Vorys Benefits Brief: Two Key PBM Developments for Employers – Part Two

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PBM Provisions in CAA 2026

On February 3, 2026, President Trump signed the Consolidated Appropriations Act, 2026 (CAA 2026). The CAA 2026 includes significant changes governing pharmacy benefit managers (PBMs) and any entities providing pharmacy benefit management services (PBM Entities). The legislation applies to certain group health plans, health insurance issuers, and entities providing pharmacy benefit management services.

Background

CAA 2026 establishes comprehensive transparency and other requirements for PBM entities across multiple federal statutes including the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986.

Key Takeaways

The PBM provisions are effective for plan years beginning on or after the date that is 30 months after enactment (the Effective Date). For calendar year self-insured plans, the requirements would generally apply January 1, 2029.

Enhanced Transparency Obligations to Plan Sponsors

On and after the Effective Date, PBM Entities must submit reports to larger group health plans (generally those covering at least 100 employees) at least every 6 months (or quarterly upon request) in plain language and machine-readable format. Reports must include detailed drug-specific information for specified large plans and summary documents for all plans regardless of size.

Reports must contain comprehensive data including:

- Contracted compensation paid by plans and to pharmacies for each covered drug identified by National Drug Code.
- Difference between amounts paid under compensation structures.
- Drug names, codes, and dispensing channel types (retail, mail order, specialty).
- Brand name versus generic classification with wholesale acquisition costs or average wholesale prices.
- Net price per treatment course after rebates and remuneration.
- Total out-of-pocket spending by participants and beneficiaries.
- Total net spending and amounts received in rebates from applicable entities.

When plans or PBM Entities have affiliated pharmacies, reports must explain:

- Benefit design parameters encouraging prescription fills at affiliated pharmacies.
- Percentage of total prescriptions dispensed by affiliated pharmacies.
- Detailed cost comparisons including median amounts charged and interquartile ranges versus non-affiliated network pharmacies.

Additionally, on and after the Effective Date, group health plans and PBM Entities cannot enter into a contract unless the other party to the contract agrees that it will (1) not limit or delay the disclosure of information to the group health plan that then prevents the PBM Entity from providing its required reports; and (2) provide the PBM Entity with all relevant information necessary for the PBM Entity to provide its required reports.

Full Rebate Pass-Through Requirements

On and after the Effective Date, PBM Entities must remit 100 percent of rebates, fees, alternative discounts, and other remuneration received from any applicable entity that are related to utilization of drugs or drug spending to ERISA group health plans quarterly within 90 days. Contracts with PBM Entities must reflect this rebate pass-through requirement. Records must be available for annual audits, and rebate contracts must be made available for plan audits subject to confidentiality restrictions.

Privacy and Enforcement

All PBM Entity reporting must comply with HIPAA privacy regulations and contain only summary health information. Civil monetary penalties include $10,000 per day for failure to disclose required information and up to $100,000 per item of false information for knowingly providing false information. The Secretary may waive penalties for good-faith compliance efforts.

ERISA Fiduciary Relief

There is included an “innocent plan fiduciary” exemption for failures attributable to PBMs, provide the fiduciary did not know and reasonably believed compliance occurred.

Next Steps for Employers

Employers that sponsor a group health plan should review existing contractual arrangements with pharmacy benefit managers or other entities that provide pharmacy benefit management services to ensure that these new requirements are reflected in the agreement. It is expected that agreements will have to be amended for plan years beginning on or after August 3, 2028, for these new rules.

Contact Legal Counsel

For questions or additional information about this Vorys Benefits Brief and its application, consult with legal counsel.