



April 15, 2026

Comment to Proposed Rule RIN 1210-AB37, “Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure”

Introduction

This comment addresses the following specific requests for comment in the Notice of Proposed Rulemaking issued by the Department of Labor (the “Department”) on January 30, 2026 (the “NPRM”), regarding the proposed rule entitled, “*Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure*” (the “Proposed Rule”):

- Whether and to what extent the Department should expand the disclosures in the NPRM to cover additional service providers and, if so, which service providers should be covered.¹
- Whether the disclosures proposed would be sufficient to bring transparency into arrangements with those additional service providers or whether additional disclosures would be needed, such as claims data, payments to providers, and other fee and pricing data.²

Executive Summary

State financial officers support the Proposed Rule because they have a vested interest as fiduciaries of public investment funds in ensuring that corporations in which those funds hold shares are preserving shareholder value by controlling group health plan costs. In that vein, state financial officers have called on Fortune 500 companies in recent months to conduct detailed analyses of actual price and claims data from service providers.³ The Proposed Rule’s required disclosures for pharmacy benefit managers (“PBMs”) are consistent with state financial officers’ efforts to rein in group health plan costs. Disclosure of PBM compensation is essential for plan

¹ <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure>.

² <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure>.

³ <https://sfof.com/wp-content/uploads/2025/12/Healthcare-Pricing-Transparency-Letter2.pdf>.

fiduciaries to identify conflicts of interest and satisfy their duty under ERISA to evaluate the reasonableness of plan expenditures and service provider fees.

To enable truly effective fiduciary oversight, however, the Department should take two additional steps. First, expand the Proposed Rule’s coverage to all health plan service providers (including third-party administrators (“TPAs”) and insurers for fully insured plans). Requiring full compensation disclosures of all service providers (not just PBMs) is consistent with recent action by Congress to clarify that covered service provider status under ERISA § 408(b)(2) extends to virtually all entities providing services to the plan, and with ERISA’s fiduciary duties which require plan sponsors to monitor expenses and fees with regard to all service providers. Second, expand fiduciary access to claims data, payments to providers, and pricing data, rather than just compensation summaries. Requiring transaction-level claims and pricing data across the full transaction chain—in standardized, machine-readable formats—is crucial to enable employer plan sponsors and auditors to verify the reasonableness of the compensation paid to service providers and control plan costs.

State Financial Officers and Auditors Have Taken a Leadership Role in Calling for Public Companies to Analyze Healthcare Spending to Control Costs and Protect Shareholder Value

Healthcare overcharging in the United States erodes shareholder value by driving up costs for employers (and patients).⁴ Healthcare spending in the U.S. reached nearly \$5 trillion in 2023, constituting 17.6 percent of GDP.⁵ And healthcare costs clearly impact corporations’ bottom lines, as employer spending on healthcare was approximately \$1.3 trillion in 2024, and is growing by over five percent every year.⁶

State financial officers, as fiduciaries for public investment funds holding public company shares, have assumed a leadership role in demanding corporate health plan cost control. In December 2025, 17 state financial officers sent a letter to Fortune 500 companies requesting that those companies undertake a detailed payment-integrity analysis of their spending on employer-provided health plans.⁷ The letter explicitly tied waste to pension portfolio performance, noting that “healthcare overcharging ... erodes shareholder value” for public companies in which state funds invest.⁸ The letter highlighted common abusive practices of PBMs and TPAs that could be uncovered through a payment-integrity analysis, and encouraged companies to require actual price and claims data from service providers.⁹

⁴ See, e.g., https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf; <https://oversight.house.gov/release/hearing-wrap-up-oversight-committee-exposes-how-pbms-undermine-patient-health-and-increase-drug-costs/>; <https://www.patientrightsadvocate.org/pricevariationreport>; <https://pmc.ncbi.nlm.nih.gov/articles/PMC3999538/>.

⁵ <https://www.ama-assn.org/about/ama-research/trends-health-care-spending>.

⁶ <https://archive.ph/8Ov66>; <https://www.reuters.com/markets/us/us-employers-expect-nearly-6-spike-health-insurance-costs-2025-mercere-says-2024-09-12/> (noting that employers expected six percent increase in costs in 2025).

