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Proposed Fee Transparency Rules and New Legislation for Group Health Plan PBMs

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President Trump's April 15, 2025, Executive Order on lowering the cost of prescription drug pricing, among other things, directed the Department of Labor (DOL) to propose regulations to improve the transparency of fees and compensation arrangements of pharmacy benefit managers (PBMs). In response, the DOL issued proposed regulations on January 30, 2026 that, once finalized, would require PBMs to disclose their compensation arrangements to self-insured group health plans.

The proposed regulations reflect the DOL's position that group health plan fiduciaries have a duty to ensure the reasonableness of fees and that transparent fee disclosures should help them to evaluate PBM arrangements. However, the DOL recognizes that negotiating PBM arrangements requires specialized expertise, and that most group health plans must work with benefits consultants or brokers who may have conflicts of interest due to payments or rebates they receive from PBMs. The proposed regulations address only the disclosures, but do not provide guidance on how fiduciaries can use them to negotiate more favorable prescription drug prices.

In addition to the PBM disclosure regulations, on February 3, 2026, the President signed into law the Consolidated Appropriations Act, 2026 (CAA), which will impose significant PBM reforms, including increased prescription drug transparency and limitations on the sources of revenue available for PBMs under contracts with ERISA-covered group health plans, once it is effective. In addition, federal legislation has been introduced in 2025 and 2026 which is intended to reign in prescription drug costs for health plans. The PBM Fiduciary Accountability Act has been introduced in Congress, which, if enacted, would deem PBMs to be ERISA fiduciaries.

Background

PBMs are a critical part of prescription drug coverage under group health plans. PBMs design the prescription drug formulary (list of prescription drugs covered with cost-sharing tiers), develop pharmacy networks for the

plan, and may provide other administrative services such as administering prescription drug claims and assisting with federal reporting and disclosures. Many critics have challenged that PBMs drive up drug costs by acting as "middlemen" (as characterized in the Executive Order) by charging group health plans substantial mark-ups on drugs relative to the costs the PBM has negotiated with pharmacies.

PBMs are compensated for their services under complex arrangements, which may include a pass-through pricing model or a spread pricing model, where the PBM retains the difference between the price paid by the plan and the price negotiated with the pharmacy. Group health plans may contract with PBMs directly or through third-party administrators or other parties.

The complexity of these arrangements can potentially lead to excess or hidden costs and/or conflicts of interest with PBMs and consultants that group health plan fiduciaries may be able to better evaluate with PBM disclosure rules. However, the complexity of these arrangements coupled with the employer's lack of expertise and lack negotiating power also raises questions as to how group health plan fiduciaries will be able to negotiate more favorable PBM costs, even with transparent pricing.

Proposed Regulations

The proposed regulations would provide disclosure requirements through the prohibited transaction exemption for "reasonable compensation" under ERISA section 408(b)(2). Accordingly, a prohibited transaction could result from a failure of a PBM to provide the required fee disclosures.

The DOL first imposed fee disclosure requirements under section 408(b)(2) for retirement plan service providers in 2012. The Consolidated Appropriations Act of 2021 expanded the section 408(b)(2) disclosure requirements to group health plan service providers, who provide "consulting services" and "brokerage services." Under Field Assistance Bulletin 2021-03, the DOL adopted a reasonable, good faith interpretation standard for compensation disclosures to group health plans, and PBMs were not explicitly included as covered service providers under this guidance.

While the proposed regulations follow a similar structure to the retirement plan disclosure rules, they are tailored to give fiduciaries of self-insured group health plans the information necessary to evaluate complex PBM compensation arrangements. Specifically, PBMs and certain affiliated entities would be required to provide disclosures related to compensation received through rebates and other payments from pharmaceutical manufacturers, spread pricing, claw-back payments recouped from pharmacies, and price protection

arrangements. These disclosures would be required to be made prior to entering into, renewing, or extending a contract and semiannually thereafter. The proposed rule would also permit the plan fiduciary to audit the accuracy of the information disclosed at the plan's expense.

