

National Compliance Update

USI EMPLOYEE BENEFITS

November 12, 2026

PBM Fee Disclosure Final Rule Issued

On October 29, 2026, the U.S. Department of Labor ("DOL") issued the pharmacy benefit manager fee disclosure final rule ("Final Rule").

Briefly, the Final Rule:

- Requires providers of pharmacy benefit manager ("PBM") services and certain affiliates to make detailed disclosures to fiduciaries of large, self-insured group health plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA").
- Confirms that other services providers, such as PBMs and third-party administrators ("TPAs"), are service providers under amended ERISA Section 408(b)(2) and must disclose direct and indirect compensation to group health plans. However, the DOL did not include additional guidance, beyond enforcement relief, in this rulemaking.

The Final Rule's PBM disclosure requirements apply to plan years beginning on or after July 1, 2027.

BACKGROUND

As previously reported,[1] the DOL issued a Proposed Rule requiring covered service providers that provide pharmacy benefit management services to disclose compensation information to fiduciaries of ERISA-covered self-insured group health plans.

The goal of the Proposed Rule was to ensure plan fiduciaries have access to clear information that helps them understand PBM compensation flows, identify conflicts of interest, and determine whether PBM contracts or arrangements are reasonable under Section 408(b)(2), which provides a prohibited transaction exemption when:

- The contract or arrangement is reasonable,
- The services are necessary for the establishment or operation of the plan, and
- No more than reasonable compensation is paid for the services.

[1] See USI's Compliance Update, DOL Proposes PBM Disclosure Rule for Self-Insured Plans (Feb. 12, 2026).

This summary is intended to convey general information and is not an exhaustive analysis. This information is subject to change as guidance develops. USI does not provide legal or tax advice. For advice specific to your situation, please consult an attorney or other professional.

Shortly after issuance of the Proposed Rule, the Consolidated Appropriations Act, 2026 ("CAA-26") became law.[2] CAA-26 introduced significant PBM reforms, including creating its own PBM transparency, reporting, and disclosure requirements under newly created ERISA Section 726, and requiring full pass-through of rebates and other remuneration to ERISA group health plans. The PBM provisions of CAA-26 and rebate pass-through do not take effect until the first plan year on or after August 3, 2028.

In addition, CAA-26 expanded the entities required to furnish Section 408(b)(2) compensation disclosures to include a broader range of service providers, such as PBMs and TPAs. However, it was unclear when the expanded compensation disclosure under Section 408(b)(2) went into effect.

The Final Rule codifies new PBM disclosure requirements and clarifies the Final Rule's scope in the context of the broader Section 408(b)(2) disclosure requirements. It also confirms the expanded compensation disclosure under Section 408(b)(2) became effective upon enactment of CAA-26 on February 3, 2026.

PBM DISCLOSURES

What is a covered plan?

Disclosures must be furnished by covered service providers to covered plans.

For this purpose, a covered plan is a self-funded plan subject to ERISA:

- with at least 100 participants;[3] or
- that is offered by a private employer with at least 100 employees.[4]

Covered plans do not include:

- A fully insured group health plan (regardless of size);
- A group health plan established by a plan sponsor that is (or is affiliated with) a drug manufacturer, distributor, wholesaler, pharmacy benefit manager, or rebate aggregator (or other purchasing entity designed to aggregate rebates); and
- Non-ERISA plans (e.g., government or church plans);

> ***USI Note*.** While excluded from the PBM disclosure requirement under the Final Rule, ERISA plans are subject to the Section 408(b)(2) general compensation disclosure requirement for group health plans.

[2] See USI's Compliance Update, Legislation Paves Way for PBM Transparency (Feb. 12, 2026).
[3] An average of at least 100 participants on business days during the preceding plan year. Whether a group health plan is a specified large plan is determined by taking the sum of the total number of participants (not including beneficiaries) for each calendar month in the preceding plan year, and dividing by 12 (rounded down).
[4] An employer who employs an average of at least 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the calendar year. This is determined under rules similar to the rules for counting employees under the employer shared responsibility provisions in Code Section 4980H and implementing regulations.

