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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Health, Education, Labor and Pensions Committee

of the

U.S. Senate

"Executive Session"

July 22, 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 Health, Education, Labor and Pensions Committee on July 22.

S. 2355, PATIENTS DESERVE PRICE TAGS ACT

The bill would amend Title XXVII of the Public Health Service Act to mandate that hospitals, insurers, laboratories, imaging providers and ambulatory surgical centers publicly disclose standard charges, discounted cash prices, payer-specific negotiated charges and ownership information in accessible formats.

AHA Response:

We appreciate the substantial work done by committee staff and the bill's sponsors to respond to stakeholder feedback and improve S. 2355. While the manager's amendment reflects meaningful changes, we continue to have serious concerns that the legislation does not yet sufficiently advance the goal of providing patients with clear, accurate healthcare price information in a manner that avoids unnecessary administrative burdens on providers. We remain committed to working with the

committee to address these outstanding issues to find a path forward that achieves our shared goal of meaningful price transparency for patients while allowing hospitals and health systems to focus resources on patient care.

As currently drafted, the manager's amendment will increase the administrative burden placed on hospitals and health systems to comply with myriad new reporting requirements that will be both difficult to execute and costly to maintain. These could be especially onerous for small and rural hospitals, some of which are already struggling to serve their communities with current staff and resources.

While the manager's amendment to S. 2355 addresses some issues the AHA identified in the discussion draft, we remain concerned about the following elements, many of which are detailed in our July 2 letter to the HELP Committee.

Section 2: Strengthening Hospital Price Transparency

Hospitals must compile and publish their standard charges for items and services in both a machine-readable file (MRF) and consumer-friendly format. This includes at least 300 shoppable services, with a clear indication if certain services are not provided. MRFs are to be updated quarterly if there have been changes to the standard charges. In the future, all shoppable services will be required. Price estimator tools may be used by hospitals but are not considered to meet the shoppable service requirements.

Ownership disclosures must include all persons or entities with ownership, controlling interests, management roles or significant equity investments. The act defines key terms such as "gross charge," "discounted cash price," "payer-specific negotiated charge" and "shoppable service."

Hospitals failing to comply will receive notifications and may face escalating civil monetary penalties based on bed count, with higher penalties for persistent noncompliance. Extraordinary collection actions against patients are prohibited if hospitals fail to comply. The secretary is tasked with monitoring compliance annually and providing technical assistance.

AHA's Response:

While the manager's amendment includes several meaningful improvements, additional changes are needed to ensure the legislation provides patients with clear, accurate and actionable information without diverting hospital resources from patient care. Our remaining concerns include the following:

- **Price estimator tools.** The legislation would eliminate hospitals' ability to use price estimator tools to satisfy the shoppable services requirement. Hospitals and health systems have invested significant financial resources into these tools to provide patients with personalized estimates of their expected out-of-pocket costs. These tools are more useful and accessible for patients than large data

files or spreadsheets. Eliminating this option would reduce patients' access to a familiar, consumer-friendly resource while disregarding the significant investments hospitals have made to develop and maintain these tools. We urge the committee to preserve price estimator tools as a compliant method of providing patients with actionable pricing information.

- **Expansion of the shoppable service requirements.** The legislation would increase the current requirement from 300 services to all shoppable services in a spreadsheet will require additional burden on hospitals and be of limited use to patients. We recommend focusing the requirement on services that patients most frequently schedule and for which advance pricing information is most useful.
- **Disclosure of ownership information.** The legislation would require hospitals to disclose ownership information without clearly defining the scope of the requirement or accounting for information hospitals already report to the federal government. Before establishing a new hospital-level posting requirement, there should be a review of how it would interact with section 1124 of the Social Security Act and section 6101(b) of the Patient Protection and Affordable Care Act. Because the Centers for Medicare & Medicaid Services already collects and publicly reports much of this information, relying on a centralized federal source may give patients and the public more consistent information while avoiding duplicative reporting requirements.
- **Facility Fee Information.** The legislation would require hospitals to post the amount of any facility fee or other patient charges that would be added to a patient's bill, as well as any information that might help the patient avoid the charge. Hospitals already include institutional fees, also known as facility fees, in their MRF and typically include these fees in their price estimator tools. While the term "facility fee" is often used to describe these institutional fees, the charges are generally referred to by their standard description in the MRF. We support ensuring that patients understand the total amount they may owe before receiving scheduled care. However, the legislation should clarify how this requirement differs from existing disclosures and what hospitals would be expected to do to help patients avoid facility fees.
- **Enforcement provisions.** We appreciate that the manager's amendment removed the language that allowed increased penalties even when a hospital was not "knowingly or willfully" noncompliant. However, we remain concerned that a hospital receiving a civil monetary penalty for failure to address a corrective action plan also would be disallowed from engaging in any extraordinary collections actions (ECA) while out of compliance. The AHA encourages hospitals, through our Patient Billing Guidelines, not to garnish wages, place liens on a primary residence, apply interest to the debt, make contributions to adverse credit reports or file lawsuits against patients. However, as drafted, the provision in the manager's amendment is overly broad and likely to result in unintended consequences. We recommend that the committee more narrowly tailor the enforcement mechanism to protect patients while preserving appropriate flexibility for hospitals to address unpaid balances and maintain the financial resources necessary to serve their communities.

