IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, *et al.*,

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)

REPLY MEMORANDUM IN FURTHER SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

OTHER AUTHORITIES

INTRODUCTION

In Section 2718(e) of the Public Health Service Act ("PHS Act"), Congress required each hospital to publish "a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title." 42 U.S.C. § 300gg-18(e). Plaintiffs insist that this provision "quite plainly" requires just one thing: that hospitals publish their chargemaster rates. *See* Pls.' Opp'n & Reply Br. 5, ECF No. 27 ("Opp'n Br."). In other words, Plaintiffs think that Congress could have replaced all 26 of those words, from "a list" to "this title," with just three—"the hospital's chargemaster"—and it would have had no effect on the provision's meaning. Plaintiffs are wrong.

When the Department of Health and Human Services ("HHS") issued a rule interpreting Section 2718(e), it gave meaning to the provision's full text. *See* Price Transparency Requirements, 84 Fed. Reg. 65,524 (Nov. 27, 2019) (to be codified at 45 C.F.R. pt. 180) ("the Price Transparency Rule" or "the Rule"). The agency recognized that, in light of the complexity of the market for hospital services, hospitals do not have just one "standard" charge. Rather, they charge different regular rates to defined groups of patients. What makes these rates "regular," and thus different from the kinds of one-off negotiated prices in other industries that Plaintiffs discuss at length, is that they are set in advance and apply to all similarly situated patients.

A narrower definition of "standard charges"—like Plaintiffs' attempt to limit the term to "chargemaster prices"—would garble the rest of Section 2718(e). Plaintiffs and their two amici ably illustrate this point, as they collectively offer no fewer than *five* conflicting theories for why Congress included certain diagnosis-related groups ("DRGs") as distinct "items and services" under the statute, even though DRGs do not appear on chargemasters and do not have chargemaster prices. The inability of Plaintiffs and their amici to agree on the interpretation of a supposedly straightforward provision is strong evidence that this is a case where *Chevron* deference, if needed, is appropriate.

Plaintiffs' remaining arguments, arising under the First Amendment and the Administrative Procedure Act ("APA"), are really two sides of the same coin. For although Plaintiffs portray the

Price Transparency Rule as a menacing example of government compulsion, the Rule has a negligible effect on *speech*. That is why nearly all of Plaintiffs' arguments about the burden the Rule imposes are the same under both the First Amendment and the APA, and it is why they end up conceding that the Rule does not chill commercial speech. Moreover, despite their many attempts to downplay the utility of making hospitals' standard charges public, Plaintiffs do not—and cannot—dispute that the Rule will provide millions of patients with information that they need to estimate their out-of-pocket costs for hospital care. And although that benefit will come at some administrative cost to hospitals, that choice is a reasonable one and is not open to second-guessing under the APA.

ARGUMENT

I. THE PRICE TRANSPARENCY RULE IS SQUARELY WITHIN HHS'S AUTHORITY UNDER THE PHS ACT.

A. HHS Has the Best Reading of the PHS Act's Text, Structure, and Purpose.

Plaintiffs apparently agree with HHS that Congress used the term "standard charges" to mean a hospital's "regular rates." *Compare* 84 Fed Reg. at 65,541 ("[A] standard charge can be identified as a regular rate[.]"), *with* Opp'n Br. 1 ("Hospitals must disclose a list of their regular charges[.]"). The question, then, is whether Congress assumed that hospitals have only *one* "regular" rate—*i.e.*, the chargemaster (or "gross") rate. There are four reasons—most of them ignored by Plaintiffs—why that assumption is incompatible with the PHS Act and why HHS has the better reading of the statute.

First, chargemaster rates simply are not the "customary, regular, or normal price" for hospital items and services, and Plaintiffs offer no persuasive argument to the contrary. *See* Opp'n Br. 2. Plaintiffs never contest, for instance, that chargemaster rates do not "apply to most consumers of hospital services" because "approximately 90 percent" of patients "have third party payer coverage." 84 Fed. Reg. at 65,575. Nor do they dispute that chargemaster rates "bear little relationship to market rates, are usually highly inflated, and tend to be an artifact of the way in which Medicare used to reimburse hospitals." *Id.* at 65,538. Hospitals charge those rates to the minority of patients who either a) lack third-party coverage and have not been offered a cash discount, or b) have third-party coverage

but are receiving out-of-network care. And Plaintiffs have put forward no evidence to suggest that Congress required hospitals to publish only charges that apply to this limited class of patients—or even a theory for why Congress would have wanted to do so.

Instead, Plaintiffs have argued by analogy—to car dealerships and restaurants—that "standard charges" can never include "negotiated" rates. *See* Opp'n Br. 3, 4. But the word "negotiated" is a red herring here. At a car dealership, or in Plaintiffs' restaurant example, a customer is presented with a price and may then try to negotiate a truly individualized rate. Plaintiffs' contention is that the price the customer is initially quoted in these transactions is the "standard" charge, and any rate the customer subsequently negotiates—a rate that is "individualized based on payer-specific factors"—is non-standard. *Id.* But that framework does not map onto the hospital industry in a way that helps Plaintiffs. When a patient with insurance goes to a hospital for treatment, the rates that the hospital will charge have already been set—usually through an agreement between the hospital and the insurer. Those rates are "regular" or "standard" or "customary" for that patient and all similarly situated patients. Indeed, the entire market for hospital services relies on the premise that the most commonly charged rates will be those set in advance by hospitals and third-party payers. By contrast, third-party payers are not setting the regular prices customers will be charged for cars or sandwiches.

What Plaintiffs' examples actually parallel are categories of charges that HHS does *not* consider standard—namely, rates negotiated with individual patients for a particular episode of care or rates that are otherwise tailored to particular patients. HHS expressly excluded "the amount [a] hospital is ultimately paid" from its definition of negotiated rates. 84 Fed. Reg. at 65,546. For instance, HHS does not consider "charity care," "bill forgiveness," or individualized cash discounts to be "standard charges." *Id.* at 65,553. Because those rates are not the kind that would appear on a hospital's rate sheets or fee schedules, they are not "standard charges" under the PHS Act. *See* 84 Fed. Reg. at 65,546.

Second, Congress did not use the term "chargemaster rates," which has a defined meaning in the hospital industry; it chose the term "standard charges," which does not. *See* AR 5154 ("Every

hospital maintains a file system known as the chargemaster[.]"); 84 Fed. Reg. at 65,544 ("We are . . . not aware of any historical usage of the term ['standard charges'] by the industry[.]").[1] In other words, if Congress had wanted to limit the charges hospitals would be required to make public, it had an obvious "term of art" available. *See Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 252 (2010). That term, however, is "conspicuously absent" from Section 2718(e). *See id.*

Plaintiffs and their amici suggest this choice cuts in the other direction—that, if Congress had wanted hospitals to publish their agreed-upon charges with insurers, it would have said something other than "standard charges." *See* Opp'n Br. 9; Chamber Br. 18-20, ECF No. 26-1. Not so. As the government explained in its opening brief, "standard charges" is an appropriate term to use if Congress wanted to sweep in multiple kinds of regular rates. *See* Def.'s MSJ Br. 15, ECF No. 19. If Congress had wanted to *single out* payer-specific negotiated rates, perhaps it would have said so—just as Congress would have singled out "chargemaster charges" if it had wanted to address only those rates. But Congress chose "'deliberately expansive' language," and the Court should "give[] effect" to that choice. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129 (1992) (citation omitted).

