

**Statement
of the
American Hospital Association
for the
United States House of Representatives
Committee on Ways and Means
July 15, 2026**

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on legislation being marked up by the Ways and Means Committee on July 15.

H.R. 3108, the "Rural Patient Monitoring Access Act" (RPM Access Act)

The bill would establish minimum practice expense and malpractice geographic indices of 1.00 for Medicare physician fee schedule (PFS) payment calculations for remote physiologic monitoring services beginning Jan. 1, 2028, through Dec. 31, 2032. Medicare PFS payment for these services would only be available if the Secretary of Health and Human Services (HHS) determines that specific standards are met, including supplier response capability, real-time data transmission and data reporting. The secretary must submit a report to Congress by Jan. 1, 2031, on hospitalization rates, average number of days for an inpatient stay following a hospital admission, care management assessments and beneficiary demographics.

AHA Response:

The AHA supports the RPM Access Act, as it expands access to remote physiologic monitoring while ensuring Medicare is paying for clinically meaningful services. We appreciate the legislation's intent to increase provider participation for remote physiologic monitoring services in rural and underserved areas through enhanced



Medicare reimbursement. We believe the federal evaluation of the impact on patient outcomes and hospitalization rates will be beneficial for patients and policymakers.

H.R. 9642 Medicare Access to Rural Anesthesiology Act

The bill expands the rural anesthesia pass-through payments to include anesthesiologists. Under current law, certain rural hospitals are eligible to bill anesthesia services performed by nonphysician anesthesiologists as Part A services using a reasonable cost-based reimbursement in place of Part B payments. This legislation allows rural hospitals that meet specified criteria to employ or contract with physician anesthesiologists and receive enhanced cost-based payments.

AHA Response:

The AHA appreciates the committee's efforts to increase anesthesiology payments to certain rural hospitals to address workforce shortages. But we believe the legislation should allow all hospitals eligible for nonphysician anesthesiology pass-through reimbursements to receive the new physician anesthesiology pass-through reimbursements.

Due to low population density in rural areas, many hospitals lack the scale to cover the high fixed operating costs. Rural hospitals are also more likely to serve a population that relies on Medicare and Medicaid. Those challenges create and exacerbate shortfalls in the recruitment and retention of healthcare professionals in rural communities. This legislation provides rural hospitals with the ability to expand access to the essential anesthesiology services needed for surgeries and other procedures. We urge the committee to include all rural hospitals eligible for the current law nonphysician anesthesiology pass-through reimbursements in these expanded payments.

H.R. 9468, the "Saving Today's Acute-Care Resources Act," or the "STAR Act."

The STAR Act would strengthen Medicare's long-term care hospital (LTCH) payment system through targeted reforms designed to better align policy with the clinical complexity of patients requiring extended hospital-level care. The legislation expands access for certain medically complex beneficiaries and improves pathways to care for patients transitioning from critical access hospitals. In doing so, the bill reinforces the critical role LTCHs play in caring for high-acuity patients and relieving capacity pressures across the healthcare continuum.

AHA Response:

The AHA is pleased to support the STAR Act. This bill is a positive step forward and lays an important foundation for future policy reforms to strengthen the LTCH payment system. We particularly appreciate the bill's efforts to expand access for certain high-acuity beneficiaries and to improve pathways to LTCH care for beneficiaries.

transitioning from rural hospitals and communities where access to specialized post-acute services is often limited.

The AHA applauds the committee's efforts to address longstanding challenges within the LTCH payment system, particularly for certain high-acuity patients who require specialized long-term hospital care. We are grateful that the STAR Act reflects [principles](#) AHA and other LTCH stakeholders developed earlier this year to help guide efforts to strengthen and stabilize the LTCH field. As we noted in those principles, ensuring long-term access to LTCH care will require continued attention to broader payment and policy challenges facing LTCHs. The AHA looks forward to continuing to work with the committee to support the timely implementation of these reforms and to advance additional policies needed to ensure long-term access to LTCH care for the vulnerable patients these hospitals serve.

