ORAL ARGUMENT NOT YET SCHEDULED

No. 20-5193

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, *et al*.,
Appellants,

v.

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

On Appeal from the United States District Court for the District of Columbia,
(No. 19-3619, Honorable Carl J. Nichols)

BRIEF OF *AMICI CURIAE* FORTY (40) STATE HOSPITAL ASSOCIATIONS IN SUPPORT OF APPELLANTS

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CERTIFICATE AS TO PARTIES, RULINGS AND RELATED CASES

A. Parties and *amici*

All parties, intervenors, and amici are listed in the Certificates as to Parties, Rulings Under Review, and Related Cases filed in this Court on July 3, 2020.

B. Rulings under review

References to the rulings at issue appear in the Certificate as to Parties, Rulings Under Review, and Related Cases filed in this Court on July 3, 2020.

C. Related cases

Amici are not aware of any cases related to this appeal.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS II
TABLE OF AUTHORITIES III
CORPORATE DISCLOSURE STATEMENT 1
STATEMENT REGARDING CONSENT TO FILE AND SEPARATE BRIEFING 2
INTEREST OF AMICI CURIAE 3
INTRODUCTION 4
I. HHS'S INTERPRETATIONS OF "STANDARD CHARGE" AND "A LIST" CANNOT BE RECONCILED WITH HOW HOSPITALS OPERATE IN THE REAL WORLD 11
II. HHS'S INTERPRETATIONS OF "STANDARD CHARGE" AND "A LIST" WILL IMPOSE SEVERE BURDENS ON HOSPITALS 23
CONCLUSION 30

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Arlington, Texas v. FCC,
569 U.S. 290 (2013).....22

Chevron, U.S.A. Inc. v. Natural Res. Def. Council, Inc.,
467 U.S. 837 (1984).....30

Department of Homeland Security v. Regents of Univ. of Cal.,
No. 18-587, 2020 WL 3271746 (U.S. June 18, 2020).....4

Hertz Corp. v. Friend,
559 U.S. 77 (2010).....21

Maine Community Health Options v. United States,
140 S. Ct. 1308 (2020).....23

Maldonado v. Ochsner Clinic Foundation,
493 F.3d 521 (5th Cir. 2007).....13

NACS v. Board of Governors of Federal Reserve System,
746 F.3d 474 (D.C. Cir. 2014).....10

O'Connell v. Springfield Hospital, Inc.,
No. 5:16-cv-289, 2018 WL 4699312 (D.Vt. July 17, 2018).....20

Spectrum Health--Kent Community Campus v. NLRB,
647 F.3d 341 (D.C. Cir. 2011).....16

United States v. Hansen,
772 F.2d 940 (D.C. Cir. 1985).....16

United States v. Zacks,
375 U.S. 59 (1963).....16

United States v. Zazove,
334 U.S. 602 (1948).....29

Utility Air Regulatory Group v. Environmental Protection Agency,
573 U.S. 302 (2014).....10, 29

Whitman v. American Trucking Associations,
531 U.S. 457 (2001).....10

FEDERAL STATUTES

42 U.S.C. § 300gg-18(e).....passim

FEDERAL REGULATIONS

84 Fed. Reg. 42,044.....15

84 Fed. Reg. 65,524-01 (Nov. 27, 2019).....passim

OTHER AUTHORITIES

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).....passim

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Minnesota Hospital Association, *Cost and Quality Transparency* (June 1, 2019), https://www.mnhospitals.org/newsroom/news/id/2180/cost-and-quality-transparency (describing price transparency tools used in Minnesota) 24

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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/ 15

Wisconsin Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3247) (Sept. 27, 2019), https://www.regulations.gov/document?D=CMS-2019-0109-3247 25

CORPORATE DISCLOSURE STATEMENT

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

STATEMENT REGARDING CONSENT TO FILE AND SEPARATE BRIEFING

All Parties have consented to the filing of this brief. *Amici curiae* filed their notice of intent to participate as *amici curiae* on July 24, 2020.