In addition, the proposed rule would provide relief to plan fiduciaries in certain circumstances when a PBM fails to meet its disclosure requirements with a correction mechanism similar to those for disclosure failures for retirement plans under section 408(b)(2).

The PBM disclosure rules would become effective 60 days after publication of the final rule. The public comment period for the proposed rule runs through March 31, 2026.

Consolidated Appropriations Act, 2026

Although not effective until 30 months after enactment (August 3, 2028), the CAA goes further than the transparency requirements under the proposed regulations. It includes comprehensive drug-level and plan-level reporting requirements for PBMs as well as related participant notice requirements for group health plans that are covered by ERISA. The CAA is also likely to substantively impact contracts between PBMs and ERISA plans through amendments to section 408(b)(2) of ERISA that eliminate indirect compensation arrangements that are currently available to PBMs under such contracts by deeming them unreasonable.

The CAA imposes on PBMs drug-level reporting requirements to large employers and plan-level reporting requirements to employers of all sizes. With respect to large employers, PBMs will be obligated to provide semi-annual reports (and quarterly reports upon request) that include pricing information on each drug for which a claim was filed and an explanation of any benefit design features that encourage the use of pharmacies affiliated with the PBM. PBMs will also be required to provide sponsors of all group health plans with a detailed summary of this information. In turn, group health plans will be required to provide this summary information to participants and beneficiaries as part of a new mandatory annual notice. Rather than relying on the prohibited transaction penalties for enforcement, as is the case in the proposed regulations, the CAA imposes significant civil monetary penalties for failing to comply with the reporting requirements. When a PBM or group health plan fails to provide the required information, it will face a penalty of $10,000 per day. If a PBM or group health plan knowingly reports false information, the penalty will be $100,000. However, unlike the proposed regulations, the CAA does not provide audit rights to group health plans with respect to PBMs' disclosures.

The CAA also amends section 408(b)(2) of ERISA to require that, in order for any contract between an ERISA-covered plan and a PBM to be deemed reasonable (and thus exempt from prohibited transaction rules), the contract must require that PBMs remit to the group health plan 100 percent of all rebates, fees, alternative discounts, and other remuneration, with the exception of bona fide service fees, received under such contract on a quarterly basis. Group health plans must be permitted to audit such payments under the contract. Any contract which fails to include these terms will be deemed a non-exempt prohibited transaction. Additional regulatory guidance on the CAA's amendments to ERISA may be needed prior to its effective date.

Considerations for Plan Fiduciaries

While fee disclosure requirements for PBMs may be helpful to group health plans in understanding PBM pricing structures, they would also keep a focus on the responsibility that fiduciaries have in ensuring that compensation received by PBMs is reasonable for the services provided. Recent lawsuits filed against group health plan fiduciaries over prescription drug pricing have not been successful to this point. For example, in November, a federal court found that it was "too speculative" that allegedly excessive fees paid to PBMs had any effect on premium rates and out-of-pocket costs.[1] However, PBM fee disclosures would potentially make it easier for plaintiffs to connect excessive PBM fees to the costs borne by group health plan participants.

The PBM fee disclosure rules are only proposed regulations for now, and the CAA provides for a long runway of 30 months before its provisions become effective. However, plan fiduciaries should focus on developing a strategy to ensure that they have an appropriate process in place to review the disclosures required under both the proposed regulations and the CAA and evaluate PBM arrangements. In the longer term, plan fiduciaries may want to develop a strategy with respect to how the CAA's amendments to the prohibited transaction exemption under section 408(b)(2) of ERISA may impact their contractual relationships with PBMs. Both the short-term and long-term considerations may require the assistance of benefits consultants and counsel to ensure that fee disclosures are received, evaluated, and used to negotiate favorable pricing.

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[1] *Lewandowski v. Johnson and Johnson*, D. N.J. (Nov. 26, 2025).