Section 10: Requirement for Explanation of Benefits

The act requires plans or issuers to provide participants with advanced explanations of benefits (AEOBs) including good-faith estimates (GFEs) of plan liability with itemized billing codes and descriptions. Participants are held harmless for charges substantially exceeding these estimates except for medically necessary unforeseen circumstances. Final explanations of benefits must be provided within 45 days of claim decision, detailing payments, cost-sharing, site of service and discrepancies from the AEOB.

AHA Response:

We support the goal of providing patients with reliable advance information about their expected financial responsibility and protecting them from unexpected costs. However, the legislation should more clearly define how financial responsibility will be allocated when the final cost of care differs from the GFE or AEOB.

While a GFE reflects the services reasonably anticipated at the time it is prepared, a patient's treatment needs may change based on clinical findings, complications, additional medically necessary services or other circumstances that could not reasonably have been anticipated in advance. Providers should not be required to absorb the cost of appropriate care furnished in response to these changes.

The legislation also should make clear that health plans are responsible for differences resulting from inaccurate benefit information, errors in calculating a patient's cost-sharing obligation or other aspects of the AEOB that are within the plan's control.

Section 11: Transparency in Billing

Healthcare providers and facilities must notify individuals of their right to request itemized bills, including language assistance and charity care information. Providers cannot bill or collect unless these notices are given and charges align with federal price transparency regulations or good-faith estimates, barring unforeseen changes in medically necessary care. Penalties of up to $10,000 per violation may be imposed for noncompliance.

AHA Response:

We are concerned that the legislation does not provide clarity as to which estimate is the appropriate reference for payment, whether that is the AEOBs, GFEs or any other estimate a patient receives (i.e., from a third-party estimator tool). Without this clarity, patients could receive conflicting information, while providers and plans could face unnecessary disputes over financial responsibility.

S. 1874, TITLE VIII NURSING WORKFORCE REAUTHORIZATION ACT OF 2025

The bill seeks to strengthen the nursing workforce by reauthorizing Title VIII nursing workforce development programs through FY 2030. The legislation supports advanced nursing education, nurse faculty development, and programs that help recruit and retain nurses in rural and underserved communities. It also expands support for clinical training, modern educational technologies and nursing school capacity to help address ongoing workforce shortages.

AHA Response:

The AHA supports the Title VIII Nursing Workforce Reauthorization Act of 2025. America's hospitals and health systems continue to face significant nursing shortages, driven in part by faculty shortages, limited clinical training capacity and increasing workforce demands. This legislation would provide critical investments in nursing education, workforce development and retention programs to help strengthen the nursing pipeline and expand access to care. The bill's support for nurse educators, advanced nursing training, modern educational technologies and service in underserved communities will help ensure hospitals and health systems can recruit and retain the workforce needed to meet patients' growing healthcare needs.

S. 380, RURAL OBSTETRICS READINESS ACT

The bill seeks to improve obstetric emergency preparedness in rural healthcare settings, especially for those hospitals without dedicated obstetric units. The legislation focuses on training for practitioners in rural facilities that lack obstetric service units, establishes grant funding for rural obstetric readiness, creates a teleconsultation pilot program to support urgent maternal healthcare and directs the Department of Health and Human Services to study rural obstetric unit patterns and closures.

AHA Response:

The AHA supports this legislation, as it will help address maternal health needs in rural areas.