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Understanding Recent Changes to ERISA Disclosure Requirements for Group Health Plan Service Providers

Compensation & Benefits Blog on **November 17, 2026**

At the end of October, the Department of Labor ("DOL") released a final rule imposing new disclosure requirements on pharmacy benefit managers ("PBMs") and certain affiliated brokers and consultants under ERISA Section 408(b)(2). The final rule applies to both future and existing PBM arrangements for plan years starting on or after July 1, 2027.

Separately, the regulatory preamble to the final rule confirms that, consistent with the Consolidated Appropriations Act, 2026 ("CAA, 2026"), effective February 3, 2026, group health plan service providers are required to provide compensation disclosures to health plan fiduciaries under ERISA Section 408(b)(2). However, a good-faith enforcement standard applies from February 3, 2026, until the final rule's applicability date.

How did we get here?

By way of quick background, ERISA Section 406(a)(1)(C) generally provides that an arrangement for services between a group health plan and a service provider is a prohibited transaction, unless an exemption applies. ERISA Section 408(b)(2) is a statutory exemption from the prohibited transaction rules that requires that the contract be reasonable, the services be necessary for the establishment or operation of the plan, and no more than reasonable compensation be paid.

In 2012, the DOL released regulations under ERISA Section 408(b)(2) requiring *retirement* plan service providers to disclose compensation information to plan fiduciaries in order to satisfy the statutory exemption. Over the years, various advisory groups suggested that ERISA Section 408(b)(2) disclosure requirements should apply to health and welfare plan arrangements; however, these recommendations ultimately did not gain traction. At the end of 2020, Congress amended ERISA Section 408(b)(2) to apply to brokers and consultants to group health plans, which we blogged about here.

Fast-forward to 2026. On January 29, the DOL issued a proposed rule under ERISA Section 408(b)(2) that would require PBMs to disclose information about their compensation to plan fiduciaries. Five days later, Congress amended ERISA Section 408(b)(2) yet again, this time to apply the statutory exemption requirements expressly to PBMs and other health plan service providers. Now, on October 29, the DOL is finalizing its rules for PBM compensation disclosures and clarifying the applicability of ERISA Section 408(b)(2) to health plan service providers.

Who is covered by the final rule?

The final rule applies to covered service providers ("CSPs") for "large" self-insured group health plans (for single-employer plans, plans must cover at least 100 employees; for multiemployer plans, plans must cover at least 100 participants, excluding beneficiaries). The final rule does not apply to fully-insured group health plans or self-insured group health plans that do not satisfy the count limits summarized above. The final rule also excludes plans established by sponsors that are (or are affiliated with) drug manufacturers, distributors, wholesalers, PBMs, or rebate aggregators.

A CSP is a service provider to a covered group health plan that reasonably expects at least $1,000 in direct or indirect compensation for PBM services or for related brokerage and consulting services provided by a PBM. Services may be performed directly or through the CSP's affiliates, agents, or subcontractors. This includes entities that provide any services necessary to manage or administer a group health plan's prescription drug benefits, whether or not the provider calls itself a PBM.

What is required by the final rule?

Initial Disclosures. CSPs must furnish initial disclosures to the plan fiduciary reasonably in advance of entering into, extending, or renewing a contract for services. For extensions and renewals of a contract, disclosures should be provided at least 90 days in advance. The disclosures must describe:

- **Services:** The specific services the CSP will provide.
- **Direct Compensation:** Compensation expected to be received directly from the plan or plan sponsor, itemized by service provided. If the services are bundled, a description of how compensation is allocated among the services.

- **Indirect Compensation:** Compensation the CSP expects to receive from other sources, including but not limited to (1) manufacturer payments, such as rebates and fees; (2) spread compensation, broken down by drug and pharmacy channel, along with any policies or incentives that steer patients to affiliated pharmacies; (3) pharmacy recoupments, such as copay claw-backs; and (4) price-protection payments, such as additional manufacturer rebates triggered by an increase in drug prices.
- **Termination Compensation:** Any compensation tied to contract termination, including how prepaid amounts are calculated and refunded to the plan.
- **Formulary Placement Incentives:** Manufacturer incentives or arrangements that affect where a drug is placed on the formulary.
- **Drug Pricing Methodology:** The net price the plan will pay for drugs after rebates and fees. If a dollar amount cannot be determined from information available when the initial disclosures are provided, the CSP must explain how the price will be calculated and provide an objective means of verifying the calculation, such as the applicable pricing benchmark or rate schedule.
- **Fiduciary Status and Audit Rights:** A statement as to whether the CSP will provide services in an ERISA fiduciary capacity, and a statement of the plan's audit rights.

Ongoing Disclosures. CSPs must report compensation received every 6 months. If the plan fiduciary requests quarterly reports, the CSP must provide them. If a reported amount exceeds the initially disclosed compensation estimate by 5 percent or more (or a lower threshold the parties agree to), the CSP must identify and explain the overage to the plan fiduciary.

