NOT YET SCHEDULED FOR ORAL ARGUMENT

No. 20-5193

In the United States Court of Appeals for the District of Columbia Circuit

The American Hospital Association, et al.,
Plaintiffs and Appellants,

v.

Alex M. Azar II, Secretary of Health and Human Services,
Defendant and Appellee.

On Appeal From The United States District Court for the District of Columbia, Civil Action No. 1:19-cv-03619 (CJN)
The Honorable Carl J. Nichols

Amicus Brief of The Healthcare Financial Management Association Supporting Appellants and Reversal

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Certificate as to Parties, Rulings and Related Cases

Pursuant to Circuit Rule 28(a)(1), Amicus Healthcare Financial Management Association ("HFMA") provides the following information:

A. Parties and Amici

All parties, intervenors, and amici appearing before the district court and in this Court are listed in the Brief for Appellant.

HFMA makes the following disclosures: HFMA is a not-for-profit organization that has no parent corporations and does not issue stock.

B. Rulings Under Review

References to the ruling at issue appear in the Brief for Appellant.

C. Related Cases

None.

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STATEMENT OF IDENTITY, INTEREST, AND SOURCE OF AUTHORITY TO FILE, AUTHORSHIP AND FINANCIAL CONTRIBUTIONS[1]

Amicus Healthcare Financial Management Association ("HFMA") is a nonpartisan professional practice organization. It is the nation's leading membership organization for more than 56,000 healthcare financial management professionals. HFMA's diverse membership includes professionals employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards. As part of its professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices.

HFMA's detailed understanding of the financial management of hospitals and the U.S. healthcare system in its entirety gives it an important vantage point from which to advise regulators and courts on issues related to price transparency. HFMA believes improving consumer price transparency in the U.S. healthcare system is an

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[1] This brief is filed with consent of all parties. No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no person other than the *amicus curiae*, its members, or its counsel contributed money that was intended to fund preparing or submitting this brief.

important reform and advocates for changes that will allow patients to understand the true out-of-pocket costs of healthcare. HFMA is concerned the hospital price disclosure regulation that is the subject of this case creates an enormously costly administrative obligation for hospitals and will produce little to no new information that will benefit patients.

ARGUMENT

I. Introduction

It is difficult for patients to determine in advance how much healthcare will cost them. Through HFMA and others, the healthcare industry is coming together to make it easier for patients to understand the out-of-pocket costs of care, which can make it possible for patients to select lower cost and higher quality healthcare providers and treatment settings. The Department of Health and Human Services ("HHS") apparently shares our goal. However, in its hospital price disclosure rule, 84 Fed. Reg. 65524 (Nov. 27, 2019) ("Final Rule"), it has adopted an approach that is ineffective at serving this goal, imposes a great burden on hospitals, and exceeds the scope of HHS's statutory directive. The Final Rule fails to satisfy the most basic legal standards regarding the validity of agency action. The district court's judgment should be reversed.

HHS lacks statutory authority to promulgate the Final Rule. HFMA can say without hesitation that, under both the words' everyday

meaning and in the special context of healthcare finance, the statutory obligation for a hospital to publish a list of the "hospital's standard charges" does not include an obligation to publish multiple lists of prices negotiated with third-party payers or discounts negotiated with patients paying cash. The sweeping disclosure obligations in the Final Rule is simply not supported by the text of the statute.

Not only does HHS exceed its statutory authority, but in promulgating the Final Rule, it vastly underestimates the effort involved in complying with the Final Rule. HHS essentially ignored the numerous comments received from hospitals and industry groups like HFMA regarding the complexities of hospital payment systems and the burdensome administrative costs of compliance. The last thing our hospitals need at a time when they are struggling to combat the coronavirus pandemic is more administrative paperwork.

The Final Rule is all the more problematic when one considers the limited utility that the additional administrative burden will have. The price lists that would be produced would be so mammoth that they would be incomprehensible to nearly all patients, who, even if they did understand the lists, would still not have the information they would need to determine what really matters—the patient's out-of-pocket cost.