Counsel for *amici curiae* certify that it is not practicable to file a joint *amicus curiae* brief with other potential *amici* in support of Appellants and that it is necessary to file a separate brief.

Counsel reached out to potential *amici* and was able to put together the present coalition of organizations, thereby reducing the number of potential *amicus curiae* filings.

INTEREST OF AMICI CURIAE[1]

Amici curiae are forty state and regional hospital associations.[2] It is no exaggeration to say that *amici*'s member hospitals will be *most* directly and adversely 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* have the strongest possible interest in how HHS regulates the disclosure of privately-negotiated contracts in the Final Rule. They respectfully submit this brief to provide information directly relevant to the Court's consideration of this appeal.

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

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

INTRODUCTION

Amici's member hospitals know better than anyone how important it is for patients to make informed health care choices. For that reason, *amici* strongly support meaningful price transparency. 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 this Court need not decide whether the Final Rule is "sound polic[y]." *Department of Homeland Security v. Regents of Univ. of Cal.*, No. 18-587 2020 WL 3271746 *17 (U.S. June 18, 2020). The only question for this Court is one of administrative law, *i.e*. "whether the agency appreciated the scope of its discretion or exercised that discretion in a reasonable manner." *Id*. HHS did not do so here. It instead chose to achieve its laudable goals in unlawful ways.

To make matters worse, HHS's Final Rule will impose inordinate burdens on health systems across the United States without a corresponding benefit to consumers. *Amici*'s member hospitals are experiencing those burdens today—in the midst of a global pandemic.[5] Right now, they are required to spend precious dollars

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

[5] *See* Ron Shinkman, *Ratings agencies issue foreboding reports on hospital finances as AHA seeks $100B to respond to COVID-19*, Health Care Dive (March 20, 2020), https://www.healthcaredive.com/news/ratings-agencies-issue-foreboding-reports-on-hospital-finances-as-aha-seeks/574541/ ("Most U.S. hospitals typically operate on thin margins," and recent financial reporting indicates that "the fiscal fortunes of the nation's hospitals are apparently shrinking."); American Hospital Association,

and staff-hours to comply with a rule that far exceeds HHS's statutory authority and 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.

Appellants have persuasively explained why the district court erred in upholding the Final Rule. Rather than repeating those arguments, *amici* seek to provide this Court with 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 single list of standard charges (the "chargemaster" list), which is used as the "starting point" for individualized negotiations with private insurers. Memorandum Opinion ("Opinion") at 3 (June 23, 2020), ECF No. 35. The result of these complex, ongoing negotiations is a myriad of discounts and deviations from the "chargemaster's" standard pricing list.

Today, hospitals typically contract with dozens of private insurers, covering multiple types of plans, each of which has different payment rates and reimbursement methodologies. None of these thousands of different rates, which

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Letter on Proposed Rulemaking (June 29, 2020) at 1-2 ("The last several months have required all hospitals and health systems to dedicate significant resources to managing the COVID-19-surge and adapting to new ways of caring for patients.… Even attempting to comply with the rule will require a significant diversion of financial resources and staff time that hospitals and health systems cannot afford to spare as they prepare to or care for patients with COVID-19.").

are discounted from the "chargemaster" starting point, can be reasonably described as "standard." Strikingly, the district court misunderstood this argument and essentially read the word "standard" out of the statute. That misunderstanding caused the court to reject Appellants' argument under *Chevron* Step One and choose incorrectly when making what it described as a "close call" under *Chevron* Step Two.

