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2026 Pharmacy Benefit Manager Reform: What Employers Need to Know

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Years of debate and halting efforts to enact pharmacy benefit manager (PBM) reform came to a head in early 2026 with three independent but related federal actions, bringing with them substantial PBM reform.

For employers faced with health care costs that outpace inflation and opaque PBM agreements that do not provide a complete line of sight into pricing arrangements, the changes promise increased transparency and cost savings opportunities. Whether the savings materialize into meaningful cost reduction remains to be seen, however, and we will monitor developments.

What You Need to Know:

- **CAA 2026 Enacts New PBM Requirements:** The most significant action of PBM reform, the 2026 Consolidated Appropriations Act (CAA), enacted several provisions that will alter the PBM landscape for commercial group health plans, effective for plan years beginning on or after January 1, 2029, (for calendar year plans). Early review of PBM contracts is advisable, as the CAA requirements prohibit the renewal of non-compliant contracts.

- **DOL Proposes New Disclosure Rule:** On January 30, 2026, the U.S. Department of Labor (DOL) published a proposed rule intended to increase visibility into PBM compensation for plan fiduciaries of self-insured group health plans subject to ERISA. The rule remains subject to change pending public comment and final rulemaking.

- **FTC Settles with Express Scripts:** The Federal Trade Commission (FTC) entered into a settlement with Express Scripts, Inc., on February 4, 2026, requiring significant changes to Express Scripts' PBM service offerings by January 1, 2027. The FTC remains in litigation against Caremark Rx and OptumRx for similar issues.

The following is a high-level summary and chart detailing relevant provisions of the DOL proposed rule, CAA, and FTC Settlement that we believe employers should understand prior to these federal actions becoming effective.

2026 Consolidated Appropriations Act

The CAA (H.R. 7148) enacted PBM reforms related to transparency and reporting, rebates and compensation, pharmacy participation, and enforcement and remedies.

While the reforms do not take effect for more than two and a half years (plan years beginning on or after 30 months after the Act's enactment, or Jan. 1, 2029, for calendar year plans), employers will benefit from early review of their PBM contracts as the CAA requirements prohibit the renewal of contracts that do not meet the requirements imposed by the CAA. Failing to meet the relevant requirements can result in prohibited transactions.

DOL Proposed Rule

The DOL's proposed rule is intended to increase visibility into PBM compensation to assist plan fiduciaries of self-insured health plans subject to ERISA in evaluating the reasonableness of contracts or arrangements with PBMs. The proposed rule creates an exemption to ERISA's prohibited transaction rule, so long as PBMs make the required disclosures to plan fiduciaries.

It is important to note that the requirements set forth under the proposed rule are subject to change after the DOL receives comments on the proposed rule and publishes a final rule.

FTC Settlement with Express Scripts

The settlement will resolve the FTC's lawsuit against Express Scripts, which targeted Express Scripts' alleged artificial inflation of the list price of insulin drugs through the preferential use of rebates. The settlement requires Express Scripts to implement several changes to its PBM service offerings that may have a trickle-down effect on plan sponsors.

Express Scripts must implement the required changes by January 1, 2027. As of the date of this article, the other PBM defendants to the lawsuit, Caremark Rx and OptumRx, have not entered into a settlement agreement with the FTC.

PBM Reform Actions			
	2026 CAA	**DOL Proposed Rule**	**FTC Settlement**
Covered Entities	Whether an entity is covered by the CAA depends on the provision, as its various requirements affect different types of entities. For reporting and disclosure obligations, the following entities are covered:	1. Self-insured group health plans subject to ERISA (fully insured group health plans are explicitly excluded for now) 2. Covered service providers who can reasonably expect to receive $1,000 or more in direct or indirect compensation in connection with services provided, specifically:	Express Scripts, Inc.

