BILL LOCKYER
Attorney General of the State of California
STACY BOULWARE EURIE
Senior Assistant Attorney General
CHRISTOPHER E. KRUEGER
Supervising Deputy Attorney General
DOUGLAS J. WOODS, State Bar No. 161531
Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-4663
Fax: (916) 324-5567
E-mail: Douglas.Woods@doj.ca.gov

Attorneys for Defendants ATTORNEY GENERAL BILL LOCKYER, the STATE OF CALIFORNIA, and CALIFORNIA DEPARTMENT OF JUSTICE

SUPERIOR COURT OF CALIFORNIA

COUNTY OF FRESNO

EDWARD W. HUNT, in his official capacity as District Attorney of Fresno County, and in his personal capacity as a citizen and taxpayer, et al., Plaintiffs, **v.** **STATE OF CALIFORNIA, et al.,** Defendants.	Case No. 01CECG03182 **DEFENDANTS' NOTICE OF LODGING FEDERAL AUTHORITIES CITED IN DEFENDANTS' SUMMARY JUDGMENT BRIEFS** Date: February 1, 2007 Time: 3:30 p.m. Dept: 72 Before the Honorable Alan Simpson

Defendants Attorney General Bill Lockyer, the State of California, and the California Department of Justice hereby lodge with the Court copies of the federal authorities cited in their "Defendants' Memorandum of Points and Authorities in Support of Motion for Summary Judgment or, Alternatively, Summary Adjudication on Plaintiffs' Amended Complaint" and in their "Defendants' Memorandum of Points and Authorities in Opposition to Plaintiffs' Motion for

Summary Judgment or Summary Adjudication."

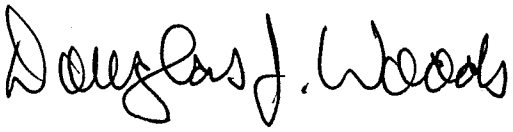
1. *Hoffman Estates v. Flipside, Hoffman Estates* (1982) 455 U.S. 489, a true and correct copy of which is attached hereto as Exhibit A; and,

2. *Shalala v. Guernsey Mem'l Hosp.* (1995) 514 U.S. 87, a true and correct copy of which is attached hereto as Exhibit B.

Dated: January 8, 2007

Respectfully submitted

BILL LOCKYER
Attorney General of the State of California
STACY BOULWARE EURIE
Senior Assistant Attorney General
CHRISTOPHER E. KRUEGER
Supervising Deputy Attorney General



DOUGLAS J. WOODS
Deputy Attorney General

Attorneys for Defendants
ATTORNEY GENERAL BILL LOCKYER,
the STATE OF CALIFORNIA, and CALIFORNIA
DEPARTMENT OF JUSTICE

Exhibit A

LEXSEE 455 US 489

VILLAGE OF HOFFMAN ESTATES ET AL. v. THE FLIPSIDE, HOFFMAN ESTATES, INC.

No. 80-1681

SUPREME COURT OF THE UNITED STATES

455 U.S. 489; 102 S. Ct. 1186; 71 L. Ed. 2d 362; 1982 U.S. LEXIS 78; 50 U.S.L.W. 4267

December 9, 1981, Argued
March 3, 1982, Decided

SUBSEQUENT HISTORY:

Petition for Rehearing Denied April 26, 1982.

PRIOR HISTORY:

APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT.

DISPOSITION:

639 F.2d 373, reversed and remanded.

DECISION:

Municipal ordinance requiring license to sell "items designed or marketed for use with illegal cannabis or drugs," held not unconstitutionally vague or overbroad.

SUMMARY:

A village enacted an ordinance regulating the sale of drug paraphernalia. The ordinance requires a business to obtain a license if it sells any items that are "designed or marketed for use with illegal cannabis or drugs". A store selling drug paraphernalia in the village brought an action in the United States District Court for the Northern District of Illinois challenging the ordinance prior to its enforcement as unconstitutionally vague and overbroad. The District Court upheld the constitutionality of the ordinance. On appeal, the United States Court of Appeals for the Seventh Circuit reversed, holding that the ordinance was impermissibly vague on its face *(639 F2d 373).*

On appeal, the United States Supreme Court reversed and remanded. In an opinion by Marshall, J., expressing the view of Burger, Ch. J., and Brennan, Blackmun, Powell, Rehnquist, and O'Connor, JJ., it was held that (1) the ordinance did not infringe upon the First Amendment rights of a merchandiser of items purported to be regulated by the ordinance and was not overbroad as inhibiting the First Amendment rights of other parties since (a) the ordinance does not restrict speech as such but simply regulates the commercial marketing of items that the labels reveal may be used for an illicit purpose and thus the ordinance does not embrace noncommercial speech, (b) insofar as any commercial speech interest was implicated, it was only the attenuated interest in displaying and marketing merchandise in the manner the retailer desires, and (c) it was irrelevant whether the ordinance had an overbroad scope encompassing other persons' commercial speech, (2) the ordinance is not impermissibly vague in all of its applications and could therefore not be challenged on its face as unduly vague in violation of due process as applied to a business engaged in selling drug paraphernalia since (a) the language "designed for use" is not unconstitutionally vague on its face insofar as it is sufficiently clear to cover at least some of the items sold by the business, and (b) the language "marketed for use" gave the business ample warning that its marketing activities required a license.

White, J., concurring in the judgment, expressed the view that the court need not have discussed the overbreadth problem in order to reach the result since the Court of Appeals did not discuss any problem of overbreadth but rather erroneously held the ordinance void for vagueness.

Stevens, J., did not participate.

LAWYERS' EDITION HEADNOTES:

[***LEdHN1]
LAW § 952

First Amendment -- drug paraphernalia ordinance -- commercial speech --
Headnote:[1A][1B]

A village's ordinance which requires a business to obtain a license if it sells any items that are "designed or marketed for use with illegal cannabis or drugs" does not infringe upon the First Amendment rights of a merchandiser of items purported to be regulated by the ordinance, and is not overbroad as inhibiting the First Amendment rights of other parties, even though guidelines interpreting the ordinance utilized the proximity of drug-related literature as an indicium that paraphernalia are "marketed for use with illegal cannabis or drugs" since (1) the ordinance does not restrict speech as such, but simply regulates the commercial marketing of items that the labels reveal may be used for an illicit purpose, (2) insofar as any commercial speech interest is implicated, it is only the attenuated interest in displaying and marketing merchandise in the manner that the retailer desires, and (3) it is irrelevant whether the ordinance has an overbroad scope encompassing protected commercial speech of other persons because the overbreadth doctrine does not apply to commercial speech.

[***LEdHN2]
CORPORATIONS § 37.7
drug paraphernalia ordinance -- vagueness --
Headnote:[2A][2B][2C]

A municipal ordinance which requires a business to obtain a license if it sells any items that are "designed or marketed for use with illegal cannabis or drugs" is not impermissibly vague in all of its applications and therefore may not be challenged on its face as unduly vague in violation of due process as applied to a business engaged in selling drug paraphernalia since (1) the language "designed for use" is not unconstitutionally vague on its face insofar as it is sufficiently clear to cover at least some of the items sold by the business and (2) the language "marketed for use" gives the business ample warning that its marketing activities require a license.

[***LEdHN3]
STATUTES § 26
statute overbreadth and vagueness challenge --
Headnote:[3]

In a facial challenge to the overbreadth and vagueness of a law, a court's first task is to determine whether the enactment reaches a substantial amount of constitutionally protected conduct and if it does not, then the overbreadth challenge must fail; the court should then examine the facial vagueness challenge and, assuming the enactment implicates no constitutionally protected conduct, should uphold the challenge only if the enactment is impermissibly vague in all of its applications since a plaintiff who engages in some conduct that is clearly proscribed cannot complain of the vagueness of the law as applied to the conduct of others, it being necessary for a court to examine the complainant's conduct before analyzing other hypothetical applications of the law.

[***LEdHN4]
COURTS § 810
facial challenge -- state law -- state court construction --
Headnote:[4A][4B]

In evaluating a facial challenge to a state law, a federal court must consider any limiting construction that a state court or state enforcement agency has proffered, and, in making that determination, a court should evaluate the ambiguous as well as the unambiguous scope of the enactment.

[***LEdHN5]
STATUTES § 17
vagueness challenge -- criteria --
Headnote:[5A][5B]

Vagueness challenges to statutes which do not involve First Amendment freedoms must be examined in the light of the facts of the case at hand.

[***LEdHN6]
STATUTES § 26
vagueness challenge -- standing --
Headnote:[6A][6B]

One to whose conduct a statute clearly applies may not successfully challenge it for vagueness, since to sustain such a challenge, the complainant must prove that the enactment is vague not in the sense that it requires a person to conform his conduct to an imprecise but comprehensible normative standard, but rather in the sense that no standard of conduct is specified at all.

[***LEdHN7]
LAW § 954
First Amendment -- commercial speech -- government regulation --
Headnote:[7]

With regard to the protections of the First Amendment on commercial speech, the government may regulate or ban entirely speech proposing an illegal transaction.

[***LEdHN8]
CORPORATIONS § 37.7
STATUTES § 17

constitutional challenge -- over Breadth --
Headnote:[8]

With regard to whether a municipal ordinance is unconstitutional by virtue of having an overbroad scope, the overbreadth doctrine does not apply to commercial speech; however, a law that does not reach constitutionally protected conduct and therefore satisfies the overbreadth doctrine may nevertheless be challenged on its face as unduly vague in violation of due process, although in order to succeed the complainant must demonstrate that the law is impermissibly vague in all of its applications.

[***LEdHN9]
LAW § 710
drug paraphernalia ordinance; substantive due process --
Headnote:[9A][9B]

A retailer's right to sell smoking accessories, and the purchaser's right to buy and use them, are entitled only to minimal due process protection, regulation of items that have some lawful as well as unlawful uses not being an irrational means of discouraging drug use; accordingly, a municipal "drug paraphernalia" ordinance which requires a business to obtain a license if it sells certain items does not constitute a denial of substantive due process on the grounds that it would inhibit innocent users of items covered by the ordinance.

[***LEdHN10]
STATUTES § 33
drug paraphernalia law -- vagueness challenge --
Headnote:[10A][10B]

In the event that a state court should construe a municipal drug paraphernalia licensing ordinance as prohibiting the sale of all pipes, of whatever description, then a seller of corncob pipes could not complain that the law is unduly vague, but could object that the law is not intended to cover such items.

[***LEdHN11]
CORPORATIONS § 37.7
municipal ordinance -- vagueness challenge --
Headnote:[11]

The degree of vagueness that the Federal Constitution tolerates of a municipal ordinance depends in part on the nature of the enactment, and therefore economic regulation is subject to a less strict vagueness test because its subject-matter is often more narrow, and because businesses can be expected to consult relevant legislation in advance of action; perhaps the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of a constitutionally protected right such as, for example, if the law interferes with the right of free speech or of association, a more stringent vagueness test should apply.

[***LEdHN12]
CORPORATIONS § 37.7
vagueness -- standards for enforcement --
Headnote:[12A][12B][12C]

A municipal ordinance regulating the sale of drug paraphernalia which requires a business to obtain a license if it sells any items that are "designed or marketed for use with illegal cannabis or drugs" is not void for vagueness in a preenforcement challenge to it on the grounds that it provides insufficient standards for enforcement, especially where the ordinance is sufficiently clear to overcome the speculative danger of arbitrary enforcement and where the possibility exists that the village enacting the ordinance will take further steps to minimize the dangers of arbitrary enforcement; the theoretical possibility that the village will enforce its ordinance against a paperclip placed next to certain literature is of no due process significance unless the possibility ripens into a prosecution.

[***LEdHN13]
CORPORATIONS § 37.7
facial vagueness -- business regulation --
Headnote:[13]

In reviewing a municipal business regulation for facial vagueness, the principle inquiry is whether the law affords fair warning of what is proscribed.

[***LEdHN14]
COURTS § 123
drug paraphernalia ordinance -- inquiry into wisdom and effectiveness -- Supreme Court --
Headnote:[14]

Whether municipal ordinances regulating or prohibiting the sale of drug paraphernalia are wise or effective is not the province of the United States Supreme Court.

SYLLABUS:

An ordinance of appellant village requires a business to obtain a license if it sells any items that are "designed or marketed for use with illegal cannabis or drugs." Guidelines define the items (such as "roach clips," which are used to smoke cannabis, "pipes," and "paraphernalia"), the sale of which is required to be licensed. Appellee, which sold a variety of merchandise in its store, including "roach clips" and specially designed pipes used to smoke marihuana, upon being noti-

fied that it was in possible violation of the ordinance, brought suit in Federal District Court, claiming that the ordinance is unconstitutionally vague and overbroad, and requesting injunctive and declaratory relief and damages. The District Court upheld the ordinance and awarded judgment to the village defendants. The Court of Appeals reversed on the ground that the ordinance is unconstitutionally vague on its face.

Held: The ordinance is not facially overbroad or vague but is reasonably clear in its application to appellee. Pp. 494-505.

(a) In a facial challenge to the overbreadth and vagueness of an enactment, a court must first determine whether the enactment reaches a substantial amount of constitutionally protected conduct. If it does not, the overbreadth challenge must fail. The court should then examine the facial vagueness challenge and should uphold such challenge only if the enactment is impermissibly vague in all of its applications. Pp. 494-495.