⁷ <https://sfof.com/wp-content/uploads/2025/12/Healthcare-Pricing-Transparency-Letter2.pdf>.

⁸ <https://sfof.com/wp-content/uploads/2025/12/Healthcare-Pricing-Transparency-Letter2.pdf> (p. 1).

⁹ <https://sfof.com/wp-content/uploads/2025/12/Healthcare-Pricing-Transparency-Letter2.pdf>.

Access to detailed transaction-level claims and pricing data is critical for fiduciaries to exercise effective oversight, validate payments, and control healthcare costs. One industry expert called this level of access to data the “single most important leverage point” for fiduciaries,¹⁰ and the “employer’s equivalent of a receipt,” without which “price transparency is incomplete.”¹¹

The Proposed Rule Is a Critical Step Toward Accountability in Employer-Sponsored Health Plans

The PBM compensation disclosures required by the Proposed Rule would bring increased accountability to employer-sponsored health plans. The disclosures would help expose conflicts of interest pervasive within the PBM industry, enable meaningful fiduciary oversight of specific categories of PBM compensation, and help plan sponsors satisfy ERISA’s requirement to pay only reasonable plan expenses and service provider fees.

PBM Compensation Disclosures Are Essential to Identifying Conflicts of Interest

PBM compensation disclosures are essential because the lack of transparency in PBM operations has enabled pervasive and costly conflicts of interest. The “center of the U.S. pharmaceutical system,”¹² “PBMs serve as middlemen, negotiating the terms and conditions for access to prescription drugs for hundreds of millions of Americans.”¹³ But the existing lack of transparency has allowed PBMs to frequently disguise conflicts to the detriment of patients and health plans, such as the following:

Manufacturer Rebates to PBMs That Incentivize Formulary Decisions – Manufacturer rebate arrangements distort formularies in ways that often benefit the PBM at the expense of the plan. Manufacturers pay rebates to PBMs in exchange for placement of certain drugs on the group health plan’s formulary, creating an incentive for PBMs to include high-list-price drugs on the formulary rather than lower-cost alternatives, even when those choices increase costs to the plan and plan participants.¹⁴ These arrangements are generally not made public, so plan sponsors often do not have insight into how much PBMs are actually paying for drugs on their formularies.¹⁵

Spread-Pricing That Benefits the PBM and Harms the Plan – Opaqueness in spread pricing—when a PBM charges an insurer one price for a drug but then pays a lower price for that drug to the

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<https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/68e953124cd2f4310b081790/1760121629458/The+Health+Plan+Turnaround.pdf> (p. 6).

¹¹ <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (p. 9).

¹² https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf (p. 71).

¹³ https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf (p. 1).

¹⁴ See <https://www.ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen>; <https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf>.

¹⁵ <https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/>.

dispensing pharmacy—has enabled PBMs to keep the difference or “spread” as profit.¹⁶ Pocketing the spread results in higher costs to the plan and participants.¹⁷

Self-Dealing Through Vertical Integration – Vertical integration among dominant PBMs creates systemic incentives for self-dealing that undermine plan and participant interests. Although there are many PBMs, a few companies dominate the overall U.S. market. The top three PBMs—OptumRx, Express Scripts, and CVS Caremark—manage 79 percent of prescription drug claims.¹⁸ Each of these PBMs owns mail order pharmacies and specialty pharmacies,¹⁹ which creates incentives for them to steer plan participants toward affiliated pharmacies even when obtaining a drug from a non-affiliated or independent pharmacy would be less expensive to the plan and the participant.²⁰

The Proposed Rule’s required disclosures—including of payments to PBMs by drug manufacturers, spread compensation, and costs to the plan for each drug *per pharmacy channel*—will better enable fiduciaries to detect these common conflicts of interest, in addition to others, and reclaim plan value.

The Proposed Rule’s Requirement That PBMs Disclose Each Stream of Revenue Received in Connection with Health Plan Contracts Is Critical to Effective Oversight

The Department is to be commended for requiring disclosure of each distinct type of compensation received (not just a handful of select fees), and for interpreting the disclosure requirements broadly. Selective fee disclosure undermines fiduciary accountability and cost control.²¹ Plan sponsors must have full visibility into all forms of PBM compensation regardless of how they are labeled or routed.

