DESCRIPTION OF AMENDMENTS TO THE INTERNAL REVENUE CODE CONTAINED IN H.R. 9645, THE "HEALTH CARE PRICE CERTAINTY FOR ALL AMERICANS ACT"

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CONTENTS

Page

INTRODUCTION.....1

A. Health Coverage Price Transparency.....2

B. Information on Prescription Drugs.....13

C. Estimated Revenue Effects of the Proposal.....14

INTRODUCTION

The House Committee on Ways and Means has scheduled a committee markup for July 15, 2026, of H.R. 9645, the "Health Care Price Certainty for All Americans Act." This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the amendments to the Code contained in this bill.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of Amendments to the Internal Revenue Code Contained in H.R 9645, the "Health Care Price Certainty for All Americans Act"* (JCX-34-26), July 13, 2026. This document can also be found on the Joint Committee on Taxation website at www.jct.gov. All section references in the document are to the Internal Revenue Code of 1986, as amended (the "Code"), unless otherwise stated.

A. Health Coverage Price Transparency

Present Law

Under the Patient Protection and Affordable Care Act ("PPACA"),[2] individual market health insurance coverage must meet various requirements to qualify for certification to be offered through an Exchange ("Exchange coverage").[3] Among these requirements, Exchange coverage must permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through an internet website and such other means for individuals without access to the internet.[4]

This transparency requirement also applies to group health plans and to health insurance issuers offering group or individual health insurance coverage.[5]

In 2020, the Department of the Treasury, Department of Labor, and Department of Health and Human Services ("HHS") (collectively, "the Departments") adopted final rules under the authority described above imposing additional transparency requirements on group health plans and health insurance issuers,[6] the Transparency in Coverage Final Rules ("TiC Final Rules").[7]

The TiC Final Rules require group health plans to make the information described below available in the formats described below.[8]

Self-service tool

Group health plans must make available to participants and beneficiaries a "self-service tool" that provides estimated cost-sharing information for a covered item or service from a

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[2] Pub. L. No. 111-148, March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, March 30, 2010.

[3] An Exchange is established under section 1311 of the PPACA.

[4] Sec. 1311(e)(3)(C) of the PPACA. These requirements do not apply to grandfathered coverage as provided under section 1251 of the PPACA.

[5] Sec. 2715A of the Public Health Service Act ("PHSA"); sec. 9815.

[6] The Departments cooperate on implementing analogous requirements applicable to both group health plans and health insurance issuers under their respective authorities. The Code, however, applies these requirements only to group health plans, see section 9801 *et seq.* Therefore, for simplicity, this document generally refers only to "group health plans" or "plans."

[7] T.D. 9929, 85 Fed. Reg. 72158, Nov. 12, 2020.

[8] These requirements do not apply to health reimbursement arrangements or other account-based plans.

particular provider or providers.[9] The self-service tool must be available over the internet, and group health plans must make the required information available in paper form,[10] upon request.

Plans are required to make the following information available:

- An estimate of the participant's or beneficiary's cost-sharing liability for a requested covered item or service;[11]
- Accumulated amounts;[12]
- The in-network rate for the item or service;
- The out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount the plan will pay for the requested covered item or service, generally reflected as a dollar amount, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider;
- If applicable, notification that coverage of a specific item or service is subject to a prerequisite; and
- A notice including specified plain language disclaimers.

This information must be made available in plain language, without subscription or other fee, through a self-service tool on an internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request.

The tool must allow users to search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting:

- A billing code or a descriptive term, at the option of the user;
- The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider; and
- Other factors utilized by the plan that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

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[9] The information made available must include 500 specified items and services for plan years beginning on or after January 1, 2023, and all items and services for plan years beginning on or after January 1, 2024.

[10] The TiC Final Rules set forth detailed requirements for the use of the paper method.

[11] The TiC Final Rules also include detailed provisions regarding the reporting of information on bundled payment arrangements.

[12] Accumulated amounts are generally defined to mean the amount of financial responsibility a participant or beneficiary has incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit.

The tool must allow users to search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount a plan will pay for a covered item or service provided by out-of-network providers by inputting:

- A billing code or descriptive term, at the option of the user; and
- Other factors utilized by the plan that are relevant for determining the applicable out-of-network allowed amount or other rate (such as the location in which the covered item or service will be sought or provided).

The tool must allow users to refine and reorder search results based on geographic proximity of in-network providers, and the amount of the participant's or beneficiary's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

The TiC Final Rules also include standards to prevent unnecessary duplication and permit a plan to satisfy these requirements by entering into a written agreement under which another party provides the required information, though the plan remains ultimately responsible for providing this information.

Machine-readable files

Group health plans must make publicly available three machine-readable files including price information for in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs. These files must be updated on a monthly basis.

