



Pharmacy Law

PBM Reform Reshaping Pharmacy Reimbursement

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The Consolidate Appropriations Act (CAA), 2026 establishes a comprehensive federal framework governing pharmacy benefit manager (PBM) transparency, compensation, and reporting across both the commercial markets and Medicare Part D. The CAA 2026 statute imposes standards that eliminate rebate-driven compensation, enhance plan sponsor oversight, and increase visibility into prescription drug pricing and pharmacy reimbursement.¹

Most of the statutory provisions included in CAA 2026 take effect for the 2028 and 2029 plan years and will be further defined through regulations issued by the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury.

These reforms are expected to accelerate the transition toward transparent, fee-based PBM business models and increase fiduciary and compliance risk for noncompliant arrangements. (See **SIDEBAR 1** for key statutory CAA 2026 changes).

Sidebar 1

Key Consolidate Appropriations Act, 2026 Statutory Changes

- 100% rebate and remuneration pass-through to commercial plan sponsors, including rebates, fees, and alternative discounts received from manufacturers and related entities
- Expanded transparency and reporting obligations, requiring semiannual—and upon request, quarterly—reports detailing gross and net drug spending, rebate flows, spread-pricing practices, pharmacy reimbursement, and affiliated pharmacy utilization
- Enhanced audit rights for plan fiduciaries, including independent audits of PBM rebate and reimbursement records, with associated documentation obligations
- Delinked PBM compensation in Medicare Part D, limiting remuneration to BFSFs that are flat, fair market–value based, and unrelated to drug prices, rebates, or utilization
- Strong AWP and essential retail pharmacy protections, with increased CMS oversight and standardized contract requirements

AWP: any willing pharmacy; BFSFs: bona fide service fees; CAA: Consolidate Appropriations Act, 2026; CMS: Centers for Medicare & Medicaid Services; PBM: pharmacy benefit manager. Source: Reference 1.

Commercial Market Transparency Provisions

CAA 2026 imposes transparency requirements on PBMs serving group health plans and health insurance issuers, as follows:

Detailed Reporting: PBMs must provide semi-annual (or quarterly upon request) reports to large employer plans (defined as those with 100 or more employees) and large group health plans. These reports must include:

- Gross and net prescription drug spending;
- Manufacturer rebates, fees, and other remuneration received;
- Spread pricing arrangements and pharmacy reimbursement details, including drug-level data and dispensing channel (retail, mail, specialty);
- Formulary structure and benefit design, including utilization management and tiering;
- Drug dispensing through PBM-affiliated pharmacies, with explanations of benefit design features that steer utilization;
- Member out-of-pocket cost metrics; and
- Summary documents tailored for plan clients and participants.²

Contractual Safeguards: PBMs are prohibited from entering into contracts that restrict their ability to provide required reports. Upstream contracts with manufacturers, wholesalers, and rebate aggregators must include provisions ensuring the timely flow of information needed for compliance.³

Audit Rights: Plan fiduciaries are expressly authorized to conduct independent audits of PBM rebate, remuneration, and reimbursement records at least once per plan year, using auditors selected by the fiduciary and independent of the PBM. PBMs may not pay for these audits, directly or indirectly, and must make all relevant documentation available. These audit rights apply notwithstanding contractual confidentiality provisions, subject to reasonable safeguards to protect proprietary information as may be established through future DOL guidance.⁴

ERISA Fiduciary Implications: CAA increases plan sponsors’ fiduciary duties under the Employee Retirement Income Security Act of 1974 (ERISA) by requiring more PBM disclosures and audit rights. A PBM’s failure to comply with rebate pass-through, reporting, or compensation disclosure requirements may render the underlying contract “unreasonable,” constituting a prohibited transaction and exposing plan fiduciaries to potential liability if compliance failures are not timely identified and corrected. Plan sponsors now have an affirmative duty to monitor PBM compliance. This will require updating request for proposal processes, strengthening audit committee oversight, and documenting due diligence related to PBM selection and ongoing oversight.

Separately, the CAA 2026 expands [the] ERISA Section 408(b)(2) compensation disclosure framework—historically limited to brokers and consultants—to virtually all group health plan service providers, including third-party administrators (TPAs), PBMs, stop-loss carriers, and ancillary vendors. Unlike the 30-month delayed effective date applicable to PBM-specific rebate and reporting provisions, this compensation disclosure expansion does not carry a specified effective date and is likely effective immediately for contracts entered into or renewed on or after February 3, 2026, prompting prompt review of existing arrangements.⁵

Medicare Part D Transparency Provisions

While the commercial market focuses on ERISA fiduciary duties, Medicare Part D builds on transparency efforts with program-specific requirements, creating a unified yet tailored federal framework.

