



Prescription Drug Transparency: CAA 2026, Proposed DOL Rules, and What's Next

By: Kate Belyayeva

Prescription drug costs remain one of the primary focus areas of federal regulators and lawmakers who have become increasingly concerned with transparency and oversight of prescription drug benefits and the entities that administer these benefits on behalf of group health plans, commonly referred to as pharmacy benefit managers ("PBMs"). This article discusses two recent developments particularly relevant to employers sponsoring prescription drug benefits.

On February 3, 2026, Congress passed the Consolidated Appropriations Act, 2026 ("CAA 2026"), which, in relevant part, includes a set of reforms in an effort to increase transparency and oversight of PBM arrangements. Around the same time, the U.S. Department of Labor ("DOL") released new proposed rules addressing PBM compensation disclosures and fiduciary considerations ("Proposed Rules"). Together, these developments reflect a broader federal effort to increase visibility into prescription drug pricing practices and the financial arrangements that govern pharmacy benefit administration.

Background

PBMs play a significant role in negotiating rebates with pharmaceutical manufacturers, managing formularies, and administration of claims. Historically, the compensation structure for PBMs has been unclear and difficult to evaluate and manage for plan fiduciaries. Over the past decade, the lack of transparency in

compensation and pricing has led various stakeholders to question whether these PBM arrangements sufficiently align with the interests of plan participants.

To that end, Congress began addressing these concerns, beginning with the Consolidated Appropriations Act, 2021 ("CAA 2021"). CAA 2021 introduced a number of transparency provisions designed to improve oversight of health plan service providers. Among other things, CAA 2021 created the Prescription Drug Data Collection ("RxDC") reporting framework, which requires group health plans and insurers to report detailed prescription drug spending information to federal regulators. Since CAA 2021, stakeholders have continued to explore additional regulatory oversight of PBMs. These efforts ultimately resulted in the introduction of CAA 2026 and the Proposed Rules.

Key Provisions

CAA 2026 is designed to provide employers with greater visibility into prescription drug pricing practices and PBM compensation arrangements, which are generally described below:

Expansion of Covered Entities. CAA 2026 expands the scope of entities subject to PBM transparency requirements. The statute broadly defines "covered entities" to include PBMs providing services to group health plans and health insurance issuers, including those administering prescription drug benefits for employer-sponsored plans. This expanded definition is intended to ensure that PBMs operating within employer-sponsored health plan arrangements are subject to the new transparency and reporting obligations.



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- **Reporting Requirements.** Under CAA 2026, PBMs must provide detailed reporting regarding prescription drug spending and compensation arrangements. Large employers and large plans (100+ employees and participants, respectively) as well participants and beneficiaries are entitled to full disclosure specific to covered drugs whereas employers and plans with less than 100 employees/participants are entitled to a summary document with aggregate information.

Among other things, these reports generally must include information regarding: (i) gross and net prescription drug spending for the plan; (ii) manufacturer rebates, discounts, and other remuneration associated with the drugs; (iii) spread pricing data and formularies; and (iv) information about rebate aggregators. The reporting must be conducted not less frequently than six months (or quarterly by plan request) and is intended to provide plan sponsors with greater insight into the financial dynamics of their pharmacy benefit programs.

- **Rebate Pass-Through.** CAA 2026 amends Section 408(b)(2)(B) of ERISA and requires PBMs to pass through 100% of the manufacturer rebates, fees, alternative discounts, and similar remuneration to the plan sponsor, rather than retaining those amounts as part of the PBM's compensation. The statute also establishes timing requirements requiring PBMs to remit rebates – payments must be made on a quarterly basis and no later than 90 days after the quarter. Of note is the fact that CAA 2026 does not expressly require that rebates must be passed through to the point of sale, and plan sponsors may continue to utilize rebates to enhance or reduce the cost of prescription drug benefits rather than attributing the rebates to individual cost shares.
- **Audit Rights.** To reinforce transparency, CAA 2026 provides employer plan sponsors with the right to audit PBM records relating to rebate arrangements; however, there is no audit right with respect to the accuracy of disclosures.
- **Penalties for Noncompliance.** The statute authorizes enforcement mechanisms and potential penalties for PBMs, including civil penalties of up to \$10,000 per day for late reporting and additional penalties of up to \$100,000 for knowingly providing false information.
- **Innocent Fiduciary Rule.** CAA 2026 also includes provisions commonly referred to as the “innocent fiduciary rule.” Under this framework, plan fiduciaries may be protected from liability if the fiduciary: (i) did not know the PBM failed to remit rebates; (ii) reasonably believed compliance would occur; (iii) took steps to compel remittance in writing after discovering a failure; and (iv) notified the DOL if the PBM fails to comply with the written request within 90 days.
- **Effective Date.** The disclosure and rebate pass-through requirements under CAA 2026 generally apply to plan years beginning on or after 30 months after the date of enactment (i.e., January 1, 2029 for calendar year plans). Notably, there may be some ambiguity regarding the effective date for the expansion of the definition of a “covered entity.” Absent further guidance, the changes to the definition appear to apply to all service providers and contracts entered into or renewed effective as of the date of enactment (i.e., February 3, 2026).