Moreover, the fact that Congress required hospitals to publish "a list" of standard charges does not support reading "standard charges" more narrowly. *See* 42 U.S.C. § 300gg-18(e). As the government emphasized in its opening brief, HHS mandated that the standard charges be available in a *single* data file, which satisfies the plain meaning of "a list." *See* Def.'s MSJ Br. 20. In response, Plaintiffs no longer meaningfully press this argument, *see* Opp'n Br. 4 n.4, but the Chamber of Commerce ("Chamber") has picked up the baton. *See* Chamber Br. 12 (contending that the Rule "requires hospitals to disclose far more than 'a list[.]'"). The Chamber is wrong, and it is easy to see why. If we replace "standard charges" in Section 2718(e) with a more complicated-sounding phrase, the provision still makes sense. If Congress had required hospitals to publish "a list of [every payment

[1] The government previously noted that the cases Plaintiffs cited on "standard charge[s]" do not suggest that the term unambiguously means "chargemaster rates," or even that it has a consistent meaning. Def.'s MSJ Br. 16-17. Plaintiffs do not argue otherwise in their Opposition and Reply Brief.

the hospital received from each patient or third-party payer]," such "a list" would include an order of magnitude more entries than what the Rule requires. But hospitals could not evade that requirement by protesting that "a list" can only have two columns or a finite number of entries. Similarly, the use of "a list" does not transform the meaning of "standard charges" in Section 2718(e).

Third, Plaintiffs' reading of Section 2718(e) fails to account for Congress's decision to include hospital service packages among the "items and services" for which hospitals must publish standard charges. As an initial matter, Plaintiffs appear to concede the premise of this argument—*i.e.*, that HHS correctly defined "items and services" to include service packages. *Compare* Def.'s MSJ Br. 18 (noting that Plaintiffs did not dispute this definition in their opening brief), *with* Opp'n Br. 6 (acknowledging that Section 2718(e) "may extend to standard charges for *groups* of 'items and services'"). Indeed, it would be hard to read the statute any other way. Section 2718(e) requires hospitals to make public "a list of the hospital's standard charges *for* items and services . . . including *for* [DRGs.]" 42 U.S.C. § 300gg-18(e) (emphasis added). The parallel use of the word "for" indicates that DRGs are an example of the items and services for which hospitals must make their standard charges public. And although Plaintiffs have other disputes about the role that DRGs play in the interpretation of Section 2718(e), *see infra* at 6-11, they do not contest a) that DRGs are a kind of service package, or b) that it made sense for HHS to include other kinds of service packages in its definition of "items and services." *See* Def.'s MSJ Br. 18; *see also* 84 Fed. Reg. at 65,533-34.

From these premises, it is impossible to conclude that Congress limited "standard charges" to only "chargemaster rates." That is because "the standard charge for a service package is not typically found on the hospital's chargemaster, which simply lists out all the *individual* items and services." 84 Fed. Reg. at 65,534 (emphasis added). Instead, "[s]tandard charges for service packages are negotiated between the hospital and payer and are identified by common billing codes," *id.*, and those billing codes do *not* appear on a chargemaster. Under Plaintiffs' reading of the statute, then, Congress told hospitals to publish a category of standard charges that does not exist—*i.e.*, the chargemaster rates for

service packages. By contrast, HHS's inclusion of negotiated rates as a "standard charge" accounts for Congress's decision to include service packages within the scope of Section 2718(e).

Fourth, limiting "standard charges" to "chargemaster rates" is at odds with Section 2718's purpose. "[I]n general, 'the best evidence of a law's purpose is the statutory text[.]'" *All. of Artists & Recording Cos., Inc. v. DENSO Int'l Am., Inc.*, 947 F.3d 849, 863 (D.C. Cir. 2020) (alterations and citation omitted). And here, Congress made the purpose of Section 2718 plain by titling it "Bringing down the cost of health care coverage." 42 U.S.C. § 300gg-18; *see, e.g.*, *Henderson ex rel. Henderson v. Shinseki*, 562 U.S. 428, 439 (2011) ("The title of a statute or section can aid in resolving an ambiguity in the legislation's text." (citation and alteration omitted)). As the government outlined in its opening brief, requiring hospitals to publish the rates they negotiate with third-party payers would do more to lower the cost of health care coverage than just requiring the publication of chargemaster rates. *See* Def.'s MSJ Br. 21. Providing insured patients the rates that a hospital will charge for *their* care is the best way to enable them "to meaningfully shop for more affordable" options. *Id.* Plaintiffs have no response to this argument; in fact, they ignore Section 2718's purpose in both of their briefs. HHS, by contrast, interpreted Section 2718 in a manner that gives effect to the provision's text *and* purpose.

B. Congress's Decision to Expressly Include DRGs in Section 2718(e) Reinforces that HHS Has the Correct Reading of the PHS Act.

As shown above, the Court need not wade into the details of DRG-based payments to uphold HHS's interpretation of the PHS Act. The government's argument is therefore not "premised" on the language in Section 2718(e) about DRGs, and that language does not alter the "meaning of the term 'standard charges.'" *See* Opp'n Br. 5. Instead, the language removes any doubt that "standard charges" mean more than chargemaster rates, and it reinforces that rates negotiated with third-party payers count as "standard charges." In other words, although the language on DRGs is not the linchpin of HHS's reading of the statute, it is the nail in the coffin for Plaintiffs'. *See, e.g.*, *Teles AG v. Kappos*, 846 F. Supp. 2d 102, 109 (D.D.C. 2012) ("[A] cardinal principle of statutory construction is that the Court must 'give meaning to every clause of the statute.'" (citation omitted)).

To briefly recap, Congress gave only one example of the "items and services" that must be included in a hospital's list of standard charges—namely, "diagnosis-related groups [DRGs] established under section 1395ww(d)(4) of this title [*i.e.*, the Medicare Act]." 42 U.S.C. § 300gg-18(e). DRGs are a means of grouping patients who, based on their diagnosis and other characteristics, face similar expected costs for their care, and they allow hospitals to structure their charges based on those expected costs, rather than based on the individual items and services a patient receives from the hospital. *See* Def.'s MSJ Br. 12-13. Both Medicare and private insurers use DRGs, and of particular relevance here, many private insurers use the *same* DRG classifications as Medicare. *See* AR 5286. Accordingly, many hospitals and private insurers have agreed-upon charges "for [DRGs] established under [the Medicare Act.]" 42 U.S.C. § 300gg-18(e).

