United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued October 15, 2020 Decided December 29, 2020

No. 20-5193

AMERICAN HOSPITAL ASSOCIATION, ET AL.,
APPELLANTS

v.

ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY
OF HEALTH AND HUMAN SERVICES,
APPELLEE

Appeal from the United States District Court
for the District of Columbia
(No. 1:19-cv-03619)

Lisa S. Blatt argued the cause for appellants. With her on the briefs was *Whitney D. Hermandorfer*.

Chad I. Golder was on the brief for *amici curiae* Forty State Hospital Associations in support of appellants.

Benjamin G. Shatz was on the brief for *amicus curiae* Healthcare Financial Management Association in support of appellants.

Daryl L. Joseffer, *Tara S. Morrissey*, *Jeffrey S. Bucholtz*, and *Joel McElvain* were on the brief for *amicus curiae*

Chamber of Commerce of the United States of America in support of appellants.

Courtney L. Dixon, Attorney, U.S. Department of Justice, argued the cause for appellee. With her on the brief were *Ethan P. Davis*, Acting Assistant Attorney General, *Scott R. McIntosh*, Attorney, *Robert P. Charrow*, General Counsel, U.S. Department of Health & Human Services, *Brenna E. Jenny*, Deputy General Counsel & Chief Legal Officer-CMS.

Robert Henneke and *Jeffrey M. Harris* were on the brief for *amici curiae* Texas Public Policy Foundation, et al. in support of appellee.

Before: TATEL and GARLAND*, *Circuit Judges*, and EDWARDS, *Senior Circuit Judge*.

Opinion for the Court filed by *Circuit Judge* TATEL.

TATEL, *Circuit Judge*: As part of the Affordable Care Act, Congress required hospitals to make public "a list" of "standard charges" in accordance with guidelines developed by the Secretary of Health and Human Services. 42 U.S.C. § 300gg-18(e). By rule, the Secretary defined "standard charges" to include prices that hospitals charge insurers. The American Hospital Association and others challenge the rule, arguing that it violates the statute, the Administrative Procedure Act, and the First Amendment. For the reasons set forth in this opinion, we affirm the district court's grant of summary judgment to the Secretary.

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* Judge Garland was a member of the panel at the time this case was argued but did not participate in the final disposition of the case.

I.

Understanding the issues before us requires an explanation of how hospitals charge for their services. In short, their charges look nothing like hotel room rates or car prices. Rather, hospitals charge different amounts for the same item or service depending on who is paying.

Three different groups pay hospitals for care: patients, insurers, and the federal and state governments (for Medicare and Medicaid). The first group, "self-pay" patients, pay directly for their care because they have no insurance, receive elective or out-of-network care, or believe that paying directly is cheaper than relying on insurance. Self-pay patients account for fewer than 10 percent of all patients. *Price Transparency Requirements for Hospitals to Make Standard Charges Public* (*Price Transparency Requirements*), 84 Fed. Reg. 65,524, 65,542 (Nov. 27, 2019). Hospitals generally charge these patients rates specified in what is called "chargemasters," which list all items and services provided by each hospital with their "gross charges." *Id.* at 65,537. Many hospitals offer discounts to self-pay patients based on standardized cash discounts or individual financial need (or both). As a result, chargemaster rates are "virtually never what hospitals ultimately receive as payment." Appellants' Br. 7. Although these gross charges "bear little relationship to market rates [and] are usually highly inflated," *Price Transparency Requirements*, 84 Fed. Reg. at 65,538, they exist for "historical and legal reasons," Appellants' Br. 7–8. Specifically, Medicare requires hospitals' charges for Medicare and non-Medicare patients to be the same for a specific service, and hospitals comply with that requirement by listing chargemaster rates as if they were applicable to everyone, even though hospitals receive different payments depending on the payer's identity.

Over ninety percent of patients rely on third-party payers, i.e., insurers, Medicaid, and Medicare. Medicaid and Medicare pay hospitals based on rates set by the states and the Centers for Medicare & Medicaid Services. Those rates are public. *Price Transparency Requirements*, 84 Fed. Reg. at 65,542, 65,552. Insurance companies have contractual agreements with hospitals to pay negotiated rates for their services. Although insurers and hospitals often treat chargemaster rates as the "starting point" for negotiations, negotiated rates are a product of a wide range of methodologies. Appellants' Br. 8. Insurers may pay fixed fees for individual items and services, or they may pay for bundled packages based on common procedures, per diem rates, or other variable factors, set out in "many dozens of pages of text." *Id.* at 8 (internal quotation marks omitted). They may also pay according to a "diagnosis-related group" methodology, under which a rate is established for a group of hospital items and services based on the typical care provided to a patient with a particular diagnosis. The Medicare statute requires diagnosis-related-group classifications for inpatient Medicare reimbursements, and some private insurers use these classifications to establish rates with hospitals. 42 U.S.C § 1395ww(d)(4); *Price Transparency Requirements*, 84 Fed. Reg. at 65,534. In addition, insurers may pay different amounts based on volume discounts, incentive payments for meeting quality metrics, and exclusions for certain services.

With so many different methodologies for setting rates, determining what negotiated rate applies to a particular patient for a particular item or service is "exceedingly complex." Appellants' Br. 8. Adding to the complexity, negotiated rates are not necessarily what insured patients would pay, as their out-of-pocket costs depend on their health insurance plan, which has its own rules on copays, deductibles, and coverage limits.

Patients usually learn what a given hospital service cost only after the fact, either from a hospital bill or an "Explanation of Benefits" form from their insurance company; the latter details the insurer's negotiated rates and the patient's out-of-pocket costs. Patients are "understandably frustrated by their inability to easily determine in advance what they may pay out-of-pocket for hospital services." *Id.* at 6. According to the Secretary, this lack of price transparency has contributed to an "upward spending trajectory" in healthcare. *Price Transparency Requirements*, 84 Fed. Reg. at 65,525–26.

Against this backdrop, Congress passed the Affordable Care Act of 2010, which added section 2718, entitled "Bringing down the cost of health care coverage," to the Public Health Service Act. In language central to this case, subsection 2718(e) requires "[e]ach hospital operating within the United States" to "each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under [the Medicare reimbursement statute]." 42 U.S.C. § 300gg-18(e). The statute nowhere defines "standard charges."

Following passage of the Affordable Care Act, the Secretary allowed hospitals to comply with section 2718(e) by making their chargemasters public. *Transparency Requirement Under the Affordable Care Act*, 79 Fed. Reg. 49,854, 50,146 (Aug. 22, 2014). But in 2018, the Secretary found that "challenges continue to exist for patients due to insufficient price transparency" because chargemaster data were "not helpful to patients for determining what they are likely to pay for a particular service or hospital stay." *Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet*, 83 Fed. Reg. 20,164, 20,549 (May 7, 2018). As a

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