In addition, HFMA, based on consultations with stakeholders throughout the industry, proposed in its comment letter to HHS alternative disclosure requirements (on health plans for insured patients

and on providers to disclose list prices for uninsured patients) that would provide more useful information to patients at lower cost to industry than what HHS has proposed. HHS acknowledged the value in HFMA's approach, and indeed has published a notice of proposed rulemaking that would impose these obligations on health plans. HHS's decision nonetheless to adopt the Final Rule, without providing any rational explanation for why the Final Rule is preferable to HFMA's alternative, is a hallmark of arbitrary and capricious rulemaking.

Given that that Final Rule imposes an enormous burden on our nation's hospitals, does little (if anything) to further HHS's stated objective, and ignores clearly superior alternatives, HHS has failed to satisfy its burdens under the Administrative Procedure Act and First Amendment. The judgment should be reversed and the Final Rule vacated.

II. The Final Rule Is Inconsistent with the Text of the Statute.

In section 2718(e) of the Public Health Service Act, 42 U.S.C. § 300gg-18(e), Congress requires each hospital to publish "the hospital's standard charges for items and services." The expansive scope of the pricing disclosures contained in HHS's Final Rule simply cannot be squared with the statute's plain text.[2] Dictionary definitions, everyday

[2] HFMA agrees with all of the statutory construction arguments in Appellants' opening brief. As an industry organization, it focuses its arguments here on the industry uses for the term "standard charges" it

usage, industry usage, HHS's interpretation of "charges" in the context of prior statutes, and even HHS's prior application of section 2718(e), all confirm that as used in this provision "standard charges" does not refer to particularized negotiated charges or discounts with an array of different payers.

The industry definition of a hospital's "standard charges" is the payment amounts unilaterally sought by the hospital, before any negotiation with the payer. This was the clear meaning of "standard charges" in 2010 when the Affordable Care Act was enacted, as much as it is today.

In light of HFMA's longstanding efforts to improve healthcare financial administration to benefit patients, HFMA convened a task force to identify ways to improve price transparency to consumers throughout the healthcare industry. The task force included representatives of major healthcare providers and hospital systems, health insurers, and patients, among others. Despite the varying perspectives they bring to these issues, it is no surprise that, given the common usage of the term, the task force easily developed a consensus definition of "charges": the "dollar amount *a provider sets* for services rendered *before negotiating any discounts*. The charge can be different from the amount paid." HFMA, *Price Transparency in Health Care* 5

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has witnessed both before the enactment of the ACA and the subsequent enforcement of this provision.

(2014), *available at* https://www.hfma.org/content/dam/hfma/document/policies_and_practices/PDF/22279.pdf (emphases added). HFMA can say unequivocally that this was the universal industry usage of the term "charges" four years earlier when the Affordable Care Act was enacted, and notes that at the time the task force published its report there was no indication that HHS believed it could interpret section 2718(e) to require anything other than publication of the chargemaster.

Further, in the context of Medicare, where HHS is the third-party payer for healthcare items and services, for years HHS has defined "charges" as "the regular rates *established by the provider for services* rendered to both beneficiaries and to other paying patients." Medicare Provider Reimbursement Manual, pt. I, ch. 22, § 2202.4 (rev. 369), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.htm. Because this definition of "charges" is a key component of how Medicare reimburses hospitals, and indeed aligns with everyday usage of the term, Congress surely was aware of, and intended, this meaning.

Congress's decision to use the modifier "standard" does not undermine this unambiguous definition of "charges." Nonstandard "charges" might include *ad hoc* unilateral discounts, or surcharges, that hospitals apply in particular cases. This does not alter the conclusion that a hospital "charge" is an amount set by the hospital, not a negotiated amount set through agreement with a payer.

Despite the text of the statute and the industry usage of the terms in the statute, HHS and the district court relied on the premise that chargemasters are so meaningless that Congress could not have meant to require hospitals to publish them. Setting aside the fact that such argument would still not give HHS a license to go beyond the limits of the statute to require publication of the sweeping hospital pricing data in the Final Rule, the premise is not even true.