	1. Group health plans (both fully insured and self-funded) 2. Health insurance issuers offering group health insurance coverage under ERISA, the Internal Revenue Code, and the Public Health Service Act 3. Entities that provide PBM services on behalf of such plans or issuers via contract requirements related to PBM fees For the rebate pass-through requirements, the CAA provides that a contract for PBM services will not be reasonable (and thus eligible for the prohibited transaction exemption) unless contracts require full rebate pass-through. Therefore, entities providing PBM services for ERISA plans will be impacted.	a. providers of PBM services; and b. providers of advice, recommendations, or referrals regarding PBM services who are themselves providers of PBM services or their affiliates	
Reporting Requirements	The level of reporting required of PBMs varies based on the size of the employers. In short, the CAA requires **drug-level** reporting for **large employers** (100 or more employees) and **plan-level** reporting for *all* employers, including those with fewer than 100 employees. Entities providing pharmacy benefit	PBMs must provide the following required disclosures: 1. Initial disclosures—in advance of when a contract or arrangement is entered, extended, or renewed 2. Ongoing disclosures—within 30 days after each six-month period <u>Initial Disclosures</u>	Under the terms of the settlement, Express Scripts's PBM service offerings will include the following: 1. Automated reporting to plan sponsors, including an annual report disclosing drug costs and pharmacy claim-level reporting

	management services must disclose the following, **drug-level** information to large employers (100 or more employees) and plans on a semi-annual basis (or quarterly upon a plan's request): 1. The compensation received by the PBM for each covered drug 2. The compensation paid to the pharmacy by the PBM 3. The spread between the compensation received by, and paid out by, the PBM 4. The rebates, fees, and other remuneration received by the plan and the PBM for each drug and therapeutic class 5. How much the PBM spent on drugs 6. How much the PBM paid to brokers and consultants for referrals 7. Any benefit design that favors affiliated pharmacies The **plan-level** reporting, which must be provided to all health plans regardless of size, will include summaries of drug pricing, cost information, and claims information. PBMs must also supply a	1. Description of services to be provided under the contract 2. Compensation expected for services under the contract 3. Drug manufacturer payments expected (rebates, fees, etc.) on a quarterly basis, including the amounts passed through to the plan and amounts retained by the PBM 4. Spread compensation expected on a quarterly basis 5. Copay claw-backs expected to be recouped from a pharmacy 6. Description of inflation protection or price protection agreements entered into with any drug manufacturer or related entity in connection with prescription drugs dispensed under the contract 7. Compensation reasonably expected for termination of contract, including calculation and refunds for prepaid amounts 8. All other compensation reasonably expected on a quarterly basis under the contract 9. Description of formulary placement incentives and arrangements entered into with drug manufacturers	2. The disclosure of data to plan sponsors that will ensure compliance with the Transparency in Coverage Regulations 3. The disclosure to plan sponsors of any payment or facilitation of compensation to consultants or brokers that Express Scripts utilizes in connection with its provision of PBM services to those plan sponsors.

	document for plans to provide to participants and beneficiaries upon request that includes a summary of aggregate data related to claims, drug spending, rebates, and remuneration. Additionally, large employers who offer group health insurance may opt to require their PBM to submit a combined report to the group health plan, including both the drug-level reporting information *and* the plan-level summaries. Health plans must notify their participants and beneficiaries annually of the PBMs' reporting obligations and provide relevant reporting documents received by the Plan to participants upon request.	for services under the contract 10. Description of net cost to the plan or pricing methodology to determine the cost of each drug on the formulary 11. Acknowledgement that PBM will be providing fiduciary services to the plan under the contract, with a pledge to disclose activity or policies that may create conflicts of interest with the contract and plan 12. Audit rights of the plan <u>Ongoing Disclosures</u> 1. Compensation received on a quarterly basis for services under the contract 2. Drug manufacturer payments received on a quarterly basis for services under the contract 3. Spread compensation received on a quarterly basis 4. Copay claw-back compensation recouped from pharmacies on a quarterly basis 5. Amounts received from inflation protection or price protection agreements on a quarterly basis	