PBMs have been able to conceal much of their compensation because their business model relies on a complex web of rebates, retained margins, affiliate arrangements, and formulary incentives.²²

¹⁶ See <https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/>.

¹⁷ <https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/>.

¹⁸ https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf#page=16 (p. 14).

¹⁹ <https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/>. These PBMs are also vertically integrated with major health insurers: OptumRx is owned by UnitedHealth, Express Scripts is owned by Cigna, and CVS Caremark is owned by CVS Health, which also owns Aetna. See <https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/>.

²⁰ See <https://www.ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen>; <https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/>.

²¹ <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (pp. 16–17, 29).

²² <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (pp. 16–17, 29).

As a result, the top three PBMs retain more than \$50 billion in undisclosed rebates and fees annually.²³ This opaque structure has prevented effective oversight.

In contrast to selective fee disclosure requirements that would enable PBMs to continue to hide fees, the Proposed Rule requires PBMs to disclose semi-annually “all direct compensation,” “all [manufacturer] payments,” “all spread compensation,” “all amounts received ... pursuant to ... price protection agreements,” and “all compensation” not disclosed under these other requirements.²⁴ In addition, each of these disclosure requirements is phrased in terms of compensation “in connection with services under the service contract or arrangement,”²⁵ or similar language. Consistent with the Department’s service provider disclosure regulation for pension plans, the “in connection with” language includes compensation based even *in part* on the service provider’s contract with the covered plan, so PBMs would be required to disclose payments based on a “structure of incentives” not solely related to the contract at hand²⁶—significantly improving fiduciary visibility of PBM compensation.

PBM Compensation Disclosures Are Necessary for Fiduciaries to Evaluate the Reasonableness of Plan Costs Under ERISA

Fiduciaries cannot satisfy their duty under ERISA to pay only reasonable plan costs without the kinds of compensation disclosures required by the Proposed Rule. ERISA prescribes duties of prudence and loyalty for healthcare plan fiduciaries.²⁷ These duties require fiduciaries to pay only reasonable expenses²⁸ and service provider fees²⁹ to control plan costs. In practice, this requires the plan sponsor³⁰ to compare prices to other available options;³¹ investigate and monitor expenses;³² and vigilantly negotiate the specific formula and methodology used to structure fee

²³ <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (p. 6).

²⁴ <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure> (proposed 29 CFR § 2550.408b-22(g)).

²⁵ <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure> (proposed 29 CFR § 2550.408b-22(g)).

²⁶ <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure> (part D(2)).

²⁷ See <https://www.law.cornell.edu/uscode/text/29/1104>.

²⁸ See <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/group-health-plan-fiduciary-responsibilities.pdf> (p. 2).

²⁹ See <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/group-health-plan-fiduciary-responsibilities.pdf> (p. 5) (“While the law does not specify a permissible level of fees, it does require that fees charged to a plan be ‘reasonable.’”).

³⁰ Some cases cited involve company retirement plans governed by ERISA, but ERISA’s requirement that fiduciaries act prudently and pay only reasonable expenses applies to both retirement and healthcare plans. See <https://www.law.cornell.edu/uscode/text/29/1002> (“The term ‘employee benefit plan’ or ‘plan’ means an employee welfare benefit plan [i.e., a healthcare plan] or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.”).

³¹ See, e.g., *Ramos v. Banner Health*, 461 F. Supp. 3d 1067, 1132 (D. Colo. 2020), *aff’d*, 1 F.4th 769 (10th Cir. 2021) (“A prudent fiduciary must ... evaluate whether pricing is competitive[.]”) (citing *Tussey v. ABB, Inc.*, 746 F.3d 327, 336 (8th Cir. 2014)).