Certain patients are asked to pay chargemaster rates, and section 2718(e) provides real value to these populations. These include, but are not limited to, patients who: (1) are uninsured but ineligible for financial assistance from the hospital; (2) receive only partial financial assistance from the hospital; (3) receive services from out-of-network providers; or (4) have health coverage that imposes patient cost sharing as a percent of billed charges. And, it cannot be forgotten that for much of the past decade, HHS itself interpreted section 2718(e) to require publication of only the chargemaster and the Final Rule continues to require it. *See, e.g.*, A071. It is just not true that publishing a hospital's chargemaster is a meaningless exercise.

In sum, common usage, industry usage, and HHS's own pre-existing definition, all support the uncontroversial notion that a hospital's "standard charge" is the list price that is sought unilaterally by the hospital. Conversely, HFMA is unaware of any industry use of the term "standard charges," either before the enactment of the ACA or

since that would include specifically negotiated contract rates, specific discounted rates, or a "shoppable services" list as demanded by the Final Rule.

III. The Final Rule Fails Because It Overly Burdens Hospitals and Provides No Appreciable Benefits, and Superior, Less Burdensome Alternatives Are Available.

Governmental power must be exercised based on a "rational connection between the facts found and the choice made," after consideration of all "important aspect[s] of the problem." *Motor Veh. Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29, 42-43 (1983). Regulations that fail to do so, such as the Final Rule, are arbitrary and capricious and must be set aside. 5 U.S.C. § 706. As HFMA and others explained in comment letters to HHS (*see, e.g.,* A236, 252-253, 270, 299, 347), for insured patients, the meaningful cost to patients that drives patient comparisons and hospital competition are the patient-specific cost-sharing amounts, which would appear nowhere in the thousands of lines of price data that the Final Rule would require hospitals to disclose. HHS acknowledges the truth of these premises and provides no rational justification—really no justification at all—for finalizing a rule that would heap administrative burdens on hospitals to provide information

that is neither sufficient nor necessary for patients to learn the only pricing information that is relevant to them.[3]

A. The Final Rule Creates a Tremendous Burden for Hospitals.

HHS has an unrealistic understanding of the true complexity of the effort that would be required of hospitals under the Final Rule. As described in the administrative record (*see, e.g.*, A448, 546), because of the many variables that impact negotiated rates, each hospital could be required to create and produce spreadsheets with millions of rate cells. HHS's attempts to justify the rationality of the Final Rule relies on inaccurately minimizing the unavoidable burdens of the Final Rule.

In its response to comments and in its defense of the Final Rule, HHS repeatedly recognized the complexity of the healthcare system and payment arrangements and how these create barriers to gathering and presenting relevant information. *See*, *e.g.,* 84 Fed. Reg. at 65,526 (identifying barriers to information sharing including "a complex billing structure resulting in bills from multiple providers" and "the variety of insurance benefit structures"). However, when it came to analyzing the

[3] The benefits versus burdens analysis in this section also can be applied to Appellants' First Amendment challenge. Compelled disclosures must not only relate to a substantial interest but they cannot be "unjustified or unduly burdensome." AOB p. 46; *Nat'l Inst. Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018). As set forth herein, the Final Rule is unjustified and burdensome. Accordingly, the Final Rule also fails because it violates the First Amendment.

compliance burdens on hospitals, HHS largely ignored these complexities in reaching its erroneous conclusions that the compliance burdens would be minimal. 84 Fed. Reg at 65,525.

HHS estimated first-year compliance costs for the industry will exceed $71 million and annual costs thereafter of over $21.5 million. On a per hospital basis, HHS estimated costs to be $11,898.60 in the first year and $3,610.88 thereafter. These figures deviated significantly from the estimates provided by hospitals in their comment letters. *See* A272 (Cleveland Clinic estimating $500,000 to $1 million to implement); A476 (Santa Clara Valley estimating $630,000 to start, $21,000 per year thereafter); A195 (Bassett Health estimating $500,000); A546 (University of Tennessee estimating $400,000 to start, $450,000 per year thereafter). Given the extreme complexities of hospitals' contractual arrangements and the realities of most hospital billing systems, HFMA believes that HHS's estimates related to the cost burdens on hospitals to be significantly understated.