H.R. 3514, the “Improving Seniors’ Timely Access to Care Act of 2025”

This bill streamlines prior authorization requirements under Medicare Advantage (MA) plans by eliminating complexity and promoting uniformity that would reduce the wide variation in prior authorization methods that frustrate both patients and providers. Specifically, it would establish an electronic prior authorization standard to streamline approvals, reduce the time a health plan is allowed to consider a prior authorization request, require MA plans to report on their use of prior authorization, including the use of artificial intelligence in prior authorization and the rate of approvals and denials, and encourage MA plans to adopt policies that adhere to evidence-based guidelines.

AHA Response:

The AHA supports this legislation to improve the prior authorization process, but encourages the committee to revert to the implementation date in the original version of the bill that would require MA plans to use a standard electronic format by Jan. 1, 2028 (as opposed to the AINS, which delays implementation until Jan. 1, 2029).

H.R. 9644, the “Medicare Advantage MLR Transparency Act”

The bill requires MA plans, for plan years beginning Jan. 1, 2029, to submit to HHS and publish consumer-friendly information showing how premium revenue is spent. The disclosures would include the total amount and percentage of premium revenue spent on claims, quality-improvement activities and other non-claims/overhead categories, plus the percentage retained by the issuer.

Additionally, the bill requires MA plans to report enrollee-level data on supplemental benefits. Specifically, for plan years beginning Jan. 1, 2029, MA plans would be required to report information on eligibility for supplemental benefits, the types of supplemental benefit categories offered, and data on utilization of and payments for such benefits. The secretary would make this data available to researchers and stakeholders interested in assessing MA supplemental benefit plans.

Finally, the bill would require MA plans to submit additional information as part of their encounter data beginning with plan years starting on or after Jan. 1, 2029. Specifically, plan encounter data would be required to include (1) allowed amount, (2) beneficiary cost-sharing, (3) whether the beneficiary previously received an in-home health risk assessment during the plan year from an assessment company that is owned or controlled by the MA organization, and (4) a separate indication of whether the beneficiary previously received an in-home health risk assessment from an assessment entity that is not affiliated with the MA organization. The Centers for Medicare & Medicaid Services (CMS) would be required to incorporate these new encounter data elements into the Chronic Condition Data Warehouse.

AHA Response:

We support this bill, as the AHA has become increasingly concerned with how large commercial insurance plans may be gaming Medicare Advantage medical loss ratio (MLR) regulations by directing qualifying payments to entities within the same corporate umbrella.

H.R. 9645, the “Health Care Price Certainty for All Americans Act”

The bill codifies and expands healthcare price transparency requirements for hospitals, labs, imaging providers, ambulatory surgery centers (ASCs), group health plans/issuers and pharmacy benefit managers (PBMs). Hospitals are required to post all gross charges, payer-specific negotiated charges and discounted cash prices in a machine-readable file (MRF), as well as in a consumer-friendly format for at least 300 shoppable services, with updates at least annually. Hospitals must also post discounted cash prices in a publicly accessible location and submit attestations confirming the accuracy of the information. The HHS secretary is tasked with establishing uniform methods and formats for these disclosures by Jan. 1, 2028. Compliance will be monitored through audits and complaint evaluations, with civil monetary penalties imposed for non-compliance, scaled by hospital size and severity of violations. Waivers or penalty reductions may be granted under specific hardship or rural access conditions. Additionally, hospitals with price estimator tools may be deemed compliant with meeting the shoppable service requirement. Similar price transparency reporting requirements would be applied to clinical diagnostic labs, imaging services and ASCs, including public price files, as well as the use of price estimator tools for shoppable-service information and specifications for enforcement and penalties. Group health plans and health insurance issuers must provide participants with timely cost-sharing information upon request via self-service tools or alternative disclosures. This includes in-network rates, maximum allowed amounts for out-of-network providers, estimated cost-sharing, accumulated deductibles, frequency limitations, prior authorization requirements and any financial incentives. Plans must ensure pharmacies are not restricted from informing enrollees about out-of-pocket cost differentials between plan coverage and cash prices for prescription drugs. PBMs are similarly prohibited from restricting such communications. MA organizations and prescription drug plan sponsors must report every third plan year, starting in 2028, on healthcare provider ownership and financial

arrangements, including incentive payments and recoupments related to providers with financial risk arrangements.