³² See *Turner v. Schneider Elec. Holdings, Inc.*, 530 F. Supp. 3d 127, 136 (D. Mass. 2021) (citing *Tibble v. Edison Int’l*, 843 F.3d 1187, 1197–98 (9th Cir. 2016)).

payments.³³ Plan sponsors must also ensure service provider contracts do not contain gag clause provisions preventing disclosure of compensation as “proprietary” or “confidential,”³⁴ and should ensure contracts do not contain limitations on audit rights.³⁵ Each of these tasks is made more difficult in the absence of robust compensation disclosure requirements.

The Department Should Expand the Proposed Rule to All Health Plan Service Providers So Fiduciaries Can Fulfill Their Duty to Monitor Plan-Wide Expenses

Although the PBM compensation disclosures required by the Proposed Rule are a significant step toward accountability in employer-sponsored plans, the Department should expand the Proposed Rule to include similar compensation disclosure requirements for other service providers like TPAs and insurers of fully insured plans. Such an expansion would be consistent with congressional intent and with the duties required of ERISA fiduciaries.

Congress recently clarified that covered service provider status under ERISA § 408(b)(2) extends to virtually all entities and individuals providing services to the plan. On February 3, 2026, Congress enacted the Consolidated Appropriations Act (CAA) 2026 (HR 7148), which expanded the types of service providers that must provide compensation disclosures to group health plan sponsors under ERISA § 408(b)(2).³⁶ Previously, § 408(b)(2) only required such disclosure from brokers and consultants providing plan design and implementation services, but the amendment added other covered service providers, including those providing pharmacy benefit management services, third-party administration services, and other services that would typically be performed by insurers of fully insured plans.³⁷

Confining the Proposed Rule to PBMs would hinder fiduciaries from effectively executing their duty under ERISA to monitor plan-wide expenses and service provider fees. The duties of healthcare plan sponsors run to the plan and its participants.³⁸ It is axiomatic, therefore, that the duty to monitor plan expenses and fees extends to all service providers, which is implicit in past

³³ See *Sweda v. Univ. of Penn.*, 923 F.3d 320, 328 (3rd Cir. 2019) (citing Department of Labor Advisory Opinion 2013-03A, 2013 WL 3546834, at *4); *Ramos v. Banner Health*, 461 F. Supp. 3d 1067, 1132 (D. Colo. 2020), *aff'd*, 1 F.4th 769 (10th Cir. 2021).

³⁴ See <https://www.law.cornell.edu/uscode/text/29/1185m> (gag clause prohibition); <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (p. 10).

³⁵ See <https://www.law.cornell.edu/uscode/text/29/1104> (articulating the prudent man standard of care); <https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/68e953124cd2f4310b081790/1760121629458/The+Health+Plan+Turnaround.pdf> (p. 11, 16).

³⁶ See 29 U.S.C. § 1108(b)(2), as amended by Consolidated Appropriations Act, 2026, Pub. L. No. 119-75, § 6702 (2026); <https://www.jdsupra.com/legalnews/employers-request-new-compensation-6117922/>; <https://www.reinhartlaw.com/news-insights/consolidated-appropriations-act-2026-impact-on-plan-sponsors>.

³⁷ See <https://www.law.cornell.edu/uscode/text/29/1108>; <https://blog.ifebp.org/pbm-fee-disclosure-regulatory-and-legislative-update/>; <https://www.jdsupra.com/legalnews/employers-request-new-compensation-6117922/>.

³⁸ See <https://www.law.cornell.edu/uscode/text/29/1104> (“[A] fiduciary shall discharge his duties *with respect to a plan* ... for the exclusive purpose of (i) providing benefits to *participants* and their beneficiaries; and (ii) defraying reasonable expenses of administering the *plan*.”) (emphases added).

Department guidance.³⁹ The NPRM also implicitly recognizes this by soliciting comments on the expansion of the Proposed Rule to “TPAs, health insurers,” and other service providers.⁴⁰

The Department Should Expand the Proposed Rule to Require Disclosure of Claims Data, Payments to Providers, and Pricing Data So Fiduciaries Can Fulfill Their Duty to Ensure the Plan Pays Only Reasonable Costs and Fees

To enable ERISA fiduciaries to determine whether plan assets are being spent reasonably, the final rule must extend beyond compensation summaries and require access to transaction-level claims, payments, and pricing data that is auditable, complete, and usable. Fiduciaries cannot verify whether disclosed compensation is accurate or reasonable without the ability to reconcile disclosures against actual claims and payment records. Audit rights are also ineffective unless they include access to underlying transaction-level data reflecting prices actually paid. And disclosures are meaningless unless data is provided in standardized, machine-readable formats that permit proper analysis. Without these elements, fiduciaries lack the practical ability to satisfy ERISA’s duties of prudence and loyalty.

