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Publications

High-Level Comparison of the Department of Labor's PBM Fee Disclosure Proposed Rule and the PBM Disclosure and Rebate Provisions in CAA, 2026

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SERVICES
Employers & Sponsors
- Health & Welfare Programs
- Fiduciary & Plan Governance

Health Services
- Federal Insurance Regulation
- State Insurance Regulation

Retirement Services
- Plan Services & Providers

	CAA 2026	DOL PBM Fee Disclosure NPRM
Effective date	Disclosure requirements effective for plan years beginning on or after 30 months after the date of enactment (August 2028). Rebate pass-through requirements effective for plan years beginning on or after 30 months after the date of enactment (August 2028). Extension of CAA 2021 broker and consultant fee disclosure provisions of ERISA section 408(b)(2)(B) to all health plan service providers appears effective as of the date of enactment (February 3, 2026).	Plan years beginning on or after July 1, 2026.

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Who is entitled to receive reporting on pharmacy benefit management services?	Group health plans and health insurance issuers: • A specified large employer or large plan (100+ employees/participants) is entitled to full disclosure specific to covered drugs. • Fully-insured large employer plans can opt into full disclosure specific to covered drugs. • All single employer plans (regardless of size) are entitled to a summary disclosure. • Participants and beneficiaries are also entitled to a higher-level summary disclosure.	Self-insured group health plans. Does not apply to fully-insured group health plans.
Who must provide reporting?	Requires reporting from entities providing PBM services. • Applicable entities must provide the entity providing PBM services with information necessary to issue reports. • Applicable entities include GPOs, drug manufacturers, distributors, wholesaler, rebate aggregators, or associated third parties; any subsidiary, parent, affiliate or subcontractor of a plan, issuer, or provider of PBM services; or other entities specified by the Departments.	Requires reporting from providers of PBM services or those providing advice, recommendations, or referrals regarding PBM services, including services performed by affiliates, agents, or subcontractors.
Frequency of reporting	Not less frequently than 6 months (or quarterly by plan request).	Initial disclosure not later than the date that is reasonably in advance of the date on which the service contract or arrangement is entered into, extended or renewed (30 days for extensions or renewals). Semiannual disclosure no later than 30 days after each six-month period beginning on the date the contract or arrangement is entered into, renewed, or extended.
What must be reported	A list of covered drugs and for each covered drug information related to compensation paid by the plan to the PBM, compensation paid by the PBM to the pharmacy, the difference between those categories of compensation, information related to drug pricing (wholesale acquisition cost, average wholesale price and net price per cost of treatment,	A description of services, as well as spread compensation, direct compensation, manufacturer payments, copay claw backs, price protection agreements, compensation for termination of contract, description of other compensation, description of formulary placement incentives, a description of the net cost to the plan for each pharmacy channel, statement of

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	total net spending). Total number of claims and out-of-pocket participant spending, if feasible. Total amount of rebates, fees, alternative discounts, or other remuneration received by the plan and service provider. A list of each therapeutic class for which a claim was filed, including associated gross and net spending and rebates. For drugs with gross spending over $10,000, or for the 50 drugs with the highest spending, formulary placement rationale and identification of changes from the prior year. Entities performing PBM services that have an affiliated pharmacy must disclose information about drugs filled using that pharmacy as well as benefit design parameters that encourage or require participants to use the affiliated pharmacy.	fiduciary status (if applicable), and statement of audit right.
Results of Non-Compliance	Non-Disclosure Provisions: $10,000 per day for failure to provide the required information. Rebate Pass-through Provisions: Recovery of retained amounts and potential current law fiduciary penalties and equitable relief.	Potential current law fiduciary penalties and equitable relief.
Administrative class exemption for responsible plan fiduciary	None. The disclosures are independent amendments to ERISA, PHSA, and the Code and are not based on ERISA's fiduciary requirements.	Exempts plan fiduciaries from liability if they did not know that the service provider failed or would fail to make the disclosures and reasonably believed the regulation's requirements had been met.
Full rebate pass-through to plans	Amends ERISA section 408(b)(2)(B) to require that PBMs remit 100% of rebates, fees, alternative discounts, and other remuneration to the plan or issuer. Renders any contract or contract renewal unreasonable unless such remittances are required under the contract.	No rebate pass-through requirement but does seek comment on how fully pass-through PBMs disclose information and the market share they represent.
Audit right	Plans and issuers may audit rebates remitted, but no audit right regarding the accuracy of disclosures.	Self-insured plans will have an annual right to audit the service provider for the accuracy of disclosures.

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Clarification of "covered service providers" under current 408(b)(2)	Extends the broker and consultant fee disclosure provisions of ERISA section 408(b)(2)(B) to virtually all plan service providers, including TPAs to self-insured plans.	None

This chart is a summary depiction of some, but not all, of the legal requirements and is provided for informational purposes only. You may not rely on this information as legal or any other advice.