The in-network rate machine-readable file must include the following information, with an exception for prescription drugs that are subject to a fee-for-service reimbursement arrangement, in addition to plan identifying information:

- A billing code and a plain language description for each billing code for each covered item or service;
- All applicable rates, including for bundled payment arrangements,[13] which must be:
    - Associated with the National Provider Identifier ("NPI"), Tax Identification Number ("TIN"), and Place of Service Code for each in-network provider.
    - Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and

[13] If the plan does not use negotiated rates for provider reimbursement, then the plan should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the plan uses underlying fee schedule rates for calculating cost sharing, then the plan should include the underlying fee schedule rates in addition to the negotiated rate or derived amount.

- Indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

The out-of-network allowed amount machine-readable file is required to include, in addition to plan identifying information:

- A billing code and a plain language description for each billing code for each covered item or service; and
- Unique out-of-network allowed amounts and billed charges with respect to covered items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that this data must be omitted in relation to a particular item or service and provider when inclusion would require the reporting of out-of-network allowed amounts in connection with fewer than 20 different claims for payments under a single plan). Each unique out-of-network allowed amount must be reflected as a dollar amount and associated with the NPI, TIN, and Place of Service Code for each out-of-network provider.

The prescription drug machine-readable file is required to include, in addition to plan identifying information:

- The National Drug Code ("NDC"), and the proprietary and nonproprietary name assigned to the NDC by the Food and Drug Administration ("FDA"), for each covered item or service under each coverage option offered by a plan that is a prescription drug;
- The negotiated rates, which must be:
  - Reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider;
  - Associated with the NPI, TIN, and Place of Service Code for each in-network provider; and
  - Associated with the last date of the contract term for each provider-specific negotiated rate that applies to each NDC;
- Historical net prices[14] that are:
  - Reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider;

[14] Historical net price means the retrospective average amount a plan paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees, and any additional price concessions received by the plan with respect to the prescription drug.

- Associated with the NPI, TIN, and Place of Service Code for each in-network provider; and

- Associated with the 90-day time period that begins 180 days prior to the publication date of the machine-readable file for each provider-specific historical net price that applies to each NDC (except that such data must be omitted in relation to a particular NDC and provider when inclusion would require the reporting of historical net prices calculated using fewer than 20 different claims for payment).

The machine-readable files must be available in a form and manner as specified in guidance issued by the Departments. The machine-readable files must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

The TiC Final Rules include standards to prevent unnecessary duplication and permit a plan to satisfy these requirements by entering into a written agreement under which another party provides the required information, though the plan remains ultimately responsible for providing this information.

In addition, plans may satisfy the allowed amount file requirement by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an issuer, a service provider, or other party with which the plan has entered into a written agreement to provide the information, provided the minimum claim threshold described above is independently met for each item or service and for each plan included in an aggregated file. Under such circumstances, health insurance issuers, service providers, or other parties with which the plan has contracted may aggregate out-of-network allowed amounts for more than one plan or insurance policy or contract.

Subsequent changes in law and guidance

The Consolidated Appropriations Act, 2021 ("2021 CAA"),[15] also includes transparency requirements. The 2021 CAA requires group health plans and health insurance issuers to offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that (to the extent practicable) allows an individual enrolled under the plan or coverage, with respect to participating providers, to compare the amount of cost-sharing for which the individual would be responsible under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.[16]

[15] Pub. L. No. 116-260, December 27, 2020.

[16] Sec. 9819, sec. 719 of the Employee Retirement Income Security Act ("ERISA"), and sec. 2799A-4 of the PHSA, as added by section 114 of division BB of the 2021 CAA. These provisions apply to health plans that are grandfathered under section 1251 of the PPACA, unlike the requirements of section 1311 of the PPACA.

In addition, the 2021 CAA includes reporting requirements primarily related to prescription drug expenditures, requiring that plans and issuers submit detailed information to the Departments regarding prescription drug coverage, including, for example, the 50 most frequently dispensed brand prescription drugs, and the total number of paid claims for each such drug; the 50 most costly prescription drugs by total annual spending, and the annual amount spent by the plan or coverage for each such drug; and the 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.[17] Additionally, the 2021 CAA requires the Departments to issue biannual public reports on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the impact of prescription costs on premium rates.

Based on the rationale that the price comparison guidance required by the 2021 CAA is largely duplicative of the internet-based self-service tool requirement of the TiC Final Rules (with the exception of the requirement in the 2021 CAA that information be available by telephone), the Departments proposed a rulemaking indicating that compliance with the internet-based self-service tool requirements of the TiC Final Rules satisfies the analogous requirements set forth in the 2021 CAA.[18] The proposed rulemaking requires that the same pricing information that is available through the online tool or in paper form, as described in the TiC Final Rules, also be provided over the telephone upon request.