Who is a covered service provider?

The Final Rule applies to covered service providers ("CSPs").

A CSP means a service provider that enters into a contract or arrangement with a covered plan and reasonably expects at least $1,000 in direct or indirect compensation in connection with providing:

- Any pharmacy benefit management services (whether the services are performed directly or through affiliates, agents, or subcontractors); or
- Advice, recommendations, or referrals regarding the provision of pharmacy benefit management services and is a provider of PBM services or their affiliate.[5]

A provider may be a CSP under the Final Rule if it furnishes PBM services regardless of whether the provider identifies itself as a PBM.

PBM services are defined as services necessary to manage or administer a group health plan's prescription drug benefits and include but are not limited to:

- Acting as a negotiator or aggregator of rebates, fees, discounts, and other price concessions for prescription drugs.
- Establishing or maintaining prescription drug formularies.
- Establishing or maintaining pharmacy networks, through contract or otherwise.[6]
- Performing utilization review and management, including prior authorization, step therapy protocols, patient compliance analysis, therapeutic intervention, and generic or biosimilar substitution programs.

The following services, in conjunction with any of the above, are also PBM services:

- Processing the payment of claims for prescription drugs.
- Adjudicating appeals or grievances related to the covered plan's prescription drug benefits.
- Recordkeeping related to the covered plan's prescription drug benefits.
- Performing regulatory compliance with respect to the covered plan's prescription drug benefits.

What disclosures are required?

There are initial and semiannual disclosure requirements from the CSP.

The initial disclosure is an estimate of amounts reasonably expected to be paid to the CSP.

The semiannual disclosure must cover amounts actually received during the reporting period plus any amounts reasonably expected to be received in connection with services during the period.

The disclosures must include the following information:

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[5] Briefly, an entity's affiliate is one that directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with such person or entity; or is an officer, director, or employee of, or partner in, such person or entity. An ''affiliate'' generally refers to an affiliate of the covered service provider.

[6] Including mail order, specialty, retail, nursing home, long-term care, infusion or out-patient pharmacies.

- **A description of PBM services (initial disclosure only).** A description of the services provided or the advice, recommendations, or referrals regarding the provision of PBM services.
- **Direct compensation.** Direct compensation the CSP reasonably expects to receive directly from the plan or plan sponsor (initial disclosure) and actually received (semiannual disclosure), including the amount allocated to each service in a bundled arrangement.[7]
- **Indirect compensation**, including:
  - Manufacturer payments, including rebates, administrative fees, alternative discounts, price protection agreements,[8] or other remuneration and the amount passed through to the plan.
  - Spread compensation per drug on formulary.[9]
  - Pharmacy recoupment, such as copay claw-backs[10] and retroactive adjustments to pharmacy reimbursement reasonably expected to be received by any CSP, an affiliate, agent, or subcontractor.
- **Price protection agreements.** A description of any inflation protection or price protection agreement between the CSP (or an agent, affiliate or subcontract) and any drug manufacturer, distributor, wholesaler, or rebate aggregator (or other purchasing entity designed to aggregate rebates), for prescription drugs dispensed under the plan, including any amounts reasonably expected to be retained by the CSP.
- **Compensation for termination of contract or arrangement (initial disclosure only).** A description of any compensation that the CSP reasonably expects to receive in connection with termination of the service contract or arrangement (including how any prepaid amounts are calculated and refunded upon termination).
- **Other compensation.** If not already disclosed, a description of any compensation the CSP received or reasonably expects to receive related to PBM services provided to the plan along with a description of the services and identity of the payer.
- **Formulary placement incentives (initial disclosure only).** A description of any formulary placement incentives between the CSP and any drug manufacturer, including a list of alternatives omitted from the formulary with an explanation for the omission and information about changes the provider may make to the formulary.
- **Drug pricing methodology (initial disclosure only).** A description of the net cost (in dollars) to the plan of each drug on the formulary for each pharmacy channel (e.g., retail pharmacy, mail order pharmacy, and specialty pharmacy).
- **Statement of fiduciary status.** A statement that the CSP will provide services to the plan as an ERISA fiduciary, if applicable. Along with this statement, each entity must disclose any activity or policy that may create a conflict of interest.