These facts support three important conclusions about the meaning of Section 2718(e). First, because DRGs are not listed on hospital chargemasters, Section 2718(e) plainly requires the disclosure of "charges other than the list prices" from a hospital's chargemaster. 84 Fed. Reg. at 65,539. Second, because Section 2718(e) includes at least one kind of service package that is not listed on a chargemaster, "items and services" should be read to include other service packages (like other DRG classification systems) as well. *See id.* at 65,534. It would not make sense for "items and services" to mean "all individual items and services, and *one* kind of service package, but not other service packages," given that Congress did not impose that limit in Section 2718(e). *See* Black's Law Dictionary, 11th ed. (2019) ("The participle including typically indicates a partial list."). Third, because charges for DRGs, like charges for other service packages, "are determined as a result of negotiations with third party payers," "standard charges" must encompass negotiated rates. 84 Fed. Reg. at 65,539.

Plaintiffs, having ignored the language about DRGs in their opening brief, attempt to reverse-engineer an explanation for how their prior reading of Section 2718(e) can accommodate that language. But they offer three, mutually exclusive theories—none of them persuasive. First, Plaintiffs analogize DRGs to restaurant "combo meals" that have their "own list price." Opp'n Br. 6. Plaintiffs

start from the premise that the standard charge for a combo meal "is what is printed on the menu," and they explain that any "discounted prices" for that same combo meal would not count as "standard." *Id.* at 7. The same logic, Plaintiffs reason, should apply to DRGs. *See id.* at 6-7. But unlike combo meals, DRGs are not listed on a hospital's "menu," *i.e.*., the chargemaster. *See* 84 Fed. Reg. at 65,539. As such, Plaintiffs' analogy actually reinforces the government's argument. Imagine that restaurants had combo meals but *never* listed them on the menu. Now, suppose Congress passed a law requiring each restaurant to publish "a list of the restaurant's standard charges for food and drink, including for combo meals." Any suggestion that a restaurant could satisfy that requirement by publishing *only* its menu prices would be wrong, as that interpretation would leave out the one category of products that Congress expressly chose to mention. It is equally wrong to suggest that hospitals can satisfy Section 2718(e) by publishing *only* their chargemaster prices.

Switching gears, Plaintiffs next contend that negotiated rates do not count as *standard* charges for DRGs because they are not even "charge[s]" in the first place. Opp'n Br. 7. Nonsense. As Plaintiffs acknowledge, a charge is "[t]he price required or demanded for [a] service[.]" *Id.* at 3 n.2 (citation omitted). And if a hospital and an insurer have agreed on the rate the insurer will pay for a particular DRG, the hospital in no sense "require[s] or demand[s]" anything other than that negotiated rate when it bills the insurer. That the hospital's invoice may *note* the chargemaster rates for items and services the hospital provided does not mean that the hospital is "charging" those prices. And the principal authorities Plaintiffs cite for the contrary position—an article in the administrative record and an inapposite provision of CMS's Provider Reimbursement Manual[2]—would prove too much if they applied here. In particular, the article Plaintiffs cite rests on the assumption that hospitals have only one "charge" for each item and service. *See* Hans B. Christensen et al., *The Only Prescription is*

[2] HHS noted in the Rule that the CMS Provider Reimbursement Manual uses a definition of "charges" for the "specific purpose . . . of Medicare cost reporting." 84 Fed. Reg. at 65,541. The agency also explained that, if "Congress intended [the agency] to use the [Medicare] definition of 'charges,'" then "Congress would have referenced that definition of 'charges'" in the PHS Act and would not have modified "charges" with the word "standard." *Id.* at 65,539.

Transparency: The Effect of Charge-Price-Transparency Regulation on Healthcare Prices, Chicago Booth Research Paper No. 14-33 (Feb. 21, 2019), AR 6733 (explaining that "all payers are charged *the same* amount" (emphasis added)). But if there is just one kind of hospital "charge," and every other rate is instead a reimbursement amount, *see* Opp'n Br. 3, 7, then the word "standard" is doing no work. Plaintiffs' interpretation of "standard charges" would thus "make the words redundant and one of them 'mere surplusage,' which is inconsistent with a court's duty to give meaning to each word used by Congress." *Nat. Res. Def. Council v. EPA*, 489 F.3d 1364, 1373 (D.C. Cir. 2007).[3]

Moreover, even if Plaintiffs' emphasis on the word "charge" had merit in the abstract, it leaves a central question unanswered: What should hospitals list as the "standard charge" for each DRG? Hospitals cannot just list the total "chargemaster price for each item and service utilized," Opp'n Br. 7, because the entire point of a DRG-based system is that there is not a uniform list of items and services for each DRG. Plaintiffs hint at an answer in a footnote, where they suggest that Congress wanted hospitals to calculate some kind of *average* charge to use as the standard charge for DRGs. *See id.* at 8 n.9. It is not clear whether this "average" would be an average of the hospital's past payments for each DRG, or if hospitals instead would determine the average "amount" of items and services they provide for each DRG and then multiply that amount by the chargemaster prices. But the mechanics are not important. What matters is that Plaintiffs are suggesting that the "standard charge" for DRGs should be an invented rate—one that the hospital may never have even charged or listed. That is a far cry from what Plaintiffs first described as the equivalent of a price "printed on the menu." *Id.* at 7. More to the point, there is no reason to think that when Congress required hospitals to publish their standard charges for DRGs, it wanted hospitals to come up with something other than a rate they *actually* regularly charge. HHS's interpretation of Section 2718(e) limits "standard charges" to "regular rate[s]," 84 Fed. Reg. at 65,540; Plaintiffs' second attempt to account for DRGs does not.

[3] Another indication that this argument cannot be right is that it was not in Plaintiffs' opening brief. *See* Pls.' MSJ Br. 10-16, ECF No. 13-1. If the plain meaning of the word "charges" truly rendered HHS's reading of the PHS Act untenable, then Plaintiffs would have said so from the outset.

Plaintiffs' final theory fares no better. This time, Plaintiffs accept (for argument's sake) that something other than chargemaster rates could count as "standard charges" for DRGs. *See* Opp'n Br. 8. But they maintain that the only rate that would qualify is the rate at which Medicare reimburses hospitals. *See id.* at 9. That reading makes no sense. For starters, Medicare's reimbursement rates "are already publicly disclosed." 84 Fed. Reg. at 65,552. And HHS correctly concluded that Congress did not impose a "redundant" requirement on hospitals "to re-disclose already public rates and create an unnecessary burden." *Id.* Moreover, as Plaintiffs point out, Medicare's reimbursement rates for DRGs are dictated by Medicare; they are not set or negotiated by hospitals. *See* Opp'n Br. 8 (describing Medicare's "take-it-or-leave-it reimbursement[s]"); *see also* 42 U.S.C. § 1395ww(d)(3). But if a hospital has no agency in setting rates, those rates are in no meaningful sense "*the hospital's* standard charges." *See* 42 U.S.C. sec. 300gg-18(e) (emphasis added). By contrast, when hospitals *do* set rates "for [DRGs] established under [the Medicare Act,]" *id.*, they do so through negotiations with third-party payers. Those regular rates are as thus the "standard charges" for the DRGs included in Section 2718(e).