Description of Proposal

The proposal amends the Code by replacing the 2021 CAA price comparison provision described above for plan years beginning on or after January 1, 2029. In particular, the proposal requires group health plans to make the information described below available in the formats described below.

Self-service tool

Upon request by an individual, a group health plan is required to permit individuals to learn, in a timely manner, the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a provider.

The self-service tool must include the following information:

- If the provider is a participating provider with respect to the item or service, the in-network rate for such item or service;

[17] See sec. 9825, sec. 725 of ERISA, and sec. 2799A-10 of the PHSA, as added by section 204 of division BB of the 2021 CAA.

[18] Transparency in Coverage, 90 Fed. Reg. 60432 (proposed Dec. 23, 2025) (to be codified at 26 C.F.R. pt. 54).

- If the provider is not such a participating provider, the maximum allowed amount or other dollar amount that the plan will recognize as payment for the item or service, along with a notice that the individual may be liable for additional charges;
- The estimated amount of cost-sharing (including deductibles, copayments, and coinsurance) that the individual will incur for the item or service, calculated, for providers that are not participating providers, using the maximum allowed amount or other dollar amount that the plan will recognize as payment;
- The amount the individual has already accumulated with respect to any deductible or out-of-pocket maximum, broken down for separate individuals if separate deductibles or maximums apply to separate individuals under the plan, in addition to any cumulative amount;
- If the plan imposes any applicable frequency or volume limitations (excluding medical necessity determinations), the amount that the individual has accrued towards such limitation with respect to the item or service;
- Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to the item or service;
- Any financial incentives (such as any credit, payment, or other benefit provided) available to the individual for the item or service known at the time the request is made; and
- Other information determined appropriate by the Secretary.

The self-service tool must meet the following requirements. It must:

- Be based on an internet website (or successor technology);
- Be made available in plain language at no cost;
- Provide for real-time responses to requests;
- Be updated to be timely and accurate;
- Allow individuals to make requests by:
    - A specific participating provider;
    - All participating providers; or
    - Nonspecific providers located in a relevant geographic region that are not participating providers;
- Provide that the request may be made by billing code or descriptive term; and
- Meet any other requirements determined appropriate by the Secretary.

At the option of the individual, the information described above must also be available in paper format, over the phone, or through other electronic disclosure, at no cost to the individual, as meets such requirements as the Secretary may specify.

The proposal requires that a plan take reasonable steps to ensure the accessibility of the information made available under the self-service tool, including reasonable steps to ensure that such information is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

Machine-readable file

The proposal requires that each group health plan will make available to the public the following information:

- For each item and service for which benefits are available under the plan, except for drugs:
    - In-network rate information (expressed as a dollar amount) for each participating provider, other than an excluded provider; and
    - For each participating provider, other than an excluded provider, an indication of whether the provider submitted a claim for the item or service for which payment was made (in whole or in part) during the one-year period beginning 18 months before the date the information is made public.
- Prescription drug price information for each drug (identified by NDC) for which benefits are available under the plan, including:
    - In-network rate information (expressed as dollar amounts);
    - Average amount paid by the plan (accounting for, in a manner determined appropriate by the Secretary, rebates, discounts, price concessions, and other remuneration specified by the Secretary) for such drug dispensed or administered during the 90-day period beginning 180 days before the date of publication, broken down by each provider, unless fewer than 20 claims for such drug to such plan; and
    - For a drug that is an applicable spread price drug[19] dispensed by a pharmacy, a specification that the drug is an applicable spread price drug; and for each pharmacy that has a contractual relationship for dispensing the drug, a

[19] For purposes of this proposal, an "applicable spread price drug" with respect to a plan is a drug for which benefits are available under the plan and for which, at the time the information is made public by the plan: (1) a contract is in effect between an entity providing pharmacy benefit management services (a "PBM") on behalf of the plan and a pharmacy for dispensing the drug under the plan, and (2) the specified payment amount is less than the specified reimbursement amount for the drug. The "specified payment amount" is the amount the PBM has agreed to pay the pharmacy for the ingredient costs and any applicable dispensing fee for a drug under a contract between the PBM and the pharmacy, taking in account any applicable cost sharing requirement. The "specified reimbursement amount" is the amount the plan has agreed to pay the PBM for the ingredient costs and any applicable dispensing fee for a drug, taking in account any applicable cost sharing requirement.

specification of the difference, if any, between the specified payment amount and the specified reimbursement amount.

- Out-of-network price information, including, for each item or service for which benefits are available, the amount billed, and the amount allowed, broken down by provider, for each item or service furnished during the six-month period beginning nine months before the information is made public, other than items or services for which fewer than 11 claims were submitted during the relevant period for such plan.

