

DOL Finalizes PBM Fee Disclosure Rule, Preparing for Greater Transparency and Fiduciary Oversight

Nov. 3, 2026

On October 29, 2026, the Department of Labor (DOL) finalized a rule requiring expanded disclosure of pharmacy benefit manager (PBM) compensation to fiduciaries of covered employer-sponsored health plans. The rule is intended to help fiduciaries understand how PBMs and related service providers are paid, evaluate potential conflicts of interest, and determine whether their arrangements are reasonable.

Why Does PBM Compensation Matter?

PBM compensation can extend beyond the administrative fee shown in a service agreement. Manufacturer payments, amounts retained through spread pricing, pharmacy recoupments, and payments involving related entities can affect the total economics of an arrangement. Without adequate disclosure, a plan fiduciary may have difficulty evaluating the compensation associated with the plan's pharmacy benefits. The final rule seeks to make those compensation streams more visible.

The rule is part of ERISA's framework governing prohibited transactions. ERISA section 408(b)(2) permits plans to obtain necessary services under reasonable arrangements for no more than reasonable compensation. Disclosures from covered service providers help determine whether those arrangements are reasonable. Incomplete disclosures can present more than a contractual issue because they can affect the availability of prohibited-transaction relief.

Which Plans and Providers Are Covered?

The final rules apply to covered providers who contract with large, self-insured group health plans (plans with 100 or more participants or plans offered by employers with 100 or more employees). Covered providers are those PBMs and their affiliated brokers and consultants that enter into contracts with the plans to provide PBM services or related brokerage or consulting services and expect to receive at least $1,000 in compensation, whether the services are performed directly or through affiliates, agents or subcontractors.

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What Information Must Be Disclosed?

Covered providers must disclose their services and compensation arrangements, including direct and indirect compensation. This includes:

- Payments from drug manufacturers
- Spread compensation (the difference between what the plan pays and what the pharmacy is reimbursed)
- Claw-backs (payments recouped from pharmacies)
- Price protection arrangements

These disclosures are intended to give fiduciaries a more complete picture than an administrative-fee schedule alone.

Initial disclosures must be delivered reasonably in advance of entering into, extending, or renewing a contract. For extensions and renewals, the DOL identifies at least 90 days in advance as reasonable. Ongoing compensation disclosures are due no later than 30 calendar days after each semiannual period, and plans may request quarterly disclosures. An explanation is required when ongoing compensation disclosures exceed the initial disclosure by 5% or more, or a lower threshold agreed to by the parties.

Audit Rights and Disclosure Failures

The final rule gives plans the right to audit covered disclosures at least annually. A covered provider must acknowledge an audit request within 10 business days and generally provide necessary information within 60 calendar days. The right to audit at least annually should not be confused with a requirement that every plan conduct an annual audit.

The final rule also provides for conditional relief for responsible plan fiduciaries when a provider fails to comply. That relief is not automatic; fiduciaries must take specified corrective steps, including seeking missing information and, when required, notifying the DOL. Plan sponsors should promptly involve benefits counsel when a provider refuses or fails to provide required disclosures, so applicable correction, notice, and contract-continuation requirements can be evaluated.

Sponsors should examine whether their existing agreements contain restrictions on auditor selection, data access, confidentiality, or audit scope that could interfere with meaningful verification.

When Do the Requirements Apply?

The final rule takes effect 60 days after publication in the Federal Register and applies to plan years beginning on or after July 1, 2027. Based on that applicability date, a calendar-year plan would generally begin applying the requirements on January 1, 2028. Sponsors should nevertheless address disclosure and audit provisions during upcoming negotiations rather than wait until the applicable plan year begins.

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Employer Action Items

- Confirm the plan's coverage and compliance calendar. Identify the responsible fiduciaries, the applicable plan year, and all PBM, third-party administrator, broker, and consultant arrangements connected with pharmacy benefits. Map renewal dates and notice periods so disclosures can be obtained and evaluated before the plan is committed to an extension or renewal.
- Review contracts and request a written implementation plan. Ask covered providers how they will deliver initial and ongoing disclosures, identify compensation involving related entities, explain material variances, and support audits. Review agreements for provisions that could limit access to the information needed to assess compensation.
- Document fiduciary oversight. Maintain records of the disclosures reviewed, questions raised, provider responses, and the basis for determining whether services and compensation are reasonable. Consider when an independent review or audit would be appropriate.
- Escalate disclosure failures promptly. Once the final rule is effective, consider involving benefits counsel when required information is missing or a provider refuses to cooperate, so the plan can evaluate corrective steps, any required DOL notice, and whether the arrangement should continue.

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