National Rural Health Association

July 2, 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

RE: Stakeholder Feedback on S. 2355 – Patients Deserve Price Tags Act

Dear Chairman Cassidy and Ranking Member Sanders,

The National Rural Health Association (NRHA) thanks the Committee and Senators Marshall and Hickenlooper for the opportunity to provide comments and edits on working draft of S. 2355, the *Patients Deserve Price Tags Act*. Since hospital price transparency rules went into effect in 2021, NRHA has maintained that rural hospitals are not in the best position to provide cost information to patients on this scale and should be exempt from price transparency regulations.

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 advocates small rural hospitals and critical access hospitals (CAHs) to be exempt from these regulations or alternatively have longer timelines for compliance, as well as receiving technical and financial assistance. Recognizing Congress and the Administration's focus on price transparency efforts, we emphasize that the best legislative path forward is to align statutory requirements with current regulatory requirements in order to avoid adding administrative and financial burdens on rural hospitals and negating past investments in compliance with current standards. As such, NRHA offers the following comments on the draft bill.

Section 2.

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,

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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:**

Machine readable file updates.

S. 2355 would require monthly updates to machine readable files (MRFs), which is a drastic change from the current requirement for hospitals to update MRFs annually. NRHA appreciates the intent to capture the most accurate and up-to-date prices for patients through more frequent updates, but we anticipate significant burdens on rural hospitals. For rural hospitals this change may be impossible to comply with given their limited staff and resources. An alternative approach allowing rural hospitals to recertify for each month in which prices do not change could alleviate some burden on rural hospitals. However, in practice this would still require significant staff time to check if any standard charges have changes and incorporate any adjustments and not be feasible for many rural facilities.

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. **NRHA suggests that the legislation retain the annual MRF update currently required in regulation**.[1]

Shoppable services.

S. 2355 would expand requirements for hospitals by increasing the number of shoppable services available in a consumer-friendly format from 300 to all shoppable services. **This is another burden on rural hospitals that we do not believe should be expanded beyond current regulatory requirements for the aforementioned reasons.**[2]

Uniform method and format.

Beginning July 1, 2024, all hospitals' MRFs were required to conform with a CMS template layout, data specifications, and data dictionary.[3] CMS' aim was to create consistency across all hospitals' MRFs to make data more accessible and usable by the public. S. 2355 states that the Secretary shall establish a standard, uniform method and format for making standard charges public in an MRF and a consumer-friendly format. 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. As such, the legislation should codify the use of the existing CMS template requirement.[4]

NRHA understands concerns about price estimates and the desire to move away from estimates to actual costs, however we ask that the legislation retain rural hospitals' use of price estimator tools as

[1] 42 C.F.R. § 180.50(e) (2025).
[2] § 180.60(a).
[3] § 180.50(c).
[4] *Id*.

the most effective and understandable format for consumers. Rural hospitals, however, 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. Alternatively, S. 2355 could require hospitals to include a disclaimer that the price estimator tools can only provide estimates and that actual costs may vary. Use of this type of language on price transparency webpages is already industry standard with many facilities, including rural hospitals.

An alternative to a price estimator tool may be a shoppable services spreadsheet as previously mentioned, however that method is less helpful for patients. 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. This would not be possible through a spreadsheet. Browsing a spreadsheet would also be more time consuming and less straightforward than navigating a price estimator tool. 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.

NRHA members have consistently reported that when CMS identifies a violation, the agency has worked with them towards compliance and helped to avoid civil monetary penalties (CMPs). This flexibility has allowed rural hospitals to come into compliance with much needed assistance from the agency, without losing valuable resources. CMS is actively engaged in auditing and enforcement actions,[5] but because the agency has been allowed to work alongside hospitals, CMPs have rarely been imposed.[6] NRHA is concerned that S. 2355, as drafted, would take away CMS' flexibility and instead impose a rigid standard for enforcement and CMP structure.

S. 2355 requires that each hospital's compliance is reviewed annually. This is in stark contrast to enforcement for insurers. CMS would only audit up to 20 insurers annually under this legislation. We recommend aligning compliance audits for hospitals and insurers. Steeper CMPs (discussed below) and generally harsher enforcement measures make annual compliance checks risky for rural hospitals who may struggle to stay compliant due to administrative burdens. CMS has already increased compliance measures, as throughout 2021 and 2022 CMS engaged hospitals in 1,006 enforcement activities,[7] but this number grew to over 4,200 between 2023 and 2024.[8]

S. 2355 also does not give CMS discretion as to when it requests CAPs. Current regulations state that CMS can determine whether a hospital's violation is "material" and thus requires a CAP.[9] Again, NRHA members that have received an initial warning generally resolved the issue quickly by working with

[5] https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.
[6] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions.
[7] https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.
[8] https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data.
[9] § 180.80(a).