HHS ignores the realities of the healthcare financial system and the complexities of payer contracting. These complexities will require participation of a hospital's clinical, contracting, healthcare services coding and information technology personnel to create the various price lists required by the Final Rule. As for the annual time commitment, in its comment letter, HFMA stated that certain of its members estimated an annual compliance burden of 150 hours per year. A346. HHS

apparently mistakenly adopted this figure solely for the initial year and then reduced the yearly time thereafter by nearly seventy percent. Due to frequent payer contracting changes and clinical practice changes, HFMA does not believe there will be a reduction of burden in subsequent years. HHS got both the total amount of hours and the assumed mix of professionals wrong in their cost estimate of the "standard charge" posting requirement's implementation costs.

As set forth below, each step of the information gathering process potentially creates a compliance challenge for hospitals. As a result, the actual costs burdens per year for implementing this rule will be far greater than HHS's estimates.

1. Service Identification Challenges

Each hospital subject to the Final Rule will have multiple payer contracts. To compile the information mandated by the Final Rule, hospitals must be able to match similar services provided under the various contracts. This can be difficult to do where service bundles differ from contract to contract. This difficulty is heightened with respect to the "shoppable service" list requirement in the Final Rule. That list must consist of 300 packages of services. It is not a list of individual items and services. "The primary shoppable service" (e.g., hip replacement), must be grouped together with "ancillary services customarily provided by the hospital" related to the "shoppable service" (e.g., lab tests). 84 Fed. Reg. at 65,535.

The ancillary services required by one patient will be different from the ancillary services required by another. This will require a significant time commitment from clinical staff across each of a hospital's service lines to ensure that the definition of a "shoppable service package" is as clinically accurate and representative of an "average" case as possible. In reality, very little is standard from one patient to another for more complex "shoppable" services, and hospitals will struggle to analyze their claims data and medical records to determine what ancillary services provided to particular patients should be mapped to specific primary procedures. *See* A334. These difficulties will lead to increased loss of staff time and administrative costs.

2. Payment and Discounting Methodology Challenges

Even once the services are uniformly identified, there are numerous differences in what payers pay and how they structure payment for the same service. Different payment structures include, but are not limited to, percent of gross charges, per diems, bundles driven by the diagnosis(es) and/or procedure(s), or capitated per member per month payments. Thus, two patients may have received exactly the same service at a hospital, but the hospital may be paid for that service in substantially different ways that do not lend themselves to easy comparison or reduction to a standardized list. *See* A357.

Indeed, pricing and payment terms can even differ among multiple patients covered by the same insurer and treated at the same hospital,

based on what type of coverage the patient has and what special arrangements the insurer may have made. Pricing can change depending on whether the patient is covered in an individual market plan, employer group product, Medicare, or Medicaid. Different employer groups might even have different rates, even if the claims are administered by the same insurer. A347.

Service bundling also significantly complicates the pricing information collection and production process. For example, some contracts may have discounted services within bundles while others may not. Some contracts contain "carve-outs" from packaged services while others may not. Thus, compiling data on the costs of a given service when service bundles are constructed and paid for in different manners will be difficult.

3. Hospital Billing Systems Are Not Built To Produce the Pricing Information in the Manner the Final Rule Demands.

HHS also appears to presume that hospitals have "rate sheets" stored that can be easily collated into one standardized file of negotiated charges for the multiple contracts. This is not typically the case. Hospitals typically have contract management systems to ensure they are appropriately paid by their various payers. These tools are typically automated modules in revenue cycle management systems. Given the complexity of contracts with purchasers for healthcare services the

payment calculation in the contract management system is driven by algorithms consisting of if/then statements that takes into account dozens of variables. A347. The billing algorithm will address discounts associated with multiple services if such a provision exists in the contract between the health plan and the provider. For example, if a patient received, multiple x-rays, the pricing for the first x-ray may be the full amount with subsequent x-rays billed at a discounted rate. This system insures billing accuracy, but complicates the process of generating reports about the costs of an x-ray relative to a given contracted payer.

