National Rural Health Association

July 20, 2026

The Honorable Bill Cassidy
Chairman
Senate Health, Education, Labor, and Pensions Committee
Washington, D.C. 20515

The Honorable Bernie Sanders
Ranking Member
Senate Health, Education, Labor, and Pensions Committee
Washington, D.C. 20515

The Honorable Roger Marshall
Senate Health, Education, Labor, and Pensions Committee
Washington, D.C. 20515

The Honorable John Hickenlooper
Senate Health, Education, Labor, and Pensions Committee
Washington, D.C. 20515

Dear Chairman Cassidy, Ranking Member Sanders, Senator Marshall, Senator Hickenlooper and Members of the Committee,

The National Rural Health Association (NRHA) thanks the Committee, as well as Senators Marshall and Hickenlooper 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 *Patient's Deserve Price Tags 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 bill's expanded requirements. At a minimum, we ask that rural providers receive longer timelines, robust technical assistance, and dedicated financial support to achieve compliance.

NRHA recognizes Congress' and the Administration's continued focus on health price transparency; however, we emphasize that the best legislative path forward is to avoid creating duplicative requirements and imposing unnecessary administrative and financial burdens on rural hospitals. NRHA thanks the Committee for the opportunity to submit feedback on S. 2355, and we previously provided the Committee with a letter containing section by section comments.

Rural hospitals report spending tens of thousands of dollars to maintain compliance with current health price transparency regulations while rural patients rarely access or utilize the data. NRHA members report that they have fewer than 100 visits on their health price transparency sites per 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. Additionally, patients have fewer care options in rural communities, meaning that price transparency data intended to increase competition may have little effect in these areas.

NRHA advocates for exception of rural providers from increased transparency regulations. We were grateful to see the House Committee on Ways and Means incorporate parts of NRHA's feedback

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on the *Patients Deserve Price Transparency Bill* in H.R. 9645, the *Health Care Price Certainty for Americans Act* regarding additional burden reporting requirements may create for small rural hospitals. We urge the Committee to align *Patients Deserve Price Tags* in the following ways.

Section 2.

Machine readable file updates.

Requiring quarterly updates to machine readable files (MRFs) would significantly expand current CMS requirements, which generally require annual updates and publication of 300 CMS-designated shoppable services. Rural hospitals have already invested substantial resources to comply with these standards. Requiring quarterly updates for every shoppable service would create significant new administrative burdens with little benefit for rural patients and would be operationally infeasible for rural hospitals given their limited staff and resources. While NRHA appreciates that the manager's amendment to S. 2355 requires quarterly reports as opposed to the previously suggested monthly reports, we again point to, H.R. 9645, which aligns its statutory requirements with these current regulations, requiring annual updates as opposed to monthly[1] and requiring hospitals to publish at least 300 shoppable CMS services (or, the maximum they offer, if it is less than 300)[2] as opposed to *all* shoppable services.

Price estimator tools

Rural hospitals face challenges providing exact prices rather than estimates given resource constraints. 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. 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.

Price estimator tools prompt patients to enter their plan information, allowing the tool to consider 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 to implement CMS-compliant price estimator tools. Requiring them to abandon these systems in favor of new statutory requirements would unnecessarily duplicate those investments.

Alternatively, S. 2355 could follow the lead of H.R. 9645 to temporarily allow deemed compliance with a price estimator tool and require hospitals to include a disclaimer that the price estimator tools can only provide estimates and that actual costs may vary.

Enforcement and civil monetary penalties.

As noted in our previous letter, NRHA members consistently report that CMS' current collaborative enforcement approach has successfully brought hospitals into compliance without widespread use of civil monetary penalties (CMPs). CMS is actively engaged in auditing and enforcement actions,[3] but because the agency has been allowed to work alongside hospitals, CMPs have rarely been imposed.[4]

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[1] 42 C.F.R. § 180.50(e) (2025).
[2] § 180.60(a).
[3] https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.
[4] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions.

NRHA is concerned that S. 2355, as drafted, would take away CMS' flexibility and instead impose a rigid standard for enforcement and CMP structure.

Current regulations state that CMS can determine whether a hospital's violation is "material" and thus requires a CAP.[5] S. 2355 would require CMS to issue a corrective action plan (CAP) whenever it determines a hospital has failed to comply, reducing the agency's current enforcement discretion. In contrast, H.R. 9645 allows the Secretary to determine if a CAP is necessary, and also o gives the Secretary the authority to waive CMPs for hospitals located in a rural area (defined by the Federal Office of Rural Health Policy) or an underserved area if it would result in an immediate threat to access for individuals. We urge the Committee to allow for exemptions for rural hospitals, over 50% of whom operate with negative margins. H.R. 9645 also allows for hardship exemptions in the case of public health emergencies or natural disasters, which NRHA supports.

NRHA is grateful for both S. 2355 and H.R 9645's incorporation of past feedback noting concerns on the CAP timeframe. Extending the proposed response window from 45 days to 90 days improves the ability of rural hospitals to successfully achieve compliance and aligns statutory requirements with current CMS guidance.[6] 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.

Technical assistance.

NRHA appreciates the bill's allowance for the Secretary to provide technical assistance. We further request the language be modified, as written in H.R. 9645, from "the Secretary may, to the extent practicable, provide technical assistance…" to "the Secretary shall, to the extent practicable provide technical assistance...."

NRHA encourages the Committee to provide financial assistance and resources to rural hospitals who feel the burden of health price transparency regulations regardless of their Medicare designation or operating margin. NRHA appreciates that both bills recognize the need for technical assistance. However, rural hospitals also need dedicated financial assistance to offset the significant costs of compliance. Rural hospitals report spending up to $40,000 per year just for a vendor to work on their MRFs. **NRHA urges the Committee to include financial assistance alongside technical assistance for rural hospitals who do not have the budget to implement these requirements.**

Section 11.

Section 11 appears to require all rural providers to provide itemized bills to patients. As drafted, these requirements would be operationally infeasible for many rural providers, including rural health clinics and federally qualified health centers. Vendors would require substantial lead time to redesign and incorporate these billing changes into their system nationwide, creating additional costs for already resource-constrained rural providers.

Without exception, NRHA is concerned that small clinics and hospitals will not be able to afford this change. NRHA is also concerned by the provision that states that providers cannot collect payment above the amount disclosed through price transparency regulations or good faith estimates unless items or services were added that were medically necessary. The legislation must provide more

[5] § 180.80(a).
[6] https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-enforcement-updates.

guidance on how to prove that the higher charges were due to medical necessity, such as through physician certification, in order to ensure that rural providers are not wrongfully penalized, particularly as later subsections put the burden of proof on the provider and have a presumption in favor of the patient. As H.R. 9645 does not include comparable language, NRHA urges the Committee to omit this section from S. 2355.

Thank you for considering NRHA's feedback on S. 2355 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 and encourage adoption of the rural protections reflected in H.R. 9645. If you have questions or would like to discuss further, please contact Reese Lycan (rlycan@ruralhealth.us).

Sincerely,

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