The district court's misunderstanding of this argument hits especially close to home to *amici* because the district court misconstrued *amici*'s brief below, which it cited in support of its erroneous reading of "standard charges." Specifically, the district court cited *amici*'s brief as evidence for its assertion that Appellants and *amici* believe there is only "one set of charges: those reflected in their chargemasters." Opinion at 17 (quoting Br. of Amici Curiae Thirty-Seven State Hospital Associations at 15, ECF No. 25-1 ("[T]he chargemaster remains a hospital's *only* universal list of charges for services.")). Nobody disputes that the chargemaster contains *the only* uniform set of charges. Nevertheless, the district court ignored the word "universal" in the sentence quoted from *amici*'s brief.

Let us be clear: *amici* do not dispute that patients often ultimately pay rates that are different from what is on a hospital's "chargemaster" list. In fact, *amici* agree that there are thousands of different final, individualized payment rates, and most do not match the standard "starting point." But therein lies the problem with

the district court's and HHS's interpretation of "standard charge." When every charge is so different and there are thousands of different charges, how can the agency reasonably call *all* of those charges "standard"?

By contrast, there is only one "universal" list—the "chargemaster"—and only that list can be reasonably called "standard." Everything else is a *non*-standard discount. The district court and HHS, however, would treat *every* single charge, for *every* different individual patient or insurer, as "standard." This distorts "standard" beyond both its common meaning *and* the realities of the current hospital payment system. It should be rejected under both steps of the *Chevron* test.

The district court's "close call" under *Chevron* Step Two is further undercut by its failure to seriously grapple with the statute's use of the word "list." Despite Appellants and *amici* having devoted considerable attention to this statutory term, the district court relegated its analysis of the phrase "a list" to a brief footnote. *See* Opinion at 24 n.16. This Court should not ignore that key phrase.

As an initial matter, Appellants have convincingly explained that the Final Rule requires hospitals to disclose *two* lists: both the machine-readable file and the shoppable-services list. Appellants' Br. at 37-39. More fundamentally, in giving short shrift to the term "a list," the district court stated that "a list can contain multiple categories" that are combined into a single "data file." *Id.* But that, too, stretches the concept of a "list" far beyond any reasonable understanding. An electronic data

file containing innumerable variations of separately-negotiated rates will contain an unintelligible mish-mash that no patient, doctor, hospital administrator, or legislator would ever reasonably call "*a* list," even one with "multiple categories."

Finally, given the sheer amount of information that hospitals must disclose, it is incontestable that the Final Rule will inflict immense burdens on hospitals. 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.[6]

Another amicus explained:

> This proposal, if finalized, would pose excessive burden on hospitals and health systems…. 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.[7]

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[6] 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).

[7] 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 other words, to achieve what the Final Rule requires, already-overstretched hospital staff will have to manually scour every insurance contract (some of which have hundreds of variations of payment rates), combine millions of lines of data into a massive new electronic file, and ensure that it is scrubbed appropriately for public consumption.

Contrary to HHS's back-of-the-envelope assertion, this is not an "$11,898.60 per hospital" job.[8] To take just one example, a single hospital system in Washington, D.C. explained 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. The same 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. Similarly, one Ohio hospital system estimated that the cost of compliance with the Final Rule could be as high as $2,000,000 annually, based on the analysis to produce and update the data, potential use of outside vendors, and increased support staff.

Comment after comment explained these burdens to HHS. Some of those comments are collected in footnote 44 of this brief. *See also* Appellants' Br. at 17-19 (citing similar comments from individual hospitals). Regrettably, the district court considered these burdens only in connection with Appellants' arbitrary-and-capriciousness claim. But as the Supreme Court indicated in *Utility Air Regulatory*

[8] 84 Fed. Reg. at 65,525.

Group v. Environmental Protection Agency, 573 U.S. 302, 323 (2014), regulatory burdens are relevant to the *Chevron* Step Two analysis—perhaps even more so. Here, the regulatory burdens demonstrate just how far HHS has stretched the statutory language to achieve its policy preferences. The terms "standard charge" and "a list" cannot bear the enormous costs that HHS seeks to inflict on hospitals.