(b) The ordinance here does not violate appellee's First Amendment rights nor is it overbroad because it inhibits such rights of other parties. The ordinance does not restrict speech as such but simply regulates the commercial marketing of items that the labels reveal may be used for an illicit purpose and thus does not embrace noncommercial speech. With respect to any commercial speech interest implicated, the ordinance's restriction on the manner of marketing does not appreciably limit appellee's communication of information, except to the extent it is directed at commercial activity promoting or encouraging illegal drug use, an activity which, if deemed "speech," is speech proposing an illegal transaction and thus subject to government regulation or ban. It is irrelevant whether the ordinance has an overbroad scope encompassing other persons' commercial speech, since the overbreadth doctrine does not apply to commercial speech. Pp. 495-497.

(c) With respect to the facial vagueness challenge, appellee has not shown that the ordinance is impermissibly vague in all of its applications. The ordinance's language "designed . . . for use" is not unconstitutionally vague on its face, since it is clear that such standard encompasses at least an item that is principally used with illegal drugs by virtue of its objective features, *i. e.*, features designed by the manufacturer. Thus, the "designed for use" standard is sufficiently clear to cover at least some of the items that appellee sold, such as "roach clips" and the specially designed pipes. As to the "marketed for use" standard, the guidelines refer to the display of paraphernalia and to the proximity of covered items to otherwise uncovered items, and thus such standard requires scienter on the part of the retailer. Under this test, appellee had ample warning that its marketing activities required a license, and by displaying a certain magazine and certain books dealing with illegal drugs physically close to pipes and colored rolling paper, it was in clear violation of the guidelines, as it was in selling "roach clips." Pp. 499-503.

(d) The ordinance's language is sufficiently clear that the speculative danger of arbitrary enforcement does not render it void for vagueness in a pre-enforcement facial challenge. Pp. 503-504.

COUNSEL:

Richard N. Williams argued the cause and filed briefs for appellants.

Michael L. Pritzker argued the cause and filed a brief for appellee. *

* Ronald A. Zumbrun and John H. Findley filed a brief for Community Action Against Drug Abuse as amicus curiae urging reversal.

Charles A. Trost filed a brief for American Businesses for Constitutional Rights as amicus curiae urging affirmance.

Briefs of amici curiae were filed for the State of Arkansas et al. by Steve Clark, Attorney General of Arkansas, J. D. MacFarlane, Attorney General of Colorado, Carl R. Ajello, Attorney General of Connecticut, Richard S. Gebelein, Attorney General of Delaware, Jim Smith, Attorney General of Florida, and Mitchell D. Franks, David H. Leroy, Attorney General of Idaho, Linley E. Pearson, Attorney General of Indiana, Robert T. Stephan, Attorney General of Kansas, William J. Guste, Jr., Attorney General of Louisiana, James E. Tierney, Attorney General of Maine, Stephen H. Sachs, Attorney General of Maryland, and Paul F. Strain, Dennis M. Sweeney, and Linda H. Lamone, Assistant Attorneys General, Paul L. Douglas, Attorney General of Nebraska, Richard H. Bryan, Attorney General of Nevada, James R. Zazzali, Attorney General of New Jersey, Jeff Bingaman, Attorney General of New Mexico, Rufus L. Edmisten, Attorney General of North Carolina, and David S. Crump and James L. Wallace, Jr., Deputy Attorneys General, Jan Eric Cartwright, Attorney General of Oklahoma, Leroy S. Zimmerman, Attorney General of Pennsylvania, Mark White, Attorney General of Texas, David L. Wilkinson, Attorney General of Utah, and Kenneth O. Eikenberry, Attorney General of Washington; and for the Village of Wilmette, Illinois, by Robert J. Mangler.

JUDGES:

MARSHALL, J., delivered the opinion of the Court, in which BURGER, C. J., and BRENNAN, BLACKMUN, POWELL, REHNQUIST, and O'CONNOR, JJ., joined. WHITE, J., filed an opinion concurring in the judgment, post, p. 507. STEVENS, J., took no part in the consideration or decision of the case.

OPINION BY:

MARSHALL

OPINION:

[*491] [***367] [**1189] JUSTICE MARSHALL delivered the opinion of the Court.

[***LEdHR1A] [1A] [***LEdHR2A] [2A]This case presents a pre-enforcement facial challenge to a drug paraphernalia ordinance on the ground that it is unconstitutionally vague and overbroad. The ordinance in question requires a business to obtain a license if it sells any items that are "designed or marketed for use with illegal cannabis or drugs." Village of Hoffman Estates Ordinance No. 969-1978. The United States Court of Appeals for the Seventh Circuit held that the ordinance is vague on its face. *639 F.2d 373 (1981).* We noted probable jurisdiction, *452 U.S. 904 (1981),* and now reverse.

I

For more than three years prior to May 1, 1978, appellee The Flipside, Hoffman Estates, Inc. (Flipside), sold a variety of merchandise, including phonographic records, smoking accessories, novelty devices, and jewelry, in its store located in the [**1190] village of Hoffman Estates, Ill. (village). n1 On February [*492] 20, 1978, the village enacted an ordinance regulating drug paraphernalia, to be effective May 1, 1978. n2 The ordinance makes it unlawful for any person "to sell any items, effect, paraphernalia, accessory or thing which is designed or marketed for use with illegal cannabis or drugs, as defined by Illinois Revised Statutes, without obtaining a license therefor." The license fee is $ 150. A business must also file affidavits that the licensee and its employees have not been convicted of a drug-related offense. Moreover, the business must keep a record of each sale of a regulated item, including the name and address of the [***368] purchaser, to be open to police inspection. No regulated item may be sold to a minor. A violation is subject to a fine of not less than $ 10 and not more than $ 500, and each day that a violation continues gives rise to a separate offense. A series of licensing guidelines prepared by the Village Attorney define "Paper," "Roach Clips," "Pipes," and "Paraphernalia," the sale of which is required to be licensed. n3

n1 More specifically, the District Court found:

"[Flipside] sold literature that included 'A Child's Garden of Grass,' 'Marijuana Grower's Guide,' and magazines such as 'National Lampoon,' 'Rolling Stone,' and 'High Times.' The novelty devices and tobacco-use related items plaintiff displayed and sold in its store ranged from small commodities such as clamps, chain ornaments and earrings through cigarette holders, scales, pipes of various types and sizes, to large water pipes, some designed for individual use, some which as many as four persons can use with flexible plastic tubes. Plaintiff also sold a large number of cigarette rolling papers in a variety of colors. One of plaintiff's displayed items was a mirror, about seven by nine inches with the word 'Cocaine' painted on its surface in a purple color. Plaintiff sold cigarette holders, 'alligator clips,' herb sifters, vials, and a variety of tobacco snuff." *485 F.Supp. 400, 403 (ND Ill. 1980).*

n2 The text of the ordinance is set forth in the Appendix to this opinion.

n3 The guidelines provide:

"LICENSE GUIDELINES FOR ITEMS, EFFECT, PARAPHERNALIA, ACCESSORY OR THING WHICH IS DESIGNED OR MARKETED FOR USE WITH ILLEGAL CANNABIS OR DRUGS

"Paper -- white paper or tobacco oriented paper not necessarily designed for use with illegal cannabis or drugs may be displayed. Other paper of colorful design, names oriented for use with illegal cannabis or drugs and displayed are covered.

"Roach Clips -- designed for use with illegal cannabis or drugs and therefore covered.

"Pipes -- if displayed away from the proximity of nonwhite paper or tobacco oriented paper, and not displayed within proximity of roach clips, or literature encouraging illegal use of cannabis or illegal drugs are not covered; otherwise, covered.

"Paraphernalia -- if displayed with roach clips or literature encouraging illegal use of cannabis or illegal drugs it is covered."

[*493] After an administrative inquiry, the village determined that Flipside and one other store appeared to be in violation of the ordinance. The Village Attorney notified Flipside of the existence of the ordinance, and made a copy of the ordinance and guidelines available to Flipside. Flipside's owner asked for guidance concerning which items were covered by the ordinance; the Village Attorney advised him to remove items in a certain section of the store "for his protection," and he did so. App. 71. The items included, according to Flipside's description, a clamp, chain ornaments, an "alligator" clip, key chains, necklaces, earrings, cigarette holders, glove stretchers, scales, strainers, a pulverizer, squeeze bottles, pipes, water pipes, pins, an herb sifter, mirrors, vials, cigarette rolling papers, and tobacco snuff. On May 30, 1978, instead of applying for a license or seeking clarification via the administrative procedures that the village had established for its licensing ordinances, n4 Flipside filed this lawsuit in the United States District Court for the Northern District of Illinois.

n4 Ordinance No. 932-1977, the Hoffman Estates Administrative Procedure Ordinance, was enacted prior to the drug paraphernalia ordinance, and provides that an interested person may petition for the adoption of an interpretive rule. If the petition is denied, the person may place the matter on the agenda of an appropriate village committee for review. The Village Attorney indicated that no interpretive rules had been adopted with respect to the drug paraphernalia ordinance because no one had yet applied for a license. App. 68.

[**1191] The complaint alleged, *inter alia*, that the ordinance is unconstitutionally vague and overbroad, and requested injunctive and declaratory relief and damages. The District Court, after hearing testimony, declined to grant a preliminary injunction. The case was tried without a jury on additional evidence and stipulated testimony. The court issued [*494] an opinion upholding the constitutionality of the ordinance, and awarded judgment to the village defendants. *485 F.Supp. 400 (1980).*

The Court of Appeals reversed on the ground that the ordinance is unconstitutionally vague on its face. The court reviewed the language of the ordinance and guidelines and found it vague with respect to certain conceivable applications, such [***369] as ordinary pipes or "paper clips sold next to *Rolling Stone* magazine." *639 F.2d, at 382.* It also suggested that the "subjective" nature of the "marketing" test creates a danger of arbitrary and discriminatory enforcement against those with alternative lifestyles. *Id., at 384.* Finally, the court determined that the availability of administrative review or guidelines cannot cure the defect. Thus, it concluded that the ordinance is impermissibly vague on its face.

II

[***LEdHR3] [3] [***LEdHR4A] [4A] [***LEdHR5A] [5A] [***LEdHR6A] [6A]In a facial challenge to the overbreadth and vagueness of a law, n5 a court's first task is to determine whether the enactment reaches a substantial amount of constitutionally protected conduct. n6 If it does not, then the overbreadth challenge must fail. The court should then examine the facial vagueness challenge and, assuming the enactment implicates [*495] no constitutionally protected conduct, should uphold the challenge only if the enactment is impermissibly vague in all of its applications. A plaintiff who engages in some conduct that is clearly proscribed cannot complain of the vagueness of the law as applied to the conduct of others. n7 A court should therefore examine the complainant's conduct before analyzing other hypothetical applications of the law.

[***LEdHR4B] [4B]

n5 A "facial" challenge, in this context, means a claim that the law is "invalid *in toto* -- and therefore incapable of any valid application." *Steffel v. Thompson, 415 U.S. 452, 474 (1974).* In evaluating a facial challenge to a state law, a federal court must, of course, consider any limiting construction that a state court or enforcement agency has proffered. *Grayned v. City of Rockford, 408 U.S. 104, 110 (1972).*

n6 In making that determination, a court should evaluate the ambiguous as well as the unambiguous scope of the enactment. To this extent, the vagueness of a law affects overbreadth analysis. The Court has long recognized that ambiguous meanings cause citizens to "'steer far wider of the unlawful zone' . . . than if the boundaries of the forbidden areas were clearly marked." *Baggett v. Bullitt, 377 U.S. 360, 372 (1964),* quoting *Speiser v. Randall, 357 U.S. 513, 526 (1958);* see *Grayned, supra, at 109;* cf. *Young v. American Mini Theatres, Inc., 427 U.S. 50, 58-61 (1976).*

[***LEdHR5B] [5B] [***LEdHR6B] [6B]

n7 "[Vagueness] challenges to statutes which do not involve First Amendment freedoms must be examined in the light of the facts of the case at hand." *United States v. Mazurie, 419 U.S. 544, 550 (1975).* See *United States v. Powell, 423 U.S. 87, 92-93 (1975); United States v. National Dairy Products Corp., 372 U.S. 29, 32-33, 36 (1963).* "One to whose conduct a statute clearly applies may not successfully challenge it for vagueness." *Parker v. Levy, 417 U.S. 733, 756 (1974).* The rationale is evident: to sustain such a challenge, the complainant must prove that the enactment is vague "'not in the sense that it requires a person to conform his conduct to an imprecise but comprehensible normative standard, but rather in the sense that no standard of conduct is specified at all.' *Coates v. City of Cincinnati, 402 U.S. 611, 614 (1971).* Such a provision simply has *no* core." *Smith v. Goguen, 415 U.S. 566, 578 (1974).*

The Court of Appeals in this case did not explicitly consider whether the ordinance reaches constitutionally protected conduct and is overbroad, nor whether the ordinance is vague in all of its applications. Instead, the court determined that the ordinance is void for vagueness because it is unclear in *some* of its applications to the [**1192] conduct of Flipside and of other hypothetical parties. [***370] Under a proper analysis, however, the ordinance is not facially invalid.

III

[***LEdHR1B] [1B]We first examine whether the ordinance infringes Flipside's First Amendment rights or is overbroad because it inhibits the First Amendment rights of other parties. Flipside makes the exorbitant claim that the village has imposed a "prior restraint" on speech because the guidelines treat the proximity of drug-related literature as an indicium that paraphernalia are "marketed for use with illegal cannabis or [*496] drugs." Flipside also argues that because the presence of drug-related designs, logos, or slogans on paraphernalia may trigger enforcement, the ordinance infringes "protected symbolic speech." Brief for Appellee 25.