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[7] Good-faith allocation of compensation by service is permitted.

[8] Both in the aggregate and for each drug on the formulary.

[9] The Final Rule aligns the definition of spread pricing with ERISA Section 726, which defines spread pricing as:

(I) the contracted compensation paid by the group health plan or health insurance issuer for each covered drug (identified by the National Drug Code) to the entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan or health insurance issuer;

(II) the contracted compensation paid to the pharmacy, by any entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan or health insurance issuer, for each covered drug (identified by the National Drug Code);

(III) for each such claim, the difference between the amount paid under subclause (I) and the amount paid under subclause (II).

[10] A copay claw-back is the difference between a copayment or coinsurance amount paid to the pharmacy by a plan participant that exceeds the reimbursement to the pharmacy and is recouped by the CSP.

- **Audit rights.** A statement explaining the plan's right to audit the CSP's disclosures and procedures for requesting an audit.
- **Overage explanation (semiannual disclosures only).** If an amount reported in a semiannual disclosure exceeds the amount in the initial disclosure by 5% or more, the CSP must provide a compensation overage explanation.

When are disclosures furnished?

- **Initial disclosure.** CSP must furnish the initial disclosure in writing no later than the date that is reasonably in advance of the date on which the agreement is entered and extended or renewed. For extensions and renewals, 90 calendar days in advance is deemed to be a reasonable period.
- **Semiannual disclosure.** CSP must furnish semiannual disclosures to the plan fiduciary in writing no later than 30 days after the end of each six-month period beginning on the date the service contract or arrangement is entered. The plan sponsor may request to receive quarterly disclosures which should be furnished no later than 30 days after the end of the quarter.
- **Upon request.** The CSP must provide any information the plan needs to meet its reporting obligations under Title I of ERISA upon written request from a plan fiduciary. It should be provided reasonably in advance of the compliance deadline, and if extraordinary circumstances prevent timely disclosure, the information must be provided as soon as possible.

How are disclosures furnished?

Disclosures must be furnished in writing. They must be clear, concise, free from misrepresentation, and specific enough to allow the plan fiduciary to evaluate whether the service contract or arrangement is reasonable.

This includes:

- Avoiding jargon or technical legal language (unless the disclosures include or reference the definition of those terms);
- Expressing compensation as a monetary amount (e.g., $1,000); however, CSPs may use a good-faith estimate if the amount cannot reasonably be determined; and
- Providing compensation information in a standard machine-readable file upon request.

CSPs are prohibited from restricting a covered plan's use of required disclosures or the required contract or arrangement, but third parties and their subcontractors to whom the plan discloses the information may be required to agree in writing that they generally may not redisclose the information and they may only use the information for purposes related to the covered plan's contract or arrangement.

Can disclosures be audited by the plan fiduciary?

Group health plans have the right to audit a CSP at least once a year to verify accuracy of its disclosures.

The CSP must acknowledge the audit request within 10 business days and generally must provide the necessary information (including information owned or held by its affiliates, agents, and subcontractors) within 60 calendar days.

As part of the audit, the CSP must make available all relevant records, claims and transaction-level data, and other information reasonably necessary to verify the accuracy of its disclosures. This can include contracts with retail pharmacies, drug manufacturers, and rebate aggregators, subject to reasonable confidentiality agreements.

The plan can independently choose the auditor and is responsible for paying the auditor. The CSP is responsible for any costs to produce the requested information.

