PUBLICATION

CAA 2026 and the DOL's Final PBM Fee Disclosure Rule



Mary E. Powell

The Consolidated Appropriations Act, 2026 (CAA 2026), enacted February 3, 2026, significantly expanded the fee disclosure and transparency rules that apply to group health plans and their service providers, with a particular focus on pharmacy benefit managers (PBMs). Shortly afterward, the Department of Labor (DOL) finalized its rule on PBM fee disclosure, "Improving Transparency into Pharmacy Benefit Manager Fee Disclosure" (29 CFR §2550.408b-22), which was published in the Federal Register on November 2, 2026 (the "DOL Final Rule"). This article explains the three new statutory rules ((1) the expanded ERISA §408(b)(2)(B) disclosures, (2) the new ERISA §408(b)(2)(C) rebate pass-through, and (3) ERISA §726 semiannual reporting), how the DOL Final Rule fits with them, the open issues in the DOL Final Rule, and the steps plan sponsors and fiduciaries should take now.

Background

Prohibited Transactions. Under ERISA §406(a)(1)(C), a plan fiduciary may not cause the plan to engage in a transaction the fiduciary knows or should know is a direct or indirect furnishing of goods, services, or facilities between the plan and a party in interest. Under ERISA §3(14)(B), any person providing services to the plan is a party in interest. ERISA §408(b)(2) provides the exemption that makes service provider contracts permissible: the arrangement must be reasonable, the services necessary, and the compensation no more than reasonable. If the exemption is not satisfied, both the service provider and the responsible plan fiduciary may be treated as having engaged in a prohibited transaction.

The Consolidated Appropriations Act, 2021 added detailed disclosure rules for group health plans to ERISA §408(b)(2)(B), but those rules reached only brokers and consultants. The CAA 2026 extends the disclosure condition to virtually all group health plan service providers. It also adds two new PBM-specific provisions: a 100% rebate pass-through requirement and semiannual PBM reporting.

Two Separate Layers. To understand the DOL Final Rule, it is essential to keep the CAA 2026 (the statute) and the DOL Final Rule distinct. The CAA 2026 is statutory law, passed by Congress and signed by the President. The DOL Final Rule, by contrast, was proposed on January 30, 2026, four days before the CAA 2026 was enacted. The DOL then extended the comment period by 15 days to ask whether the DOL Final Rule should be adjusted, and made changes to align it with the statute. The DOL relies on the authority the CAA 2026 gave it in ERISA §408(b)(2)(B) to regulate the "time, manner, and content" of disclosures. The DOL Final Rule may be challenged in court—and the outcome of that would be uncertain—but regardless, the statutory requirements will continue to apply.

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In practice, the layers interact as follows:

- The CAA 2026 statutory disclosure requirement under ERISA §408(b)(2)(B) applies to contracts with group health plan vendors that are entered into, extended, or renewed on and after February 3, 2026.
- The DOL Final Rule implements the statute for certain PBM agreements.
- Plans outside the DOL Final Rule receive only the statutory disclosures (ERISA §408(b)(2)(B)) together with the ERISA §408(b)(2)(C) and §726 requirements for PBM contracts entered into, extended, or renewed on or after August 3, 2028. Fully insured plans, smaller plans, and plans of drug supply chain sponsors do not receive the DOL Final Rule's detailed disclosures, but their providers must still comply with the statute.
- Before the DOL Final Rule applies, PBMs may use the DOL Final Rule as guidance on their current ERISA §408(b)(2)(B) obligations, and the DOL's good faith enforcement policy runs from February 3, 2026, until the DOL Final Rule's requirements apply (plan years beginning on or after July 1, 2027).

For example, a PBM is subject to the ERISA §408(b)(2)(B) disclosures for any contract entered into, renewed, or extended on or after February 3, 2026. For plan years beginning on or after July 1, 2027, a PBM serving a "covered plan" should follow the DOL Final Rule.

Amended ERISA §408(b)(2)(B): Disclosures by Virtually all Group Health Plan Service Providers.