These arguments do not long detain us. First, the village has not directly infringed the noncommercial speech of Flipside or other parties. The ordinance licenses and regulates the sale of items displayed "with" or "within proximity of" "literature encouraging illegal use of cannabis or illegal drugs," Guidelines, *supra* n. 3, but does not prohibit or otherwise regulate the sale of literature itself. Although drug-related designs or names on cigarette papers may subject those items to regulation, the village does not restrict speech as such, but simply regulates the commercial marketing of items that the labels reveal may be used for an illicit purpose. The scope of the ordinance therefore does not embrace noncommercial speech.

[***LEdHR7] [7] [***LEdHR8] [8] [***LEdHR9A] [9A] [***LEdHR10A] [10A]Second, insofar as any *commercial* speech interest is implicated here, it is only the attenuated interest in displaying and marketing merchandise in the manner that the retailer desires. We doubt that the village's restriction on the manner of marketing appreciably limits Flipside's communication of information n8 -- with one obvious and telling exception. The ordinance is expressly directed at commercial activity promoting or encouraging illegal drug use. If that activity is deemed "speech," then it is speech proposing an illegal transaction, which a government may regulate or ban entirely. *Central Hudson Gas & Electric Corp.* v. *Public Service Comm'n, 447 U.S. 557, 563-564 (1980); Pittsburgh Press Co.* v. *Human Relations Comm'n, 413 U.S. 376, 388 (1973).* Finally, it is irrelevant whether the ordinance has an [*497] overbroad scope encompassing protected commercial speech of other persons, because the overbreadth doctrine does not apply to commercial speech. *Central Hudson, supra*, at 565, n. 8. n9

n8 Flipside explained that it placed items that the village considers drug paraphernalia in locations near a checkout counter because some are "point of purchase" items and others are small and apt to be shoplifted. App. 43. Flipside did not assert that its manner of placement was motivated in any part by a desire to communicate information to its customers.

[***LEdHR9B] [9B] [***LEdHR10B] [10B]

n9 Flipside also argues that the ordinance is "overbroad" because it could extend to "innocent" and "lawful" uses of items as well as uses with illegal drugs. Brief for Appellee 10, 33-35. This argument seems to confuse vagueness and overbreadth doctrines. If Flipside is objecting that it cannot determine whether the ordinance regulates items with some lawful uses, then it is complaining of vagueness. We find that claim unpersuasive in this pre-enforcement facial challenge. See *infra*, at 497-504. If Flipside is objecting that the ordinance would inhibit innocent uses of items found to be covered by the ordinance, it is complaining of denial of substantive due process. The latter claim obviously lacks merit. A re-

tailer's right to sell smoking accessories, and a purchaser's right to buy and use them, are entitled only to minimal due process protection. Here, the village presented evidence of illegal drug use in the community. App. 37. Regulation of items that have some lawful as well as unlawful uses is not an irrational means of discouraging drug use. See *Exxon Corp.* v. *Governor of Maryland, 437 U.S. 117, 124-125 (1978)*.The hostility of some lower courts to drug paraphernalia laws -- and particularly to those regulating the sale of items that have many innocent uses, see, *e. g., 639 F.2d 373, 381-383 (1981); Record Revolution No. 6, Inc.* v. *City of Parma, 638 F.2d 916, 928 (CA6 1980),* vacated and remanded, *451 U.S. 1013 (1981)* -- may reflect a belief that these measures are ineffective in stemming illegal drug use. This perceived defect, however, is not a defect of clarity. In the unlikely event that a state court construed this ordinance as prohibiting the sale of all pipes, of whatever description, then a seller of corncob pipes could not complain that the law is unduly vague. He could, of course, object that the law was not intended to cover such items.

[***371] [**1193] IV

A

[***LEdHR2B] [2B]A law that does not reach constitutionally protected conduct and therefore satisfies the overbreadth test may nevertheless be challenged on its face as unduly vague, in violation of due process. To succeed, however, the complainant must demonstrate that the law is impermissibly vague in all of its applications. Flipside makes no such showing.

[*498] The standards for evaluating vagueness were enunciated in *Grayned v. City of Rockford, 408 U.S. 104, 108-109 (1972):*

"Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory applications" (footnotes omitted).

[***LEdHR11] [11]These standards should not, of course, be mechanically applied. The degree of vagueness that the Constitution tolerates -- as well as the relative importance of fair notice and fair enforcement -- depends in part on the nature of the enactment. Thus, economic regulation is subject to a less strict vagueness test because its subject matter is often more narrow, n10 and because businesses, which face economic demands to plan behavior carefully, can be expected to consult relevant legislation in advance of action. n11 Indeed, the regulated enterprise may have the ability [***372] to clarify the meaning of the regulation by its own inquiry, or by resort to an administrative process. n12 The Court has also expressed greater tolerance of [*499] enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe. n13 And the Court has recognized that a scienter requirement may mitigate a law's vagueness, especially with respect to the adequacy of notice to the complainant that his conduct is proscribed. n14

n10 *Papachristou v. City of Jacksonville, 405 U.S. 156, 162 (1972)* (dictum; collecting cases).

n11 See, *e. g., United States v. National Dairy Products Corp., 372 U.S. 29 (1963).* Cf. *Smith v. Goguen, 415 U.S., at 574.*

n12 See *Joseph E. Seagram & Sons, Inc.* v. *Hostetter, 384 U.S. 35, 49 (1966); McGowan v. Maryland, 366 U.S. 420, 428 (1961).*

n13 See *Barenblatt v. United States, 360 U.S. 109, 137 (1959)* (Black, J., with whom Warren, C. J., and Douglas, J., joined, dissenting); *Winters v. New York, 333 U.S. 507, 515 (1948).*

n14 See, *e. g., Colautti v. Franklin, 439 U.S. 379, 395 (1979); Boyce Motor Lines v. United States, 342 U.S. 337, 342 (1952); Screws v. United States, 325 U.S. 91, 101-103 (1945)* (plurality opinion). See Note, The Void-for-Vagueness Doctrine in the Supreme Court, *109 U. Pa. L. Rev. 67, 87, n. 98 (1960).*

Finally, perhaps the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of constitutionally protected rights. If, for example, the law interferes with the right of free speech [**1194] or of asso-

ciation, a more stringent vagueness test should apply. n15

n15 See, *e. g., Papachristou, supra; Grayned, 408 U.S., at 109.*

B

[***LEdHR2C] [2C]This ordinance simply regulates business behavior and contains a scienter requirement with respect to the alternative "marketed for use" standard. The ordinance nominally imposes only civil penalties. However, the village concedes that the ordinance is "quasi-criminal," and its prohibitory and stigmatizing effect may warrant a relatively strict test. n16 [*500] Flipside's facial challenge fails because, under the test appropriate to either a quasi-criminal or a criminal law, the ordinance is sufficiently clear as applied to Flipside.

n16 The village stipulated that the purpose of the ordinance is to discourage use of the regulated items. App. 33. Moreover, the prohibitory and stigmatizing effects of the ordinance are clear. As the Court of Appeals remarked, "few retailers are willing to brand themselves as sellers of drug paraphernalia, and few customers will buy items with the condition of signing their names and addresses to a register available to the police." *639 F.2d, at 377.* The proposed register is entitled, "Retail Record for Items Designed or Marketed for Use with Illegal Cannabis or Drugs." Record, Complaint, App. B. At argument, counsel for the village admitted that the ordinance is "quasi-criminal." Tr. of Oral Arg. 4-5.

The ordinance requires Flipside to obtain a license if it sells "any items, effect, paraphernalia, accessory or thing which is designed or marketed for use with illegal cannabis or drugs, as defined by the Illinois Revised Statutes." Flipside expresses no uncertainty about which drugs this description encompasses; as the District Court noted, *485 F.Supp., at 406,* Illinois law clearly defines cannabis and numerous other controlled drugs, including cocaine. Ill. Rev. Stat., ch. 56 1/2, paras. 703 and 1102(g) (1980). On the other hand, the words "items, effect, paraphernalia, accessory or thing" do not identify the type of merchandise that the village [***373] desires to regulate. n17 Flipside's challenge thus appropriately focuses on the language "designed or marketed for use." Under either the "designed for use" or "marketed for use" standard, we conclude that at least some of the items sold by Flipside are covered. Thus, Flipside's facial challenge is unavailing.

n17 The District Court apparently relied principally on the growing vernacular understanding of "paraphernalia" as drug-related items, and therefore did not separately analyze the meaning of "designed or marketed for use." *485 F.Supp., at 405-407.* We agree with the Court of Appeals that a regulation of "paraphernalia" alone would not provide much warning of the nature of the items regulated. *639 F.2d, at 380.*

1. "Designed for use"

The Court of Appeals objected that "designed . . . for use" is ambiguous with respect to whether items must be inherently suited only for drug use; whether the retailer's intent or manner of display is relevant; and whether the intent of a third party, the manufacturer, is critical, since the manufacturer is the "designer." *639 F.2d, at 380-381.* For the reasons that follow, we conclude that this language is not unconstitutionally vague on its face.

The Court of Appeals' speculation about the meaning of "design" is largely unfounded. The guidelines refer to "paper [*501] of colorful design" and to other specific items as conclusively "designed" or not "designed" for illegal use. n18 A principal meaning [**1195] of "design" is "[to] fashion according to a plan." Webster's New International Dictionary of the English Language 707 (2d ed. 1957). Cf. *Lanzetta v. New Jersey, 306 U.S. 451, 454, n. 3 (1939).* It is therefore plain that the standard encompasses at least an item that is principally used with illegal drugs by virtue of its objective features, *i. e.*, features designed by the manufacturer. A business person of ordinary intelligence would understand that this term refers to the design of the manufacturer, not the intent of the retailer or customer. It is also sufficiently clear that items which are principally used for nondrug purposes, such as ordinary pipes, are not "designed for use" with illegal drugs. Moreover, no issue of fair warning is present in this case, since Flipside concedes that the phrase refers to structural characteristics of an item. n19

n18 The guidelines explicitly provide that "white paper . . . may be displayed," and that "Roach Clips" are "designed for use with illegal cannabis or drugs *and therefore* covered" (emphasis added). The Court of Appeals criticized the latter definition for failing to explain what a "roach clip" is. This criticism is unfounded because that technical term has sufficiently clear meaning in the drug paraphernalia industry. Without undue burden, Flipside could easily de-

termine the meaning of the term. See American Heritage Dictionary of the English Language 1122 (1980) (defining "roach" as "[the] butt of a marijuana cigarette"); R. Lingeman, Drugs from A to Z: A Dictionary 213-214 (1969) (defining "roach" and "roach holder"). Moreover, the explanation that a retailer may display certain paper "not necessarily designed for use" clarifies that the ordinance at least embraces items that are necessarily designed for use with cannabis or illegal drugs.

n19 "It is readily apparent that under the Hoffman Estates scheme, the 'designed for use' phrase refers to the physical characteristics of items deemed *per se* fashioned for use with drugs; and that, if any intentional conduct is implicated by the phrase, it is the intent of the 'designer' (i. e. patent holder or manufacturer) whose intent for an item or 'design' is absorbed into the physical attributes, or structural 'design' of the finished product." Brief for Appellee 42-43. Moreover, the village President described drug paraphernalia as items *"[manufactured]* for that purpose and marketed for that purpose." App. 82 (emphasis added).

[*502] The [***374] ordinance and guidelines do contain ambiguities. Nevertheless, the "designed for use" standard is sufficiently clear to cover at least some of the items that Flipside sold. The ordinance, through the guidelines, explicitly regulates "roach clips." Flipside's co-operator admitted that the store sold such items, see Tr. 26, 30, and the village Chief of Police testified that he had never seen a "roach clip" used for any purpose other than to smoke cannabis. App. 52. The Chief also testified that a specially designed pipe that Flipside marketed is typically used to smoke marihuana. *Ibid.* Whether further guidelines, administrative rules, or enforcement policy will clarify the more ambiguous scope of the standard in other respects is of no concern in this facial challenge.

2. "Marketed for use"

Whatever ambiguities the "designed . . . for use" standard may engender, the alternative "marketed for use" standard is transparently clear: it describes a retailer's intentional display and marketing of merchandise. The guidelines refer to the display of paraphernalia, and to the proximity of covered items to otherwise uncovered items. A retail store therefore must obtain a license if it deliberately displays its wares in a manner that appeals to or encourages illegal drug use. The standard requires scienter, since a retailer could scarcely "market" items "for" a particular use without intending that use.

Under this test, Flipside had ample warning that its marketing activities required a license. Flipside displayed the magazine High Times and books entitled Marijuana Grower's Guide, Children's Garden of Grass, and The Pleasures of Cocaine, physically close to pipes and colored rolling papers, in clear violation of the guidelines. As noted above, Flipside's co-operator admitted that his store sold "roach clips," which are principally used for illegal purposes. Finally, in the [*503] same section of the store, Flipside had posted the sign, "You must be 18 or older to purchase any head supplies." n20 Tr. 30.

n20 The American Heritage Dictionary of the English Language 606 (1980) gives the following alternative definition of "head": "Slang. One who is a frequent user of drugs."