A. Service Providers Should Be Required to Disclose Transaction-Level Claims and Pricing Data Across the Full Transaction Chain in Their Semi-Annual Disclosures So Fiduciaries Can Conduct Effective Cost Analysis

Although the Proposed Rule’s focus on compensation flows aligns generally with the objective of state financial officers that employer-sponsored health plans conduct detailed payment-integrity analyses, fiduciaries need transaction-level claims and pricing data to truly verify pricing and actual costs paid. This includes—and the Proposed Rule should explicitly require in service providers’ semi-annual disclosures—access to in-network rates, allowed amounts, and amounts actually paid to providers for each transaction. Transaction-level claims data—the plan’s financial ledger—documents what services were delivered, by whom, at what price, what was allowed and paid, and how much was drawn from plan assets.⁴¹ Although summary compensation data is informative, without the ability to compare that data to the actual amounts withdrawn from plan assets, plan sponsors cannot verify that rebates, fees, and other sorts of remuneration are passed through to the plan.

Explicit requirements for transaction-level claims and pricing disclosures are necessary to prevent service providers from continuing well-documented practices that obstruct fiduciary access to data. For example, despite the prohibition on gag clauses in the Consolidated Appropriations Act of 2021, employers continue to encounter contractual restrictions—whether embedded in Administrative Services Agreements, nondisclosure agreements, or downstream agreements with

³⁹ See <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/group-health-plan-fiduciary-responsibilities.pdf> (articulating fiduciaries’ duties to evaluate and monitor the fees and performance of service providers to the plan).

⁴⁰ <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure>.

⁴¹ <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (p. 9).

other service providers—that limit access to deidentified claims data, constrain employers’ ability to share data with third-party firms for analysis, or force reliance on carrier-selected analytics vendors.⁴² These persistent issues resulted in the Department issuing additional guidance in January 2025 regarding compliance with the gag clause prohibition.⁴³ This underscores the need for explicit requirements in the Proposed Rule for disclosure of complete claims, provider-payment, and pricing data.

The Department Should Expressly Include as Part of Fiduciaries’ Audit Rights Transaction-Level Data Reflecting Actual Prices Paid

Audit rights are ineffective unless they include access to data needed to verify service providers’ disclosures, so the Department should explicitly require service providers to make available to auditors transaction-level claims and payment data that reflects actual prices paid. The Proposed Rule’s provision giving self-insured group health plans the sole authority to select the auditor and prohibiting PBMs from imposing restrictive conditions on the auditor⁴⁴ will help ameliorate some of the common methods service providers use to obstruct access to data for purposes of the audit, but more is needed. The Proposed Rule currently requires the service provider to “make available to the auditor all records, data, and other information reasonably necessary to confirm the accuracy of any disclosure made to comply with this section,”⁴⁵ but the Department should make clear that “all records [and] data” includes access to underlying claims and payment data.

Service Providers Should Be Required to Provide Data in Standardized, Machine-Readable Formats So Fiduciaries Can Properly Analyze It

Meaningful disclosure requires usable data, so the Proposed Rule should require that any disclosed data be provided in standardized, machine-readable formats to support effective analysis and verification. As employer healthcare purchasers have documented in recent comments to the Centers for Medicare & Medicaid Services on hospital price transparency enforcement, data that is incomplete, inaccurate, delayed, or delivered in inconsistent formats cannot be used to validate prices, reconcile payments, or demonstrate fiduciary prudence—even when it is technically “disclosed.”⁴⁶ Claims data provided to plan sponsors is often heavily aggregated or structured in

⁴² <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (p. 10); <https://www.help.senate.gov/imo/media/doc/Mitchell15.pdf> (p. 7); <https://natlawreview.com/article/unlocking-transparency-new-dol-guidance-clarifies-gag-clause-prohibition-rules>; see also <https://www.pbgh.org/wp-content/uploads/2023/10/PBGH-Letter-to-Tri-Agencies-Re-CAA-Section-201-Gag-Clause-Attestations-10.31.2023.pdf>; https://members.pbgh.org/wp-content/uploads/2024/03/PBGH-Response-to-ERISA-RFI_3.15.2024_Final.pdf (pp. 13–15).

