cash prices, as well as similar information regarding 300 "shoppable services." *Id*.

Plaintiffs are fully in favor of "transparency in healthcare pricing" and "enabling patients to become active consumers." That is why the associational plaintiffs have been urging CMS to facilitate a solution that would ensure that hospitals could provide patients with their out-of-pocket costs, and why many individual hospitals devote substantial resources to attempting to respond to patient inquiries about these costs. But that is not what the Final Rule does. There is no evidence that the mandated disclosure of insurer-specific information will directly and materially further the Government's stated goals. No need to take our word for it: CMS itself admits "that the impact resulting from the release of negotiated rates is largely unknown." 84 Fed. Reg. at 65,542.

Even more to the point, CMS expressly admitted in the Proposed Rule that "consumers of health care services simply want to know where they can get a needed health care service and what that service will cost them out of-pocket." 84 Fed. Reg. at 39,574.[12] And yet the Final Rule provides patients with something else entirely. CMS asserts that its mandated disclosures are useful because "pricing transparency" in the abstract is something to be promoted. But more information is not necessarily better information.

Indeed, CMS acknowledges that the mandated disclosures do not alone provide patients sufficient information to understand any out-of-pocket and cost-sharing obligations they may face individually, but are only a "first step in [the agency's] efforts to achieve price transparency

[12] *See also, e.g.*, FTC Letter for Members of the Minnesota House of Representatives (June 29, 2015) ("To be most meaningful, price information should reflect an individual consumer's desired health care coverage—including specific out-of-pocket expenditures for specific procedures and services—so that the consumer can make informed decisions when selecting a provider or choosing among treatment options."), *available at* https://bit.ly/2Py95A7.

in health care," best viewed "in the context of the broader price transparency initiative," and that it is "continuing to explore other authorities" to achieve this goal. 84 Fed. Reg. 39,574l ; *see also id.* at 65,545. Specifically, CMS asserts that "when a consumer has access to payer-specific negotiated charge information prior to receiving a healthcare service … in combination with additional information from payers, it can help him determine potential out of pocket costs." Id. at 65,543. But the agency separately admitted in the Final Rule that in order to determine their out-of-pocket costs, patients with insurance coverage would need "additional individual benefit-specific information 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." *Id.* at 65,528. As the agency itself admitted, "we do agree that a payer-specific negotiated charge does not, in isolation, provide a patient with an individualized out-of-pocket estimate." *Id.* at 65,543; *see also id.* at 65,578 (same). To survive First Amendment scrutiny, the rule must "directly and materially advance" the proffered governmental interest. A "first step" simply does not do that.

CMS's inability to demonstrate that the Final Rule will have a meaningful effect on patient behavior dooms the rule. Under any form of heightened scrutiny, the First Amendment prohibits the Government from regulating speech on "speculation or conjecture"; CMS must instead show "that the measure it adopted would 'in fact alleviate' the harms it recited 'to a material degree.' " *See Nat'l Ass'n of Mfrs.*, 800 F.3d at 526–527 (quoting *Edenfield v. Fane*, 507 U.S. 761, 770 (1993)); *see also Am. Meat Inst. v. U.S. Dep't of Agric.*, 760 F.3d 18, 26 (D.C. Cir. 2014) (requiring "evidence of a measure's effectiveness").

The requirement that hospitals disclose their "discounted cash price" for various services fares no better. CMS describes this as the "discounted rate published by the hospital, unrelated to any charity care or bill forgiveness that a hospital may choose or be required to apply to a

particular individual's bill." 84 Fed. Reg. at 65,553. While compelling all hospitals to disclose this figure, CMS nonetheless admitted that many hospitals would have no such standard "one size fits all" discount. *Id.* at 65,528–529. And yet the agency nonetheless required that hospitals lacking a "standard" discounted cash price publish the undiscounted gross charges as reflected in the chargemaster under the heading "discounted cash price." *Id*. at 65,553. That disclosure, too, is misleading, because it would erroneously suggest to patients that no discount or forgiveness is available, when that is not true. There simply is no substantial government interest—let alone a compelling one—served by such a requirement.

B. The Rule Is Not Narrowly Tailored.

Even if these hurdles could be overcome, the Final Rule is anything but narrowly tailored. CMS has failed to show that less-speech-restrictive alternatives would not be a more " 'reasonable fit' between means and ends." *Kimberly-Clark Corp. v. D.C.*, 286 F. Supp. 3d 128, 144 (D.D.C. 2017) ("Critically here, '[t]he government cannot satisfy that standard if it presents no evidence that less restrictive means would fail.' ") (citations omitted).