V

[***LEdHR12A] [12A] [***LEdHR13] [13]The Court of Appeals also held that the ordinance provides insufficient standards for enforcement. Specifically, the court feared that the ordinance might be used to harass individuals with alternative lifestyles and views. *639 F.2d, at 384.* In reviewing a business regulation for facial vagueness, however, the principal inquiry is whether the law affords fair warning [**1196] of what is proscribed. Moreover, this emphasis is almost inescapable in reviewing a pre-enforcement challenge to a law. Here, no evidence has been, or could be, introduced to indicate whether the ordinance has been enforced in a discriminatory manner or with the aim of inhibiting unpopular speech. The language of the ordinance is sufficiently clear that the speculative danger of arbitrary enforcement does not render the ordinance void for vagueness. Cf. *Papachristou v. City of Jacksonville, 405 U.S. 156, 168-171* [***375] *(1972); Coates v. City of Cincinnati, 402 U.S. 611, 614 (1971).*

[***LEdHR12B] [12B]We do not suggest that the risk of discriminatory enforcement is insignificant here. Testimony of the Village Attorney who drafted the ordinance, the village President, and the Police Chief revealed confusion over whether the ordinance applies to certain items, as well as extensive reliance on the "judgment" of police officers to give meaning to the ordinance and to enforce it fairly. At this stage, however, we are not prepared to hold that this risk jeopardizes the entire ordinance. n21

[***LEdHR12C] [12C]

n21 The theoretical possibility that thevillage will enforce its ordinance against a paper clip placed next to Rolling Stone magazine, *639 F.2d, at 382,* is of no due process significance unless the possibility ripens into a prosecution.

[*504] Nor do we assume that the village will take no further steps to minimize the dangers of arbitrary enforcement. The village may adopt administrative regulations that will sufficiently narrow potentially vague or arbitrary interpretations of the ordinance. In economic regulation especially, such administrative regulation will often suffice to clarify a standard with an otherwise uncertain scope. We also find it significant that the village, in testimony below, primarily relied on the "marketing" aspect of the standard, which does not require the more ambiguous item-by-item analysis of whether paraphernalia are "designed for" illegal drug use, and which therefore presents a lesser risk of discriminatory enforcement. "Although it is possible that specific future applications . . . may engender concrete problems of constitutional dimension, it will be time enough to consider any such problems when they arise." *Joseph E. Seagram & Sons, Inc.* v. *Hostetter, 384 U.S. 35, 52 (1966).* n22

n22 The Court of Appeals also referred to potential Fourth Amendment problems resulting from the recordkeeping requirement, which "implies that a customer who purchases an item 'designed or marketed for use with illegal cannabis or drugs' intends to *use* the item with illegal cannabis or drugs. A further implication could be that a customer is subject to police scrutiny or even to a search warrant on the basis of the purchase of a legal item." *Id.*, at 384. We will not address these Fourth Amendment issues here. In a pre-enforcement challenge it is difficult to determine whether Fourth Amendment rights are seriously threatened. Flipside offered no evidence of a concrete threat below. In a postenforcement proceeding Flipside may attempt to demonstrate that the ordinance is being employed in such an unconstitutional manner, and that it has standing to raise the objection. It is appropriate to defer resolution of these problems until such a showing is made.

VI

[***LEdHR14] [14]Many American communities have recently enacted laws regulating or prohibiting the sale of drug paraphernalia. [*505] To determine whether these laws are wise or effective is not, of course, the province of this Court. See *Ferguson v. Skrupa, 372 U.S. 726, 728-730 (1963).* We hold only that such legislation is not facially overbroad or vague if it does not reach constitutionally protected conduct and is reasonably clear in its application to the complainant.

Accordingly, the judgment of the Court of Appeals is reversed, and the case is remanded for further proceedings [***376] consistent with this opinion.

It is so ordered.

JUSTICE STEVENS took no part in the consideration or decision of this case.

[**1197] APPENDIX TO OPINION OF THE COURT

Village of Hoffman Estates Ordinance No. 969-1978

AN ORDINANCE AMENDING THE MUNICIPAL CODE OF THE VILLAGE OF HOFFMAN ESTATES BY PROVIDING FOR REGULATION OF ITEMS DESIGNED OR MARKETED FOR USE WITH ILLEGAL CANNABIS OR DRUGS

WHEREAS, certain items designed or marketed for use with illegal drugs are being retailed within the Village of Hoffman Estates, Cook County, Illinois, and

WHEREAS, it is recognized that such items are legal retail items and that their sale cannot be banned, and

WHEREAS, there is evidence that these items are designed or marketed for use with illegal cannabis or drugs and it is in the best interests of the health, safety and welfare of the citizens of the Village of Hoffman Estates to regulate within the Village the sale of items designed or marketed for use with illegal cannabis or drugs.

NOW THEREFORE, BE IT ORDAINED by the President and Board of Trustees of the Village of Hoffman Estates, Cook County, Illinois as follows:

[*506] *Section 1*: That the Hoffman Estates Municipal Code be amended by adding thereto an additional Section, Section 8-7-16, which additional section shall read as follows:

Sec. 8-7-16 -- ITEMS DESIGNED OR MARKETED FOR USE WITH ILLEGAL CANNABIS OR DRUGS

A. License Required:

It shall be unlawful for any person or persons as principal, clerk, agent or servant to sell any items, effect, paraphernalia, accessory or thing which is designed or

marketed for use with illegal cannabis or drugs, as defined by Illinois Revised Statutes, without obtaining a license therefor. Such licenses shall be in addition to any or all other licenses held by applicant.

B. Application:

Application to sell any item, effect, paraphernalia, accessory or thing which is designed or marketed for use with illegal cannabis or drugs shall, in addition to requirements of Article 8-1, be accompanied by affidavits by applicant and each and every employee authorized to sell such items that such person has never been convicted of a drug-related offense.

C. Minors:

It shall be unlawful to sell or give items as described in Section 8-7-16A in any form to any male or female child under eighteen years of age.

D. Records:

Every licensee must keep a record of every item, effect, paraphernalia, accessory or thing which is designed or marketed for use with illegal cannabis or drugs which is sold and this record shall be open [***377] to the inspection of any police officer at any time during the hours of business. Such record shall contain the name and address of the purchaser, the name and quantity of the product, the date and time of the sale, and the licensee or agent of the licensee's signature, such records shall be retained for not less than two (2) years.

[*507] E. Regulations:

The applicant shall comply with all applicable regulations of the Department of Health Services and the Police Department.

Section 2: That the Hoffman Estates Municipal Code be amended by adding to Sec. 8-2-1 Fees: Merchants (Products) the additional language as follows:

Items designed or marketed for use with illegal cannabis or drugs $ 150.00

Section 3: Penalty. Any person violating any provision of this ordinance shall be fined not less than ten dollars ($ 10.00) nor more than five hundred dollars ($ 500.00) for the first offense and succeeding offenses during the same calendar year, and each day that such violation shall continue shall be deemed a separate and distinct offense.

[**1198] *Section 4*: That the Village Clerk be and is hereby authorized to publish this ordinance in pamphlet form.

Section 5: That this ordinance shall be in full force and effect May 1, 1978, after its passage, approval and publication according to law.

CONCUR BY:

WHITE

CONCUR:

JUSTICE WHITE, concurring in the judgment.

I agree that the judgment of the Court of Appeals must be reversed. I do not, however, believe it necessary to discuss the overbreadth problem in order to reach this result. The Court of Appeals held the ordinance to be void for vagueness; it did not discuss any problem of overbreadth. That opinion should be reversed simply because it erred in its analysis of the vagueness problem presented by the ordinance.

I agree with the majority that a facial vagueness challenge to an economic regulation must demonstrate that "the enactment is impermissibly vague in all of its applications." *Ante*, at 495. I also agree with the majority's statement that the "marketed for use" standard in the ordinance is "sufficiently clear." There is, in my view, no need to go any further: If it [*508] is "transparently clear" that some particular conduct is restricted by the ordinance, the ordinance survives a facial challenge on vagueness grounds.

Technically, overbreadth is a standing doctrine that permits parties in cases involving First Amendment challenges to government restrictions on noncommercial speech to argue that the regulation is invalid because of its effect on the First Amendment rights of others not presently before the Court. *Broadrick v. Oklahoma, 413 U.S. 601, 612-615 (1973)*. Whether the appellee may make use of the overbreadth doctrine depends, in the first instance, on whether or not it has a colorable claim that the ordinance infringes on constitutionally protected, [***378] noncommercial speech of others. Although appellee claims that the ordinance does have such an effect, that argument is tenuous at best and should be left to the lower courts for an initial determination.

Accordingly, I concur in the judgment reversing the decision below.

REFERENCES: Return To Full Text Opinion

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16 Am Jur 2d, Constitutional Law 522; *56 Am Jur 2d, Municipal Corporations, Counties, and Other Political Subdivisions 367*

USCS, Constitution, 1st Amendment

US L Ed Digest, Constitutional Law 952, 954; Municipal Corporations 37.7

L Ed Index to Annos, Freedom of Speech, Press, Religion and Assembly; Licenses and License Taxes; Municipal Corporations

ALR Quick Index, Freedom of Speech and Press; Licenses and Permits; Municipal Corporations

Federal Quick Index, Freedom of Speech and Press; Licenses and Permits; Municipal Corporations

Annotation References:

Supreme Court's views as to overbreadth of legislation in connection with First Amendment rights. *45 L Ed 2d 725.*

Supreme Court's application of vagueness doctrine to noncriminal statutes or ordinances . *40 L Ed 2d 823.*

Exhibit B

LEXSEE 514 US 87

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER v. GUERNSEY MEMORIAL HOSPITAL

No. 93-1251

SUPREME COURT OF THE UNITED STATES

514 U.S. 87; 115 S. Ct. 1232; 131 L. Ed. 2d 106; 1995 U.S. LEXIS 1808; 63 U.S.L.W. 4205; 95 Cal. Daily Op. Service 1666

October 31, 1994, Argued
March 6, 1995, Decided

PRIOR HISTORY: ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT.

DISPOSITION: *996 F.2d 830,* reversed.

DECISION:

Secretary of Health and Human Services held to have properly required that hospital's Medicare reimbursement for defeasance loss from refinancing with new bonds be amortized over life of old bonds.

SUMMARY:

The refinancing of a hospital's bonded debt with new bonds resulted in a loss, for accounting purposes, of the type which is sometimes referred to as an advance refunding or defeasance loss. With respect to the Medicare reimbursement for the part of the loss for which the hospital determined that the hospital was entitled to reimbursement, the hospital contended that it was entitled to full reimbursement in the year of the refinancing, while the Secretary of Health and Human Services--in accordance with an informal Medicare reimbursement guideline that did not purport to be a regulation and had not been adopted pursuant to the notice-and-comment procedures of the Administrative Procedure Act (APA) *(5 USCS 551* et seq.)--contended that the loss had to be amortized over the life of the old bonds. After a fiscal intermediary determined, based on the guideline, that the loss had to be amortized and the Provider Reimbursement Review Board disagreed with the intermediary, the Administrator of the Health Care Financing Administration reversed the Board's decision. The United States District Court for the Southern District of Ohio sustained the Secretary's position *(796 F Supp 283).* The United States Court of Appeals for the Sixth Circuit (1) expressed the view that because the guideline departed from the generally accepted accounting principles (GAAP) that were determined by the Court of Appeals to be required under a Medicare regulation, *42 CFR 413.20(a),* with respect to reimbursement, the guideline effected a substantive change in the regulations and was void by reason of the Secretary's failure to issue the guideline in accordance with the APA's notice-and-comment procedures; and (2) reversed the District Court's judgment *(996 F2d 830).*

On certiorari, the United States Supreme Court reversed. In an opinion by Kennedy, J., joined by Rehnquist, Ch. J., and Stevens, Ginsburg, and Breyer, JJ., it was held that the Secretary's requirement, that for reimbursement purposes the defeasance loss had to be amortized, was proper, because (1) Medicare regulations did not require reimbursement according to GAAP, which included the accrual method of accounting; and (2) the informal reimbursement guideline was a valid interpretive rule, since (a) the guideline did not effect a substantive change in the Medicare regulations, and (b) interpretive rules did not require notice and comment.

O'Connor, J., joined by Scalia, Souter, and Thomas, JJ., dissenting, expressed the view that (1) general Medicare reporting and reimbursement regulations required provider costs to be treated according to GAAP, and (2) as a result, the guideline requiring amortization was invalid for failure to comply with the notice-and-comment procedures established by an APA provision, *5 USCS 553.*

LAWYERS' EDITION HEADNOTES:

[***LEdHN1]
ADMINISTRATIVE LAW § 75

SOCIAL SECURITY AND MEDICARE § 8
defeasance loss -- reimbursement guideline -- notice and comment --
Headnote:[1A][1B][1C][1D][1E][1F][1G]

The Secretary of Health and Human Services acts properly in requiring--in accordance with an informal Medicare reimbursement guideline that does not purport to be a regulation and has not been adopted pursuant to the notice-and-comment procedures of the Administrative Procedure Act *(5 USCS 551* et seq.)--that the Medicare reimbursement to which a hospital is entitled for a defeasance loss from issuing new bonds to replace old bonds that were issued to fund capital improvements must be amortized over the life of the old bonds, rather than being fully reimbursed in the year of refinancing, because (1) Medicare regulations do not require reimbursement according to generally accepted accounting principles (GAAP), which include the accrual method of accounting, since (a) *42 CFR 413.20(a)* insures the existence of adequate provider records but does not dictate the Secretary's reimbursement determinations, (b) *42 CFR 413.24* does not, simply by its accrual accounting requirement, bind the Secretary to make reimbursement according to GAAP, where GAAP is not the only form of accrual accounting, (c) the Secretary's reading of the Medicare regulations is consistent with *42 USCS 1395x*(v)(1)(A), which, rather than requiring adherence to GAAP, merely instructs the Secretary, in computing payment amounts to service providers, to consider the principles generally applied by national organizations or established prepayment organizations, and (d) the Secretary's mode of determining benefits by both rule making and adjudication--where, as to particular reimbursement details not addressed by the regulations, the Secretary relies upon an adjudicative structure which includes the right to review by the Provider Reimbursement Review Board, and, in some instances, the Secretary, as well as review in a Federal District Court of a final agency action--is a proper exercise of the Secretary's statutory mandate; and (2) the informal reimbursement guideline is a valid interpretive rule, since (a) the guideline does not effect a substantive change in the Medicare regulations, and (b) interpretive rules do not require notice and comment. (O'Connor, Scalia, Souter, and Thomas, JJ., dissented from this holding.)