At bottom, there is no good way to square Congress's decision to require the publication of "standard charges" for DRGs with Plaintiffs' preferred reading of Section 2718(e). That, perhaps, is why Plaintiffs' amici take a different approach. Instead of adopting *any* of the three explanations Plaintiffs advance, the State Hospital Associations ("State Associations") and the Chamber each suggest that the phrase "including for diagnosis-related groups established under [the Medicare Act]" added nothing to the statute. 42 U.S.C. § 300gg-18(e). The State Associations, for instance, claim that the language is simply there "to ensure that hospitals *still* made information about DRGs publicly available under the already-transparent system of Medicare payments." State Ass'ns Br. 11 n.33. Congress, they claim, feared "that the new provisions for disclosure in Section 300gg-18(e)" would somehow be "misread as superseding previous transparency efforts." *Id.* The Chamber's explanation is more complicated, but it leads to a similar conclusion: that Congress included DRGs just to make "doubly sure" that hospitals list only one charge—the chargemaster rate—for individual items and

services. Chamber Br. 17.[4] But neither the State Associations nor the Chamber explain why, if Congress wanted to *limit* the scope of Section 2718(e), it did so by *adding* an entirely new category of "items and services" for hospitals to include in their list of standard charges. If Congress had wanted to preserve other transparency requirements, or to use Medicare's definition of "charges," it would not have "chose[n] a surprisingly indirect route to convey an important and easily expressed message." Chamber Br. 15 (quoting *Landgraf v. USI Film Prods.*, 511 U.S. 244, 262 (1994)).

Stepping back, it is striking that Plaintiffs and their amici each have different, complicated theories for what Congress was doing by mentioning DRGs in Section 2718(e). HHS's reading, by contrast, requires no interpretive contortions. Congress included DRGs to ensure that hospitals did not disclose only their standard charges for *individual* items and services. That fact, in turn, reinforces that HHS was right to read "standard charges" as including the rates that hospitals usually charge for service packages like DRGs—namely, rates negotiated with third-party payers.

C. At a Minimum, HHS Is Entitled to *Chevron* Deference.

This Court should uphold HHS's definition of "standard charges" because the agency has the best reading of the statute. But if the Court disagrees, or chooses not to reach that issue, then the inability of Plaintiffs and their amici to agree on an interpretation of Section 2718(e) demonstrates that this is an easy case for deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). No one disputes that "Congress has delegated to [HHS] authority to make rules carrying the force of law[.]" *Ranbaxy Labs., Ltd v. Burwell*, 82 F. Supp. 3d 159, 182 (D.D.C. 2015); *see also* 42 U.S.C. § 300gg-92 (rulemaking authority for the relevant portion of the PHS Act). Accordingly, if "the challenged agency interpretation was promulgated in the exercise of that authority, then the agency's rule is entitled to deference 'as long as it is a permissible construction of the statute.'" *Ranbaxy*

[4] The complicated part of the Chamber's explanation involves a detour into Medicare's system for calculating what are known as "outlier payments." *See* Chamber Br. 15-17. But the crux of the argument relies on the meaning of the word "charges" in the CMS Provider Reimbursement Manual, and the contention that Congress must have relied on that understanding of "charges" in enacting the PHS Act. *See id.* at 17. As noted previously, that contention is incorrect. *See supra* at 8-9 & n.2.

Labs, 82 F. Supp. 3d at 182 (quoting *Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 158 (2013)). That is true even if HHS's interpretation "differs from how the court would have interpreted the statute in the absence of an agency regulation." *Auburn*, 568 U.S. at 158.

Plaintiffs urge the Court to jettison *Chevron* because the Rule overlaps with a proposal in an Executive Order. *See* Opp'n Br. 10 (citing Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First, Exec. Order No. 13,877, 84 Fed. Reg. 30,849 (June 24, 2019)). But they cite no case imposing that limit on *Chevron* deference. *See id.* And such a limit has no place here for two, independent reasons. *See* Def.'s MSJ Br. 22-23.

First, HHS did not rely on the Executive Order in issuing the Final Rule—a point that Plaintiffs all but ignore. While they assert that HHS's interpretation is "wholly grounded in the Executive Order, not the agency's independent decision-making,"[5] Opp'n Br. 10, HHS did not rely on the Executive Order in interpreting "standard charges"; it relied instead on Congress's delegation of authority in the PHS Act. *See* 84 Fed. Reg. at 65,539 ("Section 2718 . . . provides authority to require disclosure of hospital standard charges."). That should end the matter.

Second, even if the President *had* compelled HHS's interpretation of "standard charges," Plaintiffs overlook the extent to which *Chevron* itself rested on the political accountability of the Executive Branch. *Compare* Def.'s MSJ Br. 22-23, *with* Opp'n Br. 11-12. Moreover, when the President acts, he is responsible for—and can draw on the expertise of—the entire Executive Branch. *Cf. English v. Trump*, 279 F. Supp. 3d 307, 327 (D.D.C. 2018) ("Under the Constitution, the President must 'take care that the laws be faithfully executed[]' across the entire Executive Branch." (citation omitted)). And "[b]y virtue of Article II's command that he take care that the laws be faithfully executed," the President "quite legitimately guides his subordinates' interpretations of statutes," *Pub. Citizen v. Burke*, 843 F.2d 1473, 1477 (1988); *see also Chevron*, 467 U.S. at 865.

[5] The Executive Order did not "prescribe[] the very definition of 'standard charges' that the agency adopted in the Final Rule." Opp'n Br. 10. For instance, the Rule includes "discounted cash prices"; the Executive Order does not. *See* 84 Fed. Reg. at 65,525; Exec. Order No. 13,877 § 3.

Once *Chevron* applies, Plaintiffs offer little—aside from the tautological refrain that "'standard charges' means 'standard charges,'" Opp'n Br. 12; *id.* at 2 (same); Pls.' MSJ Br. 11 (same)—to suggest that HHS lacks "a permissible construction of the statute." *Auburn*, 568 U.S. at 158. Their only argument is that "'standard charges'" . . . cannot mean '*all* charges.'" Opp'n Br. 12. But that is not how HHS defined the term. HHS drew a clear line between the *regular* rates that apply to defined groups of paying patients and the *irregular*, patient-specific rates that hospitals charge. In fact, Plaintiffs acknowledge this distinction—and answer their own rhetorical question, *see id.* at 10 ("What is left?")—later in their brief. *See id.* at 29 (hospitals not required to display "*patient-specific* discounts in advance"). Plaintiffs do not, however, explain why the definition of "standard charges" is something other than an "archetypical *Chevron* question[.]" *City of Arlington. v. FCC*, 569 U.S. 290, 304 (2013). To that end, interpreting Section 2718(e) requires taking a term without a facially obvious meaning, analyzing it in light of the features of the relevant market (*i.e.*, hospitals, not restaurants), and considering the ends Congress sought to achieve. In short, defining "standard charges" required HHS to weigh "competing policy interests" and arrive at the best reading of the PHS Act. *Id.* That is what the agency did, and its interpretation of Section 2718(e) should be upheld.

