WINSTON & STRAWN LLP

CLIENT ALERT

# Will Hospital Price Transparency Become a Reality?: Federal District Court Affirms HHS Rule Requiring Public Disclosure of Negotiated Prices

JULY 1, 2020

## Introduction

In 2019, the Department of Health and Human Services (HHS) enacted a new rule requiring all hospitals that accept Medicare to publicly disclose their charges, including information on privately negotiated rates. This sensitive information has, until now, been guarded as trade secrets, and the change could cost hospitals millions annually. Hospitals and industry organizations have opposed the rule on several grounds, including by arguing that disclosing privately negotiated rates may reduce, not improve, incentives to offer lower rates. Nevertheless, on June 23, 2020, the District Court for the District of Columbia upheld the rule, which is now slated to go into effect on January 1, 2021.

## Development of the Rule

The Affordable Care Act requires hospitals to make public their "standard charges."[1] Until now, hospitals could comply with the requirement by publishing chargemasters.[2] Chargemasters, though, often do not reflect the actual payment rendered to a hospital by a patient or third-party private provider, like a private or public insurer.[3] Throughout 2018, the Centers for Medicare & Medicaid Services (CMS or the Agency) collected information and comments on whether a chargemaster should continue to be considered an appropriate measure of a hospital's "standard charges."[4]

In June 2019, the President issued an executive order directing the Secretary of HHS to "propose a regulation, consistent with applicable law, requir[ing] hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services," in easy-to-understand formats to inform patients about "actual prices."[5] Shortly thereafter, the HHS Secretary and CMS Administrator proposed a rule addressing these concerns.[6] As part of that rule, the Agency proposed a new construction of the term "standard charges" to include "gross charges" and "payer-specific negotiated charges."[7] Under this construction, hospitals would be required, for the first time, to make public information about charges privately negotiated with insurers.

The authority of the Agency to make these changes was challenged during the comment period.[8] Hospitals also expressed skepticism that the rule would lead to lower costs or otherwise benefit consumers and expressed concerns regarding the compliance burden.[9] Despite these concerns, the Agency issued the final version of the rule (Final Rule).[10] As a result, hospitals must, starting January 1, 2021, make public the following:

- gross charges – defined as "the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts";[11]
- payer-specific negotiated charges – defined as "the charge that the hospital has negotiated with a third party payer for an item of service";[12]
- discounted cash price – defined as "the price the hospital would charge individuals who pay cash (or cash equivalent) for an individual item or service or service package";[13]
- de-identified minimum and maximum charges – defined as "the lowest charge that a hospital has negotiated with all third party payers for an item or service" and "the highest charge that a hospital has negotiated with all third party payers for an item or service" including non-negotiated charges with third-party payers.[14]

This change will likely have a dramatic impact on the industry. Until now, privately negotiated rates were considered by the industry as protected trade secrets.[15] HHS estimated that the change could save payers—and thus cost hospitals—millions annually, and significant efforts will have to be made by most to collect and make public the large volume of data required.[16]

The Final Rule also includes an enforcement scheme.[17] HHS will first provide a written warning to hospitals that fail to make this information public.[18] If HHS determines that a hospital has continued not to make the information public after a warning, the Agency will request a corrective action plan; and if the Agency determines the hospital is still not complying, it will impose and publicize a civil monetary penalty of up to $300 per day.[19] The Rule does not include any private right of action based on a hospital's failure to comply with the disclosure requirements.

# Providers Lawsuit Against the Secretary of Health and Human Services

A collection of health care providers and provider associations[20] filed suit to challenge the Final Rule, alleging the Agency exceeded its authority under the Administrative Procedure Act, that the Final Rule violates the First Amendment, and that the Final Rule is arbitrary and capricious.[21] This week, the District Court for the District of Colombia rejected each of these arguments, denied plaintiffs' motion for summary judgment, and granted the government's, upholding the validity of the Final Rule.[22]

*A. Whether CMS Exceeded Its Statutory Authority*

Plaintiffs first argued that the term "standard charges" could refer only to a hospital's chargemaster and that by expanding the meaning of that term, CMS exceeded its authority.[23] The court rejected this argument.[24] Thecourt found that the term "standard charges" had not been previously interpreted as synonymous with "chargemaster" and that the Agency's interpretation of the term "standard charges" was reasonable as to each category of charges to be included under the new rule.[25] Plaintiffs argued that the term "standard" could not be reasonably interpreted as referring to several different sets of payer-negotiated charges.[26] The court hedged, noting it was a "close call," but concluded that the "agency's decision to define 'standard charges' based on the different patient groups [was]… a reasonable construction that accounts for the peculiar dynamics of the health care industry."[27]

Plaintiffs also argued that HHS could not, within the bounds of its statutory authority, impose penalties for failure to comply with the publication requirements.[28] The court agreed that the language authorizing the Secretary to impose penalties was included in a strange location in the statute, relative to the publication requirement, but found no basis in the legislative history to support the argument that Congress did not intend for the Secretary to have authority to enforce the publication requirement.[29] Thus, the court found the Agency had not acted beyond its statutory authority when enacting the Final Rule.