Comparison to the Proposed Rules

Shortly before CAA 2026 was signed into law, the DOL issued the

Proposed Rules to address PBM compensation transparency through a different regulatory framework. Although the Proposed Rules and CAA 2026 address similar transparency concerns, the two frameworks arise from different legal authorities and currently operate independently. The Proposed Rules operate under the ERISA fiduciary framework, specifically through the service provider disclosure requirements under ERISA Section 408(b)(2). In comparison, the provisions of CAA 2026 are independent amendments to ERISA, the Public Health Service Act, and the Internal Revenue Code and not based on ERISA's fiduciary requirements. Importantly, the Proposed Rules only apply to self-insured plans whereas the statute applies much more expansively. There are also differences to the timing requirements for reporting obligations, which may become challenging in practice in the event that the Proposed Rules become final in their current form.

If finalized, the Proposed Rules would become effective 60 days after the final rules are issued, with an applicability date for plan years beginning on or after July 1, 2026 (i.e., January 1, 2027, for calendar year plans). Because of the potential for overlap or ambiguity, many stakeholders expect that future regulatory guidance will attempt to align the DOL's disclosure requirements with CAA 2026.

Employer Impact

Despite the recency of these developments, employers sponsoring health plans or stand-alone prescription drug programs should understand the potential implications now and begin preparing for the increased scrutiny surrounding these benefits in the coming years. Although many of the requirements will apply directly to PBMs, employers sponsoring group health plans may experience indirect effects through updated contractual requirements, expanded reporting, and increased fiduciary oversight expectations.

As employers begin receiving more detailed reporting from PBMs, plan fiduciaries may be expected to evaluate this information as part of their ongoing duty to prudently monitor plan service providers. For instance, plan fiduciaries may consider establishing internal processes for reviewing PBM reports, monitoring prescription drug spending trends, and incorporating the new PBM reporting into compliance calendars and fiduciary oversight functions.

Furthermore, employers should review existing PBM service agreements to understand how compensation, rebates, and administrative fees are currently structured. Employers should also confirm that their PBM agreements provide access to the data necessary to comply with the new transparency requirements. Plan sponsors currently negotiating PBM agreements, which generally are effective for a term of three years, should consider incorporating required reporting language, full rebate pass-through provisions, audit rights, and reconciliation mechanisms in agreements.

Conclusion

CAA 2026 has the potential to significantly alter the practices of employers and PBMs with respect to contract negotiation and administration of prescription drug benefits; however, the implementation efforts and practical implications related to CAA 2026 and Proposed Rules are still unfolding, necessitating continued monitoring of future regulatory guidance for employers and PBMs alike. Employers with questions regarding how these developments may affect their prescription drug benefit programs should consult benefits counsel for further guidance.

Insurer Pays Large Sum Related to Provider Directories

By Colin Clark

Plans have quite a number of obligations related to provider directories. One of those responsibilities for health plans is that provider directories contain accurate and up to date information regarding available network providers, so that participants have correct information regarding seeking out the care they need. In a recent case from New York, one insurer's provider directories were put under the microscope during a multi-year investigation. EmblemHealth ("Emblem") settled with the New York Attorney General's Office ("The Attorney General's Office") for \$2.5 million, related to New York's claims that Emblem maintained inaccurate provider directories for mental health care, making it difficult for participants to access the care they need.

What Happened?

In a recent statement from the Attorney General's office, their investigation into EmblemHealth's provider directories "...found that Emblem's directories contained many errors, including listings for providers who were unreachable, no longer practicing, not accepting new patients, or not actually in the plan's network." When provider directories include listings that are outdated, not in network, or otherwise deficient in accessibility, the term "ghost network" has been deemed to apply, referencing the perceived non-existence of providers. In addition to publishing accurate directories, health plans must also update the directories regularly and vet them for accuracy, which, according to the Attorney General's office, EmblemHealth failed to do.

In order to obtain this information, the Attorney General's office conducted what they called a "secret shopper" survey, where they reached out to listed providers from various EmblemHealth provider directories. In the same statement referenced earlier, the Attorney General "determined that more than 80 percent of surveyed behavioral health providers Emblem listed as accepting new patients were effectively unavailable."

In addition to the fine, the Attorney General's office is requiring Emblem to take a number of steps in order to remedy their deficient provider directories:

- Correct listings within two business days of learning that information is incorrect or a provider is no longer accepting new patients;
- Put a link next to each provider listing that allows members and providers to report inaccurate listings directly;
- Require providers to verify directory information every 90 days and remove providers who fail to verify or are no longer available;
- Remove providers who have not submitted claims within the last 90 days from the directory unless they verify their continued participation;
- Implement new systems to track, monitor, and resolve complaints related to directory accuracy and access to care; and
- Conduct regular secret shopper surveys to assess access to care and publicly report the results.