AHA Response:

We appreciate the committee's interest in improving healthcare price transparency policies, and we support efforts to ensure the information available to the public is useful for patients, purchasers and policymakers. However, we are concerned that the legislation, as currently drafted, codifies regulations that do not seem to meet the healthcare price transparency goals sought by either patients or healthcare purchasers, while contributing to administrative burden in the healthcare system by continuing to require extensive investments by hospitals and health systems of staff time and other resources. In addition, by inserting specific posting requirements into statute, Congress is effectively limiting flexibility for CMS to continually improve the requirements to better reflect a changing transparency environment and/or what is most valued by stakeholders. By making the data requirements more prescriptive by codifying them, certain innovations will be difficult to achieve absent additional legislative action. We would also note that the requirement to produce the cash price data point (median cash price charged over the last three years) will be burdensome for hospitals to generate.

It is critical that H.R. 9645 acknowledges the importance of the use of price estimator tools to meet the shoppable services requirement. These tools are the most consumer-friendly way for patients to understand their out-of-pocket costs and are an important component of healthcare price transparency efforts. Unfortunately, the language seems to specify that these tools would no longer be deemed compliant with the shoppable services requirement once the advanced explanation of benefits goes into effect, as required by the No Surprises Act. The committee should clarify that hospitals may continue to use price estimator tools to satisfy the shoppable services requirement after the advanced explanation of benefits provisions are implemented.

While we support providing patients with clear, meaningful pricing information to help them make informed decisions about their care, we remain concerned that requiring hospitals to post discounted cash prices may not provide patients with the information they need when it would be most useful. More than half of all patients arrive at a hospital through the emergency department, where the urgency of their medical needs may limit their ability to compare facilities based on price. For scheduled services, patients would generally need pricing information before arriving at the hospital to meaningfully incorporate it into their care decisions.

We also are concerned that displaying discounted cash prices without sufficient context could make it harder for some patients to determine which payment option best serves their individual circumstances, particularly if they have insurance coverage or may qualify for financial assistance. Patients should have access to clear information about the full implications of choosing to use insurance or pay cash. The decision involves more than comparing the immediate price: an insured patient who pays cash may forgo important consumer protections associated with coverage, including having those

payments count toward a deductible or annual out-of-pocket maximum. As a result, paying less up front could lead to higher overall costs later in the year.

Finally, a static price list may not reflect the full range of services and charges associated with a course of treatment, such as ambulance transportation, physician services, or other care provided outside the hospital's posted price. Without that broader context, the information may not give patients a complete picture of their potential financial responsibility.

We would note that H.R. 9645 specifies compliance requirements for hospital price transparency reporting, which are redundant to the efforts CMS is already exercising with respect to oversight of hospitals — essentially requiring the agency to report what it already reports. The legislation also greatly increases (to \$10 million) the maximum civil monetary penalty for hospitals that are deemed to be out of compliance with the statute, as compared to the current maximum of \$2 million set by CMS. It should be underscored that hospitals have already undergone thousands of CMS [reviews](#) with very few civil monetary penalties [imposed](#) by the agency, and therefore, it is unnecessary to excessively increase the maximum penalty amount.

The health plan transparency section specifies significant details about which negotiated rate data needs to be included in health plan MRFs, though these are not consistent with what is required for hospitals to report. We would like to understand why the bill requires the creation of two separate data sets that cannot be cross-referenced. The bill also envisions using health plan data to generate national research on negotiated prices, which seems to indicate that the plans' publicly posted information is preferential for research purposes, and challenges the need for hospitals to also provide MRFs. And while oversight of hospitals is detailed in the bill, there are no similar enforcement mechanisms or penalties specified for health plans, raising the question as to why providers are being held to a different — and higher — standard.

We ask that the committee work with us to further refine this bill as it moves through the legislative process.