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Submitted electronically via www.regulations.gov

April 14, 2026

Daniel Aronowitz
Assistant Secretary, Employee Benefits Security Administration
U.S. Department of Labor
Office of Regulations and Interpretations, Room N-5655
200 Constitution Avenue NW
Washington, DC 20210

RE: Improving Pharmacy Benefit Manager Compensation Transparency (RIN 1210-AB37)

Dear Assistant Secretary Aronowitz,

The CHRO Association ("Association") submits these comments in response to the U.S. Department of Labor's (DOL) proposed rule, Improving Transparency into Pharmacy Benefit Manager Fee Disclosure ("proposed rule"), published in the Federal Register on January 30, 2026. The proposed rule would require pharmacy benefit managers (PBMs) and affiliated brokerage and consulting service providers to disclose information about their compensation to fiduciaries of self-insured group health plans governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The Proposed Rule would shed light on historically opaque forms of PBM remuneration, including manufacturer rebates, fees, spread pricing, pharmacy claw-backs, and payments to affiliates, agents, and subcontractors. Such disclosures could help plan sponsors compare PBM offerings more effectively, recognize previously less-visible compensation arrangements, and use this information to ensure compliance with ERISA's prohibited transaction rules and to negotiate more favorable terms on behalf of their plans.

The CHRO Association is a public policy advocacy organization representing the most senior human resources officers (CHROs) at nearly 400 of the largest corporations doing business in the United States and globally. Collectively, these companies employ more than 10 million employees in the United States—nearly nine percent of the private-sector workforce—and approximately 20 million employees worldwide. The CHRO Association—formerly known as HR Policy Association until our name change in October 2025—has a long-standing history of engaging on and representing our member companies' interests on health care issues that are critical to their employees and to their businesses.

The Association's member companies are leaders in designing and delivering competitive, comprehensive benefits that meet the diverse and evolving needs of today's workforce, including self-insured employer-sponsored health plans. They view benefits not as a transactional expense but as a strategic tool to attract, retain, and engage top talent while supporting long-term employee well-being. In a dynamic labor market, our members are committed to offering benefits that are both adaptable and forward-looking.

Employer-sponsored health insurance remains the largest source of coverage in the United States, providing benefits to nearly 177 million Americans. Health care costs continue to be one of the most significant expenses for employers, rising sharply in recent years—nearly 9% per employee on average for the same level of coverage. Even after adjusting plan designs, employers are experiencing the largest cost increases in 15 years, according to a Mercer survey of over 1,700 organizations.[1]

Employers face cost pressures across the healthcare ecosystem where spending outpaces inflation and wage growth. Within employer-sponsored plans hospital and physician spending represent the largest share of costs. Pharmacy expenses account for roughly 20-25% of total healthcare spending, with that share expected to rise in the future. For many employers, prescription drug costs are now among the leading drivers of annual premium increases, driven by a complex interplay of market dynamics, structural features of the pharmaceutical supply chain, and a lack of transparency. Data from the Kaiser Family Foundation shows that U.S. spending on prescription drugs has grown more than 45% over the past decade, outpacing both inflation and wage growth.

The situation is particularly concerning because a small fraction of prescriptions drives the majority of costs. Specialty drugs—used to treat complex, chronic conditions such as cancer, rheumatoid arthritis, and multiple sclerosis—make up less than 2% of prescriptions but account for more than half of total drug spending.

It is important to note, the CHRO Association includes member companies that operate as PBMs. While we recognize the important role PBMs play in managing prescription drug benefits, we also acknowledge the growing concerns around rising healthcare costs and their impact on both employers and employees. Given this broader context, the Association strongly supports measures that enhance transparency and implement meaningful PBM reforms. We believe such reforms are essential not only for reducing costs for self-insured health plans and patients, but also for ensuring that plan fiduciaries can make informed decisions that ultimately benefit participants and contribute to a more sustainable health care system for society as a whole.

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[1] https://www.mercer.com/en-us/insights/us-health-news/employers-prepare-for-the-highest-health-benefit-cost-increase-in-15-years/

As the Department of Labor notes, "[t]his PBM proposed rule would give plan fiduciaries an invaluable tool to address rising drug costs for American workers and businesses." Our members strongly support measures that enhance transparency and accountability in PBM arrangements, as such reforms directly benefit self-insured group health plans while supporting fiduciary compliance under ERISA. Specifically, we note the following key benefits:

Improved Transparency and Cost Visibility
Requiring PBMs to disclose all fees, rebates, and spread pricing allows plan fiduciaries to make informed, prudent decisions about plan operations. Transparent pricing ensures that fiduciaries can demonstrate that plan assets are being managed solely for the benefit of participants and that all compensation received by PBMs is reasonable and necessary, consistent with ERISA standards.