To begin with, the "standard charge" disclosure fails the narrow-tailoring requirement because it requires the disclosure of a broad swath of data that is much more extensive than necessary to serve the proffered interest. The negotiated-charges information now subject to disclosure is highly confidential and commercially sensitive. Hospitals similarly have long been afforded a range of legal protections against disclosure for precisely these reasons. "Information regarding pricing and rates constitutes trade secret information," *see, e.g.*, *West Penn Allegheny Health Sys., Inc. v. UPMC*, 2013 WL 121441532 (W.D. Pa. Sept. 16, 2013)); *see also* Restatement of Torts § 757, cmt. B; 18 U.S.C. § 1839(3), and negotiated rates between health plans and hospitals are routinely protected from discovery on substantially similar grounds, *see, e.g.*, *Medical Ctr. at Elizabeth Place, LLC v. Premier Health Partners*, 294 F.R.D. 87 (S.D. Ohio

2013) (shielding pricing agreements between health plan and hospitals from discovery on basis that they were highly confidential); *Ball Mem. Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1346 (7th Cir. 1986) (entering protective order and noting that pricing negotiated between health plans and hospitals was "unquestionably sensitive trade secrets" of the health plans). CMS itself has also previously taken the position that hospitals' negotiated-rates data qualifies as "confidential" or "proprietary" information that is shielded from disclosure under Exemption Four to the Freedom of Information Act, 5 U.S.C. § 552(b)(4). *See* 73 Fed. Reg. 30,664, 30,675–75 (May 28, 2008) ("Thus, for example, we do not expect that any pricing data included on the claim that fits within FOIA Exemption 4 would be required to be released under FOIA."). Making public proprietary negotiated-charges data would immediately wipe away all those legal protections, threatening to undermine—rather than promote—competition system-wide.

CMS disingenuously suggests that insurer-negotiated charges are not confidential because a patient will see a single piece of data—the specific charge that the hospital charged her insurer for her specific service—on the Explanation of Benefits (EOB) that patient privately receives, or in the more narrow, limited disclosures currently required by some states. 84 Fed. Reg. at 65,539–540. But that is a far cry from mandating that *all* negotiated rates for *all* insurers and *all* services be collected and posted publicly on the internet for all the world to see. That information is considerably more commercially sensitive than a single rate disclosed to a hospital patient. It also may not be representative of what a patient covered by the same insurer but through a different employer would pay. The Final Rule thus goes much too far in requiring public disclosure of negotiated rates—well beyond the scope of regulation necessary to achieve the Final Rule's stated aims.

The Final Rule is not narrowly tailored in another way, too: The sheer burden of compliance with the rule is staggering, and way out of line with any projected benefits associated with the rule. In the Proposed Rule, CMS stated: "we recognize that requiring release of all payer-specific negotiated charges for all hospital items and services (both individual items and services as well as service packages) would mean releasing a large amount of data." 84 Fed. Reg. at 39,580. That is a colossal understatement. The disclosure chart required by the Final Rule would be enormous, including not only the items and services reflected in the chargemaster (often tens of thousands of rows in and of itself, *id*. at 65,533) but also rows reflecting the myriad different ways individual health plan issuers define payments (e.g., per diems, diagnosis-related groups, and other episode and value-based payments). In addition to descriptions, codes, and gross charges, the spreadsheet would need to include separate columns for each health plan issuer contract. And the agency itself has admitted that many hospitals have negotiated charges with many payers representing hundreds of plans. *Id.* at 65,551. CMS acknowledged that commenters estimated that the resulting file "could be 300 lines long with dozens of columns or could lead to 100,000 rows of data with millions of fields." *Id.* at 65,575. The agency also has admitted that the data required to be disclosed in each of these spreadsheet cells is not likely to be readily accessible from the hospitals' contracts with insurers, and instead must be pulled from other parts of the hospital's billing and accounting systems and/or from rate sheets, and would require "some thought and clinical input." *Id*. To state the obvious: This is not narrow tailoring.

C. The Rule Fails Even Under The More Deferential *Zauderer* Standard.

Presumably cognizant that its rule fails the applicable First Amendment test, CMS claims that the Final Rule should be subject not to heightened scrutiny but to the reasonableness standard announced in *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985). 84 Fed. Reg. at 65,545. Not so, for two reasons.

First, by its own terms *Zauderer* applies only in the context of commercial "advertising." *Id.* at 651. Outside this narrow exception, the First Amendment's normal heightened standard governs. Again, because CMS's Rule does "not involve voluntary commercial advertising," but rather imposes an affirmative duty to speak against a backdrop of silence, "*Zauderer* has no application to this case." *Nat'l Ass'n of Mfrs.*, 800 F.3d at 523–524.

Second, the *Zauderer* standard applies only to "purely factual and uncontroversial information." 471 U.S. at 626. Disclosures that are "one-sided or incomplete," *Am. Meat Inst*, 760 F.3d 18, 27 (D.C. 2014), as well as those that "might be misinterpreted by consumers" even if not patently false do not fall within *Zauderer*'s scope. *See CTIA-Wireless Ass'n v. City & Cty. of San Francisco, Cal.*, 494 F. App'x 752, 753–754 (9th Cir. 2012) (affirming conclusion that compelled disclosure advising how to "reduce exposure to radiofrequency energy emissions" when using cellphones, without evidence that normal levels of "radiofrequency energy exposure" causes harm, fell outside *Zauderer*'s scope when it could be "interpreted by consumers" as suggesting "that using cell phones is dangerous").