If a specific dollar amount for an in-network rate cannot be determined prospectively on the basis that such rate is determined as a percentage of the billed charges for such item or service, the plan must report the percentage and the median amount recognized by such plan as payment with respect to claims for such item or service submitted by in-network providers and indicate that the median amount represents an estimate of the in-network rate.

The information must be made available quarterly in machine-readable file format (or successor technology, such as application program interface technology, as determined to be appropriate by the Secretary) and as separate files that meet requirements specified by the Secretary, including requirements relating to whether such information should be made available on the plan or coverage level, with respect to individual provider networks, or aggregated in such manner as specified by the Secretary. The requirements specified by the Secretary must ensure that such files are limited to an appropriate size, do not contain information that is unnecessarily duplicative of information contained in other files made available pursuant to the machine-readable file requirement, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials. The machine-readable file requirement does not apply to grandfathered plans[20] or church plans.[21]

Each plan must also make available to the public instructions written in plain language explaining how individuals may search for this information. The Secretary is required to develop and publish a template that a plan may use in developing these instructions.

The proposal requires that a plan take reasonable steps to ensure the accessibility of the information made available under the machine-readable files, including reasonable steps to ensure that such information is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

Summary data file

For each plan year, a group health plan must make public a data file containing a summary of the rate and payment information on the machine-readable files made public by the

[20] Section 1251(e) of the PPACA.

[21] Sec. 414(e).

plan during the plan year. The summary data file must be able to be easily downloaded and read by standard spreadsheet software and meet requirements as established by the Secretary. The summary data file must include the following:

- The mean, median, and interquartile range of the in-network rate, and out-of-network amount allowed, for each item or service for which benefits are available, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished;
- Trends in payment rates for items and services over the plan year, including instances in which such rates have increased, decreased, or remained the same;
- Certain plan-identifying information;
- For each item or service which is paid as part of a bundled or capitated rate, a description of the information used to calculate the rate and a list of the items and services included in such rate; and
- The percentage of items and services that is paid for on a fee-for-service basis and the percentage that is paid for as part of a bundled rate, capitated payment rate, or other alternative payment model.

Attestation

The proposal requires each plan to submit to the Secretary an attestation that the information required by the proposal is true, accurate, and complete. The attestation must include a link to the website where the machine-readable files described above may be accessed, except this requirement to include the link to the website does not apply for grandfathered plans and church plans. The attestation also must be signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of the plan.

Reports

The proposal requires the Comptroller General to submit a report to Congress not later than January 1, 2029, containing an analysis of compliance with the requirements described above, an analysis of enforcement by the Secretary, the Secretary of Labor, and the Secretary of Health and Human Services (collectively, the "Secretaries"), and any recommendations for improving enforcement.

The proposal requires the Secretaries to submit a report to Congress not later than January 1, 2029, and biennially thereafter, containing an assessment of differences in negotiated prices, and any trends in such prices, in the private market between: (1) rural and urban areas; (2) the individual, small group, and large group markets; (3) consolidated and nonconsolidated health care provider areas; (4) nonprofit and for-profit hospitals; (5) nonprofit and for-profit insurers; and (6) insurers serving local or regional areas and insurers serving multistate or national areas.

The proposal requires the Secretaries to submit a report to Congress not later than one year after the date of enactment on the feasibility of including data related to the quality of health

care items and services with the price transparency information described above, including recommendations for legislative and regulatory actions to identify appropriate metrics for assessing and comparing quality of care.

Effective Date

The proposal is effective on the date of enactment, with the requirements generally applying for plan years beginning on or after January 1, 2029.

B. Information on Prescription Drugs

Present Law

For a summary of the requirements imposed on group health plans by the Code, ERISA and the PHSA, see section A of this document.

Description of Proposal

The proposal is intended to codify an existing restriction in the PHSA. The proposal provides that a group health plan must not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug from informing (or penalizing such pharmacy for informing) an individual of any differential between the individual's out-of-pocket cost under the plan with respect to the acquisition of the drug and the amount an individual would pay for the drug without using any group health plan or health insurance coverage.

The proposal also ensures that any PBM under a contract with any such plan does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalizing such pharmacy for informing) an individual of any differential between the individual's out-of-pocket cost under the plan with respect to the acquisition of the drug and the amount an individual would pay for the drug without using any group health plan or health insurance coverage.

For purposes of this proposal, the term "out-of-pocket cost" means, with respect to the acquisition of a drug, the amount to be paid by the individual under the plan, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.

Effective Date

The proposal is effective on the date of enactment.

C. Estimated Revenue Effects of the Proposal

An estimate of the effects on Federal fiscal year budget receipts will be provided by the Congressional Budget Office.