II. THE COURT SHOULD REJECT PLAINTIFFS' ATTEMPT TO REWRITE SECTION 2718'S ENFORCEMENT PROVISION.

Section 2718(e) requires hospitals to publish their standard charges. Doing so, however, requires time and money that—as this litigation confirms—some hospitals would rather not expend. Accordingly, Congress did what it often does when imposing a requirement that regulated parties might wish to avoid: It made the requirement enforceable. Specifically, it authorized HHS to issue "regulations for enforcing the provisions of this section," *i.e.*, the section that includes the "standard charges" requirement. 42 U.S.C. § 300gg-18(b)(3). Plaintiffs implausibly maintain that Congress's use of the word "section" was a mistake. And not just any mistake—one "so 'unthinkable' that any reasonable reader would know immediately" that the there is a mistake and what the statute actually means. *Lexington Ins. Co. v. Precision Drilling Co., L.P.*, 830 F.3d 1219, 1223 (10th Cir. 2016) (Gorsuch,

J.) (quoting Antonin Scalia & Bryan A. Garner, Reading Law 237-38 (2012)). That a statute imposing a new obligation would also include an enforcement provision is not "so bizarre as to permit this Court to declare a 'scrivener's error,'" *Clinton v. City of New York*, 524 U.S. 417, 454-55 (1998) (Scalia, J., concurring in part), and Plaintiffs' arguments to the contrary are meritless.

In particular, Plaintiffs acknowledge—as they must—that when Congress merged the draft bills that became the Affordable Care Act ("ACA"), it made edits to what is now Section 2718 to account for that merger. *See* Opp'n Br. 13-14 (recognizing that "subsections (c) and (d)" of Section 2718 were edited to "refer to provisions originally from the Medical Loss Ratio bill"). That concession resolves this issue. Plaintiffs' theory is that, amidst the "complicated and fast-moving drafting history" of the ACA, Pls.' MSJ Br. 17, Congress simply forgot to pay attention to how the various subsections of the bills it was combining would interact. But as the government explained in its opening brief, Congress *did* pay attention to how Section 2718's subsections would work together. *See* Def.'s MSJ Br. 26. And Plaintiffs have not offered any reason to think that Congress was selectively careless—*i.e.*, that it paid attention to how some of Section 2718's subsections interact, but not others.

Finally, Plaintiffs have not offered a workable "fix" to the alleged error in either of their briefs. *Compare* Pls.' MSJ Br. 18 (Congress could have "update[ed] the word ['section'] to be 'subsection'"), *with* Opp'n Br. 13 n.14 (conceding this change would not be "sufficient"). If Plaintiffs cannot state clearly how Congress supposedly meant to write the statute, they should not be asking the Court to rewrite it. *See Lexington Ins.*, 830 F.3d at 1223 ("correct meaning" must be "immediately" obvious).

III. THE PRICE TRANSPARENCY RULE SATISFIES THE FIRST AMENDMENT.

The Price Transparency Rule requires hospitals to make public the regular rates they charge for patient care—*i.e.*, it requires hospitals to publish their prices. Requiring a business to disclose the prices it charges raises no difficult First Amendment issues under established precedent. Indeed, this case is a particularly poor fit for searching forms of First Amendment scrutiny because the burden on Plaintiffs' *speech* is negligible. To be sure, Plaintiffs have tried to shoehorn alleged *economic* burdens and

criticisms of the Rule's reasonableness into their First Amendment claim, perhaps to skirt the APA's deferential standard of review. But First Amendment doctrine is calibrated to account for these kinds of cases. Where, as here, the only burden on commercial speech[6] is a straightforward disclosure requirement, the "lower level of scrutiny" from *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985), applies. *Nat'l Inst. of Family & Life Advocates ("NIFLA") v. Becerra*, 138 S. Ct. 2361, 2372 (2018). The Rule easily satisfies this relaxed form of First Amendment scrutiny, and in any event, it also satisfies intermediate scrutiny under *Central Hudson Gas & Electric Corp. v. Public Service Commission of New York*, 447 U.S. 557 (1980).

A. *Zauderer's* Lower Level of First Amendment Scrutiny Applies.

Less than two years ago, the Supreme Court confirmed that *Zauderer* applies to disclosures of "purely factual and uncontroversial information about the terms under which . . . services will be available." *NIFLA*, 138 S. Ct. at 2372 (alteration in original) (quoting *Zauderer*, 471 U.S. at 651). That is precisely the kind of disclosure the Rule requires—prices, after all, are the central "term" that governs the provision of services. But Plaintiffs ask this Court to read the phrase "terms under which . . . services will be available" to mean only "advertisement[s]," on the ground that *Zauderer* was a case about advertising. *See* Opp'n Br. 23-24. But *Zauderer* is not limited to "advertising," and if it were, *NIFLA* would have said so. In *NIFLA*, the Court considered whether it violated the First Amendment to require licensed pregnancy clinics to disseminate a *notice*—*i.e.*, not an advertisement—informing patients that the state provides free or low-cost family-planning services, including abortion. 138 S. Ct. at 2368. The Court held that *Zauderer* did not apply. "Most obviously," it explained, "the licensed notice is not limited to 'purely factual and uncontroversial information about'" the clinics'

[6] Plaintiffs' renewed suggestion that a list of hospital charges is not commercial speech is baseless, and even Plaintiffs' amici decline to echo the argument. *See* Chamber Br. 19-25 (applying commercial speech precedents); *see also, e.g.*, *RCP Publications Inc. v. City of Chicago*, 304 F. Supp. 3d 729, 735 (N.D. Ill. 2018) ("alcohol prices," "pharmacy prices," and "real estate prices" are commercial speech). Under any reasonable definition, if "informational pamphlets" that "contain discussions of important public issues" can count as "commercial speech," *Bolger v. Youngs Drug Prod. Corp.*, 463 U.S. 60, 67-68 (1983), then so can a list of prices. Plaintiffs have identified no case holding otherwise.

services. *Id.* at 2372 (citation omitted). If *Zauderer* came with a threshold "advertising" requirement, then the "most obvious" reason—or at a minimum, a reason worth mentioning—for not applying *Zauderer* would have been that the speech at issue was not an advertisement.

Moreover, the D.C. Circuit has held that *Zauderer* applies beyond advertising. In *American Meat Institute ("AMI") v. USDA*, 760 F.3d 18 (D.C. Cir. 2014) (en banc), the en banc court upheld the validity of a country-of-origin labeling requirement and rejected a similar attempt to narrow *Zauderer*'s reach. *See id.* at 22. Plaintiffs' fallback position, accordingly, is that *Zauderer* applies in only *two* contexts: "advertisements and point-of-sale disclosures." Opp'n Br. 15. Plaintiffs point to nothing in the reasoning of *Zauderer*, *NIFLA*, or *AMI* that would support drawing that line, and other courts have not adopted it. *See, e.g.*, *N.Y. State Rest. Ass'n v. N.Y.C. Bd. of Health*, 556 F.3d 114, 118, 131-36 (2d Cir. 2009) (upholding a requirement to post calorie-content information under *Zauderer*); *United States v. Bell*, 414 F.3d 474, 484-85 (3d Cir. 2005) (upholding a requirement to prominently display an injunctive order on a website under *Zauderer*).