IT personnel will necessarily have to be part of the team that pulls the data from a hospitals billing systems. While HHS acknowledges this comment, they apparently did not take into account the technical complexities of securing the data from billing systems not designed to create these outputs. They also failed to account for the time necessary to determine how to display all of these disparate contracts in a "single digital file" for the machine-readable version.

* * *

The three sections above identify just some of the many variables and complexities that hospitals will have to deal with in creating the pricing information disclosures demanded by the Final Rule. When one considers that the spreadsheets the Final Rule envisions will include potentially millions of entries, HFMA believes that HHS's burden and

cost assumptions are substantially off-base. While HFMA did not perform a complete analysis, based on its survey of its members it believes that the estimates provided by hospitals in their comment letters are more in line with what the actual costs of compliance with the Finale Rule will be.

Given the complexity of this undertaking, it is questionable whether all hospitals will even be able to complete the required disclosures by January 1, 2021. And it will cause the redeployment of significant clinical and analytic resources away from quality improvement and cost reduction efforts for an administrative task that does not even achieve HHS's stated goal, as discussed next.

B. The Final Rule Does Not Achieve the Desired Goal of Providing Consumers Relevant Pricing Information.

HHS has explained its objective in the Final Rule is to improve the affordability of healthcare by improving cost transparency to patients and thereby encouraging hospitals to compete for patients on the basis of prices. *See*, *e.g.*, Final Rule, 84 Fed. Reg. at 65526. Even if HHS possesses statutory authority to achieve this objective by requiring disclosure of negotiated prices, which HFMA does not believe HHS possesses, as discussed above in Part II, there is no rational connection between the hospital disclosures it requires and the objectives it seeks to achieve.

1. The Cost That Matters To Patients Is Their Out-Of-Pocket Cost, Which The Final Rule Does Nothing To Help Patients Learn.

What matters most to patients as they make their decision about where to receive care is their out-of-pocket cost, or cost sharing. *See* A347. For patients with health coverage, this depends on the setting in which they are receiving care, whether each of the providers from which they receive care is in-network or out-of-network, the particular rate the payer has established for the provider, the benefit design of their coverage and whether the patient has yet satisfied the coverage's annual deductible or annual out-of-pocket limit. The lists that would be published by the hospital under the Final Rule will not provide this universe of information, especially on the critical questions of what cost-sharing parameters apply to a particular patient and to a particular healthcare claim. For example, even if a patient could reasonably discern from the potentially millions of data points in the Final Rule's required lists (or hundreds of data points in the supposedly simplified list of three hundred "shoppable" services), the patient would still need to know both the particular plan design (for example, the amount of the deductible and annual limit on cost sharing, and the level of coinsurance or copayments that would apply), *and* precisely what phase of the benefit they are in.

A patient that has satisfied their annual limit on cost sharing (i.e., the out-of-pocket maximum) for the year—or will have satisfied it by the

time they incur the planned healthcare expense—does not need to pay anything out-of-pocket for additional healthcare claims with in-network doctors at in-network hospitals and so learning even the negotiated price is irrelevant, and misleading, to this patient, since the health plan is responsible for 100% of the claim. Under other benefit plans, or for patients in the same plan who have not yet satisfied the annual limit on cost sharing, the patient may be responsible for a percentage of the negotiated amount, or may be responsible for a fixed-dollar copay, regardless of the negotiated amount. In all of these cases, the range of prices negotiated by *other* payers is irrelevant to the patient, and the lists that would be published under the Final Rule provide little to no information about the patient's actual anticipated out-of-pocket liability.