Rebate Pass-Through Requirements
Ensuring that PBMs pass through the full value of manufacturer rebates to the plan reduces net prescription drug costs, ensures that PBMs receive only reasonable compensation, and strengthens fiduciaries' ability to fulfill their obligations to act in the best interests of participants.

Standardized Contracting and Reporting
Clear, consistent contract terms and reporting obligations simplify fiduciary oversight and help meet ERISA reporting requirements, including Form 5500 disclosures and Schedule C filings. Standardized data enhances plan sponsors' ability to evaluate and monitor PBM performance, value, and compensation. We recommend that the DOL issue clear subregulatory guidance, including model disclosure forms, to support plan sponsors in understanding and acting on disclosures they receive.

Mitigation of Conflicts of Interest
Limiting incentives that favor higher-cost drugs over clinically appropriate alternatives promotes cost-effective care and ensures plan decisions are made in participants' best interests rather than based on PBM profitability.

Enhanced Negotiating Power for Plans
Greater transparency allows self-insured plans to benchmark PBM performance and negotiate reasonable administrative fees and formulary discounts, further enabling fiduciaries to comply with ERISA's prohibited transaction rules and their duty of prudence.

As the agency moves to finalize the proposed PBM reforms we recommend the following:

Proactive Enforcement of the Proposed Rule and ERISA Violations

- The proposed rule’s administrative class exemption requires fiduciaries to notifiy DOL when PBMs fail to comply with disclosure obligations. DOL should commit to using these notifications, along with investigative data, to bring enforcement action for noncompliance, conscious evasion, or unreasonable compensation practices.
- DOL should commit to regulatory nimbleness and closely monitor market evolution in reaction to this rule. DOL should be prepared to amend these regulations or issue additional guidance in response to evidence of evasion or noncompliance.

Finalize Rule without Delay While Aligning Disclosures with Federal Transparency Requirements

- DOL should move forward with finalizing this rule without delay, notwithstanding the passage of PBM provisions in the 2026 Consolidated Appropriations Act (CAA), as further delay would be inconsistent with its statutory mandate under ERISA to protect plan participants and beneficiaries and would leave plan fiduciaries without the tools needed to meet their obligations. At the same time, to ensure practical implementation—particularly if the final rule is not fully aligned with CAA 2026—compliance should be required beginning with the first plan year that starts at least 12 months after issuance, consistent with the standard timeline for new group health plan requirements. ERISA plan fiduciaries have an affirmative, ongoing duty to monitor PBM compensation arrangements. Under ERISA sections 404 and 408(b)(2), plan fiduciaries must act prudently in selecting and overseeing service providers, ensure that the plan pays only reasonable expenses necessary for plan administration, and act solely in the interest of plan participants and beneficiaries. The proposed rule helps fiduciaries comply with these statutory obligations by requiring PBMs to disclose their compensation.
- Finalizing this proposed rule advances DOL's core mandate to protect plan participants and beneficiaries, and will provide valuable implementation experience in advance of the CAA's effective date. Prompt implementation will also give DOL, plan sponsors, and covered service providers valuable operational experience with fee disclosure and audit requirements before the CAA's broader reforms take effect.
- To the extent there are overlapping requirements in the proposed rule and the CAA, DOL can and should harmonize those requirements in the final rule without creating delay—for example, by standardizing definitions, terminology or scope differences for reporting elements --ensuring that compliance with the final rule will facilitate subsequent compliance with CAA statutory requirements. This ensures disclosures are clear, comparable across PBMs, and actionable for plan fiduciaries.

- In practice, the three largest PBMs frequently use complex and inconsistent terminology, making it challenging for employers to extract meaningful insights. Clear definitions and uniform reporting formats would address these issues and enhance transparency.

Clarify That Disclosure Compliance Primarily Rests with PBMs and Service Providers

- While the rule assigns disclosure obligations to PBMs, plan fiduciaries continue to bear responsibility under ERISA for evaluating whether compensation is "reasonable" under the prohibited transaction exemption for service arrangements.
- The final rule should explicitly state that PBMs and affiliated service providers are responsible for the accuracy and completeness of their compensation disclosures. This ensures that employers are not exposed to additional fiduciary risk if disclosures are incomplete or inaccurate despite their good-faith review efforts.