Audit Rights. Under the final rule, plans are entitled to audit the accuracy of CSP disclosures at least annually using an auditor of their choosing (and at their own cost). The CSP must acknowledge an audit request within 10 business days and generally must provide the requested information within 60 calendar days. The CSP must make available relevant records, including claims and transaction-level data, and contracts with retail pharmacies, drug manufacturers, and rebate aggregators, subject to reasonable confidentiality agreements.

CSP Disclosure Guidelines. CSP disclosures must be sufficient for the fiduciary to evaluate whether the arrangement is reasonable. Compensation must be stated as a monetary amount, although a good-faith estimate is permitted if the amount is not reasonably ascertainable. CSPs may not restrict the plan's use of the disclosures. They may, however, require third parties who receive the information from the plan to agree in writing to limit redisclosure and use.

What are the consequences if a CSP does not comply?

If a CSP fails to provide the required disclosures to the responsible plan fiduciary, this creates a potential prohibited transaction issue because the arrangement does not comply with the ERISA Section 408(b)(2) service provider exemption. (Similar issues exist today when retirement plan service providers fail to provide compensation disclosures to plan fiduciaries.)

The final rule provides a new administrative class exemption that allows responsible plan fiduciaries to obtain relief under specified conditions. The administrative class exemption does not apply to CSPs. To qualify for relief:

- The plan fiduciary must have lacked knowledge of the CSP failure and reasonably believed the requirements were satisfied;
- The plan fiduciary must request correction from the CSP in writing and notify the DOL within 30 calendar days after the earlier of the CSP's refusal to correct the failure or the expiration of 90 calendar days after the written request; and
- The plan fiduciary must decide whether to continue or terminate the arrangement if the CSP fails to comply within 90 calendar days of the request and document its rationale.

When do the final rule requirements apply?

The CSP requirements under the final rule apply to plan years beginning on or after July 1, 2027; for calendar-year plans, this means that the CSP requirements will apply starting January 1, 2028. Arrangements entered into on or after the applicable date, including renewals and extensions, are subject to the initial disclosure requirements. For arrangements already in effect on the applicable date, the final rule does not expressly address the timing of the new disclosure requirements.

How does the final rule compare with the CAA, 2026 disclosure requirements under ERISA Section 408(b)(2)?

As explained above, on February 3, 2026, the CAA, 2026 revised Section 408(b)(2)(B) to expressly cover PBMs and other service providers to group health plans, including third-party administrators (TPAs). The final rule implements ERISA Section 408(b)(2) for PBMs and affiliated brokers and consultants with respect to the covered plans described above. However, the preamble to the final rule confirms that a broad range of service providers to group health plans are covered service providers and are required to make disclosures as provided by ERISA Section 408(b)(2) in order to rely on the statutory exemption. This means that covered service providers to group health plans that are not covered by the final rule are nevertheless required to make compensation disclosures to plan fiduciaries to rely on the ERISA Section 408(b)(2) exemption.

What ERISA Section 408(b)(2) disclosures are required under CAA, 2026 for a covered service provider not covered by the final rule?

The statutory disclosure requirements reach plans and providers outside the final rule's scope, including fully-insured plans. The preamble to the final rule confirms that service providers such as third-party administrators and recordkeepers are covered by the CAA, 2026 changes and required to disclose the following to the plan fiduciary: (1) description of their services and fiduciary status; (2) expected direct and indirect compensation, including the arrangements generating indirect compensation; (3) certain transaction-based payments among providers, affiliates, and subcontractors; and (4) termination compensation, prepaid refunds, and how compensation will be received.

When do the ERISA Section 408(b)(2) disclosure requirements under CAA, 2026 apply?

The CAA, 2026 changes apply as of February 3, 2026. However, the preamble to the final rule confirms a temporary enforcement policy providing relief to service providers and fiduciaries who act in accordance with a good-faith interpretation of Section 408(b)(2)(B). The policy applies from February 3, 2026, through the final rule's applicability date. The temporary enforcement policy will apply to both CSPs that are covered by the final rule and service providers who are covered by the CAA, 2026 changes, but not covered by the final rule.

What about the other CAA, 2026 changes for PBMs? When do those apply?

CAA, 2026 added separate rebate pass-through requirements under ERISA Section 408(b)(2)(C) and broader periodic reporting requirements covering prescription drug utilization, plan and participant spending, and pharmacy pricing comparisons under ERISA Section 726. These requirements apply to plan years beginning on or after August 3, 2028.

Proskauer's Perspective

Plan fiduciaries should put together a game plan for identifying service providers to group health plans that are covered by the CAA, 2026 changes and the final rule. Two comments to get the game plan going:

- **Consider adapting existing retirement plan disclosure procedures for health plans**. Plan sponsors and fiduciaries should consider leveraging their existing procedures for obtaining, reviewing, and monitoring retirement plan disclosures and applying them to CSP disclosures (with appropriate adjustments).
- **Start requesting disclosures now**. As described above, the DOL confirmed there is a temporary enforcement policy in place based on a good-faith interpretation, starting on February 3, 2026, through the date the final rule is applicable. However, that is no reason to delay asking for compensation disclosures from service providers.

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