[***LEdHN2]
SOCIAL SECURITY AND MEDICARE § 9
administrative interpretation of regulation -- judicial deference --
Headnote:[2A][2B][2C]

With respect to *42 CFR 413.20(a)*--which provides that the methods of determining costs payable under Medicare involve making use of data available from a Medicare provider's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries--the position of the Secretary of Health and Human Services that 413.20(a) does not bind the Secretary to reimburse according to generally accepted accounting principles (GAAP) is a reasonable regulatory interpretation to which the United States Supreme Court must defer, as such interpretation is supported by (1) the text of 413.20(a), since the text confirms the distinction between record keeping practices and principles of reimbursement by contemplating that a provider's basic financial information is organized according to GAAP as a beginning point from which the Secretary arrives at equitable and proper payment for services, which result is different from saying that GAAP is by definition an equitable and proper measure of reimbursement; and (2) the overall structure of the Medicare regulations, since (a) the essential distinction between record keeping requirements and reimbursement principles is confirmed by the organization of the regulations in 42 CFR Part 413, in which record-keeping requirements are considered in earlier subparts than are cost reimbursement matters, (b) it does not follow from the fact that a provider's cost accounting is the first step toward reimbursement that it is the only step, and (c) the regulations' description of the role of a fiscal intermediary in assisting providers in generating reimbursement claims underscores the view that a provider's cost accounting systems are only the first step in the ultimate determination of reimbursable costs. (O'Connor, Scalia, Souter, and Thomas, JJ., dissented from this holding.)

[***LEdHN3]
ADMINISTRATIVE LAW § 84
interpretation of regulation --
Headnote:[3]

The logical sequence of an administrative agency's regulation or a part of the regulation can be significant in interpreting the meaning of the regulation.

[***LEdHN4]
SOCIAL SECURITY AND MEDICARE § 8
administrative rule making -- obligation --
Headnote:[4]

To the extent that *42 USCS 1395x*(v)(1)(A)'s broad delegation of authority to the Secretary of Health and Human Services concerning Medicare reimbursement determinations imposes on the Secretary a rule-making obligation, such obligation is discharged by the Secretary, because (1) there is no basis for suggesting that the Secretary has a statutory duty to promulgate regulations that, either by default rule or by specification, address every conceiv-

able question in the process of determining equitable reimbursement; and (2) the Secretary has issued regulations to address a wide range of reimbursement questions, which regulations are comprehensive and intricate in detail and address matters such as limits on cost reimbursement, apportioning costs to Medicare services, and the specific treatment of numerous particular costs.

[***LEdHN5]
ADMINISTRATIVE LAW § 92
SOCIAL SECURITY AND MEDICARE § 8
general regulations -- precise rules --
Headnote:[5]

The fact that the regulations of the Secretary of Health and Human Services do not resolve a specific timing question before the United States Supreme Court--whether the Medicare reimbursement to which a hospital is entitled for a defeasance loss from issuing new bonds to replace old bonds that were issued to fund capital improvements must be amortized over the life of the old bonds rather than being fully reimbursed in the year of the refinancing--in a conclusive way, or could use a more exact mode of calculating, does not render the regulations invalid, for (1) the methods for the estimation of a Medicare provider's reasonable costs required by *42 USCS 1395x*(v)(1)(A) need be only generalizations that necessarily will fail to yield exact numbers, and (2) the Administrative Procedure Act *(5 USCS 551* et seq.) does not require that all the specific applications of a rule evolve by further, more precise rules rather than by adjudication.

[***LEdHN6]
SOCIAL SECURITY AND MEDICARE § 8
interpretive guideline -- provider reimbursement -- amortization --
Headnote:[6A][6B]

It is proper for the Secretary of Health and Human Services to issue a guideline or interpretive rule in determining that for purposes of reimbursement to Medicare providers, defeasance losses--accounting losses from refinancing of debts incurred for capital expenditures--should be amortized rather than being fully reimbursable in the year of the refinancing, because (1) the interpretive guideline issued by the Secretary is the means to insure that capital-related costs allowable under the Medicare regulations are reimbursed in a manner consistent with the mandate, under *42 USCS 1395x*(v)(1)(A)(i), that the program bear neither more nor less than its fair share of costs; (2) proper reimbursement requires proper timing, where (a) reimbursement in 1 year of costs attributable to a span of years would be determined by the provider's Medicare utilization for that 1 year and would lead to distortion, and (b) with respect to full reimbursement in 1 year, if the provider's utilization rate changed or the provider dropped from the program, the Secretary would have reimbursed up front an amount other than that attributable to Medicare services, which would result in the cross-subsidization--reimbursement of an amount other than that attributable to Medicare--which 1395x(v)(1)(A)(i) forbids; (3) the guideline (a) implements the statutory ban on cross-subsidization in a reasonable way, and (b) as an application of the statutory ban on cross-subsidization and the requirement, under *42 CFR 413.9*, that only the actual cost of services rendered to beneficiaries during a given year be reimbursed, is a prototypical example of an interpretive rule issued by an agency to advise the public of the agency's construction of the statutes and rules which the agency administers. (O'Connor, Scalia, Souter, and Thomas, JJ., dissented from this holding.)

[***LEdHN7]
ADMINISTRATIVE LAW § 86
rules -- force and effect --
Headnote:[7]

Rules issued by a federal administrative agency that interpret federal legislation do not have the force and effect of law and are not accorded that weight in the adjudicatory process.

[***LEdHN8]
SOCIAL SECURITY AND MEDICARE § 8
provider reimbursement -- generally accepted accounting principles --
Headnote:[8]

With respect to accounting methods used to determine reimbursement to Medicare providers, the Secretary of Health and Human Services is not self-bound to delegate the determination of any matter not specifically addressed by the Medicare regulations to the conventions of financial accounting that comprise generally accepted accounting principles (GAAP); the nature and objectives of GAAP illustrate the unlikelihood that the Secretary would choose such a course, where (1) contrary to the Secretary's mandate to match reimbursement with Medicare services, GAAP does not necessarily parallel economic reality, (2) financial accounting has as its foundation the principle of conservatism, with a corollary that possible errors in measurement should be in the direction of understatement rather than overstatement of net income and net assets, which orientation may be consistent with the objective of informing investors but ill-serves the needs of Medicare reimbursement and its mandate to avoid cross-subsidization, and (3) rather than being a single-source accounting rulebook, GAAP (a) encom-

passes the conventions, rules, and procedures that define accepted accounting practice at a particular point in time, (b) changes, and (c) even at any one point, is often indeterminate. (O'Connor, Scalia, Souter, and Thomas, JJ., dissented from this holding.)

SYLLABUS: After the refinancing of its bonded debt resulted in a "defeasance" loss for accounting purposes, respondent health care provider (hereinafter Hospital) determined that it was entitled to Medicare reimbursement for part of that loss. Although the Hospital contended that it should receive its full reimbursement in the year of the refinancing, the fiscal intermediary agreed with petitioner Secretary of Health and Human Services that the loss had to be amortized over the life of the Hospital's old bonds in accord with an informal Medicare reimbursement guideline, PRM § 233. The District Court ultimately sustained the Secretary's position, but the Court of Appeals reversed. Interpreting the Secretary's Medicare regulations, 42 CFR pt. 413, to require reimbursement according to generally accepted accounting principles (GAAP), the latter court concluded that, because PRM § 233 departed from GAAP, it effected a substantive change in the regulations and was void by reason of the Secretary's failure to issue it in accordance with the notice-and-comment provisions of the Administrative Procedure Act (APA).

Held:

1. The Secretary is not required to adhere to GAAP in making provider reimbursement determinations. Pp. 91-97.

(a) The Medicare regulations do not require reimbursement according to GAAP. The Secretary's position that *42 CFR § 413.20(a)* -- which specifies, *inter alia*, that "the principles of cost reimbursement require that providers maintain sufficient financial records . . . for proper determination of costs," and that "standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed" -- ensures the existence of adequate provider records but does not dictate the Secretary's own reimbursement determinations is supported by the regulation's text and the overall structure of the regulations and is therefore entitled to deference as a reasonable regulatory interpretation. Moreover, § 413.24 -- which requires that a provider's cost data be based on the accrual basis of accounting -- does not mandate reimbursement according to GAAP, since GAAP is not the only form of accrual accounting. In fact, PRM § 233 reflects a different accrual method. Pp. 92-95.

(b) The Secretary's reading of her regulations is consistent with the Medicare statute, which does not require adherence to GAAP, but merely instructs that, in establishing methods for determining reimbursable costs, she should "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) . . .," *42 U.S.C. § 1395x*(v)(1)(A). Nor is there any basis for suggesting that the Secretary has a statutory duty to promulgate regulations that address every conceivable question in the process of determining equitable reimbursement. To the extent that § 1395x(v)(1)(A)'s broad delegation of authority to her imposes a rulemaking obligation, it is one she has without doubt discharged by issuing comprehensive and intricate regulations that address a wide range of reimbursement questions and by relying upon an elaborate adjudicative structure to resolve particular details not specifically addressed by regulation. The APA does not require that all the specific applications of a rule evolve by further, more precise rules rather than by adjudication, and the Secretary's mode of determining benefits by both rulemaking and adjudication is a proper exercise of her statutory mandate. Pp. 95-97.

2. The Secretary's failure to follow the APA notice-and-comment provisions in issuing PRM § 233 does not invalidate that guideline. It was proper for the Secretary to issue a guideline or interpretive rule in determining that defeasance losses should be amortized. PRM § 233 is the Secretary's means of implementing the statute's mandate that the Medicare program bear neither more nor less than its fair share of reimbursement costs, *42 U.S.C. § 1395x*(v)(1)(A)(i), and the regulatory requirement that only the actual cost of services rendered to beneficiaries during a given year be reimbursed, *42 CFR § 413.9*. As such, PRM § 233 is a prototypical example of an interpretive rule issued by an agency to advise the public of its construction of the statutes and rules it administers. Interpretive rules do not require notice-and-comment, although they also do not have the force and effect of law and are not accorded that weight in the adjudicatory process. APA rulemaking would be required if PRM § 233 adopted a new position inconsistent with any of the Secretary's existing regulations. However, because the Secretary's regulations do not bind her to make Medicare reimbursements in accordance with GAAP, her determination in PRM § 233 to depart from GAAP by requiring bond defeasance losses to be amortized does not amount to a substantive change to the regulations. Pp. 97-100.

3. An examination of the nature and objectives of GAAP illustrates the unlikelihood that the Secretary would choose to impose upon herself the duty to go through the time-consuming rulemaking process whenever she dis-

agreed with any announcements or changes in GAAP and wished to depart from them. Pp. 100-102.

(a) GAAP does not necessarily reflect economic reality, and its conservative orientation in guiding judgments and estimates ill-serves Medicare reimbursement and its mandate to avoid cross-subsidization. Pp. 100-101.

(b) GAAP is not a lucid or encyclopedic set of pre-existing rules. It encompasses the conventions, rules, and procedures that define accepted accounting practice at a particular point in time, and changes over time. Even at any one point, GAAP consists of multiple sources, any number of which might present conflicting treatments of a particular accounting question. Pp. 101-102.

COUNSEL: Kent L. Jones argued the cause for petitioner. With him on the briefs were Solicitor General Days, Assistant Attorney General Hunger, Deputy Solicitor General Kneedler, Anthony J. Steinmeyer, and John P. Schnitker.

Scott W. Taebel argued the cause for respondent. With him on the brief was Diane M. Signoracci. *

> * Briefs of amici curiae urging affirmance were filed for the American Hospital Association et al. by Robert A. Klein and Charles W. Bailey; for the hospitals participating in St. John Hospital v. Shalala by William G. Christopher, Chris Rossman, and Kenneth R. Marcus; and for the Mother Frances Hospital et al. by Dan M. Peterson.

JUDGES: KENNEDY, J., delivered the opinion of the Court, in which REHNQUIST, C. J., and STEVENS, GINSBURG, and BREYER, JJ., joined. O'CONNOR, J., filed a dissenting opinion, in which SCALIA, SOUTER, and THOMAS, JJ., joined, post, p. 102.

OPINION BY: KENNEDY

OPINION: [*89] [**1234] [***113] JUSTICE KENNEDY delivered the opinion of the Court.