Patients would reasonably expect the mandated disclosures would allow them to compare the costs that actually matter to them. Revealing, instead, the rates that insurers have individually agreed to pay, but which may not even apply to them, is by any definition, "misleading." *See, e.g.*, *Giant Food Inc. v. FTC*, 322 F.2d 977, 982 (D.C. Cir. 1963) (concluding that consumer advertisement suggesting that a particular "list price" reflects ordinary charges is "deceptive" when that "list price" does not accurately reflect the prices actually paid).

But the Final Rule does not satisfy the *Zauderer* standard, even assuming it applies. A rule fails *Zauderer* where its disclosure requirement is either "unjustified or unduly burdensome." *See Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2376–77. The Final

Rule is both for all the reasons given above. The compelled "negotiated charge" disclosure is "unjustified" because publicizing payer-specific negotiated rates at the plan level will confuse patients, and thus frustrate rather than improve patient decision-making. And it is "unduly burdensome" because the mass dissemination of highly sensitive pricing data will impose enormous compliance costs on hospitals, without any countervailing benefit to patients. The Final Rule thus fails under *Zauderer*, too.

III. THE FINAL RULE IS ARBITRARY AND CAPRICIOUS.

An agency decision is arbitrary and capricious if the agency "offered an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *see also Clark County, Nev. v. FAA*, 522 F.3d 437, 441–442 (D.C. Cir. 2008). The same is true when an agency ignores evidence bearing on the issue before it. *Butte County, Cal. v. Hogen*, 613 F.3d 190 (D.C. Cir. 2010). To survive arbitrary and capricious review, "an agency action must be the product of reasoned decisionmaking." *Fox v. Clinton*, 684 F.3d 67, 74–75 (D.C. Cir. 2012). "[N]o deference is owed to an agency action that is based on an agency's 'purported expertise' where the agency's explanation for its action 'lacks any coherence.' " *Id.*

CMS's compelled disclosure requirement ostensibly seeks to enhance patients' ability to make better-informed healthcare decisions. 84 Fed. Reg. at 65,526. But the agency does not know whether publicizing negotiated rates would have any impact whatsoever on patient behavior; as the agency candidly concedes, "the impact resulting from the release of negotiated rates is largely unknown." *Id.* at 65,542.

CMS nonetheless asserts that "[h]aving insight into the charges that have been negotiated on one's behalf" will help patients "to determine their potential out-of-pocket obligations prior to receipt of a health care service." *Id.* 65,524. But the agency itself provides the evidence that

counters this bald assertion. CMS has admitted that a patient's out-of-pocket costs for a particular hospital visit are dictated by a number of factors that can have nothing to do with the negotiated charge, such as the amount of the patient's co-pay and deductible, how much of the deductible has been satisfied, and whether the patient has complied with contractual prerequisites to coverage. *Id.* at 65,528.

The mandatory disclosure of a partial, concededly inconclusive list of negotiated contract rates not only fails to advance the goal of price transparency, it also promises to *exacerbate* customer confusion. If a patient concludes that a high contract price correlates with higher out-of-pocket costs—after all, why would the Government mandate such a list otherwise?—that misleading signal could, at the very least, impede her ability to compare prices or discourage her from seeking care. As a result, the Final Rule will not give patients meaningful insight into their own costs, but instead will result in greater patient confusion.

The Final Rule also is arbitrary because it imposes a disproportionately large cost: despite the agency's benign projections regarding burden, the real-world burden of complying with the Final Rule will be severe. The file required by the Final Rule would require production of a chart comprising potentially hundreds of thousands of rows, and hundreds to thousands of columns. *See* 84 Fed. Reg. 65,575. That chart would need to be prepared manually by hospital employees, and incorporate the clinical judgment of medical providers, *id*., directing already-scarce resources away from tasks more directly supportive of patient care.

The requirement that hospitals disclose their "discounted cash price" for various services fares no better. CMS describes this as the "discounted rate published by the hospital, unrelated to any charity care or bill forgiveness that a hospital may choose or be required to apply to a particular individual's bill." 84 Fed. Reg. at 65,553. While compelling all hospitals to disclose

this figure, CMS nonetheless admitted that many hospitals would have no such standard one-size-fits-all discount. *Id.* And yet the agency nonetheless required that hospitals lacking a "standard" discounted cash price publish the undiscounted gross charges as reflected in the chargemaster under the heading "discounted cash price." *Id*. That disclosure, too, is misleading, because it erroneously suggests to patients that no discounts or forgiveness is available, even though that is not true.

For all these reasons, the Final Rule is arbitrary and capricious, and fails to satisfy the APA's threshold demand for reasoned decision-making.

CONCLUSION

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

Respectfully submitted,

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