National Rural Health Association

July 20, 2026

The Honorable Brett Guthrie
Chairman of the Full Committee
House Committee on Energy and Commerce
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member of the Full Committee
House Committee on Energy and Commerce
Washington, D.C. 20515

The Honorable Morgan Griffith
Chairman of the Health Subcommittee
House Committee on Energy and Commerce
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member of the Health Subcommittee
House Committee on Energy and Commerce
Washington, D.C. 20515

Dear Chairman Guthrie, Ranking Member Pallone, Representative Griffith, Representative DeGette, and Members of the Committee,

The National Rural Health Association (NRHA) thanks the Committee for their continued efforts in supporting rural hospitals. While NRHA understands the Committee's dedication to lowering costs and facilitating increased transparency, we maintain that rural hospitals are not in the best position to provide cost information to patients on the scale outlined in the *Lower Costs, More Transparency Act*.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA urges Congress to exempt small rural hospitals and critical access hospitals (CAHs) from the *Lower Costs, More Transparency Act*'s expanded requirements. At a minimum, we ask that rural providers receive longer timelines, robust technical assistance, and dedicated financial support to achieve compliance.

Rural hospitals have been required to comply with hospital price transparency (HPT) regulations from the Centers for Medicare and Medicaid Services (CMS) since January 2021. Since this time, CMS has continued to impose new requirements on hospitals by regularly updating HPT regulations and sub-regulatory guidance. In general, rural hospitals have come into compliance with HPT regulations but struggle to keep up with CMS' continuous changes. Rural hospitals report spending tens of thousands of dollars to maintain compliance with regulations while rural patients rarely access or utilize the data. Many NRHA members report that they have less than 100 visits on their HPT sites per year (with one noting that they saw 2 visitors to their webpage in a year), most visitors are payers, and that patients are more likely to come in to talk to a person about the cost of their care rather than use the tools available online.

Section 2 of the bill expands HPT beyond what is in regulation currently and poses a major concern for NRHA members. **NRHA highlights the following provisions as particularly problematic for rural hospitals.**

Uniform method and format

Beginning July 1, 2024, all hospitals' machine readable files (MRFs) were required to conform with a CMS template layout, data specifications, and data dictionary.[1] CMS' aim was to create consistency across all hospitals' MRFs to make data more accessible and usable by the public. H.R. 9393 states that the Secretary shall establish a standard, uniform method and format for making standard charges public in an MRF. For almost two years, hospitals have had to use the CMS template for their MRF and significant changes would create undue administrative burden for resource-constrained rural hospitals.[2]

Commercial insurer contracts are proprietary, so national average data on how many commercial insurance contracts are held by rural hospitals does not exist. Anecdotally, small rural hospitals contract with two to six plans while larger rural hospitals may have up to fifteen. While this is not as many contracts as urban or suburban hospitals, rural hospitals have fewer staff and less money to expend on additional updates to their MRFs each time that contracts are renegotiated.

Rural hospitals face large challenges providing exact prices rather than estimates. The complexity of hospital pricing and contract negotiations with insurance companies complicate rural hospitals' ability to present the actual cost that a patient could pay for a service. Price estimator tools prompt patients to enter their plan information, allowing the tool to take into account plan benefit design. Therefore, the tool produces an estimate that accounts for cost-sharing requirements, prior utilization, and the deductible. Rural hospitals have already made significant investments in making price estimator tools available, and would be further burdened by throwing discarding these tools to invest in new price transparency resource.

Ultimately, rural hospitals must be allowed to continue offering the consumer-friendly formats currently in place, which are generally price estimator tools.

Enforcement and civil monetary penalties.

Steeper civil monetary penalties (CMPs) and generally harsher enforcement measures make annual compliance checks risky for rural hospitals who may struggle to stay compliant due to administrative burdens. Current regulations state that CMS can determine whether a hospital's violation is "material" and thus requires a CAP.[3] NRHA members have consistently reported that when CMS identifies a violation, the agency has worked with them towards compliance and helped to avoid CMPs, allowing them to come into compliance with much needed assistance and without losing valuable resources.

CMS has already increased compliance measures, as throughout 2021 and 2022 CMS engaged hospitals in 1,006 enforcement activities,[4] but this number grew to over 4,200 between 2023 and 2024.[5] Past HPT enforcement data shows that out of the over 10,000 enforcement actions taken by

[1] § 180.50(c).
[2] *Id*.
[3] § 180.80(a).
[4] https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.
[5] https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.

CMS, only 1,681 rose to the level of CMS requesting a CAP from the hospital.[6] More often, CMS issued an initial warning notice (2,694), or even more often hospitals were already complying (3,114).[7] NRHA believes that this demonstrates that CMS can work with hospitals to become compliant without putting them at financial risk.

NRHA also appreciates the inclusion of language granting the Secretary the authority to waive CMPs in situations where a penalty would disrupt patient care for a hospital in a rural or underserved area. To further protect rural patients, additional safeguards could be implemented such as requiring the Secretary to review CMP determinations for rural hospitals prior to implementation (see below for definition of rural hospital). [8],[9] Additionally, NRHA suggests removing the language prohibiting the Secretary from waiving penalties more than once in a 6-year period.

Technical assistance.

NRHA appreciates the bill's requirement for the Secretary to provide technical assistance for hospitals, including CAHs and rural emergency hospitals. As stated above, CMS has historically worked closely with rural hospitals to move towards compliance. NRHA would like to see this provision remain in H.R. 9393, coupled with the addition of financial assistance to help small rural hospitals.

NRHA encourages the Committee to provide financial assistance and resources to rural hospitals, all of whom hospitals feel the burden of HPT regulations regardless of their Medicare designation or operating margin. Rural hospitals report spending up to $40,000 per year just for a vendor to work on their MRFs. We suggest that the following definition of rural hospitals be used:

- Critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act),
- Rural emergency hospital (as defined in section 1861(kkk)(2) of the Social Security Act),
- A sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act),
- Medicare-dependent hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act), *or*
- A subsection (d) hospital (as defined in section 1886(d)(1)(B) with not more than 50 beds located in a rural area (as defined in section 1886(d)(2)(D), not including hospitals treated as being rural pursuant to section 1886(d)(8)(E).

This definition captures the majority of rural hospitals that need both financial and technical assistance to comply with ever changing HPT regulations. Language in the fifth bullet point would exclude reclassified rural hospitals (i.e., those that are geographically urban) so that resources would be targeted to geographically rural hospitals and to keep costs associated with assistance as low as practicable while still being meaningful.

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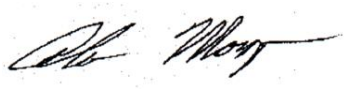
6 https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.

7 https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.

National Rural Health Association

Thank you for considering NRHA's feedback on H.R. 9393 and for your continued dedication to supporting rural providers and strengthening rural health care systems. We appreciate the Committee's willingness to engage stakeholders throughout this process. If you have questions or would like to discuss further, please contact Reese Lycan (rlycan@ruralhealth.us).

Sincerely,



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