Big Changes to PBM Contracting and Group Health Plan Service Provider Disclosures—Some NOW and some later!

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On February 3, 2026, Congress passed and the President signed the Consolidated Appropriations Act, 2026 ("CAA 2026"). The news outlets primarily discussed the funding provisions of this legislation for many federal agencies. For benefits professionals, we noted the significant disclosure requirements applicable to pharmacy benefit managers (PBMs)—effective 30 months following the enactment of the legislation—and the requirement for ALL service providers to group health plans to disclose all direct and indirect compensation they receive in connection with the plan, effective for contracts entered into or renewed after the effective date of the CAA 2026. These new rules will have a significant impact on the contracting process for all group health plan contracts.

Effective Now—Expanded Fee Disclosure Requirements under ERISA

*Basic Rule***.** The Consolidated Appropriations Act, 2021 ("CAA 2021") amended ERISA § 408(b)(2) to require certain "covered service providers" to group health plans to disclose specified information to a responsible plan fiduciary about the direct and indirect compensation the covered service provider expects to receive in connection with its services to the plan. The CAA 2021 disclosure requirements apply to persons who provide "brokerage services" or "consulting" to ERISA-covered group health plans who reasonably expect to receive $1,000 or more in direct or indirect compensation in connection with providing those services. In general, this information must be disclosed reasonably in advance of the parties entering into such contract or arrangement, or before the contract or arrangement is extended or renewed. The required disclosures are intended to provide the responsible plan fiduciary with sufficient information to assess the reasonableness of the compensation (both direct and indirect) to be received and potential conflicts of interest that may exist as a result of a covered service provider receiving indirect compensation from sources other than the plan or the plan sponsor.

The CAA 2026 expands the type of services that renders an entity a "covered service provider" under this disclosure rule so that it applies to virtually all group health plan service providers, including vendors that provide any of the following services: plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management

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services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, employee assistance programs, or third-party administration services or consulting services related to any such services.

Focused on the Services Provided. While the CAA 2021 disclosure rule applied to those who provided brokerage and consulting services, the CAA 2026 removes the title of "brokerage services" and "consulting" and expands it to a wide variety of services that the vendors provide in connection to the group health plan—regardless of how the vendors label those services. The CAA 2026 also states that when an entity providing plan services contracts with a provider that performs pharmacy benefit management services, that contract is considered an indirect furnishing of services between the plan and the service provider for pharmacy benefit management services. For example, a PBM does not escape the rules by being bundled into a layered contract with an insurance carrier.

Effective Date. There is no specific effective date for these rules. Unless stated otherwise by the DOL (such as through non-enforcement relief), the provision is effective for contracts entered into, extended or renewed after February 3, 2026. Failure to comply with the disclosure requirements means that the service arrangement is not reasonable and is, therefore, a prohibited transaction for which the statutory ERISA §408(b)(2) exemption does not apply.

Trucker Huss Comment. Plan fiduciaries will need to create new processes when entering into agreements with vendors that provide services to group health plans. A responsible plan fiduciary will need to provide a form to the vendor requesting information about direct and indirect compensation. When the information is returned, the fiduciary will need to understand it—i.e., how the vendor is paid and if incentives align with the plan (rather than the vendor). With these disclosures, plan fiduciaries will have a better window into the vast network of service providers that are paid amounts related to plan services. The initial disclosures from the covered service providers may be limited or difficult to understand, as many of these vendors have not operated their organization with this disclosure in mind.

Full Rebate Pass Through to Plan

Basic Rule. For a contract between a covered plan (or the sponsor of a covered plan) and a covered service provider for the provision of pharmacy benefit management services to be considered reasonable for the ERISA §408(b)(2) prohibited transaction rules, the entity providing the pharmacy benefit management services must remit "100 percent of rebates, fees, alternative discounts, and other remuneration received from any applicable entity that are related to utilization of drugs or drug spending under such health plan or health insurance coverage to the group health plan or, in the case of a health insurance issuer offering group health insurance coverage in connection with a group health plan, to the health insurance issuers offering group health insurance coverage on behalf of the plan." In essence, PBMs are required to pass through 100% of the rebates and discounts from drug manufacturers and PBM affiliates to health plan and issuer clients.