Even for patients for whom the negotiated price is relevant—for example, those patients that know they have a plan that obligates them to pay a percentage of the negotiated price and that they have not yet satisfied the annual limit on cost sharing—making the *hospitals* the locus of the negotiated price disclosures is unhelpful. A single insurance company often has many different reimbursement rates for the same service with the same hospital. As discussed above, the rates may vary depending on what type of benefit plan they apply to—employer group coverage, individual market health insurance coverage, Medicare, and Medicaid may each have different reimbursement rates, even if the same insurance company administers or underwrites the benefits and

contracts with the same hospital. Further, even within the same market, rates may vary depending on how restrictive the network is and how the insurance product is structured, such as how tightly the plan manages patients' access to specialty care. Because of this complexity, patients reviewing the hospital's negotiated prices will need to locate the correct price applicable to the particular benefit plans in which they are enrolled, which can vary widely even within the same insurance company. Then, they would need to repeat this process with each hospital that they are seeking to compare. There is a reasonable likelihood that in at least one of these price lists the patient will be confused and pick a price related to the wrong benefit plan, leaving the patient misinformed.

2. Differences in the Way Hospitals are Staffed and Report Their Pricing Data Could Create Consumer Confusion.

There are numerous aspects to the Final Rule that could create further consumer confusion with respect to healthcare pricing. A key example of this problem relates to employed versus unemployed physicians. In the Final Rule, CMS adopts a very broad definition of "Items and Services." 84 Fed. Reg. at 65,533. The definition includes services provided by employed physicians and non-physicians in its definition of "Items and Services." *Id.* The definition specifically

excludes, however, services performed by non-employed physicians and non-physicians. *Id.* at 65,534.

Since the Final Rule excludes costs for non-employed physicians, numerous problems arise with respect to the true comparability of the prices for hospital "items and services." Hospitals do not all employ the same types of physicians and non-physicians. For example, Hospital A may employ its anesthesiologists. While Hospital B's anesthesiology coverage is provided by a free-standing practice that has privileges at the hospital. The free-standing practice has negotiated its own contracts with managed care plans for the services it provides and bills its patients separately from the hospital. The gross and payer-specific negotiated charges for any service or service package requiring an anesthesiologist identified by Hospital A (who employs their anesthesiologists) will very likely be greater than at Hospital B (who does not employ anesthesiologists). As a result, consumers looking to make price based decisions for their care may mistakenly choose a higher cost provider who appeared less expensive because a key component of the service was not included. Providing multiple gross and payer specific negotiated charges that do not necessarily reflect staffing differences for the same service may very well create more consumer confusion than it helps to alleviate.

3. Hospital Pricing Data Is an Incomplete Picture of the Healthcare Marketplace.

Even if patients did all of this and gathered the right price data, understood their benefit design, and knew their status relative to their cost-sharing requirements, they are still missing key information that will allow them to make a value-based decision. First, the Final Rule does not provide them with access to price data for potentially cheaper options in freestanding settings. The rule applies only to hospitals, even though one of the main ways patients can reduce both their out-of-pocket costs and overall costs to the healthcare systems, is by selecting treatment at less resource-intensive settings when medically appropriate, such as ambulatory surgery centers, physician offices, and urgent care centers—instead of hospital outpatient departments or emergency rooms. The Final Rule provides no data useful for these decisions. Second, the Final Rule does not make service-specific quality data available to consumers when valid measures are available, leaving consumers to wonder whether there is any basis for the price differentials they may discover.

C. HFMA Offered Alternative Less Burdensome Approaches for Obtaining HHS's Goals.

Relying on the work of its industrywide Price Transparency Taskforce and its 2014 study on the subject, HFMA proposed commonsense alternatives to HHS's proposal in HFMA's comments on

the proposed rule. A358-360. In short, HFMA explained that health plans should be the primary source of information for insured patients about their expected cost-sharing, because the insurer is the only entity that already has all the information necessary to determine accurately the anticipated cost-sharing. HFMA proposed that health plans provide, upon request of any enrollee, information about the total cost for treatment by a particular provider, including the total amount that would be paid to the provider, the portion paid by the plan, the portion paid by the enrollee in cost-sharing, and, where available, information about the provider's quality. This would provide a simple mechanism for a patient to determine the actual cost-sharing that would apply to the patient based on the patient's particular plan parameters and the particular provider selected, as well as alternative providers and treatment settings that may be covered under the plan. HHS has statutory authority to impose these requirements on health plans, 42 U.S.C. § 300gg-15a, and, indeed, has already proposed a regulation that would do so, Transparency in Coverage, 84 Fed. Reg. 65464 (Nov. 27, 2019).