In the past, this Court has considered regulatory burdens based on an *amicus* brief. Indeed, this Court looked to those costs to when considering whether Congress was hiding an elephant in a statutory mousehole.[9] *Amici* respectfully submit that this Court should do the same here. The information *amici* provide regarding regulatory burdens reveals a prominent pachyderm.

At bottom, the district court's conclusion that HHS's interpretation survives *Chevron* review cannot withstand scrutiny. The Final Rule bends the key statutory terms "standard" and "a list" far past their breaking points, and it imposes extreme

[9] *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. [*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.").

burdens on hospitals. These multiple errors make plain that HHS's interpretation is, at worst, incorrect under *Chevron* Step One, and, at best, unreasonable such that the district court's *close* call under *Chevron* Step Two was the *wrong* call. Accordingly, *amici* respectfully request that the Court reverse the district court's decision.

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

To understand why the Final Rule exceeds 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 century and continues to play today; and (3) the innumerable variations in rates that hospitals negotiate with private insurers. With this background in mind, it quickly becomes clear that a hospital's "chargemaster" is the *only* realistic list of its "standard charges," and that the Final Rule's definition of "*a* list" impermissibly shatters that singular statutory term into thousands of different lists.

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."[10] In the 19th and early 20th centuries, hospitals "were primarily philanthropic organizations" that "hous[ed] the poor and insane who were sick."[11]

This began to change in the 1920s. At that time, "the ability of hospitals to improve the health status of patients increased dramatically."[12] As a result, "[f]or the first time, rich and poor Americans sought out hospital care when they became seriously ill."[13]

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—became available, and "more highly trained personnel" were needed to provide these services.[14] 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 document maintained by each

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[10] 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").

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] *Id.*

hospital that contains a list of prices for each [individual] item and procedure offered."[15] "Initially there were only a few items on the list."[16] Over time, that list grew to reflect the many different types of services, products, medicines, and devices provided during a hospital stay. Today, as the Final Rule observed, the chargemaster list "can include tens of thousands of line items, depending on the type of facility."[17]

Shortly after hospitals began developing their "chargemaster" lists, the Great Depression began to make it "difficult for hospitals to get paid for services."[18] 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."[19] Insurance programs like these "proliferated," with insurers paying hospitals based upon the "chargemaster" list.[20] This private insurance system accelerated after World War II, particularly as

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[15] Opinion at 3; *see* Christopher P. Tomkins et al., *The Precarious Pricing System 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 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.").

[16] Anderson Testimony.

[17] 84 Fed. Reg. at 65,533.

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

[19] *Id*.

[20] Anderson Testimony.

Congress made health insurance tax exempt.[21] 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."[22]

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 percent) allowance.[23] 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."[24]

Medicare and the DRG. The next several decades experienced important changes with the enactment of Medicare and Medicaid.[25] 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).

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[21] *Id.*

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

[23] Anderson Testimony.

[24] *Id*.

[25] *See* Anderson Testimony; *see also* Centers for Medicare & Medicaid Services, *Acute Inpatient PPS*, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

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."[26] 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."[27] Significantly, the Medicare payment system is "fully transparent."[28] 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

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[26] 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.").

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

[28] *Id*.

"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* DRGs[29]—does not remotely suggest that Congress intended to authorize the Final Rule's sweeping disclosure requirements. "To give the [DRG language] the controlling weight that is claimed for [it] … would allow the tail to wag the dog." *United States v. Zacks*, 375 U.S. 59, 70 (1963).

As *amici* explained below, there is an easy explanation for why Section 300gg-18(e) refers to "diagnosis-related groups established under section 1395ww(d)(4) of this title."[30] 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 existing transparency measures. *See Spectrum Health--Kent Community Campus v. NLRB*, 647 F.3d 341, 346 (D.C. Cir. 2011) ("[D]rafters of legislation … sometimes take a belt-and-suspenders approach in order 'to make assurance doubly sure.'" (quoting *United States v. Hansen*, 772 F.2d 940, 947 (D.C. Cir. 1985)). Far from "odd," as the district court described it (at 23), this belt-and-suspenders approach makes good sense when Congress was

[29] Opinion at 19 ("[S]ection 2718(e) references the DRGs established *by* Medicare.").