Covered Service Provider—ERISA §408(b)(2)(B). The CAA 2026 extends the ERISA §408(b)(2)(B) statutory disclosure requirement to virtually all group health plan service providers, including PBMs and third-party administrators, that reasonably expect $1,000 or more in direct or indirect compensation for services such as brokerage, plan design, recordkeeping, benefits administration, stop-loss insurance, PBM services, wellness, and consulting. As the preamble to the DOL Final Rule confirms, all of these providers must comply with the statute to rely on the prohibited transaction exemption, while the DOL Final Rule's more detailed requirements are limited to PBMs and affiliated brokers and consultants. A PBM that contracts with an insurer is also treated as an indirect service provider and party in interest, so PBMs serving fully insured plans must satisfy an exemption as well.

What Must Be Disclosed—ERISA §408(b)(2)(B). Covered service providers must disclose the following in writing to the responsible plan fiduciary, reasonably in advance of entering into, extending, or renewing the contract:

- a description of the services to be provided;
- if applicable, a statement that the provider expects to provide services as a fiduciary;
- a description of expected direct compensation, in the aggregate or by service;
- a description of expected indirect compensation, including compensation from a vendor to a brokerage firm, and specified information about the arrangement, such as incentives not solely related to the contract with the plan and identification of the payer;
- a description of transaction-based compensation (such as commissions or finder's fees) paid among the provider and its affiliates or subcontractors;
- a description of compensation reasonably expected in connection with termination of the arrangement; and
- a description of the manner in which compensation will be received.

Changes must be disclosed "as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change," subject to an exception for extraordinary circumstance
A good faith disclosure error or omission does not make the contract unreasonable if the provider discloses

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the correct information as soon as practicable, but not later than 30 days after it learns of the error. Providers must also timely furnish compensation information that a responsible plan fiduciary or plan administrator requests to satisfy reporting or disclosure requirements.

Note that a plan fiduciary will not be treated as having engaged in a prohibited transaction because of a provider's failure to disclose if the fiduciary did not know of the failure, reasonably believed the disclosures would be made, requested the information in writing, and, if no response was received within 90 days, notified the DOL. If the requested information relates to future services and is not disclosed promptly after the 90-day period, the fiduciary may terminate the contract.

Effective Date and Temporary Enforcement Policy—ERISA §408(b)(2)(B). The amendments became effective on February 3, 2026, upon enactment; the statute does not set a separate effective date. The DOL has made clear that the statutory disclosure requirement applies to contracts entered into, extended, or renewed on and after that date. For example, if an employer enters into a contract with a third-party administrator (TPA) for its self-funded medical plan effective January 1, 2027, the TPA must provide the ERISA §408(b)(2)(B) disclosures reasonably in advance, and the responsible plan fiduciary should confirm it has received them during the contract negotiation process.

Under a temporary enforcement policy described in the preamble to the DOL Final Rule, which runs from February 3, 2026, until the DOL Final Rule's applicability date, the DOL will not treat a covered service provider as having failed to make the required disclosures if it made them in accordance with a good faith interpretation of amended §408(b)(2)(B). Likewise, the DOL will not treat a responsible plan fiduciary as having engaged in a prohibited transaction if the fiduciary acted in accordance with a good faith interpretation of its obligations to determine the reasonableness of the contract or arrangement.

New ERISA §408(b)(2)(c): 100% Rebate Pass-Through.

The CAA 2026 also adds a 100% rebate pass-through requirement. For plan years beginning on or after August 3, 2028 (January 1, 2029, for calendar-year plans), no PBM services contract or arrangement, or renewal or extension of one, entered into on or after August 3, 2028, will be considered reasonable unless the entity providing PBM services remits to the plan (or, for an insured plan, to the insurer on the plan's behalf) 100% of rebates, fees, alternative discounts, and other remuneration received from drug manufacturers, rebate aggregators, and other applicable entities that are related to drug utilization or drug spending under the plan. The requirement reaches only contracts, renewals, and extensions entered into on or after the effective date; the statute provides that the requirement does not "affect the term" of a contract as in effect on the effective date, but applies to any renewal or extension of that contract entered into on or after the effective date.

The statute does not require remittance of bona fide service fees and does not prohibit reasonable payments for bona fide services under a fee structure that is transparent and quantifiable to the plan. Remittances must be made quarterly, no later than 90 days after the end of each quarter, and the plan (or the plan sponsor, insurer, or a third party the sponsor designates) may audit the rebate records and disclosures at least once per plan year, using an auditor selected by the responsible plan fiduciary and not paid, directly or indirectly, by the PBM. A fiduciary relief procedure, similar to the one for disclosure failures, applies if a PBM fails to remit.