For uninsured patients or patients who elect to seek care out of network, patients should seek price estimates from healthcare providers, who will generally provide chargemaster rates, which of course they must already make public.

HHS offers no explanation for why it has promulgated a Final Rule that is less effective and more burdensome than the approach HFMA proposed in its comment letter. As such, HHS fails to offer any "rational connection between the facts found and the choice made," after consideration of all "important aspect[s] of the problem," *State Farm*, 463 U.S. at 42-43, and the Court must conclude that the Final Rule is arbitrary and capricious.

HHS agrees with HFMA's conclusion that publication of negotiated prices by hospitals will be insufficient for patients to learn their out-of-pocket cost in advance: "[w]e . . . agree with commenters who indicated that disclosure of hospital charge information alone may be insufficient or does not go far enough for consumers to know their out-of-pocket costs in advance of receiving a healthcare service." Final Rule, 84 Fed. Reg. at 65528. Then HHS posits that one failing of disclosure of negotiated prices is that self-pay patients will want to know "the amount a healthcare provider will accept in cash (or cash equivalent) as payment in full," *id.—which of course hospitals are already required to disclose under the statute without imposing the Final Rule*—and "an individual with health insurance may want to know the charge negotiated between the healthcare provider and payer, along with additional individual benefit-specific information such as the amount of cost-sharing, the network status of the healthcare provider, how much of a deductible has been paid to date, and other information," *id.—which is information*

available only from the health insurer. HHS says it "recognizes that these policies to require hospitals to make public their standard charges are merely a necessary first step," *id.*, but provides no justification for this claim that the Final Rule is "necessary" to provide the patient price transparency HHS says is its ultimate goal. The information an insured patient needs regarding out-of-pocket costs is available from the health insurer (and only the health insurer), regardless of whether the hospital is independently required to disclose its negotiated rates. There is no necessity for the hospital to also release the negotiated rates, especially not in the incredibly burdensome form required by the Final Rule. HHS appears to claim that the hospital disclosure requirement is an essential, albeit incomplete, step in ensuring patients have transparency regarding out-of-pocket costs, yet provides no justification that this step is in fact essential.

HHS's rejection of HFMA's proposal is little more than a string of non sequiturs. While acknowledging that HHS, with the Departments of Labor and the Treasury, has proposed a rule that would require health insurance issuers and group health plans to provide the cost-sharing transparency that HFMA proposes, HHS says it "disagree[s] that insurers alone should bear the complete burden or responsibility for price transparency." *Id.* But there is no reason that imposing this superfluous disclosure obligation on hospitals somehow makes it easier for insurers to provide the information about anticipated out-of-pocket

costs that only they can provide. Certainly, insurers cannot provide information they may not have—such as the cash price that self-pay patients would be required to pay hospitals. But this is the chargemaster data that hospitals are already required to disclose—and insurers' inability to release chargemaster data is in no way a justification for requiring hospitals to disclose negotiated prices when insurers are best positioned to disclose information that is actually relevant to patients.

CONCLUSION

The Court should reverse the judgment.

Respectfully submitted,

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Certificate of Compliance

This amicus brief complies with the type-volume limit of Fed. R. App. P. 32(a)(7)(B) and the word limit Fed. R. App. P. 29(a)(5) because, excluding the parts of the documents exempted by Fed. R. App. P. 32(f), this brief contains 5,305 words (within the 6,500 permitted). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in Century Schoolbook 14-point font.

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