[30] The district court acknowledged this explanation (at 19 n.12), but did not respond to it.

imposing new *private* transparency requirements that may have been misunderstood as supplanting preexisting *Medicare*-related ones. At a minimum, the DRG language cannot overcome the combined effect of the many other unreasonable aspects of HHS' interpretation—from its misreading of "standard" to its distortion of "a list" to the massive burdens it imposes on hospitals.

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."[31] These managed care plans began to "negotiate with hospitals" over pricing and payments.[32] The plans had distinct advantages through their volume, and their negotiating clout increased.[33] Consequently, managed care plans were able to "successfully negotiate[] sizeable discounts with hospitals."[34] Other private insurers, which competed with managed

[31] Anderson Testimony.

[32] *Id.*

[33] 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) (same).

[34] Anderson Testimony.

care plans, quickly caught up. "Soon commercial insurers asked for similar discounts"[35]—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 huge 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 that insurer offers a variety of plans.

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. The following responses reveal just some of the complexity and variability of modern hospital charges:

- 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."

[35] Anderson Testimony.

- 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."
- A Washington, D.C. hospital answered: "We have approximately 35 contract/products for the facility and approximately 40 different contracts on the professional side."
- 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. … Each of the changes requires a review by managed care professionals, legal and operational staff."

These survey responses indicate that HHS got at least one thing right in the Final Rule: "some hospitals may have negotiated charges with many payers representing *hundreds* of plans."[36]

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" continues to be a hospital's *only* **universal** list of charges for services. *Contra* Opinion at 17 (ignoring the word "universal"). 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 health care consumers. "[F]or most insurance companies, the price is simply a 'discounted' chargemaster price."[37] As one court 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."[38]

This history of hospital pricing undercuts the Final Rule's attempts to: (1) require hospitals to publish multiple "lists" of payer-specific negotiated charges; and

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[36] 84 Fed. Reg. at 65,551 (emphasis added).

[37] *Id*. at 12.

[38] *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).

(2) subdivide the statutory term "standard charge" into more than thousands of different "standard charges." As to the statutory phrase "*a* list," the real-world operation of hospital pricing makes plain that hospitals across America have hundreds or thousands of *different* lists of charges. Indeed, as indicated by *amici*'s members and as acknowledged by HHS itself, hospitals in some cases have many 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."[39] Given the sheer amount and variety of data involved in real-world hospital pricing, requiring hospitals to publish *each* of these individualized 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"). And at a minimum, as Appellants have explained, this Rule requires two lists under any conceivable understanding of the term: the unwieldy machine-readable spreadsheet and the shoppable-services list. Appellants' Br. at 37-39.

The district court's short-shrift answer, which it included in a four-sentence footnote, cannot rehabilitate HHS's unreasonable interpretation of "a list." The

[39] 84 Fed. Reg. at 65,567.

district court all but concedes that the Rule requires hospitals to take these thousands of individualized lists, reformulate them into something new, and create a "data file" with "multiple categories." What the district court failed to recognize, however, is that this data file is not anything close to "a list." It is a sprawling electronic record containing millions of lines and dozens of columns of individualized payment rates that cannot be reasonably understood as "a list" within the meaning of the statute. Put simply, the district court's and HHS's "multiple-category-data-file" reading of "a list" exceeds "the bounds of reasonable interpretation." *Arlington, Texas v. FCC*, 569 U.S. 290, 296 (2013).