Plaintiffs rely on *National Association of Manufacturers ("NAM") v. SEC*, 800 F.3d 518 (D.C. Cir. 2015), a case in which the majority pointedly disagreed with the reasoning of *AMI* and declined to apply *Zauderer* to a disclosure requirement that did not further the defendant agency's usual "economic or investor protection benefits[.]" *Id.* at 520-24 & n.6. But in *United States v. Philip Morris USA Inc.*, 855 F.3d 321, 328 (D.C. Cir. 2017), the D.C. Circuit expressly rejected the argument that *NAM* "directs us to apply *Central Hudson* scrutiny to" any disclosures that are "unconnected to advertising or labeling at the point of sale." As the court noted, a prior decision in the same litigation had already applied *Zauderer* outside those contexts—namely, to an order requiring cigarette manufacturers to issue corrective statements. *Id.* at 323, 327 (citing *United States v. Philip Morris USA Inc.*, 566 F.3d 1095, 1144-45 (D.C. Cir. 2009)). Plaintiffs' proposed limitation on *Zauderer* is thus foreclosed by precedent.

Plaintiffs' final argument against applying *Zauderer* is that a hospital's standard charges are "not purely factual" information. Opp'n Br. 24. That contention is meritless, and it relies on the same

"'heads-I-win, tails-you-lose' approach to the issue of consumer confusion" that the government discussed in its opening brief. Def.'s MSJ Br. 42. While Plaintiffs hypothesize that consumers could somehow be misled by these lists of standard charges, they conspicuously ignore the substantial evidence in the record that price transparency measures work. They do not dispute, for instance, that in states that release information about negotiated rates, the result has been that patients choose lower-cost options, healthcare prices go down, and a more competitive market for hospital services emerges. *See* Def.'s MSJ Br. 33. And even in Plaintiffs' worst-case scenarios, patients are no worse off under the Rule than they are now. Take, for instance, the patient who reviews a hospital's standard charges, determines that she needs to spend $1,000 for a treatment, and "budgets accordingly[.]" Opp'n Br. 25. According to Plaintiffs, that disclosure is misleading because she could later discover that the treatment "is considered experimental" and "is not covered by her insurance plan," leaving her out $10,000. *Id.* But under the current system, that patient would not have better information about whether a treatment is experimental, and she might have *no* idea what the treatment would cost—aside from what she can glean from Google, crowdsourcing websites, or other unreliable sources. Moreover, in the majority of circumstances the Rule affects—where the treatment is *not* experimental and a patient is trying to comparison shop for common services, *see* Def.'s MSJ Br. 36—patients would finally have accurate pricing information.[7] Requiring the disclosure of standard charges does not mislead patients; it gives them information they need to make better decisions about their healthcare.

In sum, because a list of hospital charges is "purely factual and uncontroversial information about the terms" for providing hospital services, *Zauderer* applies. *NIFLA*, 138 S. Ct. at 2372.

[7] The Chamber worries that other circumstances could make the disclosures misleading—like the fact that "[a] patient may receive ancillary services" or treatment "performed by practitioners with independent billing arrangements[.]" Chamber Br. 9. But HHS thought of those contingencies and accounted for them in the Rule. *See* 84 Fed. Reg. at 65,568 (requiring hospitals to list ancillary services "when the shoppable service is customarily accompanied by the provision of ancillary services"); *id.* at 65,567 (providing an example of an entry for "shoppable services" that notes both the ancillary services and the services that "may be billed separately").

B. The Rule Is Plainly Permissible Under *Zauderer*.

The Price Transparency Rule satisfies the First Amendment under *Zauderer* because it is "reasonably related" to the government's substantial interests in informing consumers and lowering healthcare costs, and it is not "unjustified or unduly burdensome" in a manner that might "chill[] protected commercial speech." *Zauderer*, 471 U.S. at 651. Plaintiffs do not argue that the Rule fails the "reasonably related" prong of this inquiry, *see* Opp'n Br. 25, and any such argument would be unavailing. Given that "the government's interest [includes] assuring that consumers receive particular information" about hospital charges, *Zauderer's* "means-end fit is self-evidently satisfied" if the government uses "a reasonably crafted mandate to disclose 'purely factual and uncontroversial information' about attributes of the product or service being offered." *AMI*, 760 F.3d at 26. Indeed, the D.C. Circuit has found that the kind of disclosure requirement at issue here "will almost always demonstrate a reasonable means-ends relationship," unless the disclosure "is 'unduly burdensome' in a way that 'chill[s] protected commercial speech[.]'" *Id.* (citation omitted).

To that end, Plaintiffs concede that the Rule "does not chill commercial speech," Opp'n Br. 25, and that concession forecloses their argument under *Zauderer*. The fact that the Rule does not *chill* commercial speech does not, as Plaintiffs implausibly suggest, *see id.*, somehow mean that the Rule fails to *regulate* commercial speech. To see why, consider a law requiring grocery stores to post their prices underneath each item. Even though Plaintiffs presumably would concede that such a law regulates commercial speech (as a point-of-sale disclosure), it is hard to see how the law could have a chilling effect. A grocery store could *try* to argue that the disclosures would take up too much shelf space—just as Plaintiffs could, in theory, argue that a list of standard charges will take up finite space on hospital websites. *See, e.g.*, *Disc. Tobacco City & Lottery, Inc. v. United States*, 674 F.3d 509, 530-31 (6th Cir. 2012) (size of required warnings is not unduly burdensome where remaining portions of packaging are available for other information). But the fact that those arguments would be unpersuasive just confirms that the disclosures pose no real First Amendment threat.

C. The Rule Also Satisfies Intermediate Scrutiny Under *Central Hudson*.

Central Hudson applies to compelled commercial disclosures only when "the compulsion to speak becomes more like a speech *restriction* than a disclosure." *Pursuing America's Greatness v. FEC*, 831 F.3d 500, 507 n.3 (D.C. Cir. 2016) (emphasis added). For the reasons outlined above, the Rule is far from that territory. But even if *Central Hudson* applies, the Rule satisfies intermediate scrutiny.

Plaintiffs do not dispute that both of the government's asserted interests—providing consumers with information that will help them make more informed health care decisions and lowering health care costs, *see* 84 Fed. Reg. at 65,544-45—are "substantial." Opp'n Br. 16; *see also Cent. Hudson*, 447 U.S. at 566. Instead, they question whether the Rule "directly advance[s]" those interests and whether there is a "reasonable fit[]" between the Rule's means and ends. *See AMI*, 760 F.3d at 26 (citation omitted). Neither argument has merit.