Maintain a Practical Compliance Framework for Employers
The disclosure framework should enable fiduciaries to make informed decisions without imposing unnecessary administrative burdens or duplicative reporting obligations. Regarding the DOL's proposed PBM fee disclosure rule, we offer the following observations and recommendations:

- **Lack of Transparency in PBM Fees:** PBMs remain the only key health plan partner without regulatory-required compensation disclosure, even as drug costs escalate. DOL has recognized this gap for over a decade: the ERISA Advisory Council recommended action in 2014, and the case for transparency has only grown stronger since then. Greater transparency is critical for meaningful fiduciary oversight. As written, PBMs must only report compensation paid "in connection with" its service contract. DOL should replace "in connection with" with "as a result of" to ensure that all forms of compensation are fully reported.
- **PBMs as ERISA Fiduciaries:** DOL should provide specific guidance to plan sponsors on the distinction between settlor and fiduciary functions because it is essential for ensuring that PBMs act prudently and solely in the interest of the plan and it's participants. We view managing plan assets, administering benefits according to plan terms, monitoring service provider performance, and exercising discretionary authority over plan operations as fiduciary functions. Meanwhile, settlor functions include the decisions to offer pharmacy benefits, which drugs or therapeutic categories to cover, which formulary tier structures to adopt, which PBM pricing models to use, member cost-sharing, whether to include or exclude certain specialty drugs, and which pharmacy benefit vendors to hire. To assist employers with scenarios where the distinction is not self-evident, the DOL should include a list of examples that illustrate when PBMs are acting as plan fiduciaries, if performed with delegated discretionary authority.

- **High Cost of Prescription Drug Coverage:** For many employers with self-funded group health plans, prescription drug benefits have more recently been a leading driver of premium increases (as explained earlier in this comment letter). Despite cost-containment efforts, pharmacy benefit costs continue to rise, particularly for employers seeking to avoid significant premium increases for employees. Greater visibility into PBM compensation can lead to broader reform of PBM arrangements, creating the conditions necessary for directly lower drug prices for employers and their employees.
- **Manufacturer Payment Reporting:** In addition to reporting aggregate and per claim manufacturer payments, PBMs should disclose these payments by type (e.g., rebate, fee, discount). PBMs should also provide the percentage of compensation from manufacturers tied to drug price or utilization.
- **Disclosure Timing – Unilateral Fee Increases:** PBMs sometimes retain the right to increase fees mid-term due to changes in formulary, plan design, generic drug availability, or onsite pharmacy usage. The final rule should require PBMs to disclose the specific factors driving fee increases, allowing plan fiduciaries to understand the rationale before renewal and helping mitigate potential ERISA fiduciary litigation from participants concerned about rising costs.
- **Substantive Disclosure – Affiliate and Spread Compensation:** Some PBMs with affiliated services—such as mail-order or specialty pharmacies—encourage or require plan designs that steer participants toward those affiliates and limit participant-level savings opportunities. These arrangements, along with affiliated brokerage or consulting compensation, create potential conflicts of interest and should be fully disclosed. Consistent with concerns highlighted in the FTC's interim reports on PBMs, DOL should expand compensation disclosure requirements to capture PBM self-preferencing and other conflict-of-interest transactions, ensuring fiduciaries and participants have transparency into these financial flows.
- **Other Compensation – Onsite Pharmacy Arrangements:** Onsite clinics or pharmacies, particularly those with Section 340B designation, may involve undisclosed profit-sharing agreements between PBMs and the clinic. Full transparency of these arrangements is essential to avoid conflicts of interest, protect plan fiduciaries and participants, and improve regulatory oversight of the 340B program.
- **Prohibition on Unilateral Payment Offsets:** PBMs often reconcile drug rebates or guaranteed payments at year-end. They should be prohibited from unilaterally offsetting amounts owed to employers without notice, consent, and supporting documentation, particularly in cases involving indirect compensation disputes or 340B-designated drugs.

- **Disclosure of Compensation to Unaffiliated Brokers and Consultants:** Some employers use consulting firms not affiliated with PBMs, which may receive compensation from PBMs for employer placement or services. PBMs should disclose all such payments to plan fiduciaries, even if the amounts are not disclosed, to allow monitoring of potential conflicts of interest.
- **Clarify Effective Date and Compliance Expectations for CAA 2026:**

We also recommend that the DOL issue guidance clarifying the effective date and compliance expectations for plan vendors under the CAA 2026 "covered service provider" designation, which does not carry an explicit effective date. Employers and their service providers require certainty on this point. An ambiguous effective date creates the risk that employers face immediate prohibited transaction exposure under ERISA § 406.

In summary, we believe the DOL's proposed regulation will give employers and their group health plans much-needed transparency into both drug pricing and service provider compensation, a goal we strongly support. Greater transparency can empower employers and plan sponsors to take meaningful steps to manage health care costs more effectively, potentially delivering higher-value care to participants and beneficiaries, while also strengthening fiduciary compliance under ERISA. Thank you for considering these comments; we would be pleased to provide additional operational insights on how PBMs interact with self-insured, employer-sponsored health plans.

To schedule a meeting to discuss further or with any questions, please contact me at **Cbirbal@chro.org**.

Thank you for your consideration.

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