In addition, HHS's definition—or really, its multiple definitions—of "standard" cannot be squared with on-the-ground realities of contemporary hospital charging practices. The district court rightly concluded that hospitals use the "chargemaster" as the "starting point" for negotiations with insurers. Opinion at 3. The Final Rule appears to do so as well. It states that "for the insured population, hospitals charge amounts reflect *discounts* to the chargemaster rates that the hospital has negotiated with third party payers."[40] Commonsense therefore suggests that the only conceivable "standard" charge is the "chargemaster," and the many discounted variations are *non*-standard discounted charges from the "chargemaster's" "standard

[40] 84 Fed. Reg. at 65,537 (emphasis added); *see id*. 65,540 ("[H]ospitals routinely use gross charges as a starting point for negotiating discounted rates.").

charge." Accordingly, HHS's attempt to fractionate each insurer's negotiated rate into hundreds of different per-insurer "standards" does not reflect the real-world way in which hospital pricing works. Congress was well aware of that real-world system when it enacted the term "standard charge" in Section 300gg-18(e).[41] HHS cannot now creatively redefine that statutory language to conjure its own new reality.

II. HHS'S INTERPRETATIONS OF "STANDARD CHARGE" AND "A LIST" WILL IMPOSE SEVERE BURDENS ON HOSPITALS

The reason why the Final Rule inflicts such severe burdens on hospitals should come as no surprise. By requiring hospitals to disclose millions of lines of data across dozens of spreadsheet columns, hospitals will have to devote substantial resources to manually create and maintain the new electronic files required under the Final Rule. They also will have to update these files every time new rates are negotiated, making this a never-ending task given how frequently rates change.[42]

Amici support meaningful transparency in health care pricing. But transparency can be accomplished through far less burdensome initiatives that are

[41] What is more, if there were any indication at the time of enactment that Congress intended to impose such a sweeping and onerous disclosure requirement on hospitals, hospitals would have objected vociferously to that "sea change," just as they did during the comment period here. *Maine Community Health Options v. United States*, 140 S. Ct. 1308, 1324-25 (2020); *id*. at 1321 n.6. They did not.

[42] Critically, this year-round negotiation with insurers conflicts with the statutory phrase "each year," 42 U.S.C. § 300gg-18(e). Only the "chargemaster" is determined annually.

more useful for consumers. 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—not an enormous "data file" containing "multiple categories" of unintelligible information.[43] For all the data that the Final Rule requires to be disclosed, it ignores the information patients actually want. In that respect, it is as unhelpful as it is unlawful.

HHS was well aware of these burdens. Numerous *amici* identified them during the rulemaking process,[44] as did many individual hospitals, *see* Appellants'

[43] *E.g.*, 84 Fed. Reg. at 65,526; California Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3038) (Sept. 27, 2019) at 3, https://www.regulations.gov/document?D=CMS-2019-0109-3038 (explaining that the rule requires disclosure of information that will be "indecipherable" to patients, and that by contrast "California hospitals have developed ways to provide potential patients information on estimated out-of-pocket costs from hospital charges associated with a procedure."); Texas Hospital Association, *Price Transparency*, https://www.tha.org/PriceTransparency ("Through online tools like PricePoint and conversations with patients ahead of elective and scheduled procedures, Texas hospitals have long empowered health care consumers to make informed decisions about their medical care."); Minnesota Hospital Association, *Cost and Quality Transparency* (June 1, 2019), https://www.mnhospitals.org/newsroom/news/id/2180/cost-and-quality-transparency (describing price transparency tools used in Minnesota); Consumers for Affordable Health Care, *New Maine Website Gives Patients Tools to Compare Hospital Costs* (Nov. 2, 2015), https://www.mainecahc.org/new-maine-website-gives-patients-tools-to-compare-hospital-costs/ (same for Maine).