CMS and did not receive a CAP. The language in S. 2355 appears to require that CMS issue a CAP if it determines that a failure to comply exists by saying the Secretary "shall" include a request for a CAP. NRHA is concerned that this language removes the flexibility from which both CMS and hospitals have benefited. Immediately moving to request a CAP removes the option for CMS to work with the rural hospital, as explained above, to remedy noncompliance, thereby placing an additional burden on the hospital to create and execute the CAP when it may not be necessary.

Past HPT enforcement data shows that out of the over 10,000 enforcement actions taken by CMS, only 1,681 rose to the level of CMS requesting a CAP from the hospital.[10] NRHA believes that this demonstrates that CAPs should not be the first step in bringing hospitals into compliance. More often, CMS issued an initial warning notice (2,694), or even more often hospitals were already complying (3,114).[11]

NRHA is deeply concerned with the addition of the provision stating that hospitals that have received a CAP and have not reached compliance within 90 days cannot collect payment from an individual for services rendered during that time, even after they come back into compliance. Nearly half of rural hospitals operate in negative margins[12] and have fewer than 30 days of cash on hand.[13] Rural providers with limited administrative capacity struggle to navigate complex reporting frameworks and may have difficulty quickly achieving compliance. Permanently prohibiting them from collecting payment for services rendered further exacerbates financial risk and potentially threatens facility closure. We strongly urge for the removal of this provision.

Finally, the legislation imposes higher CMPs for many rural hospitals than is currently outlined in regulation.[14] The inflexible enforcement proceedings may lead to CMS imposing CMPs on more rural hospitals. The legislation should codify current regulations. Allowing the Secretary to adjust CMPs through rulemaking should be removed and, if increases must be included in the legislation, replaced with language that increases CMPs by a standardized amount on a predictable basis.

NRHA is grateful for the incorporation of past feedback noting concern on the corrective action plan (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.[15] NRHA also appreciates the inclusion of language granting the Secretary the authority to waive CMPs in situations where a penalty would disrupt patient care. 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).

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

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

[12] https://www.chartis.com/insights/2026-rural-health-state-state

[13] https://strengthenhealthcare.org/wp-content/uploads/2024/11/Coalition-Rural_White-Paper_11182024.pdf

[14] Only small rural hospitals with 30 beds or less, which would include CAHs, would be subject to the same CMPs currently in regulation at § 180.90(c)(2)(ii). Rural hospitals with more than 30 beds would be subject to higher CMPs under S. 2355 compared to at § 180.90(c)(2)(ii).

[15] https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-enforcement-updates.

Technical assistance.

NRHA appreciates the bill's allowance for the Secretary to provide technical assistance. As stated above, CMS has historically worked closely with rural hospitals to move towards compliance. NRHA would like to see this provision remain in S. 2355, coupled with the addition of financial assistance to help small rural hospitals.

NRHA suggests that the language be strengthened from "the Secretary may, to the extent practicable, provide technical assistance […]" to "the Secretary must~~, to the extent practicable,~~ provide technical assistance relating to compliance with provisions of this section to hospitals requesting such assistance." Technical assistance would be bolstered by providing financial assistance and resources to small rural hospitals and CAHs.

NRHA encourages the Committee to provide financial assistance and resources to all rural hospitals, not just CAHs or hospitals with negative operating margins. All rural 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.

Section 11.

Rural providers may face technology limitations in coming into compliance with the requirement associated with provision of itemized bills depending on the vendor that they use. In Texas, a similar policy went into effect in 2023, and some technology vendors could not create itemized bills or had to dramatically change the format of the statements that they already offered. This would likely be the case nationwide should Congress pass this legislation. Vendors need substantial lead time to incorporate these changes into their system and then offer this new service to rural providers.

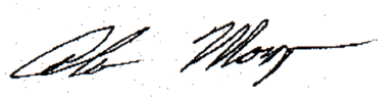
Further, once vendors make changes to their systems to allow for itemized bills that comply with S. 2355, rural providers would need further time to test and implement these changes. Rural facilities upgrading their technology would also undoubtedly be another cost associated with compliance. There is no language in Section 11 that exempts any kind of rural provider and NRHA is concerned that rural hospitals and small clinics, such as rural health clinics and rural community health centers,

will not be able to afford this change, should their current vendor come into compliance. NRHA requests phased implementation of this provision as the current iteration would be unfeasible for many rural providers as drafted.

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 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.

Thank you again for inviting NRHA to submit comments on S. 2355 and considering our feedback. If you have questions or would like to discuss further, please contact Reese Lycan (rlycan@ruralhealth.us).

Sincerely,



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