Effective Date. This rule is effective for plan years beginning on or after 30 months from the date of the CAA 2026's enactment. For calendar plan years, the effective date is January 1, 2029.

Trucker Huss Comments. This will significantly change the negotiation process with PBMs (and other entities that provide PBM services, such as third-party administrators). This has been a major source of revenue for PBMs, and they will likely increase fees in other places. This provision does not prohibit the practice of "spread pricing" where the plan pays a higher fee to the PBM than what the PBM pays to the dispensing pharmacy.

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Nor does it prohibit other ways that a PBM can make money in a contract, such as broad exclusions of certain types of drugs from various financial guarantees. So, while this is a welcome change, plan sponsors still need to be very diligent in their contract negotiations (and drafting).

Transparency Provisions

The CAA 2026 amends ERISA by adding a new section 726 and adds parallel provisions to the Public Health Service Act (PHSA) and the Internal Revenue Code. The rule requires extensive reporting requirements from an entity providing pharmacy benefit management services to group health plans and from group health plans to participants.

Reports to Large Employers and Large Plans. There is a very detailed set of reporting obligations that must be made to self-funded group health plans offered by large employers (at least 100 employees) or that qualify as large plans (at least 100 participants). (Large insured health plans can opt into receiving the reports.) The rule prohibits the entity providing pharmacy benefit management services from entering into contacts that would limit their ability to provide the required reporting. The transparency provisions state that the required information must be provided not less frequently than every six months (or, at the request of the group health plan, not less frequently than quarterly). The required report includes such information as:

- A list of drugs for which a claim was filed and with respect to each such drug, the contracted rates paid by the plan, rates paid to the dispensing pharmacy, the difference between those two amounts and the type of dispensing channel used (retail, mail order or specialty pharmacy)
- Net pricing
- Details about participant cost-shares (including copayments, coinsurance and deductibles)
- Amount of rebates, fees, alternative discounts, or other remuneration to be received by the plan or issuer and the entity providing pharmacy benefit management services
- A list of each therapeutic class for which a claim was filed including detailed cost information
- Other detailed information regarding drug claims
- Additional reporting of all drugs for which the plan incurred $10,000 or more in gross spending during the reporting period (or the top 50 drugs in gross spending if fewer than 50 drugs met the $10,000 threshold)
- If the entity providing pharmacy benefit management services has affiliated pharmacies (e.g., specialty home delivery programs), an explanation of any benefit design parameters that encourage or require the use of those pharmacies and percentage of total prescriptions dispensed by such pharmacies.

Reports to all Plans. Entities providing pharmacy benefit management services must provide all plans (insured and self-funded) with a summary document of most of the information required to be disclosed to large employers and large group health plans.

Disclosures to Participants. Entities providing pharmacy benefit management services must provide a summary document for plans to provide to participants and beneficiaries upon request. Written notice must be provided to plan participants, on an annual basis, regarding the new reporting requirements. Participants and beneficiaries can request specific claim-level information for claims incurred by the participant or beneficiary.

Penalties. Failure to meet these requirements can result in a civil monetary penalty of up to $10,000 per day during which the information is not provided and $100,000 (for each item of false information) if the entity knowingly provides false information.

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Trucker Huss Comment. Much of this information is similar to the information that must be disclosed under the Department of Labor proposed rule titled "Improving Transparency into Pharmacy Benefit Manager Fee Disclosure." While those regulations may be subject to judicial challenges, the Congressional statute will not. This information will help plan sponsors understand cost issues, drug trends, potential conflicts and incentives that are not aligned with the plan (but rather aligned with the interests of vendors). We anticipate proposed regulations being issued within the next year. It will be interesting to see if there will be challenges to certain state laws that require reporting by PBMs, claiming preemption of those state laws now that ERISA contains a specific reporting requirement.

If you have questions regarding the requirements of CAA 2026, how it will impact plan fiduciaries obligations or the negotiation process with PBMs, please contact us.

PUBLICATION INFO:

The Trucker Huss Benefits Report is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of the Benefits Report are posted on the Trucker Huss website (www.truckerhuss.com (https://www.truckerhuss.com))

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