*B. Whether the Rule Violates the First Amendment*

Plaintiffs separately challenged the Final Rule as a violation of the First Amendment.[30] The court rejected this challenge, too.[31] The First Amendment prohibits the government from compelling certain speech.[32] To the extent the Final Rule compels speech, the court held, it is a regulation of commercial speech and does not include any expressive component and so the Rule is not subject to strict scrutiny review.[33] To be constitutional, the court concluded, the Final Rule need only "be reasonably related to the agency's interests and cannot be so unjustified or unduly burdensome that it chills protected speech."[34]

Plaintiffs argued that the Final Rule does not meet these requirements. They agreed that the Agency has a legitimate interest in improving patient access to information and in lowering health care costs, but contended that the publications required would continue to confuse and frustrate patients, the disclosure of the information would not lower costs, and the burden on hospitals was unjustified.[35] The court agreed with the Agency that the evidence showed the publication of charges would further the Agency's interest in informing patients about the cost of care and lowering the cost of health care and so the court concluded the Final Rule was "reasonably related to the agency's interests."[36] The court also agreed with the Agency that the Final Rule is not unduly burdensome.[37] It concluded any logistical or financial burdens of compliance would not unreasonably burden or chill plaintiffs' speech and that the Rule would not likely chill negotiations between hospitals and insurers, because only the final agreed-upon price must be published, not information about the negotiations.[38]

The court then addressed plaintiffs' argument that the Rule could actually result in anti-competitive consequences and cause costs to increase, contrary to the Agency's asserted interests, because it would allow all competitors to see what prices a payer is willing to accept.[39] The court acknowledged that the evidence was not definitive but relied on studies cited by the Agency that show disclosing prices would result in greater transparency and lower costs.[40] The court concluded this was enough to satisfy the requirement that the Rule be reasonably related to the Agency's interests.[41] Thus, the court upheld the Rule as constitutional.[42]

*C. Whether the Rule Is Arbitrary and Capricious*

Plaintiffs' third argument also focused on assertion that the Rule would not improve patients' decision-making and that the Rule imposes a disproportionately large cost on hospitals.[43] For these reasons, plaintiffs argued, the Rule is arbitrary and capricious and should not be upheld.[44] Proving an agency action arbitrary and capricious is a difficult standard to meet,[45] and the court determined that plaintiffs failed to do so.[46]

Plaintiffs asserted that providing patients with all the information required under the new Rule would be more confusing and might deter them from seeking care, if they, unable to understand the wealth of information, think the cost is higher than what they would actually pay.[47] This, of course, would be the opposite of the Rule's stated goal of informing patient decision-making. This argument was made during the comment period; the Agency considered it and determined that, although some patients might be confused, overall the availability of more information would be beneficial.[48] This is sufficient, the court determined, to establish that the Rule is not arbitrary or capricious.[49] The court also noted that the same confusion stems from publication of hospital chargemasters alone.[50]

Plaintiffs then asserted that the Agency underestimated the cost of compliance, which they contend would outweigh any benefit.[51] Again, the court found the agency appropriately took the cost of compliance into consideration and so the resulting Rule is not arbitrary and capricious.[52]

# Conclusion

Despite persistent advocacy by hospitals and hospital associations during the notice and comment period and throughout this litigation, the Final Rule has been published and upheld by the court. Plaintiffs have filed a notice of appeal, but unless and until the District Court's decision is stayed or its judgment overturned, the Rule will take effect January 1, 2021. Compliance with the Rule with require all hospitals in the United States that accept Medicare to publish gross charges, payer-negotiated charges, cash discount prices, de-identified minimum charges, and

de-identified maximum charges. Collecting and publishing that information will likely take time and considerable effort for many hospitals, and so hospitals are encouraged to start preparing.

For further information or questions on the new requirements or obligations under the HHS Rule, please contact Libby Deshaies or your Winston relationship attorney.

---

[1] Patient Protection and Affordable Care Act, Pub. L. No. 1110148 § 10101(f), 124 Stat. 119, 887 (2010), *codified at* 42 U.S.C. § 300gg-18(e).

