

FACT SHEET



**U.S. Department of Labor
Employee Benefits Security Administration
October 2026**

Pharmacy Benefit Manager Fee Disclosure Final Rule

The U.S. Department of Labor released a final rule under the Employee Retirement Income Security Act (ERISA) to improve transparency into fees and compensation received by pharmacy benefit managers (PBMs) and their affiliates, like providers of brokerage and consulting services.

The final rule requires providers of pharmacy benefit management services to make detailed disclosures to fiduciaries of large, employer-sponsored, self-insured group health plans to satisfy ERISA's statutory prohibited transaction exemption for service arrangements. It also provides compliance assistance information for other service providers who must now report fees and compensation to group health plans following the passage of the Consolidated Appropriations Act, 2026.

The final rule also supports broader efforts under Executive Order 14273 to lower drug costs and increase transparency across the healthcare system. The administration is focused on lowering prescription drug costs for American workers and their families, as these costs make up a significant share of employer-sponsored health care spending.

Background

On April 15, 2025, President Trump signed Executive Order 14273, *Lowering Drug Prices by Once Again Putting Americans First*, directing the Department to improve transparency into the direct and indirect compensation PBMs receive to let employer health plan fiduciaries make better cost-control decisions.

PBMs play a central role in managing prescription drug benefits for employer-sponsored group health plans. They develop drug formularies, or lists of prescription drugs covered by a health plan. They also negotiate rebates and fees with drug manufacturers, establish pharmacy networks, and process prescription drug claims. While PBMs provide valuable services, their compensation arrangements can be complex, making them difficult for plan fiduciaries to evaluate. PBMs may receive compensation from the group health plan as well as from drug manufacturers, pharmacies, rebate aggregators, and others.

Overview of the Final Rule

The final rule will ensure that group health plan fiduciaries have the necessary information to satisfy their duties under ERISA.

The final rule applies to covered service providers (CSPs) to large, self-insured group health plans. These are generally self-insured plans with 100 or more participants or self-insured plans offered by employers with 100 or more employees.

For purposes of this final rule, CSPs are entities that provide pharmacy benefit management services, including PBM-affiliated brokers and consultants, that:

- Enter into contracts or arrangements with large, self-insured group health plans to provide pharmacy benefit management services or related brokerage or consulting services; and
- Expect to receive \$1,000 or more in compensation, whether the services are performed directly or through affiliates, agents, or subcontractors.

Pharmacy benefit management services are any services necessary to manage or administer a group health plan's prescription drug benefits, regardless of whether the service provider identifies itself as a PBM. These services generally include negotiating rebates, managing drug formularies and pharmacy networks, conducting utilization review, processing claims, and performing compliance activities.

The final rule requires CSPs to provide both initial and ongoing disclosures that give plan fiduciaries information about PBM compensation and potential conflicts of interest. This information will help fiduciaries evaluate whether the plan's contract or arrangement with the PBM is reasonable and whether the compensation that PBMs receive is reasonable. Also, CSPs must allow plan fiduciaries to audit the disclosed information for accuracy.

The Final Rule's Requirements

Initial Disclosures

CSPs must provide written initial disclosures to plan fiduciaries reasonably ahead of entering into, extending, or renewing service contracts or arrangements. For renewals and extensions, providing the initial disclosure at least 90 days in advance is considered reasonable.

These disclosures will give fiduciaries information to evaluate whether a contract or arrangement is reasonable. Initial disclosures must include a description of:

- **Services:** The pharmacy benefit management services, advice, recommendations, or referrals the CSP will deliver under the contract or arrangement.
- **Direct Compensation:** The amount of compensation the CSP reasonably expects to receive directly from the plan or plan sponsor, by service and in total, including the amount allocated to each service in a bundled arrangement.
- **Indirect Compensation:** The amount of compensation the CSP reasonably expects to receive from sources other than the plan or plan sponsor for prescription drug claims during the disclosure period, including:
 - **Manufacturer Payments:** Rebates, fees, discounts, or other payments from drug manufacturers and related entities related to drug utilization or spending on drugs, specifying what will be passed to the plan and what will be retained by the CSP.
 - **Spread Compensation:** The difference between what the plan will pay the CSP and what the CSP will pay pharmacies for drugs, with amounts specified by drug and pharmacy channel. CSPs must describe arrangements or contractual

provisions, incentives, and policies that will be implemented to direct patients to pharmacies that are affiliates of the CSP.

- **Pharmacy Recoupment:** Copay claw-backs and other retroactive adjustments to the CSP's reimbursement to pharmacies, including the anticipated number of transactions.
- **Price Protection Agreements:** Inflation or price protection contracts with manufacturers and related entities, including amounts reasonably expected to be passed through to the plan and retained by the CSP.
- **Compensation for Termination:** Any expected compensation related to contract termination, including how prepaid amounts are calculated and refunded.
- **Other Compensation:** Any compensation not already disclosed, including the payer, services involved, and a description of the arrangement.
- **Formulary Placement Incentives:** Incentives or arrangements with manufacturers that affect drug placement on formularies and their impact on the plan and participants. The disclosure must also, in some cases, identify a list of alternatives omitted from the formulary, along with an explanation for the omission, and provide information about changes the CSP may make to the formulary.
- **Drug Pricing Methodology:** The net price that will be paid for drugs after rebates and fees, or the methodology used to determine the net price if a monetary amount cannot be determined.
- **Statement of Fiduciary Status:** If applicable, a statement that the CSP expects to act as a fiduciary with respect to the plan.
- **Statement of Audit Rights:** A statement explaining the plan's right to audit the CSP's disclosures and procedures for requesting an audit.