The administrative record makes clear that the Rule directly advances the government's cited interests. To start, Plaintiffs do not dispute that the APA's record-review principles apply to their First Amendment claim. *See* Def.'s MSJ Br. 9 (citing *R.J. Reynolds Tobacco Co. v. FDA*, 696 F.3d 1205 at 1217-18 (D.C. Cir. 2012)). As such, they and their amici cannot rely on extra-record evidence—like surveys, articles, or declarations—that were not before the agency during the rulemaking.[8] *See, e.g.*, *Pharm. Research & Mfrs. of Am. v. HHS*, 43 F. Supp. 3d 28, 34 n.6 (D.D.C. 2014) (amicus extra-record surveys would be stricken "[t]o the extent they were relevant to the Court's merits analysis").

With respect to the first interest, Plaintiffs do not meaningfully dispute that the Rule gives patients access to necessary pricing information; they just emphasize that the Rule does not *directly* give patients their out-of-pocket costs. But HHS has never claimed otherwise. Rather, the agency has explained that patients want to know hospitals' standard charges because those charges are often necessary to calculate out-of-pocket expenses. *See* Def.'s MSJ Br. 34, 36; *see also* AR 0683, 0778, 2359,

[8] To be sure, the government highlighted some of Plaintiffs' declarations in its opening brief. But it did so to point out the inconsistencies in Plaintiffs' arguments; it does not rely on them for their substance. *See, e.g.*, Def.'s MSJ Br. 35 (clarifying that the declarations do not belong in the record).

2754 (comments demonstrating patient interest in hospitals' standard charges). Again, one of Plaintiffs' hypotheticals illustrates the point. Under the Rule, patients with high deductibles can "consult both the applicable negotiated rate and their insurance plan and do the math to obtain their out-of-pocket rate." Opp'n Br. 19-20 (emphasis omitted). Under the current system, by contrast, that first key variable—the applicable negotiated rate—is missing.

Turning to the government's second interest, the record strongly supports HHS's conclusion that the Rule will lower healthcare costs. Plaintiffs do not question the vast majority of the evidence HHS cited in reaching that conclusion. *See* Def.'s MSJ Br. 32-34 (summarizing that evidence). For example, they never dispute that in New Hampshire, where patients can see insurer-specific negotiated rates, prices went down. *See* 84 Fed. Reg. at 65,527, 65,544; *see also* AR 4926-27. Instead, they quibble with cherry-picked portions of the record. For instance, they describe a California price transparency rule as having negligible effects, *see* Opp'n Br. 16, but they ignore that California does not require disclosure of negotiated rates. *See* AR 4780. Similarly, Plaintiffs and the Chamber express concerns about the Rule's effect on competition in the hospital industry. *See* Opp'n & Repy Br. 17; Chamber Br. 22-23. But HHS carefully considered the alleged effects of the Rule on competition. *See* 84 Fed. Reg. 65,542, 65,544. And it was reasonable for the agency to be more persuaded by recent evidence showing a lack of anti-competitive effects in the hospital industry, *see id.* at 65,544, than by studies or articles from other sectors, like the literature on the Danish concrete industry the Chamber highlights, *see* Chamber Br. 22. The Rule thus directly advances at least two substantial government interests.

Finally, the Rule satisfies the last step in the *Central Hudson* inquiry because there is a "reasonable fit[]" between the above-described goals and the "means" HHS chose to further them. *See AMI*, 760 F.3d at 26. Given that HHS's goals include providing patients with hospitals' standard charges, it is hard to see how a rule requiring that hospitals provide exactly that information could be insufficiently tailored. *See id.* (noting that disclosure mandates have a "self-evident tendency . . . to assure that recipients get the mandated information").

Plaintiffs' principal argument to the contrary—that there are less burdensome alternatives to the Rule—rests on a misapplication of the cases they cite. As the Supreme Court explained in *McCullen v. Coakley*, the question is whether there are "alternative measures that burden substantially less *speech*[.]" 573 U.S. 464, 495 (2014) (emphasis added); *see also Bd. of Trustees of State Univ. of N.Y. v. Fox*, 492 U.S. 469, 478 (1989) (explaining that a "regulation [must] not 'burden substantially more speech than is necessary to further the government's legitimate interests'" (citation omitted)). And although Plaintiffs point to the proposed Transparency in Coverage Rule, 84 Fed Reg. 65,464 (Nov. 27, 2019), which would put in place additional price transparency requirements for insurers and group health plans, they do not claim that *either* rule would burden speech. *See supra* at 18 (explaining that the Rule imposes a negligible burden on speech). In any event, a key rationale behind the Price Transparency Rule is that it gives patients the opportunity to view different standard charges for the same hospital, allowing them to make useful comparisons. *See* 84 Fed. Reg. at 65,552. For instance, a patient with a high deductible health plan can compare the rate his insurance company has negotiated, along with any discounted cash rate the hospital makes available, and choose the more affordable option. *See id.* The Transparency in Coverage Rule, if promulgated, would not give patients the information necessary for those comparisons.

Finally, Plaintiffs reiterate their concern over the alleged commercial sensitivity of negotiated rates. *See* Opp'n Br. 20-21. But they acknowledge that every negotiated rate the Rule requires hospitals to disclose is already provided to patients in explanations of benefits ("EOBs"), with two key differences. First, the EOB arrives *after* a patient has received care, which means it does the patient no good in terms of shopping for more affordable options. And second, EOB disclosures to patients are piecemeal, whereas the Rule provides all of a hospital's standard charges at once. Plaintiffs suggest that it is this *compiling* of rate information that is commercially sensitive. *See id.* But that view overlooks the fact that private entities, like crowdsourcing websites, are already compiling these data. *See* 84 Fed. Reg. at 65,544. Those entities are trying to correct an information asymmetry in fits and starts; the

Rule simply accomplishes that goal more efficiently. If anything, that fact reinforces that the Rule is appropriately tailored to the interests it advances. The Rule therefore satisfies any heightened scrutiny.

IV. THE RULE IS NOT ARBITRARY OR CAPRICIOUS.

Plaintiffs' final claim is that the Rule violates the APA's requirement of reasoned decision-making. But although Plaintiffs clearly disagree with how HHS weighed the Rule's expected costs and benefits, they fail to demonstrate any of the serious flaws in an agency's reasoning that are necessary for a court to invalidate agency action. *See Ark Initiative v. Tidwell*, 816 F.3d 119, 127 (D.C. Cir. 2016) (agency must "examine the relevant data and articulate a satisfactory explanation for its action").

With respect to the Rule's benefits, Plaintiffs continue to minimize the value that information about hospital charges will have for patients. In particular, they insist that providing *necessary* information for a patient's out-of-pocket expenses somehow does not count as "further[ing] the interests" on which the Rule rests. Opp'n Br. 28. The record forecloses that view. HHS amply explained who the Rule will help, *see, e.g.*, 84 Fed. Reg. at 65,528 (individuals with high deductibles who would use negotiated rates to determine their out-of-pocket costs); how the Rule will help them, *see, e.g. id.* at 65,550 (describing physician interest in knowing cost information to better counsel patients); and why the evidence supports those conclusion, *see, e.g.*, *id.* at 65,529 (recounting successful price transparency efforts in New Hampshire and Maine). Nothing in Plaintiffs' briefs calls into question those conclusions, especially given that the APA's "'arbitrary and capricious' standard is particularly deferential in matters implicating predictive judgments." *Rural Cellular Ass'n v. FCC*, 588 F.3d 1095, 1105 (D.C. Cir. 2009).