[44] *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 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."); 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 ("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…. 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."); HANYS, Comment Letter on Proposed Rulemaking (CMS-2019-0109-0002) (Sept. 26, 2019) at 4, https://www.regulations.gov/document?D=CMS-2019-0109-1980 ("HANYS agrees with AHA that this proposal, if finalized, would pose excessive burden on hospitals and health systems — far exceeding CMS' estimate of 12 hours. Compiling, standardizing and issuing this information online in a machine-readable format would require staff time reallocations and new hires (executive, finance, IT, legal, and patient relations). These resources would not only be required to aggregate the information and build web interfaces, but also keep the information and technology up to date and to respond to patient inquiries.") (emphasis omitted); Oregon Association of Hospitals and Health Systems, Comment Letter on Proposed Rulemaking (CMS-2019-0109-0002) (Sept. 27, 2019) at 3, https://www.regulations.gov/document?D=CMS-2019-0109-3302 ("To prepare for the January 2019 deadline to post all standard charges in a machine-readable format, hospitals and health systems often spent more than 100 hours manually creating the files and updating their websites. The file CMS would require under the proposed rule would be exponentially larger…. This could introduce thousands or even hundreds of thousands of additional rows to the required spreadsheet.

CMS's proposal also would require hundreds to thousands of columns. In addition to descriptions, codes, and gross charges, the spreadsheet would need to include separate columns for each health plan issuer contract. Many hospitals and health systems have over 100 contracts with different health plan issuers, often with

Br. at 17-19. While dense, the burdens these comments described demand far more attention than the district court and HHS gave them.

To the extent there is any doubt about these burdens, *amici*'s survey of member hospitals further elucidates them:

- 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." 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, 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.
- A 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

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multiple contracted rates depending on the type of health plan (e.g., Medicare Advantage, individual market health maintenance organization (HMO), individual market preferred provider organization (PPO), each self-insured plan). Hospitals and health systems report that a file of this size could easily crash most standard computer systems, and some members worry about the ability of their websites to function at all with such a large file.").

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, chargemaster 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 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 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." 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."
- A Washington hospital called the burdens "a nightmare." The hospital's administrator 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 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."

The massive burdens that the Final Rule imposes on hospitals across the United States demonstrate the unreasonableness of HHS's radical interpretation of "standard charge" and "a list." *E.g.*, *Utility Air Regulatory Group*, 573 U.S. at 322-323 ("Start with the PSD program, which imposes numerous and costly requirements on those sources that are required to apply for permits.… Not surprisingly, EPA acknowledges that PSD review is a 'complicated, resource-intensive, time-consuming, and sometimes contentious process' suitable for 'hundreds of larger sources,' not 'tens of thousands of smaller sources.'") (citation omitted). Those burdens—on their own—are enough to defeat HHS's interpretation. *Id*. at 323-324 ("The fact that EPA's greenhouse-gas-inclusive interpretation of the PSD and Title V triggers would place plainly excessive demands on limited governmental resources is alone a good reason for rejecting it."); *United States v. Zazove*, 334 U.S. 602, 616-17 (1948) ("Yet Congress nowhere specified that the United States would bear the huge cost of the enhanced liability that it would necessarily have anticipated had it impressed upon s 602(h)(2) the meaning that respondent finds there; and that striking omission is persuasive, in the absence of cogent considerations to the contrary, that no generosity of this magnitude was contemplated."). Unfortunately, the district court only considered these burdens in its consideration of whether the Final Rule is arbitrary and capricious. *See* Opinion at 41-42. But these burdens *also* are relevant to the *Chevron* Step Two analysis. When piled on top of HHS's

unreasonably aggressive readings of "standard" and "a list," these burdens cinch the conclusion that the Final Rule is *not* "based on a permissible construction of the statute." *Chevron, U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984).

CONCLUSION

This Court should reverse the district court's opinion and vacate the Final Rule.

Dated: July 24, 2020

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Dated: July 24, 2020

/s/ Chad I. Golder
Chad I. Golder

CERTIFICATE OF SERVICE

I hereby certify that on July 24, 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: July 24, 2020

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