IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, THE FEDERATION OF AMERICAN HOSPITALS, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS, INC., MEMORIAL COMMUNITY HOSPITAL AND HEALTH SYSTEM, PROVIDENCE HEALTH SYSTEM - SOUTHERN CALIFORNIA d/b/a PROVIDENCE HOLY CROSS MEDICAL CENTER, and BOTHWELL REGIONAL HEALTH CENTER,

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

DECLARATION OF MOLLY SMITH IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Molly Smith, hereby declare and state the following:

1. My name is Molly Smith. I am over 21 years of age and competent to testify to the facts set forth herein. I am an adult citizen of the United States. I reside in Washington, DC.

2. The facts set forth in this declaration are based on my personal knowledge and upon information available to me through the files and records of the American Hospital Association (AHA). If called upon as a witness, I could and would testify to these facts.

3. I am the Vice President, Coverage and State Issues Forum, of the AHA. I have served in this capacity since May 2017. In this role, I am responsible for the development of the association's policy and advocacy agenda as it relates to health coverage, which requires an awareness of health policy issues and their impact on hospitals and health care systems, including federal requirements that impact contractual relationships between providers and health plans. In my capacity as the Vice President for Coverage and State Issues Forum, I have personal knowledge of the impact that the new CMS rule challenged in this lawsuit will have on AHA's members.

4. The AHA is a national, not-for-profit organization headquartered in Washington, D.C. The AHA represents and serves nearly 5,000 hospitals, health care systems, and networks, and over 43,000 individual members. Its mission is to advance the health of individuals and communities by leading, representing, and serving the hospitals, systems, and other related organizations that are accountable to the community and committed to health improvement. The AHA provides extensive education for health care leaders and is a source of valuable information and data on health care issues and trends. It also ensures that members' perspectives and needs are heard and addressed in national health-policy development, legislative and regulatory debates, and judicial matters. One of the critical ways in which AHA serves its mission is to protect its members' interests through advocacy and litigation in connection with policy changes initiated by the Centers for Medicare & Medicaid Services (CMS).

5. On behalf of its members, AHA (with its co-plaintiffs) has filed this lawsuit challenging a recent rule issued by CMS requiring the public disclosure of charges privately negotiated between hospitals and commercial health insurers (Final Rule).

6. In the Final Rule, CMS requires hospitals to publicly disclose the following information on their websites:

a. "Gross charges," "payer-specific negotiated charges," "the amount the hospital is willing to accept in cash from a patient," and "the minimum and maximum negotiated charges" for "all items and services"; and

b. "Payer-specific negotiated charges," "the amount the hospital is willing to accept in cash from a patient for an item or service," and "the minimum and maximum negotiated charges" for 300 common shoppable services."

7. The AHA's member hospitals and care providers are committed to providing patients with the information they need to make informed decisions about their health care.

8. Research, including that cited in the Proposed and Final Rule, demonstrates that what patients care about most is their own out-of-pocket costs, not the rates negotiated between hospitals and insurers.

9. To that end, AHA supports policy options that would facilitate sharing with patients the out-of-pocket amounts they will be expected to pay for care, recognizing that each patient's circumstances will be differently affected by numerous variables in her health insurance coverage.

10. But the Final Rule will confuse patients rather than help them. Public disclosure of all negotiated rates will not help a patient determine her own out-of-pocket costs. Patients will understandably be confused by information relating to insurer-specific negotiated rates for all items and services for all health plans, when those data do not reveal whether and how service is covered and may bear no relationship to the amount that the patient will be expected to pay.

11. The Final Rule also will irreparably harm the nation's hospitals, including AHA's members. Virtually all of AHA's members (including but not limited to the plaintiff hospitals in this case: Memorial Community Hospital and Health System, Providence Health System – Southern California dba Providence Holy Cross Medical Center, and Bothwell Regional Health Center) will suffer severe, non-remediable harm if the Final Rule is permitted to go into effect.

12. Hospitals (including AHA's members) and insurers typically negotiate contracts governing the prices that the individual insurance plan will be expected to pay the hospital for specific services. These contracts are negotiated at arms' length between either an individual hospital or a broader hospital system and each specific insurer. The negotiated rates typically vary not only by insurer, but also among plans offered by a single insurer. Thus, each hospital will typically have hundreds of contracts and/or rate sheets covering a number of insurers and each of their various insurance plans. The payment arrangements negotiated with insurers can take many different forms: some are based on a percentage of the chargemaster charge, others are based on a per diem rate, and still others are a flat dollar amount per service, billing code, or other specified metric. Some payers may negotiate bundled payment arrangements, where a single payment is made for multiple services furnished by multiple providers during an episode of care. Some contracts reflect value-based arrangements whereby hospitals agree to take financial risk for meeting certain performance standards for patient care; these seek to improve access to care, quality of care, and patient health outcomes while reducing costs.