		6. All other compensation received for services under the contract 7. Identification of any compensation materially exceeding the quarterly estimate (5 percent or more, unless otherwise agreed upon with the plan) 8. Audit rights of the plan	
Rebate Pass-Through, Spread Pricing, and Other Requirements	PBMs must fully (i.e., 100 percent) pass through rebates to ERISA plans on a quarterly basis. The pass-through requirement includes specific obligations related to timing (remitted to the plan within 90 days of the end of each quarter, or 45 days if coming from rebate aggregators or group purchasing organizations). "Rebates" are defined broadly to include fees, alternative discounts, and other remuneration from any "applicable entity related to drug utilization or spending." PBMs are prohibited from requiring any contract terms that restrict or delay disclosure of compensation, fees, or information on manufacturer and pharmacy payments.		Under the terms of the settlement, Express Scripts will also have to make the following changes to its PBM standard service offerings: 1. The offering must not discriminate in any way against low wholesale cost versions of drugs. To accomplish that, Express Scripts agreed not to provide any standard formulary where a lower-cost drug is omitted, placed on a less favorable tier, or encumbered by additional restrictions such as pre-authorization or step therapy when the higher cost version of the drug is not. 2. The offering must pass through all rebates and discounts directly at the point of sale to "enable members to

			receive the benefit" and charge no fee for the administration of such rebate program. 3. The offering must refrain from making any guarantees to plan sponsors regarding any pre-determined amount of compensation. 4. The offering must refrain from employing spread pricing. 5. The offering must provide health plan participants access to its Patient Assurance Program's insulin benefits, if applicable. 6. The offering must compensate each retail pharmacy based on its actual cost of acquiring drugs, plus a dispensing fee, so long as such retail pharmacies meet certain conditions. 7. The offering must agree to pay retail pharmacies for all non-dispensing services performed by such retail pharmacies. 8. The offering may not exclude any retail community pharmacy from participating in its standard offering

			for retail community pharmacies. 9. Importantly, and despite the limitations related to its standard offering imposed by the settlement, Express Scripts may **make changes to its standard offering upon the written request of a plan sponsor or its agent**, so long as Express Scripts makes its standard offering to plan sponsors available to the plan sponsor requesting changes. If changes are made, the parties must fill out an exhibit provided by the FTC, acknowledging that the plan sponsor understands and agrees to the changes.
Audits	PBMs must allow, on an annual basis, ERISA plans to audit the PBM's rebate contracts with aggregators and manufacturers. The plan fiduciary must select an auditor, and the PBM may not pay for the auditor.	PBMs must notify plans of audit rights and procedures. Plans can audit at least on an annual basis. Audits are used to verify the accuracy of PBM disclosures.	Upon five days' notice, any member of the FTC shall be entitled to access Express Scripts' records and interview Express Scripts employees related to compliance with the settlement.
Civil Penalties and Fiduciary Relief / Safe Harbor	**$10,000** per day where a group health plan, health insurance issuer, or PBM fails to provide information required by the CAA	PBM noncompliance with disclosures can result in a prohibited transaction under ERISA, subject to enforcement action and civil penalties by the DOL.	None specified in the settlement

	$100,000 for each piece of false information provided by a group health plan, health insurance issuer, or PBM There may be plan fiduciary exemptions for failures attributable to PBMs, provided the fiduciary did not know and reasonably believed compliance occurred. Noncompliance with the rebate pass-through can result in a prohibited transaction under ERISA.	If plan fiduciaries become aware of noncompliance, plan fiduciaries must request PBM come into compliance within 90 calendar days. If the PBM does not come into compliance within 90 calendar days, plan fiduciaries must notify the DOL and decide whether to terminate the contract. Plan fiduciaries are not required to automatically terminate contracts with PBMs for noncompliance. Relief provided to plan fiduciaries who reasonably believed requirements were met and took steps to correct noncompliance.	
Timeline	The requirements of the CAA are effective August 3, 2028—30 months after the effective date of the CAA. For plan years based on the calendar year, the requirements of the CAA will be applicable on or after January 1, 2029. In addition, final regulations must be issued no later than August 3, 2027—18 months after the effective date of the CAA.	Effective 60 days after the publication of the final rule Applicable to plan years beginning on or after July 1, 2026	Most of the requirements listed above, including the reporting requirements, rebate pass-through, guaranteed compensation prohibition, spread pricing prohibition, and requirements related to retail community pharmacies, must be implemented as soon as commercially feasible, but no later than January 1, 2028. Other requirements imposed upon Express Scripts' standard PBM service offerings but