Moreover, on the issue of discounted cash prices, Plaintiffs ignore the benefits that the Rule will bring to the vast majority of patients—insured and uninsured alike—who currently may not know *anything* about available cash discounts. *See* 84 Fed. Reg. at 65,552-53. Plaintiffs also overlook that any patient who will allegedly have an "inaccurate understanding" of cash discounts under the Rule likely has an *even less accurate* understanding about hospital charges under the current system. *See* Opp'n

Br. 30. And with respect to Plaintiffs' fear that patients will look up a hospital's charges and see there are no *standard* cash discounts, nothing in the Rule prevents Plaintiffs and their members from stating explicitly, in large font, on the page where the standard charges are listed, that additional cash discounts may be available based on financial need. *See* 84 Fed. Reg. at 65,547.

Finally, Plaintiffs claim that HHS "grossly underestimates" the compliance burden the Rule will impose on hospitals. Opp'n Br. 21. But they cite no flaw in the agency's process for estimating the average cost of compliance, nor do they dispute that an appropriate measure of relative cost is roughly the list price of just one vial of anti-cancer medication. *See* Def.'s MSJ Br. 38. Above all, though, Plaintiffs' and their amici's arguments about the burden on hospitals fall short because they focus myopically on the relatively minor challenges that hospitals might face, without considering the challenges that patients already do. For instance, in promoting "private-sector solutions" as an alternative to the Rule, the Chamber highlights that some hospitals now provide "financial counselors" who "assist patients . . . in contacting their insurers" to help the patients "determine their cost-sharing obligations." Chamber Br. 25. Put differently: Patients are desperate for information about the costs of hospital care and do not know whom to contact. When they turn to a hospital for answers, perhaps (if they're lucky) the hospital will have financial counselors. Those counselors, however, do not have the answers; instead, they will help the patient contact another entity. And even then, there is no guarantee that the insurer will answer the phone, have the relevant information available, or agree to provide it. The Chamber chooses to celebrate this rigmarole as "a less burdensome means to promote CMS's goal of price transparency." *Id.* And in one sense, the Chamber is right—the existing hoops patients have to jump through to figure out what their care will cost are indeed "less burdensome" *for hospitals* than the Rule's disclosure requirements. But it was eminently reasonable for HHS to conclude that hospitals are in a better position than patients to correct the industry's acute information asymmetries. Yes, the Rule shifts to hospitals some of the burden that patients currently have to bear. That is not the problem. That is the point.

V. THE COURT SHOULD TAILOR ANY RELIEF IT AWARDS.

Even if the Court were to rule for Plaintiffs on the merits, any relief it awards should be tailored in two important ways.

First, Article III and longstanding equitable principles preclude vacating or enjoining the Rule on a nationwide basis. *See Gill v. Whitford*, 138 S. Ct. 1916, 1933, 1934 (2018) (holding that "[a] plaintiff's remedy must be tailored to redress *the plaintiff's* particular injury" (emphasis added)). Although Plaintiffs advocate for nationwide relief, *see* Opp'n Br. 31, they make no argument that such far-reaching relief is needed "to provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). To the contrary, what Plaintiffs want is to be free of the Rule's disclosure requirements themselves, which would make any broader relief "more burdensome to the defendant than necessary" and therefore impermissible. *Id.* at 702.

Instead, Plaintiffs' principal argument is that "nationwide relief 'is compelled by the text of the [APA].'" Opp'n Br. 31 (citation omitted). That is false. *See, e.g.*, *Va. Soc'y for Human Life, Inc. v. FEC*, 263 F.3d 379, 393-94 (4th Cir. 2001) ("Nothing in the language of the APA . . . requires us to exercise such far-reaching power."), *overruled on other grounds as recognized in The Real Truth About Abortion, Inc. v. FEC*, 681 F.3d 544 (4th Cir. 2012). Indeed, as Defendants noted in their opening brief, *see* Def.'s MSJ Br. 44, the D.C. Circuit's decision in *National Mining Ass'n v. U.S. Army Corps of Engineers*, 145 F.3d 1399, 1408 (D.C. Cir. 1998), recognized that courts enjoy broad discretion in determining whether to award equitable relief. Accordingly, any order vacating or enjoining the Rule should be limited to Plaintiffs with standing. That leaves out, at a minimum, the Association of American Medical Colleges, the Federation of American Hospitals, and the National Association of Children's Hospitals, Inc.—none of which have established that "at least one *identified* member ha[s] suffered or [will] suffer harm." *Summers v. Earth Island Inst.*, 555 U.S. 488, 498 (2009) (emphasis added).

Plaintiffs also seek to justify nationwide relief on the ground that the American Hospital Association ("AHA"), whose membership appears to include the three hospitals in this challenge, has "nearly 5,000 member hospitals" representing "80% of the nation's hospitals." Opp'n Br. 32. That

statistic, of course, does not explain how this Court can issue relief to the other 20% of U.S. hospitals consistent with the mandates of Article III and equity. And if AHA truly has "associational standing" to "represent[]" nearly 5,000 hospitals across the nation, *id.*, then it and its members must take the bitter with the sweet: A loss in this litigation will preclude every one of those hospitals from bringing its own challenge to the Rule. *See UAW v. Brock*, 477 U.S. 274, 290 (1986) (observing that constitutional problems would arise if "a judgment won against" an association did not "preclude subsequent claims by the association's members"). Otherwise, AHA and its members could take advantage of the same set of asymmetric stakes associated with nationwide injunctions: A win by AHA here would tie the government's hands as to every one of its members, but a loss would do nothing to stop those hospitals from running off to "the 93 other districts for more bites at the apple." *City of Chicago v. Sessions*, 888 F.3d 272, 298 (7th Cir. 2018) (Manion, J., concurring in part and dissenting in part). In all events, Plaintiffs have offered no justification for a nationwide injunction untethered from AHA's membership or alleged representative capacity.

Second, this Court should sever any portion of the Rule it determines to be unlawful, leaving the rest of the Rule intact. Plaintiffs do not contest severability; they just reiterate their merits view that "[e]ach provision of the Final Rule is independently invalid." Opp'n Br. 33. Accordingly, if the Court finds that any "standard charges" are unlawful, or decides that HHS cannot impose penalties on noncompliant hospitals, it should leave the Rule's remaining provisions in place. *See* Def.'s MSJ Br. 44-45.

CONCLUSION

For the foregoing reasons, the Court should grant Defendant's motion for summary judgment and deny Plaintiffs' motion for summary judgment.

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Respectfully submitted,

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