New ERISA §726: Semiannual PBM Reporting



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Separately, for plan years beginning on or after August 3, 2028, and for PBM contracts (including extensions and renewals) entered into on or after that date, PBMs must report to plans at least every six months (or quarterly on request). Large self-insured plans receive a detailed, drug-by-drug report showing plan payments, pharmacy payments, the PBM's spread, and rebates (large fully insured plans may opt in), while all plans receive a summary report. Plans sponsored by, or affiliated with, drug manufacturers, wholesalers, or other participants in the drug supply chain will receive a limited form of report to be defined by regulation. Plans must also notify participants annually of the reporting requirement and, upon request, provide participants the summary document and information for their own claims. The agencies must issue a standard report format and implementing regulations by August 3, 2027.

The DOL Final Rule

Scope. The DOL Final Rule implements ERISA §408(b)(2)(B) for PBMs and applies to plan years beginning on or after July 1, 2027. It covers only large self-insured plans: generally, single-employer plans of employers with an average of at least 100 employees, or plans sponsored by employee organizations or multiple employers with an average of at least 100 participants. Three groups of plans are excluded, though they still receive the statutory disclosures:

- fully insured plans (all benefits provided through an insurance contract);
- plans that are neither plans of a specified large employer nor specified large plans; and
- plans whose sponsor is, or is affiliated with, a drug manufacturer, distributor, wholesaler, pharmacy benefit manager or rebate aggregator. The preamble adds market authorization holders, GPOs, and affiliated retail, mail-order, and specialty pharmacies, and states that the list is not exhaustive.

Covered service providers under the DOL Final Rule are entities that contract with the plan to provide pharmacy benefit management services, regardless of whether they call themselves PBMs, including TPAs that contract to provide those services through a PBM subcontractor, and PBM-affiliated brokers and consultants.

Initial Disclosures. PBMs must provide written disclosures reasonably in advance of entering into, extending, or renewing a contract; for extensions and renewals, 90 calendar days in advance is deemed reasonable. For example, if a contract renewal date is January 1, 2028, the employer should obtain the initial disclosures by October 3, 2027. Compensation must be stated in dollar amounts (good faith estimates are permitted), not merely as formulas or percentages.

Required disclosures include:

- a description of each pharmacy benefit management service;
- direct compensation from the plan or plan sponsor, such as per-member-per-month fees, with a good faith allocation by service for bundled arrangements;
- indirect compensation:
    - rebates and other manufacturer payments, in total and by drug, showing what is passed through and what is retained;
    - spread compensation for each drug and by retail, mail-order, and specialty channel;
    - copay claw-backs, other pharmacy recoupments, and price protection agreements;
- termination payments, other compensation, formulary placement incentives, and the net price of each dru (or the pricing methodology if a dollar amount is not ascertainable); and

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- a statement of fiduciary status and of the plan's audit right.

If the PBM retains authority to modify the formulary during the contract term (for example, by adding or deleting drugs or changing their tiering), it must explain why it retains that authority and the expected frequency of changes, and must state that the fiduciary will be notified reasonably in advance of any modifications that, individually or in the aggregate, are reasonably expected to have a material impact on the reasonableness of compensation, as well as the plan's right to terminate the contract on reasonably short notice under the circumstances. For this purpose, "material" means 5% or more of the aggregate manufacturer rebates, fees, alternative discounts, and other remuneration disclosed for the semiannual (or quarterly) period, adjusted for previously disclosed increases, or a lower percentage or dollar amount agreed to in writing in the contract.

Ongoing Disclosures. PBMs must provide disclosures every six months (or quarterly on request) within 30 days after each period ends, showing amounts received or reasonably expected for the period. If any category of compensation to the PBM and its affiliates, agents, or subcontractors, in the aggregate, exceeds the corresponding estimate by 5 percent or more (or a lower threshold agreed to in writing in the contract), the PBM must identify the overage and explain it.

Audit Rights. At the plan's written request, the PBM must allow an audit of the accuracy of the disclosures at least once per year, using an auditor selected by the responsible plan fiduciary, without PBM restrictions on the timing of the audit, its location, or the number of records. The PBM must make available all records, claims and transaction-level data, and other information reasonably necessary to confirm the accuracy of the disclosures, including contracts with retail pharmacies, drug manufacturers, and rebate aggregators, subject to reasonable confidentiality agreements, and is responsible for information held by its affiliates, agents, and subcontractors.