[2] *See* 79 Fed. Reg. 49,853, 50,146 (2014) ("We reiterate that our guidelines for implementing section 2718(e) of the Public Health Service Act are that hospitals either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry.").

[3] *See* 84 Fed. Reg. 65,524, 65,538 (2019) (noting that "[c]hargemaster (gross rates charged to self-pay individuals 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").

[4] *See* 83 Fed. Reg. 20,164, 20,549 (May 7, 2018).

[5] Exec. Order No. 13877, Improving Price and Quality Transparency in American Healthcare to Put Patients First, 84 Fed. Reg. 30,849 (June 24, 2019).

[6] 84 Fed. Reg. 39,398 (Aug. 9, 2019).

[7] 84 Fed. Reg. at 39,578.

[8] 84 Fed. Reg. 65,524, 65,537–38, 65,543 (published Nov. 27, 2019).

[9] 84 Fed. Reg. at 65,527–28.

[10] 84 Fed. Reg. 65,524 (Nov. 27, 2019).

[11] 84 Fed. Reg. at 65,540.

[12] 84 Fed. Reg. at 65,542.

[13] 84 Fed. Reg. at 65,552.

[14] 84 Fed. Reg. at 65,555.

[15] *See* Stephanie Armour, *Trump Administration Price-Transparency Rule Covering Hospitals Upheld*, Wall Street Journal (June 23, 2020), https://www.wsj.com/articles/trump-administration-price-transparency-rule-covering-hospitals-upheld-11592945973.

[16] *Id.*; *see Am. Hosp. Ass'n v. Azar*, 19-cv-3619, dkt. 25-1, Br. of *Amicus Curiae* 37 State Hosp. Ass'ns in Support of Pl.'s Mot. for Summ. J. (detailing the concerns of *amici* regarding compliance).

[17] 84 Fed. Reg. at 65,584–90.

[18] 84 Fed. Reg. at 65,586.

[19] 84 Fed. Reg. at 65,586.

[20] Plaintiffs include American Hospital Association, Association of American Medical Colleges, Federation of American Hospitals, National Association of Children's Hospitals, Memorial Community Hospital and Health System, Providence Health System d/b/a Providence Holy Cross Medical Center, and Bothwell Regional Health Center.

[21] *Am. Hosp. Ass'n v. Azar*, 19-cv-03619, Dkt. 1.

[22] *Am. Hosp. Ass'n v. Azar*, 19-cv-03619, 2020 U.S. Dist. LEXIS 110130 (D.D.C. Jun. 23, 2020).

[23] *See id.* at *17.

[24] *Id.* at *17–*26.

[25] *Id.*

[26] *Id*. at *26.

[27] *Id*. at *28.

[28] *Id*. at *34.

[29] *Id*. at *34–*36.

[30] *See id*. at *36.

[31] *Id.* at *51.

[32] U.S. Const., amend. I; *see Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371 (2018) (explaining that a law compelling an individual "to speak a particular message ... alte[rs] the content of [their] speech" and thus "abridge[s] the freedom of speech").

[33] *Am. Hosp. Ass'n v. Azar*, 19-cv-03619, 2020 U.S. Dist. LEXIS 110130, *37–*39 (D.D.C. June 23, 2020).

[34] *Id.* at *44.

[35] *See id.* at *44.

[36] *Id.* at *47.

[37] *Id.* at *48–*49.

[38] *Id.*

[39] *See id.* at *49.

[40] *Id.* at *50–*51.

[41] *Id.* at *51.

[42] *Id.*

[43] *See id.* at *51–*52.

[44] *See id.*

[45] *See id.* at *52 (citing *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 658 (2007), and noting that, "[u]nder the arbitrary and capricious standard, the scope of judicial review is deferential and narrow").

[46] *Id.* at *57–*58.

[47] *See id.* at *52–*53.

[48] *See id.* at *53; *see also* 84 Fed. Reg. at 65,528.

[49] *Am. Hosp. Ass'n v. Azar*, 19-cv-03619, 2020 U.S. Dist. LEXIS 110130, *52–*56 (D.D.C. June 23, 2020).

[50] *Id.* at *54–*55.

[51] *See id.* at *56.

[52] *Id.* at *57–*58.

10 Min Read

## Related Locations

Charlotte | Chicago | Dallas | Houston | Los Angeles | New York | San Francisco | Silicon Valley | Washington, DC

## Related Topics

Health Care | Employee Benefits and Executive Compensation

## Related Capabilities

Health Care

## Related Regions

North America

# Related Professionals

Libby Deshaies