Takeaways

Creating, maintaining, updating, and vetting provider directories may seem like a tedious task when compared to the mountain of responsibilities often incurred by health plans. However, accurate directories are a legal obligation that need not be overlooked. EmblemHealth faces \$2.5 million in fines, which is a large price to pay for inaccurate or misleading information. Now that a state's Attorney General's office has successfully investigated and fined an insurer for inaccurate and out-of-date provider directory information, sponsors and employers should take some time to vet their own provider directories for accuracy to avoid costly litigation and/or fines, as well as to ensure participants have access to the care they need.



Compliance Corner: Provider Directories

By Colin Clark

Provider directories are vital to participants in order to access the care they need. ERISA, the Internal Revenue Code (the "Code"), and the Public Health Service Act (PHSA) were all modified by the Consolidated Appropriations Act of 2021, placing a responsibility on group health plans to maintain an accurate, verifiable, and regularly updated provider directory. Such information was deemed critical to participants' ability to locate not only the care they need, but also whether the plan has a contractual relationship with the care listed in the directory.

Requirements

Group health plans must establish a database on the public website of the plan that contains a list of each health care facility with which the plan has either a direct or indirect contractual relationship for furnishing items and services under the plan, and provider directory information regarding these providers and/or facilities.

In addition to establishing and maintaining an easily accessible database on a public website, group health plans must also have a verification process. Group health plans verify and update the information included in the provider directory every 90 days. Plans are under an obligation to remove information that cannot be reasonably verified for accurate information. If a plan received any new information about pertinent data in the provider directory, it must update it within two business days.

Group health plans must also establish a Response Protocol related to participant requests for information. This procedure must be in

place for an individual enrolled in the plan who requests information by phone or electronic means. If the request is made via telephone, the plan must respond to such a request as soon as possible and in no cases later than 1 business day after the telephone request is received. A response may be through a written, electronic, or print communication and must retain such communication in the individual's file for at least two years following such response.

If a group health plan maintains the required provider directory in print format (in addition to the public website), then there are some additional requirements regarding accuracy. Print directories are required to include a disclaimer and/or notification that states the information was accurate at the time of print, but that participants should check the public website directory for the most accurate and up-to-date information.

Lastly, if an individual obtains out-of-network care when the individual thought that the care was actually in-network, group health plans have specific duties in this regard. Plans must (1) limit cost-sharing for those items and services to an amount that is no greater than the cost-sharing that would apply under the plan for items or services furnished by the participating provider; and (2) apply the deductible or out-of-pocket maximum that would apply if the items or services were furnished by a participating provider. The relevant guidance highlights the circumstances in which these duties would apply

- A participant or beneficiary receives, through the plan's public website database/provider directory, or through a response, information that indicates that the provider was a participating provider with respect to the furnished item or service.
- Information was not provided to the participant or beneficiary through the public website/provider directory, and the participant or beneficiary requested information, and the information indicated that the furnished item or service was a participating provider.

Takeaways

While it could seem like a relatively inconsequential detail, accurate provider directories benefit everyone involved in the group health plan. There has been some recent litigation on inaccurate or incomplete information from provider directories, leading to a wide range of issues for participants and sponsors. Participants need to know where to go and need to have accurate information, and plan sponsors and employers have an interest in following pointed regulation on how and when to get this information to their participants. Adhering to the provider directory regulations will decrease the likelihood of issues, resulting in a smoother experience for all.



STAY IN THE KNOW...

- Last month, the U.S. Department of Labor's Wage and Hour Division rescinded the Biden-era rules governing lawful independent contractor relationships and reinstated the rule it last implemented in 2021, during the first Trump administration. The reinstated rule is more permissive of independent contractor use and focuses on the "economic reality" of the workers' circumstances to determine whether the worker has been lawfully classified as an independent contractor. The frequent pendulum swing from permissive to restrictive guidance from DOL has, however, resulted in most judges and state agencies tuning out the noise while continuing their efforts to prevent the expansive use of independent contractors.
- New York has expanded its Earned Safe and Sick Time Act (ESSTA). The latest amendments to the already expansive law add new reasons that employees may utilize the benefit, including public disasters, time off to apply for government benefits, and workplace violence.
- The U.S. Department of Labor's Employee Benefits Security Administration has extended the public comment period for its proposed "Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure" rule to April 15, 2026 to allow stakeholders to assess how it should align with recent statutory amendments to ERISA under the CAA 2026. The Department is asking stakeholders to address whether existing provisions should be revised, or new provisions should be added for administrative alignment with CAA 2026. Ultimately, the proposal would require PBMs and related service providers, including brokerage and consulting services, to disclose detailed information about their compensation and financial arrangements to fiduciaries of ERISA-covered group health plans, enhancing fee transparency and fiduciary oversight.

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