The audit is limited to "the period covered by the disclosures under this section" (29 CFR §2550.408b-22(j)(6)), which the DOL stated in the preamble means the period after the effective date of the DOL Final Rule as applied to the particular arrangement. The PBM must confirm receipt of an audit request within 10 business days and provide the records within a commercially reasonable period, but no later than 60 calendar days absent extraordinary circumstances beyond its control; the plan pays the auditor, and the PBM bears the cost of providing the requested information.

Protection for Plan Fiduciaries. If a PBM fails to provide the required disclosures or permit an audit, the DOL Final Rule protects the responsible plan fiduciary if the fiduciary did not know of the failure and had a reasonable basis to believe the requirements were met. Upon discovering the failure, the fiduciary must ask the PBM in writing to correct it. If the PBM does not comply within 90 days, the fiduciary must notify the DOL (no later than 30 days after the earlier of the PBM's refusal or the end of the 90-day period) and, consistent with its duty of prudence, decide whether to terminate or continue the contract and document that decision. The exemption protects only the fiduciary; the PBM remains exposed to prohibited transaction liability and civil penalties.

How the DOL Final Rule Builds on the Statute. The DOL Final Rule converts the statute's general categories into specific items. The general duty to disclose payments from the plan becomes dollar amounts by service for each six-month period; the statute permits compensation to be described as a monetary amount, formula, or per capita charge, but the DOL Final Rule requires a monetary amount. The general duty to disclose third-par payments becomes per-drug rebates, spread by channel, recoupments, and price protection. The statute's 60-

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day change rule is replaced by semiannual reports with overage explanations. The DOL Final Rule also adds items not found in ERISA §408(b)(2)(B), including net drug prices and an audit of all disclosures under the DOL Final Rule, which is broader than the ERISA §408(b)(2)(C) audit right covering rebate records, the related disclosures, and rebate contracts.

Some Open Issues in the DOL Final Rule.

Spread and PBM-owned pharmacies. Under 29 CFR §2550.408b-22(e)(3)(ii), spread compensation is measured against the amount paid to "the pharmacy." When the pharmacy is owned by the PBM, that payment stays within the PBM's corporate family. Commenters asked the DOL to break out spread for affiliated and non-affiliated pharmacies; the DOL declined. Instead, it added 29 CFR §2550.408b-22(e)(3)(ii)(C), requiring a description of arrangements, incentives, contract terms, and policies that steer patients to PBM-affiliated pharmacies, and treats compensation affiliated pharmacies receive as "other" compensation under paragraph (e)(5). The DOL Final Rule does not say how affiliated pharmacy compensation is to be measured.

NOTE: Plan fiduciaries will still need to review PBM contracts for spread pricing issues.

Affiliates, agents, and subcontractors. The definitions in 29 CFR §2550.408b-22(m) determine whose compensation must be included in every disclosure category. An "affiliate" is defined by control; an "agent" is any person or entity authorized, expressly or impliedly, to act on behalf of another; and a "subcontractor" is a non-affiliate expecting $1,000 or more for PBM services under the contract. Commenters noted that the control-based affiliate definition may not reach rebate aggregators and group purchasing organizations (GPOs) that have only contractual relationships with the PBM, some of which are offshore. The DOL retained the definitions as proposed and relies on the "agent" term to capture these entities.

NOTE: Plan fiduciaries should consider whether this issue needs to be addressed in the PBM contract, to avoid a later dispute about the scope of compensation disclosed by the PBM.

Action Items

The immediate priority should be the ERISA §408(b)(2)(B) disclosures, which already apply. Plan sponsors and fiduciaries should take the following actions:

1. Inventory contracts. List every group health plan service contract (PBM, TPA, insurer, stop-loss, broker, consultant, point solution vendors, and others), noting the dates each was entered into, renewed, or extended, and any automatic renewal terms.
2. Flag post-February 3, 2026, contracts. For any contract entered into, extended, or renewed on or after February 3, 2026, confirm whether written ERISA §408(b)(2)(B) disclosures were received, and request them in writing if not.
3. Review disclosures. Ensure a fiduciary reviews the disclosures and document the process for evaluating the reasonableness of the compensation.

If you have questions regarding CAA 2026 and the DOL's final PBM fee disclosure rule, please contact us.

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