Ongoing Disclosures

CSPs must provide ongoing disclosures to the plan of compensation received for services no later than 30 calendar days after the end of each semiannual period under the contract or arrangement. If the plan requests quarterly disclosures, the CSP must provide them.

Ongoing disclosures generally include the same categories of compensation as the initial disclosures. This allows a fiduciary to compare actual compensation with the amounts originally disclosed and monitor the contract or arrangement over time. The comparison helps a fiduciary determine whether the CSP's compensation remains reasonable.

For each semiannual period, or each quarter if requested by the plan, the CSP must disclose the actual amounts received or reasonably expected to be received for direct compensation, manufacturer payments, spread compensation, pharmacy recoupment, price protection agreements, and any other compensation not covered in these categories.

CSPs must also provide a compensation overage explanation if an amount reported in an ongoing disclosure exceeds the amount in the initial disclosure by 5 percent or more (or a lower threshold as agreed to by the parties). The overage explanation must identify the amount of the overage and explain the reason for it.

Information Upon Request

At the written request of a plan fiduciary, a CSP must provide any information the plan needs to meet its reporting and disclosure obligations under Title I of ERISA. The CSP must provide the requested information reasonably in advance of the compliance deadline. If extraordinary circumstances prevent timely disclosure, the CSP must provide the information as soon as practicable.

Manner of Disclosure

Required disclosures 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.

Disclosures must also:

- Avoid jargon or technical legal language unless the disclosures include or reference the definitions of those terms.
- Express compensation as a monetary amount. CSPs may use a good-faith estimate if the amount cannot reasonably be determined.
- Provide compensation information in a standard machine-readable file upon request, using industry-standard identifiers for drugs.

CSPs may not restrict a covered plan's use of required disclosures or the required contract or arrangement. However, 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 must use the information only for purposes related to the covered plan's contract or arrangement.

Audit Rights

The final rule grants group health plans audit rights to help plan fiduciaries monitor their CSPs.

A group health plan may audit a CSP at least once a year to verify accuracy of its disclosures. The plan has the right to independently choose its auditor. CSPs may not restrict that choice or limit the timing or location of the audit, or access to information needed for it. However, the scope of the audit is limited to the period covered by the disclosures required under the final rule.

A CSP must acknowledge an audit request within 10 business days and generally must provide the necessary information within 60 calendar days.

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

CSPs must also provide information owned or held by its affiliates, agents, and subcontractors within the specified deadlines. The plan is responsible for paying the auditor. The CSP pays for producing the requested information.

Administrative Class Exemption for Responsible Plan Fiduciary

The Department recognizes that CSPs may sometimes fail to meet their obligations under the regulation. For that reason, the final rule provides an additional administrative exemption for responsible plan fiduciaries when a CSP fails to comply with the regulation. To rely on the exemption, fiduciaries must take certain steps, including notifying the Department if the CSP does not correct the failure. The administrative exemption supplements the existing statutory provision in ERISA section 408(b)(2)(B)(viii).

Effective and Applicability Dates

The final rule takes effect 60 days after publication in the Federal Register. Its requirements apply to plan years beginning on or after July 1, 2027. Because the final rule implements statutory disclosure requirements under ERISA section 408(b)(2)(B), the Department seeks to give parties the time they need to develop compliance structures without delaying unnecessarily implementation.

Statutory Disclosure Obligations

Effective February 3, 2026, amendments to ERISA section 408(b)(2)(B) further clarified the statutory disclosure obligations that a broad range of covered service providers to group health plans must satisfy to rely on the prohibited transaction exemption.

The final rule's more specific disclosure obligations apply only to large, self-insured group health plans, generally those with 100 or more participants or those offered by employers with 100 or more employees. Service providers to smaller group health plans and to fully insured group health plans must still meet the statutory requirements to rely on the prohibited transaction exemption.

Similarly, group health plans engage a wide variety of service providers other than providers of pharmacy benefit management services. While all service providers to group health plans must comply with the statutory provisions in ERISA section 408(b)(2)(B) to be able to rely on the statutory prohibited transaction exemption, the scope of the Department's final rule is limited to providers of pharmacy benefit management services and affiliated providers of consulting or brokerage services.

The Department is providing a temporary enforcement policy for the period from February 3, 2026, until the final rule's requirements apply, while parties develop mechanisms to comply with the statutory and, as applicable, regulatory disclosure requirements. During this period:

- The Department will not treat a covered service provider as defined in ERISA section 408(b)(2)(B)(ii)(I)(bb) as having failed to make the required disclosures to a responsible plan fiduciary under ERISA section 408(b)(2)(B) as long as the covered service provider

made disclosures in accordance with a good faith interpretation of ERISA section 408(b)(2)(B), as amended.

- The Department will not treat a responsible plan fiduciary of a covered plan as defined in ERISA section 408(b)(2)(B)(ii)(I)(ee) as having engaged in a prohibited transaction in entering into a contract or arrangement with a covered service provider 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.

Contact Information

For questions about the final rule, contact EBSA's Office of Regulations and Interpretations at 202-693-8500.

For questions about the administrative class exemption, contact EBSA's Office of Exemption Determinations at 202-693-8540.

The information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.