13. Many hospitals and health systems have over 100 contracts with different health plans issuers, often with multiple contracted rates depending on the type of health plan.

14. AHA's member hospitals take great care to protect the confidentiality of their negotiated, insurer-specific rates, including but not limited to: abiding by contractual

confidentiality obligations, restricting access to a limited number of employees, and training those employees not to disclose the information to third parties or use it for an unauthorized purpose.

15. If the rates privately negotiated between hospitals and insurers become publicly known, AHA's member hospitals' ability to negotiate with insurers at arms' length in the future will be hindered. Among other foreseeable harms, dominant health plans will use disclosed negotiated rates to deter and punish hospitals that lower rates or enter into value-based arrangements with the dominant plan's competitors.

16. Such conduct would chill hospitals' and health systems' efforts to develop new and innovative care arrangements designed to improve efficiency and affordability by working with new entrants or commercial health plans that focus on value-based arrangements and will undoubtedly make it even more difficult for new or existing competitors to penetrate already concentrated commercial health insurance markets.

17. The Final Rule's requirement that hospitals disclose "the amount the hospital is willing to accept in cash from a patient" is equally problematic. This requirement assumes that there is a single cash figure that a hospital would be willing to accept from a patient who either lacks insurance or chooses not to use it for a specified service. But for many hospitals, there simply is no such one-size-fits-all number. Instead, hospitals work individually with patients to reach an accommodation on pricing based on patient-specific factors including the patient's financial and personal circumstances and whether there are other means of payment for which the patient qualifies, e.g., Medicaid, that could pay for her care.

18. Hospitals use a variety of criteria to determine the discounted cash amounts that will be offered to a patient. Many are linked to the federal poverty level, but hospitals also may

consider other facts and circumstances, such as the amount a patient has spent on health care over the preceding year regardless of their income level. For those who don't meet the criteria, the hospital typically negotiates directly with them for payment and may offer discounts or other abatement based on a number of criteria, including the timing of payments and ability to pay.

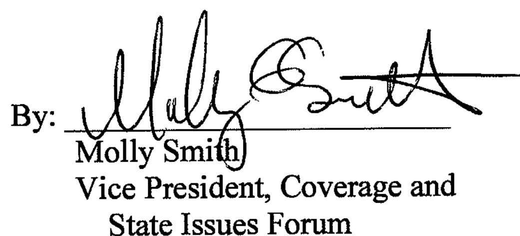
19. The estimated burden on hospitals set forth in the Final Rule of 6 full days and nearly $12,000 a piece in costs to come into compliance is grossly underestimated. There is currently no turnkey system hospitals could purchase or employ to provide the disclosures required. Each hospital and hospital system would be required to develop and staff its own system for numerous commercial health insurers contracted rates. Hospitals will need to hire new or divert current personnel to begin the laborious process of manually gathering information responsive to the Final Rule—some of which either is not currently available to them, or requires extensive review of patient claims history to decipher. Then, hospitals must prepare that massive amount of data for formatting, processing, uploading, and hosting—a not-insignificant task given that for some hospitals and health systems there are expected to be thousands of rows and hundreds to thousands of columns in the finished product. Many hospitals will be required to hire e-vendors to assist with that process, which will add additional time on the back end. All of that comes at a severe cost, and it would cause an unnecessary diversion of resources if the Final Rule is declared invalid.

20. The Final Rule requires hospitals to publicly disclose their negotiated rates and amount that they would be willing to accept in cash by January 1, 2021. Hospitals will have to start devoting substantial resources immediately to complying with the rule in order to make the rule's deadline. All of this imposes a substantial burden on hospitals—especially smaller and rural hospitals that are already operating with scarce resources and on thin margins.

21. Plaintiffs respectfully request a decision on the merits as soon as practical, so that hospitals are not required to commit funds and personnel to developing a method to comply with this sweeping (and unlawful) mandate.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct.

Executed this 9 day of December 2019.

By: 

Molly Smith
Vice President, Coverage and
State Issues Forum