In this case a health care provider challenges a Medicare reimbursement determination by the Secretary of Health and Human Services. What begins as a rather conventional accounting problem raises significant questions respecting the interpretation of the Secretary's regulations and her authority to resolve certain reimbursement issues by adjudication [*90] and interpretive rules, rather than by regulations that address all accounting questions in precise detail.

[***LEdHR1A] [1A]The particular dispute concerns whether the Medicare regulations require reimbursement according to generally accepted accounting principles (GAAP), and whether the reimbursement guideline the Secretary relied upon is invalid because she did not follow the notice-and-comment provisions of the Administrative Procedure Act (APA) in issuing it. We hold that the Secretary's regulations do not require reimbursement according to GAAP and that her guideline is a valid interpretive rule.

I

Respondent Guernsey Memorial Hospital (hereinafter Hospital) issued bonds in 1972 and 1982 to fund capital improvements. In 1985, the Hospital refinanced its bonded debt by issuing new bonds. Although the refinancing will result in an estimated $ 12 million saving in debt service costs, the transaction did result in an accounting loss, sometimes referred to as an advance refunding or defeasance loss, of $ 672,581. The Hospital determined that it was entitled to Medicare reimbursement for about $ 314,000 of the loss. The total allowable amount of the loss is not in issue, but its timing is. The Hospital contends it is entitled to full reimbursement in one year, the year of the refinancing; the Secretary contends the loss must be amortized over the life of the old bonds.

The Secretary's position is in accord with an informal Medicare reimbursement guideline. See U.S. Dept. of Health and Human Services, Medicare Provider Reimbursement Manual § 233 (Mar. 1993) (PRM). PRM § 233 does not purport to be a regulation and has not been adopted pursuant to the notice-and-comment procedures of the Administrative Procedure Act. The fiscal intermediary relied on § 233 and determined that the loss had to be amortized. The Provider Reimbursement Review Board disagreed, see App. to Pet. for Cert. 54a, but the Administrator of the Health Care [*91] Financing Administration reversed the Board's decision, see *id.*, at 40a. In the [**1235] District Court the Secretary's position was sustained, see *Guernsey Memorial Hospital v. Sullivan, 796 F. Supp. 283* [***114] *(SD Ohio 1992),* but the Court of Appeals reversed, see *Guernsey Memorial Hospital v. Secretary of Health and Human Services, 996 F.2d 830 (CA6 1993).* In agreement with the Hospital, the court interpreted the Secretary's own regulations to contain a "flat statement that generally accepted accounting principles 'are followed'" in determining Medicare reimbursements. *Id., at 833* (quoting *42 CFR § 413.20(a)*). Although it was willing to accept the argument that PRM § 233's treatment of advance refunding losses "squares with economic reality," *996 F.2d at 834,* the Court of Appeals concluded that, because PRM § 233 departed from GAAP, it "effects a substantive change in the regulations [and is] void by reason of the

agency's failure to comply with the Administrative Procedure Act in adopting it." *Id., at 832.* Once the court ruled that GAAP controlled the timing of the accrual, it followed that the Hospital, not the Secretary, was correct and that the entire loss should be recognized in the year of refinancing.

We granted certiorari, *511 U.S. 1016 (1994),* and now reverse.

II

Under the Medicare reimbursement scheme at issue here, participating hospitals furnish services to program beneficiaries and are reimbursed by the Secretary through fiscal intermediaries. See *42 U.S.C. § § 1395g* and 1395h (1988 and Supp. V). Hospitals are reimbursed for "reasonable costs," defined by the statute as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." § 1395x(v)(1)(A). The Medicare Act, 79 Stat. 290, as amended, *42 U.S.C. § 1395 et seq.*, authorizes the Secretary to promulgate regulations "establishing the method or methods to be used" for determining reasonable costs, directing [*92] her in the process to "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing" reimbursement amounts. § 1395x(v)(1)(A).

The Secretary has promulgated, and updated on an annual basis, regulations establishing the methods for determining reasonable cost reimbursement. See *Good Samaritan Hospital v. Shalala, 508 U.S. 402, 404-407, 124 L. Ed. 2d 368, 113 S. Ct. 2151 (1993).* The relevant provisions can be found within 42 CFR pt. 413 (1994). Respondent contends that two of these regulations, § § 413.20(a) and 413.24, mandate reimbursement according to GAAP, and the Secretary counters that neither does.

A

Section 413.20(a) provides as follows:

> "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's [***115] basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries."

[***LEdHR1B] [1B]Assuming, *arguendo*, that the "standardized definitions, accounting, statistics, and reporting practices" referred to by the regulation refer to GAAP, that nevertheless is just the beginning, not the end, of the inquiry. The decisive question still remains: Who is it that "follow[s]" GAAP, and for what purposes? The Secretary's view is that § 413.20(a) ensures [*93] the existence of adequate provider records but does not dictate her own reimbursement determinations. We are persuaded that the Secretary's reading is correct.

[***LEdHR2A] [2A]Section 413.20(a) sets forth its directives in an ordered progression. The first sentence directs that providers must maintain records that are sufficient for proper determination of costs. It does not say the records are conclusive of the entire reimbursement process. The second sentence makes it clear to providers that standardized accounting practices are followed. The third sentence reassures [**1236] providers that changes in their recordkeeping practices and systems are not required in order to determine what costs the provider can recover when principles of reimbursement are applied to the provider's raw cost data. That sentence makes a distinction between recordkeeping practices and systems on one hand and principles of reimbursement on the other. The last sentence confirms the distinction, for it contemplates that a provider's basic financial information is organized according to GAAP as a beginning point from which the Secretary "arrive[s] at equitable and proper payment for services." This is far different from saying that GAAP is by definition an equitable and proper measure of reimbursement.

[***LEdHR2B] [2B] [***LEdHR3] [3]The essential distinction between recordkeeping requirements and reimbursement principles is confirmed by the organization of the regulations in 42 CFR pt. 413 (1994). Subpart A sets forth introductory principles. Subpart B, containing the regulation here in question, is entitled "Accounting Records and Reports." The logical conclusion is that the provisions in subpart B concern recordkeeping requirements rather than reimbursement, and closer inspection reveals this to be the case. Section 413.20 is the first section in subpart B, and is entitled "Financial data and reports." In addition to § 413.20(a), the other paragraphs in § 413.20 govern the "frequency of cost reports," "recordkeeping requirements for new providers," "continuing provider recordkeeping requirements," and "suspen-

sion of program [*94] payments to a provider . . . [who] does not maintain . . . adequate records." Not until the following subparts are cost reimbursement matters considered. Subpart C is entitled "Limits on Cost Reimbursement," subpart D "Apportionment [of Allowable Costs]," subpart E "Payments to Providers," and subparts F through H address reimbursement of particular cost categories. The logical sequence of a regulation or a part of it can be significant in interpreting its meaning.

[***LEdHR2C] [2C]It is true, as the Court of Appeals said, that § 413.20(a) "does not exist in a vacuum" but rather is a part of the overall Medicare reimbursement scheme. *996 F.2d at 835.* But it does not follow from the fact that a provider's cost accounting is [***116] the first step toward reimbursement that it is the only step. It is hardly surprising that the reimbursement process begins with certain recordkeeping requirements.

The regulations' description of the fiscal intermediary's role underscores this interpretation. The regulations direct the intermediary to consult and assist providers in interpreting and applying the principles of Medicare reimbursement to generate claims for reimbursable costs, § 413.20(b), suggesting that a provider's own determination of its claims involves more than handing over its existing cost reports. The regulations permit initial acceptance of reimbursable cost claims, unless there are obvious errors or inconsistencies, in order to expedite payment. § 413.64(f)(2). When a subsequent, more thorough audit follows, it may establish that adjustments are necessary. *Ibid.;* see also § § 421.100(a), (c). This sequence as well is consistent with the Secretary's view that a provider's cost accounting systems are only the first step in the ultimate determination of reimbursable costs.

The Secretary's position that § 413.20(a) does not bind her to reimburse according to GAAP is supported by the regulation's text and the overall structure of the regulations. It [*95] is a reasonable regulatory interpretation, and we must defer to it. *Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512, 129 L. Ed. 2d 405, 114 S. Ct. 2381 (1994);* see also *Martin v. Occupational Safety and Health Review Comm'n, 499 U.S. 144, 151, 111 S. Ct. 1171, 113 L. Ed. 2d 117 (1991)* ("Because applying an agency's regulation to complex or changing circumstances calls upon the agency's unique expertise and policymaking prerogatives, we presume that the power authoritatively to interpret its own regulations is a component of the agency's delegated lawmaking powers"); *Lyng v. Payne, 476 U.S. 926, 939, 90 L. Ed. 2d 921, 106 S. Ct. 2333 (1986)* ("agency's construction of its own regulations is entitled to substantial deference").

[***LEdHR1C] [1C]Respondent argues that, even if § 413.20(a) does not mandate reimbursement according to GAAP, § 413.24 does. This contention need not detain us long. Section 413.24 requires that a provider's cost data be based on the accrual basis of accounting, under which "revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." § 413.24(b)(2). But GAAP is not the only form of accrual accounting; in fact, both the GAAP approach and PRM § 233 reflect different [**1237] methods of accrual accounting. See Accounting Principles Board (APB) Opinion No. 26, PP5-8, reprinted at App. 64-66 (describing alternative accrual methods of recognizing advance refunding losses, including the one adopted in PRM § 233). Section 413.24 does not, simply by its accrual accounting requirement, bind the Secretary to make reimbursements according to GAAP.

B

The Secretary's reading of her regulations is consistent with the Medicare statute. Rather than requiring adherence to GAAP, the statute merely instructs the Secretary, in establishing the methods for determining reimbursable costs, to "consider, among other things, the principles generally applied by national organizations or established prepayment [*96] [***117] organizations (which have developed such principles) in computing the amount of payment . . . to providers of services." *42 U.S.C. § 1395x*(v)(1)(A).

[***LEdHR4] [4]Nor is there any basis for suggesting that the Secretary has a statutory duty to promulgate regulations that, either by default rule or by specification, address every conceivable question in the process of determining equitable reimbursement. To the extent the Medicare statute's broad delegation of authority imposes a rulemaking obligation, see *ibid.*, it is one the Secretary has without doubt discharged. See *Good Samaritan Hospital v. Shalala, 508 U.S. at 418, and n. 13, 419, n. 15.* The Secretary has issued regulations to address a wide range of reimbursement questions. The regulations are comprehensive and intricate in detail, addressing matters such as limits on cost reimbursement, apportioning costs to Medicare services, and the specific treatment of numerous particular costs. As of 1994, these regulations consumed some 640 pages of the Code of Federal Regulations.

[***LEdHR1D] [1D] [***LEdHR5] [5]As to particular reimbursement details not addressed by her regulations, the Secretary relies upon an elaborate adjudicative structure which includes the right to review by the Provider Reimbursement Review Board, and, in some in-

stances, the Secretary, as well as judicial review in federal district court of final agency action. *42 U.S.C. § 1395oo*(f)(1); see *Bethesda Hospital Assn. v. Bowen, 485 U.S. 399, 400-401, 99 L. Ed. 2d 460, 108 S. Ct. 1255 (1988).* That her regulations do not resolve the specific timing question before us in a conclusive way, or "could use a more exact mode of calculating," does not, of course, render them invalid, for the "methods for the estimation of reasonable costs" required by the statute only need be "generalizations [that] necessarily will fail to yield exact numbers." *Good Samaritan, supra, at 418.* The APA does not require that all the specific applications of a rule evolve by further, more precise rules rather than by adjudication. See *NLRB v. Bell Aerospace Co., 416 U.S. 267, 40 L. Ed. 2d 134, 94 S. Ct. 1757* [*97] *(1974); SEC v. Chenery Corp., 332 U.S. 194, 91 L. Ed. 1995, 67 S. Ct. 1575 (1947).* The Secretary's mode of determining benefits by both rulemaking and adjudication is, in our view, a proper exercise of her statutory mandate.

III

[***LEdHR6A] [6A]We also believe it was proper for the Secretary to issue a guideline or interpretive rule in determining that defeasance losses should be amortized. PRM § 233 is the means to ensure that capital-related costs allowable under the regulations are reimbursed in a manner consistent with the statute's mandate that the program bear neither more nor less than its fair share of costs. *42 U.S.C. § 1395x*(v)(1)(A)(i) ("The necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so [**1238] covered will not be borne by [Medicare]"). The Secretary has promulgated regulations authorizing reimbursement of capital-related costs such as respondent's that are "appropriate [***118] and helpful in . . . maintaining the operation of patient care facilities," *42 CFR § 413.9(b)(2)* (1994); see generally § § 413.130-413.157, including "necessary and proper interest" and other costs associated with capital indebtedness, § 413.153(a)(1); see also § § 413.130(a)(7) and (g). The only question unaddressed by the otherwise comprehensive regulations on this particular subject is whether the loss should be recognized at once or spread over a period of years. It is at this step that PRM § 233 directs amortization.