⁴³ See <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-69.pdf>; <https://www.wtwco.com/en-us/insights/2025/02/departments-issue-guidance-on-gag-clause-prohibition-and-no-surprises-act>.

⁴⁴ <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure> (proposed 29 CFR § 2550.408b-22(j)(2)).

⁴⁵ <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure> (proposed 29 CFR § 2550.408b-22(j)(3)).

⁴⁶ https://members.pbgh.org/wp-content/uploads/2025/07/PBGH-Response-to-CMS-Hospital-Price-Transparency-Enforcement-RFI_7.21.2025_Final.pdf.

ways that prevent reconciliation with Hospital Price Transparency or Transparency in Coverage files, undermining payment validation and cost control.⁴⁷ Standardized, machine-readable formats are required for effective fiduciary oversight.

Requested Actions

To ensure that the final rule meaningfully enables ERISA fiduciaries to assess the reasonableness of group health plan expenses and control plan costs, the Department should take the following actions in addition to those in the Proposed Rule:

- **Expand the Proposed Rule’s coverage to all health plan service providers.** Extend compensation disclosure obligations beyond PBMs to include TPAs, insurers, and any other entities providing services to group health plans, consistent with ERISA § 408(b)(2) as amended by the CAA, 2026.
- **Require disclosure of transaction-level claims, provider-payment, and pricing data** with the following additions, so disclosed compensation can be verified and reconciled against actual withdrawals from plan assets:
 - Require semi-annual disclosures of per-transaction claims and pricing data, including in-network rates, allowed amounts, and amounts actually paid to providers.
 - Make explicit that service providers must provide plan-selected auditors access to underlying claims and payment records reflecting actual prices paid, not merely summaries or aggregated reports.
 - Require that all disclosed compensation, claims, and pricing data be provided in standardized, machine-readable formats capable of supporting analysis, cross-dataset reconciliation, and payment validation.

Conclusion

The Department’s proposed PBM compensation disclosure rule is an important step toward improving transparency in employer-sponsored health plans, but it will fall short of its objectives unless it is expanded to reflect the realities of modern health plan administration. ERISA fiduciaries cannot fulfill their statutory duties based on partial disclosures, aggregated summaries, or PBM-only transparency.

By extending disclosure obligations to all health plan service providers and requiring access to transaction-level claims and pricing data in a standardized and machine-readable format, the Department can equip fiduciaries with the tools necessary to protect plan assets, reduce wasteful healthcare spending, and ensure that a plan pays only reasonable costs and service provider fees.

⁴⁷ <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf> (p. 5); https://members.pbgh.org/wp-content/uploads/2025/07/PBGH-Response-to-CMS-Hospital-Price-Transparency-Enforcement-RFI_7.21.2025_Final.pdf.

These reforms would align the final rule with ERISA's fiduciary framework and recent congressional action, materially improving accountability in employer-sponsored health plans.

Sincerely,


Indiana Comptroller Elise Nieshalla


Kansas Treasurer Steven Johnson


Louisiana Treasurer John Fleming

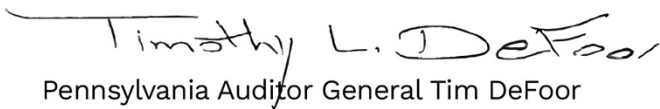

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Oklahoma Auditor & Inspector Cindy Byrd


Pennsylvania Auditor General Tim DeFoor


South Carolina Treasurer Curtis Loftis


Utah Auditor Tina Cannon


Utah Treasurer Marlo Oaks

Larry Pack
West Virginia Treasurer Larry Pack

Curt Meier
Wyoming Treasurer Curt Meier