			not discussed in this article must be implemented as soon as commercially feasible, but no later than January 1, 2027.

What Employers Should Do Now

The implementation of the CAA is expected to introduce significant changes to the financial landscape for group health plans and PBMs. Although the FTC settlement agreement is only applicable to one PBM and the DOL proposed rule has not been finalized, these developments are a strong indicator of the current administration's policy as it relates to PBM compensation and transparency. Employers and plan fiduciaries should take the following actions:

In the near term:

- **Establish governance structures.** Consider establishing appropriate governance structures around fiduciary decision-making related to the review of PBMs.

- **Develop a disclosure review strategy.** Develop strategies to ensure an appropriate process for reviewing disclosures required under both the CAA and DOL proposed rule, evaluating downstream impacts on drug costs, premiums, and compensation arrangements, and negotiating favorable pricing.

- **Assess PBM fee structures carefully.** While 100 percent rebate pass-through and transparency requirements appear positive for group health plans, other restrictions may be less desirable. For example, to adjust for 100 percent rebate pass-through, PBMs may seek increased per-member-per-month administrative fees and other bona fide service fees not calculated based on drug utilization, such as performance-based payments calculated on a percentage of cost savings.

- **Monitor PBM compensation for reasonableness.** Plan fiduciaries must continue to ensure that compensation received by PBMs is reasonable for the services provided. New fee disclosures may make it easier for plaintiffs in litigation to assert that excessive PBM fees affect participant premium rates and out-of-pocket costs.

- **Evaluate Express Scripts' new standard offerings.** Group health plans that contract with Express Scripts—and potentially other PBMs that enter into similar FTC settlements—should engage legal counsel and consultants to understand alternatives to these PBMs' standard offerings that may better suit the plan, including whether to retain the plan's current pharmacy benefit design. As mentioned above, the FTC settlement acknowledges that a plan may request Express Scripts to make changes that deviate from many of the new restrictions imposed on the standard PBM service offerings.

- **Monitor state PBM legislation.** Continue to monitor state PBM legislation and challenges to such laws. While the CAA does not appear to directly address price spreading caused by the difference in what the PBM charges the plan sponsor versus the amount paid to the dispensing pharmacy, further rulemaking may address this issue more directly.

Once the CAA Requirements Are in Effect (Beginning January 1, 2029, for Calendar Year Plans):

- Review contracts with PBMs to identify whether such contracts must be renegotiated to include the requirements imposed by the CAA.
- Ensure RFPs for new contracts address the changes.

Once the DOL Rule is Finalized:

- Review PBM disclosures prior to entering contracts or arrangements.
- Conduct ongoing monitoring of PBMs every six months through receipt and review of semiannual disclosures.
- Exercise annual audit rights to confirm the accuracy of disclosures.
- Create protocols for noncompliance with disclosure obligations.

Prior to Express Scripts' Requirements Becoming Effective:

- Review and re-negotiate contract provisions to encompass required changes to Express Scripts' standard PBM service offerings.
- Alternatively, evaluate whether to request changes to Express Scripts' standard offerings or to retain the current pharmacy benefit design.

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For additional information about the issues discussed in this *Insight,* please contact the attorney(s) listed on this page or the Epstein Becker Green attorney who regularly handles your legal matters.

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