Although one-time recognition in the initial year might be the better approach where the question is how best to portray a loss so that investors can appreciate in full a company's financial position, see APB Opinion 26, PP4-5, reprinted at App. 64, the Secretary has determined in PRM § 233 that amortization is appropriate to ensure that Medicare only reimburse its fair share. The Secretary must calculate how much of a provider's total allowable costs are [*98] attributable to Medicare services, see *42 CFR § § 413.5(a), 413.9(a),* and (c)(3) (1994), which entails calculating what proportion of the provider's services were delivered to Medicare patients, § § 413.50 and 413.53. This ratio is referred to as the provider's "Medicare utilization." App. to Pet. for Cert. 49a. In allocating a provider's total allowable costs to Medicare, the Secretary must guard against various contingencies. The percentage of a hospital's patients covered by Medicare may change from year to year; or the provider may drop from the Medicare program altogether. Either will cause the hospital's Medicare utilization to fluctuate. Given the undoubted fact that Medicare utilization will not be an annual constant, the Secretary must strive to assure that costs associated with patient services provided over time be spread, to avoid distortions in reimbursement. As the provider's yearly Medicare utilization becomes ascertainable, the Secretary is able to allocate costs with accuracy and the program can bear its proportionate share. Proper reimbursement requires proper timing. Should the Secretary reimburse in one year costs in fact attributable to a span of years, the reimbursement will be determined by the provider's Medicare utilization for that one year, not for later years. This leads to distortion. If the provider's utilization rate changes or if the provider drops from the program altogether the Secretary will have reimbursed up front an amount other than that attributable to Medicare services. The result would be cross-subsidization, *id.*, at 50a, which the Act forbids. *42 U.S.C. § 1395x*(v)(1)(A)(i).

That PRM § 233 implements the statutory ban on cross-subsidization in a reasonable way is illustrated by the Administrator's application of § 233 to the facts of this case. The Administrator found that respondent's loss "did not relate exclusively to patient care services rendered in the year of the loss . . . . [but were] more closely related to [patient care services in] the years over which the original bond term extended." App. to Pet. for Cert. 49a. Because the loss [*99] was associated with patient services over a period of time, the Administrator concluded that amortization was required to avoid the statutory ban on cross-subsidization:

> "The statutory prohibition against cross-subsidization [citing the provision [***119] codified at *42 U.S.C. § 1395x*(v)(1)(A)], requires that costs recognized in one year, but attributable to health services rendered over a number of years, be amortized and reimbursed during those years when Medicare beneficiar-

ies use those services." *Id.*, at 50a (footnote omitted).

"By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases. Further, the program is protected from making a payment attributable to future years and then having the provider drop out of the Program before services are rendered to Medicare beneficiaries in those future years." *Id.*, at 49a (footnote omitted).

[**1239]

[***LEdHR1E] [1E] [***LEdHR6B] [6B] [***LEdHR7] [7]As an application of the statutory ban on cross-subsidization and the regulatory requirement that only the actual cost of services rendered to beneficiaries during a given year be reimbursed, *42 U.S.C. § 1395x*(v)(1)(A)(i); *42 CFR § 413.9* (1994), PRM § 233 is a prototypical example of an interpretive rule "'issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers.'" *Chrysler Corp. v. Brown, 441 U.S. 281, 302, n. 31, 60 L. Ed. 2d 208, 99 S. Ct. 1705 (1979)* (quoting Attorney General's Manual on the Administrative Procedure Act 30, n. 3 (1947)). Interpretive rules do not require notice and comment, although, as the Secretary recognizes, see Foreword to PRM, they also do not have the force and effect of law and are not accorded that weight in the adjudicatory process, *ibid.*

[*100]

[***LEdHR1F] [1F]We can agree that APA rulemaking would still be required if PRM § 233 adopted a new position inconsistent with any of the Secretary's existing regulations. As set forth in Part II, however, her regulations do not require reimbursement according to GAAP. PRM § 233 does not, as the Court of Appeals concluded it does, "effect a substantive change in the regulations." *996 F.2d at 832.*

IV

[***LEdHR8] [8]There is much irony in the suggestion, made in support of the Hospital's interpretation of the statute and regulations, that the Secretary has bound herself to delegate the determination of any matter not specifically addressed by the regulations to the conventions of financial accounting that comprise GAAP. The Secretary in effect would be imposing upon herself a duty to go through the time-consuming rulemaking process whenever she disagrees with any announcements or changes in GAAP and wishes to depart from them. Examining the nature and objectives of GAAP illustrates the unlikelihood that the Secretary would choose that course.

Contrary to the Secretary's mandate to match reimbursement with Medicare services, which requires her to determine with some certainty just when and on whose account costs are incurred, GAAP "do[es] not necessarily parallel economic reality." R. Kay & D. Searfoss, Handbook of Accounting and Auditing, ch. 5, p. 7 (2d ed. 1989). Financial accounting is not a science. It addresses many questions as to which the answers [***120] are uncertain and is a "process [that] involves continuous judgments and estimates." *Id.*, ch. 5, at 7-8. In guiding these judgments and estimates, "financial accounting has as its foundation the principle of conservatism, with its corollary that 'possible errors in measurement [should] be in the direction of understatement rather than overstatement of net income and net assets.'" *Thor Power Tool Co. v. Commissioner, 439 U.S. 522, 542, 58 L. Ed. 2d 785, 99 S. Ct. 773 (1979)* (citation omitted). This orientation may be consistent with the objective [*101] of informing investors, but it ill serves the needs of Medicare reimbursement and its mandate to avoid cross-subsidization. Cf. *id., at 543* ("The accountant's conservatism cannot bind the Commissioner [of the IRS] in his efforts to collect taxes").

GAAP is not the lucid or encyclopedic set of preexisting rules that the dissent might perceive it to be. Far from a single-source accounting rulebook, GAAP "encompasses the conventions, rules, and procedures that define accepted accounting practice at a particular point in time." Kay & Searfoss, ch. 5, at 7 (1994 Update). GAAP changes and, even at any one point, is often indeterminate. "The determination that a particular accounting principle is generally accepted may be difficult because no single source exists for all principles." *Ibid.* There are 19 different GAAP sources, any number of which might present conflicting treatments of a particular accounting question. *Id.*, ch. 5, at 6-7. When such conflicts arise, the accountant is directed to consult an elaborate hierarchy of GAAP sources to determine which treatment to follow. *Ibid.* We think it is a rather extraordinary proposition that the Secretary has consigned herself to this process in addressing the timing of Medicare reimbursement.

[***LEdHR1G] [1G]The framework followed in this case is a sensible structure for the complex Medicare [**1240] reimbursement process. The Secretary has promulgated regulations setting forth the basic principles and methods of reimbursement, and has issued interpre-

tive rules such as PRM § 233 that advise providers how she will apply the Medicare statute and regulations in adjudicating particular reimbursement claims. Because the Secretary's regulations do not bind her to make Medicare reimbursements in accordance with GAAP, her determination in PRM § 233 to depart from GAAP by requiring bond defeasance losses to be amortized does not amount to a substantive change to the regulations. It is a valid interpretive rule, and it was reasonable for the Secretary to follow that [*102] policy here to deny respondent's claim for full reimbursement of its defeasance loss in 1985.

The judgment of the Court of Appeals is reversed.

It is so ordered.

DISSENT BY: O'CONNOR

DISSENT:

JUSTICE O'CONNOR, with whom JUSTICE SCALIA, JUSTICE SOUTER, and JUSTICE THOMAS join, dissenting.

Unlike the Court, I believe that general Medicare reporting and reimbursement regulations require provider costs to be treated according to "generally accepted accounting principles." As a result, I would hold that contrary guidelines issued [***121] by the Secretary of Health and Human Services in an informal policy manual and applied to determine the timing of reimbursement in this case are invalid for failure to comply with the notice and comment procedures established by the Administrative Procedure Act, *5 U.S.C. § 553*. Because the Court holds to the contrary, I respectfully dissent.

I

It is undisputed, as the Court notes, *ante*, at 90, that respondent, Guernsey Memorial Hospital (Hospital), is entitled to reimbursement for the reasonable advance refunding costs it incurred when it refinanced its capital improvement bonds in 1985. The only issue here is one of timing: whether reimbursement is to be made in a lump sum in the year of the refinancing, in accordance with generally accepted accounting principles (known in the accounting world as GAAP), or in a series of payments over the remaining life of the original bonds, as the Secretary ultimately concluded after applying § 233 of the Medicare Provider Reimbursement Manual (PRM). The Hospital challenged the Secretary's reimbursement decision under the Medicare Act, *42 U.S.C. § 1395oo*(f), which incorporates the Administrative Procedure Act, *5 U.S.C. § 551 et seq.* (1988 ed. and Supp. V), by reference. Under the governing standard, reviewing courts are to "hold [*103] unlawful and set aside" an agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *5 U.S.C. § 706*(2)(A). We must give substantial deference to an agency's interpretation of its own regulations, *Lyng v. Payne, 476 U.S. 926, 939, 90 L. Ed. 2d 921, 106 S. Ct. 2333 (1986),* but an agency's interpretation cannot be sustained if it is "'plainly erroneous or inconsistent with the regulation.'" *Stinson v. United States, 508 U.S. 36, 45, 123 L. Ed. 2d 598, 113 S. Ct. 1913 (1993)* (quoting *Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 414, 89 L. Ed. 1700, 65 S. Ct. 1215 (1945)).* In my view, that is the case here.

The Medicare Act requires that, for reimbursement purposes, the actual reasonable costs incurred by a provider "shall be determined in accordance with regulations establishing the method or methods to be used . . . in determining such costs." *42 U.S.C. § 1395x*(v)(1)(A). The Secretary's regulations similarly provide that the "reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." *42 CFR § 413.9(b)(1)* (1994). The Secretary is not bound to adopt GAAP for reimbursement purposes; indeed, the statute only requires that, in promulgating the necessary regulations, "the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment . . . to providers of services . . . ." *42 U.S.C. § 1395x*(v)(1)(A). Neither the Hospital nor the Court of Appeals disputes that the Secretary [**1241] has broad and flexible authority to prescribe standards for reimbursement. See *Good Samaritan Hospital v. Shalala, 508 U.S. 402, 418, n. 13, 124 L. Ed. 2d 368, 113 S. Ct. 2151 (1993).*

Nevertheless, the statute clearly contemplates that the Secretary will [***122] state the applicable reimbursement methods in regulations -- including default rules that cover a range of situations unless and until specific regulations are promulgated to supplant them with respect to a particular type of [*104] cost. Indeed, despite the Court's suggestion to the contrary, *ante*, at 96, only by employing such default rules can the Secretary operate the sensible, comprehensive reimbursement scheme that Congress envisioned. Otherwise, without such background guidelines, providers would not have the benefit of regulations establishing the accounting principles upon which reimbursement decisions will be based, and administrators would be free to select, without having to comply with notice and comment procedures, whatever accounting rule may appear best in a particular context (so long as it meets minimum standards of rationality). In my view, the question becomes simply whether the Secretary has in fact adopted GAAP as the default rule for cost reimbursement accounting.

Like the Court, see *ante*, at 95-96, I do not think that *42 CFR § 413.24(a)* (1994), which provides that Medicare cost data "must be based on . . . the accrual basis of accounting," requires the use of GAAP. As the regulation itself explains, "under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." § 413.24(b)(2). This definition of "accrual basis" simply incorporates the dictionary understanding of the term, thereby distinguishing the method required of cost providers from "cash basis" accounting (under which revenue is reported only when it is actually received and expenses are reported only when they are actually paid). GAAP employs the generally accepted form of accrual basis accounting, but not the only possible form. In fact, both the applicable GAAP rule, established by Early Extinguishment of Debt, Accounting Principles Board Opinion No. 26 (1972), reprinted at App. 62, and PRM § 233 appear to reflect accrual, as opposed to cash basis, accounting principles.

Although § 413.24 simply opens the door for the Secretary to employ GAAP, § 413.20 makes clear that she has, in fact, [*105] incorporated GAAP into the cost reimbursement process. That section provides that "standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed." § 413.20(a). As the Court of Appeals noted, "it is undisputed, in the case at bar, that Guernsey Memorial Hospital keeps its books on the accrual basis of accounting and in accordance with generally accepted accounting principles." *Guernsey Memorial Hospital v. Secretary of HHS, 996 F.2d 830, 834 (CA6 1993)*. Similarly, related entities in the health care field employ GAAP as their standardized accounting practices. See American Institute of Certified Public Accountants, Audits of Providers of Health Care Services § 3.01, p. 11 (1993) ("Financial statements of health care entities should be prepared in conformity with generally accepted accounting principles"); Brief for American Hospital Association et al. as *Amici Curiae* 7-8 ("Generally accepted accounting principles have always provided the standard definitions and accounting practices applied by nongovernment hospitals in [***123] maintaining their books and records"). Accordingly, the Secretary concedes that, under § 413.20, the Hospital at the very least was required to submit its request for Medicare reimbursement in accordance with GAAP. *Guernsey Memorial Hospital v. Sullivan, 796 F. Supp. 283, 288-289 (SD Ohio 1992);* Tr. of Oral Arg. 8.

The remainder of § 413.20 demonstrates, moreover, that the accounting practices commonly used in the health care field determine how costs will be reimbursed by Medicare, not just how they are to be reported. The first sentence of § 413.20(a) begins with a statement that the provision explains what "the principles of *cost reimbursement* require." (Emphasis added.) And the sentence emphasizing that standardized accounting and reporting practices "are followed" is itself accompanied by the promise that "changes in these practices and systems [**1242] will not be required in order to determine costs payable [that is, reimbursable] under the [*106] principles of reimbursement." The language of the regulation, taken as a whole, indicates that the accounting system maintained by the provider ordinarily forms the basis for determining how Medicare costs will be reimbursed. I find it significant that the Secretary, through the Administrator of the Health Care Finance Administration, has changed her interpretation of this regulation, having previously concluded that this provision generally requires the costs of Medicare providers to be reimbursed according to GAAP when that construction was to her benefit. See *Dr. David M. Brotman Memorial Hospital* v. *Blue Cross Assn./Blue Cross of Southern California*, HCFA Admin. Decision, CCH Medicare and Medicaid Guide P30,922, p. 9839 (1980) (holding that, "under 42 CFR 405.406 [now codified as § 413.20], the determination of costs payable under the program should follow standardized accounting practices" and applying the GAAP rule -- that credit card costs should be treated as expenses in the period incurred -- and not the PRM's contrary rule -- that such costs should be considered reductions of revenue).