What if CSPs do not furnish the required disclosures?

If CSPs fail to provide the required disclosures under the Final Rule, the agreement between the plan and the CSP to provide PBM services to the plan would constitute a prohibited transaction under ERISA. Without an exemption, the CSP would be prohibited from providing any services to the plan.

The DOL provides an administrative class exemption to provide relief from a prohibited transaction for fiduciaries if:

- The fiduciary did not know the CSP failed to comply and reasonably believed the requirements were satisfied;
- Upon discovering the failure, the fiduciary requests the CSP correct the failure in writing;
- The fiduciary notifies the DOL of the failure if the CSP does not comply with the request to correct the failure within 90 days;
- The fiduciary must determine whether termination of the CSP's contract is consistent with ERISA's requirements and document the basis for that decision.

Notice to the DOL is furnished electronically or by mail. The DOL has set up a website for fiduciaries to provide this notice.[11]

When will the Final Rule apply?

The Final Rule, which takes effect on January 4, 2027, applies to plan years beginning on or after July 1, 2027.

For a calendar year plan, the Final Rule applies to the plan year beginning January 1, 2028.

> ***USI Note*.** Separately, CAA-26's requirements pertaining to rebate pass-through and detailed PBM reporting on prescription drug benefits apply to plan years beginning on or after August 3, 2028. Further guidance is expected in 2027.

ERISA SECTION 408(B)(2) DISCLOSURES – COVERED SERVICE PROVIDERS

CAA-26 amended ERISA Section 408(b)(2) to expand the definition of a covered service provider for purposes of this compensation and disclosure requirement. In addition to brokers and consultants, this broader definition encompasses other vendors, such as TPAs and PBMs. The Final Rule confirms these changes became effective upon enactment of CAA-26 on February 3, 2026.

[11] https://beta.dol.gov/policy-regulations/pay-benefits/health-plans/improving-transparency-pharmacy-benefit-manager-fee-disclosure.

The DOL addresses several comments it received related to these disclosures. Based on these comments, the DOL believes disclosures for the expanded group of service providers would be best addressed in separate guidance tailored to those other types of service providers and will consider adding this to a future regulatory agenda.

However, the DOL expects the expanded group of service providers to make a good-faith effort to comply with their disclosure obligations and announces a temporary enforcement policy. For the period from February 3, 2026, until the first plan year on or after July 1, 2027, the DOL will not treat:

- A covered service provider under Section 408(b)(2) as having failed to make the required disclosures as long as it made disclosures in accordance with a good-faith interpretation of the amended statute;
- A plan fiduciary as having engaged in a prohibited transaction as long as the fiduciary acted in accordance with a good-faith interpretation of their obligations under ERISA to determine the reasonableness of the contract or arrangement.

EMPLOYER NEXT STEPS

Large, self-insured ERISA group health plans should:

- Ensure in upcoming PBM renewals that agreements reflect disclosure obligations and incorporate the plan's audit rights under the Final Rule; and
- Establish and maintain procedures to ensure initial and semiannual disclosures from PBMs pursuant to the Final Rule are received timely and reviewed.

All plan sponsors of ERISA group health plans should continue to:

- Ensure Section 408(b)(2) disclosures are obtained from all covered service providers, including brokers, consultants, TPAs and PBMs, reasonably in advance of entering into or renewing a contract;
- Monitor compensation and fees of all covered service providers for reasonableness of the costs and quality of services; and
- Document the process used to make fiduciary decisions on behalf of the plan.

RESOURCES

- For text of the Final Rule, please visit: https://www.govinfo.gov/content/pkg/FR-2026-11-02/pdf/2026-22306.pdf
- For the DOL's Fact Sheet, please visit: https://beta.dol.gov/system/files/media/policy-regulations/pay-benefits/health-plans/pbm-fee-disclosure/pharmacy-benefit-manager-fee-disclosure-final-rule-fs.pdf.

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