Following the Secretary's current position, the Court concludes, *ante*, at 92-93, that § 413.20 was intended to do no more than reassure Medicare providers that they would not be required fundamentally to alter their accounting practices for reporting purposes. Indeed, the Court maintains, the regulation simply ensures the existence of adequate provider financial records, maintained according to widely accepted accounting practices, that will enable the Secretary to calculate the costs payable under the Medicare program using some other system-wide method of determining costs, which method she does not, and need not, state in any regulations. For several reasons, I find the Court's interpretation of § 413.20 untenable.

Initially, the Court's view is belied by the text and structure of the regulations. As the Court of Appeals noted, "the sentence in [§ 413.20(a)] that says standardized reporting [*107] practices 'are followed' does not exist in a vacuum." *996 F.2d at 835*. The Provider Reimbursement Review Board has explained: "The purpose of cost reporting is to enable a hospital's costs to be known so that its reimbursement can be calculated. For that reason, there must be some consistency between the fundamental principles of cost reporting and those principles used for cost reimbursement." *Fort* [***124] *Worth*

Osteopathic Medical Center v. *Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of Texas*, CCH Medicare and Medicaid Guide P40,413, p. 31,848 (1991). The text of § 413.20 itself establishes this link between cost reporting and cost reimbursement by explaining that a provider hospital generally need not modify its accounting and reporting practices in order to determine what costs Medicare will reimburse. That is, "the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries." § 413.20(a). By linking the reimbursement process to the provider's existing financial records, the regulation contemplates that both the agency and the provider will be able to determine what costs are reimbursable. It would make little sense to tie cost reporting to cost reimbursement in this manner while simultaneously mandating different accounting systems for each.

In addition, as the Court aptly puts it, "the logical sequence of a regulation . . . can be significant in interpreting its meaning." *Ante*, at 94. Consideration of how a provider's claim for reimbursement is processed undermines the Court's interpretation of § 413.20(a). The Court suggests that the fiscal intermediaries who make the initial reimbursement decisions take a hospital's cost report as raw data and apply a separate set of accounting principles to determine the proper amount of reimbursement. In certain situations, namely where the regulations provide for specific departures from GAAP, this is undoubtedly the case. But the [*108] description of the intermediary's role in the regulations contemplates reliance on the GAAP-based cost report *as determining reimbursable costs* in considering the ordinary claim. See, *e. g.*, § 413.60(b) (providing that, "at the end of the [reporting] period, the [**1243] actual apportionment, *based on the cost finding and apportionment methods selected by the provider, determines* the Medicare reimbursement for the actual services provided to beneficiaries during the period" (emphasis added)); § 413.64(f)(2) ("In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For this purpose, *the costs will be accepted as reported, unless there are obvious errors or inconsistencies, subject to later audit.* When an audit is made and the final liability of the program is determined, a final adjustment will be made" (emphasis added)). The fiscal intermediary, then, is essentially instructed to check the hospital's cost report for accuracy, reasonableness, and presumably compliance with the regulations. But that task seems to operate within the framework of the hospital's normal accounting procedure -- *i. e.*, GAAP -- and not some alternative, uncodified set of accounting principles employed by the Secretary. See generally *42 CFR § § 421.1-421.128* (1994).

I take seriously our obligation to defer to an agency's reasonable interpretation of its own regulations, particularly "when, as here, the regulation concerns 'a complex and highly technical regulatory program,' in which the identification and classification of relevant 'criteria necessarily require significant expertise [***125] and entail the exercise of judgment grounded in policy concerns.'" *Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512, 129 L. Ed. 2d 405, 114 S. Ct. 2381 (1994)* (quoting *Pauley v. BethEnergy Mines, Inc., 501 U.S. 680, 697, 115 L. Ed. 2d 604, 111 S. Ct. 2524 (1991))*. In this case, however, the Secretary advances a view of the regulations that would force us to conclude that she has not fulfilled her statutory duty to promulgate regulations determining the methods by which reasonable Medicare costs are to be [*109] calculated. If § 413.20 does not incorporate GAAP as the basic method for determining cost reimbursement in the absence of a more specific regulation, then there is *no* regulation that specifies an overall methodology to be applied in the cost determination process. Given that the regulatory scheme could not operate without such a background method, and given that the statute requires the Secretary to make reimbursement decisions "in accordance with regulations establishing the method or methods to be used," *42 U.S.C. § 1395x*(v)(1)(A), I find the Secretary's interpretation to be unreasonable and unworthy of deference.

Unlike the Court, therefore, I would hold that § 413.20 requires the costs incurred by Medicare providers to be reimbursed according to GAAP in the absence of a specific regulation providing otherwise. The remainder of my decision flows from this conclusion. PRM § 233, which departs from the GAAP rule concerning advance refunding losses, does not have the force of a regulation because it was promulgated without notice and comment as required by the Administrative Procedure Act, *5 U.S.C. § 553*. And, contrary to the Secretary's argument, PRM § 233 cannot be a valid "interpretation" of the Medicare regulations because it is clearly at odds with the meaning of § 413.20 itself. Thus, I would conclude that the Secretary's refusal, premised upon an application of PRM § 233, to reimburse the Hospital's bond defeasement costs in accordance with GAAP was invalid.

II

The remaining arguments advanced by the Court in support of the Secretary's position do not alter my view of the regulatory scheme. The Court suggests that a contrary decision, by requiring the Secretary to comply with the notice and comment provisions of the Administrative Procedure Act in promulgating reimbursement regulations, would impose an insurmountable burden on the

Secretary's administration of the Medicare program. I disagree. Congress obviously [*110] thought that the Secretary could manage that task when it required that she act by regulation. Moreover, despite the Court's suggestion, *ante*, at 96, nothing in my position requires the agency to adopt substantive rules addressing every detailed and minute reimbursement issue that might arise. An agency certainly cannot foresee every factual scenario with which it may be presented in administering its programs; to fill in the gaps, it must rely on adjudication of particular [**1244] cases and other forms of agency action, such as the promulgation of interpretive rules and policy statements, that give effect to the statutory principles and the background methods embodied in the regulations. Far from being foreclosed from case-by-case adjudication, the Secretary is simply [***126] obligated, in making those reimbursement decisions, to abide by whatever ground rules she establishes by regulation. Under the Court's reading of the regulations, the Secretary in this case did not apply any accounting principle found in the regulations to the specific facts at issue -- and indeed could not have done so because no such principles are stated outside the detailed provisions governing particular reimbursement decisions. I believe that the Medicare Act's command that reimbursement requests by providers be evaluated "in accordance with regulations establishing the method or methods to be used" precludes this result.

Moreover, I find it significant that the bond defeasement situation at issue here *was* foreseen. If the Secretary had the opportunity to include a section on advance refunding costs in the PRM, then she could have promulgated a regulation to that effect in compliance with the Administrative Procedure Act, thereby giving the public a valuable opportunity to comment on the regulation's wisdom and those adversely affected the chance to challenge the ultimate rule in court. An agency is bound by the regulations it promulgates and may not attempt to circumvent the amendment process through substantive changes recorded in an informal policy [*111] manual that are unsupported by the language of the regulation. Here, Congress expressed a clear policy in the Medicare Act that the reimbursement principles selected by the Secretary -- whatever they may be -- must be adopted subject to the procedural protections of the Administrative Procedure Act. I would require the Secretary to comply with that statutory mandate.

The PRM, of course, remains an important part of the Medicare reimbursement process, explaining in detail what the regulations lay out in general and providing those who must prepare and process claims with the agency's statements of policy concerning how those regulations should be applied in particular contexts. One role for the manual, therefore, is to assist the Secretary in her daunting task of overseeing the thousands of Medicare reimbursement decisions made each year. As the foreword to the PRM explains, "the procedures and methods set forth in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished." Indeed, large portions of the PRM are devoted to detailed examples, including step-by-step calculations, of how certain rules should be applied to particular facts. The manual also provides a forum for the promulgation of interpretive rules and general statements of policy, types of agency action that describe what the agency believes the statute and existing regulations require but that do not alter the substantive obligations created thereby. Such interpretive rules are exempt from the notice and comment provisions of the Administrative Procedure Act, see *5 U.S.C. § 553*(b)(A), but they must *explain* existing law and not *contradict* what the regulations require.

As a result, the policy considerations upon which the Court focuses, see *ante*, at 97-100, are largely beside the [***127] point. Like the Court of Appeals, I do not doubt that the [*112] amortization approach embodied in PRM § 233 "squares with economic reality," *996 F.2d at 834,* and would likely be upheld as a rational regulation were it properly promulgated. Nor do I doubt that amortization of advance refunding costs may have certain advantages for Medicare reimbursement purposes. It is certainly true that the Act prohibits the Medicare program from bearing more or less than its proper share of hospital costs, *42 U.S.C. § 1395x*(v)(1)(A)(i), but immediate recognition of advance refunding losses does not violate this principle. While the Court, like the Secretary, assumes that advance refunding costs are properly attributed to health care services rendered over a number of years, it does not point to any evidence in the record substantiating that proposition. In fact, what testimony there is [**1245] supports the view that it is appropriate to recognize advance refunding losses in the year of the transaction because the provider no longer carries the costs of the refunded debt on its books thereafter; the losses in question simply represent a one-time recognition of the difference between the net carrying costs of the old bonds and the price necessary to reacquire them. See, *e. g.*, App. 14-15, 22. While reasonable people may debate the merits of the two options, the point is that both appear in the end to represent economically reasonable and permissible methods of determining what costs are properly reimbursable and when. Given that neither approach is commanded by the statute, the cross-subsidization argument should not alter our reading of § 413.20.

Finally, the Secretary argues that she was given a "broad and flexible mandate" to prescribe standards for Medicare reimbursement, and that, as a result, "it is exceedingly unlikely that the Secretary would have intended, in general regulations promulgated as part of the initial implementation of the Medicare Act, to abdicate to the accounting profession (or to anyone else) ultimate responsibility for making particular cost reimbursement determinations." Brief for Petitioner 19. She points out that the purpose of Medicare [*113] reimbursement, to provide payment of the necessary costs of efficient delivery of covered services to Medicare beneficiaries, may not be identical to the objective of financial accounting, which is "to provide useful information to management, shareholders, creditors, and others properly interested" and "has as its foundation the principle of [financial] conservatism." *Thor Power Tool Co. v. Commissioner, 439 U.S. 522, 542, 58 L. Ed. 2d 785, 99 S. Ct. 773 (1979)* (rejecting taxpayer's assertion that an accounting principle that conforms to GAAP must be presumed to be permissible for tax purposes). The Court makes this argument as well. See *ante*, at 100-101.

Reading the regulations to employ GAAP, even though it is possible that the relevant reimbursement standard will change over time as the position of the accounting profession evolves, does not imply an abdication of statutory authority but a necessary invocation of an established body of accounting principles to apply where specific regulations have not provided otherwise. The Secretary is, of course, not bound by GAAP in such a situation and, indeed, [***128] has promulgated reimbursement *regulations* that depart from the GAAP default rule in specific situations. Compare, *e. g.*, § 413.134 (f)(2) (limited recognition of gain or loss on involuntary conversion of depreciable asset) with R. Kay & D. Searfoss, Handbook of Accounting and Auditing, ch. 15, p. 14 (2d ed. 1989 and 1994 Supp.) (gains or losses are recognized under GAAP in the period of disposal of a depreciable asset, even if reinvested in a similar asset). The Secretary would also be free to devise a reimbursement scheme that does not involve GAAP as a background principle at all if she believes, as the Court argues, that use of GAAP binds her to a cost allocation methodology ill suited to Medicare reimbursement, see *ante*, at 101. Our task is simply to review the regulations the Secretary has in fact adopted, and I conclude that the Secretary has incorporated GAAP as the reimbursement default rule.

[*114] III

Contrary to the Court's conclusion, I do not believe that the Administrator's reimbursement decision can be defended as a rational application of the statute and the existing regulations. The Hospital sought reimbursement for its advance refunding costs in accordance with GAAP and in compliance with the Secretary's published regulations. The Administrator applied PRM § 233, which calls for a departure from GAAP in this instance, to deny the Hospital's request; that decision contradicted the agency's own regulations and therefore resulted in a reimbursement decision that was "not in accordance with law" within the meaning of the Administrative Procedure Act, *5 U.S.C. § 706*(2)(A). I agree with the court below that "the 'nexus' that exists in the regulations between cost reporting and cost reimbursement [**1246] is too strong . . . to be broken by a rule not adopted in accordance with the rulemaking requirements of the Administrative Procedure Act." *996 F.2d at 836.* Because the Court holds otherwise, I respectfully dissent.

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2 Federal Procedure, L Ed, Administrative Procedure 2:110; 31 Federal Procedure, L Ed, Social Security and Medicare 71:962

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Supreme Court's view as to weight and effect to be given, on subsequent judicial construction, to prior administrative construction of statute. *39 L Ed 2d 942.*

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