Annual Standardized Reporting: PBMs must submit comprehensive annual reports to Part D plan sponsors and the Centers for Medicare & Medicaid Services (CMS), including:

- Drug-level and aggregate pricing, reimbursement, and out-of-pocket spending data
- Manufacturer-derived revenue, including rebates and bona fide service fees (BFSFs)
- Dispensing activity by PBM-affiliated pharmacies, with transparency into 340B drug dispensing
- Formulary and benefit design information, especially regarding generics and biosimilars
- Aggregate spending metrics, including total

plan spending, PBM-retained amounts, and net drug costs after rebates and direct and indirect remuneration

- Broker or consultant compensation related to PBM services
- Documentation of benefit design features that encourage use of PBM-affiliated pharmacies.⁶

Audit and Certification: Part D sponsors may audit PBM compliance annually, and PBMs must provide all requested information within 6 months. Sponsors must certify annual compliance to CMS.⁷

Commercial Market Compensation Oversight and Bona Fide Service Fee Rules

100% Rebate Pass-Through: PBMs must remit 100% of rebates, fees, alternative discounts, and other remuneration received from manufacturers, group purchasing organizations, and rebate aggregators to plan sponsors on a quarterly basis, no later than 90 days after the end of each quarter. Upstream entities must pass through rebates to PBMs within 45 days to facilitate timely remittance. The statute states that nothing in this provision should be read as requiring rebates to be passed through to the point of sale. Plan sponsors may continue to use rebate value to reduce overall plan costs or enhance benefits, rather than applying savings to individual cost sharing at the pharmacy counter.⁸

Compensation Disclosure: The definition of “covered service provider” under ERISA is expanded to include PBMs, requiring disclosure of all direct and indirect compensation received in connection with plan services. This includes compensation from manufacturers, pharmacies, and other third parties.⁹

BFSFs: PBMs may receive and retain compensation solely in the form of reasonable payments for bona fide services actually performed, provided such fees are transparent, quantifiable, and consistent with fair market value. The DOL is directed to issue implementing regulations further defining BFSFs and acceptable valuation methodologies.¹⁰

Medicare Part D Compensation Oversight and BFSF Rules

While the commercial market’s BFSF rules emphasize ERISA-compliant disclosures and

rebate pass-throughs for group health plans, Medicare Part D extends similar principles with program-specific delinked compensation requirements.

Delinked Compensation: PBMs acting on behalf of Part D sponsors may receive compensation only in the form of BFSFs. For Medicare Part D purposes, the statute defines a BFSF as compensation that must, at a minimum, satisfy the following statutory criteria subject to further clarification by CMS through rulemaking: a flat fee, consistent with fair market value; for services actually performed by the PBM or its affiliate; not passed on to clients or customers; and not varying based on drug price, rebates, coverage, formulary decisions, or volume/value of referrals.¹¹

Prohibition of Rebate-Linked Compensation: PBMs are prohibited from receiving any income tied to Part D drug utilization other than BFSFs. Manufacturer rebates must be fully passed through to plan sponsors and reported in accordance with direct and indirect remuneration (DIR) requirements.¹²

CMS Oversight: The Secretary of HHS is authorized to review PBM remuneration arrangements for consistency with fair market value and to issue further guidance as needed.¹³

Implementation Timelines and Effective Dates

Most PBM provisions take effect August 3, 2028, or January 1, 2029, for calendar year plans.¹⁴

Commercial Market: The 100% rebate pass-through, compensation disclosure, and audit requirements apply to contracts entered into, renewed, or extended for plan years beginning on or after January 1, 2029.¹⁵

Medicare Part D: The BFSF compensation rules, annual reporting, and any willing pharmacy (AWP) contract standards take effect for the 2028 plan year, with certain AWP standards finalized by April 2028 and effective for the 2029 plan year.¹⁶

Regulatory Rulemaking: The Secretaries of Labor, HHS, and Treasury are directed to issue implementing regulations and standardized reporting formats within 18 months of enactment, providing additional clarity and operational guidance to stakeholders. Key areas for anticipated rulemaking include BFSFs and fair

market value standards; audit procedures and confidentiality; participant notice and access; and enforcement and penalties.¹⁷

Enforcement Mechanisms and Penalties

The DOL oversees compliance for ERISA-covered plans; CMS administers and enforces Medicare Part D requirements; and the Department of the Treasury may impose excise taxes under the Internal Revenue Code for reporting failures¹⁸:

Civil Monetary Penalties: The Secretary of HHS or Labor may impose civil monetary penalties of up to \$10,000 per day for each day a required report is not provided and up to \$100,000 per item for knowingly providing false information.¹⁹

Excise Taxes: The Secretary of the Treasury may enforce parallel excise taxes under the Internal Revenue Code for noncompliance with reporting requirements.²⁰

Contractual Remedies: A PBM's failure to comply with ERISA plan rebate pass-through or compensation disclosure requirements renders the

contract “unreasonable” and constitutes a prohibited transaction, exposing both the PBM and plan fiduciaries to additional legal risks.²¹

Audit and Certification: Plan sponsors must certify annual compliance with PBM contractual requirements, and PBMs are responsible for any penalties imposed on sponsors due to PBM non-compliance.²²

CMS and DOL Oversight: Federal agencies are empowered to investigate, audit, and enforce compliance, with authority to issue further guidance and regulations as needed.²³

Impact on PBM Business Models and Revenue Streams

Transition From Rebate-Driven to Service Fee-Based Models: CAA 2026 reforms alter the PBM business model, which has relied on retaining manufacturer rebates and engaging in spread pricing. By mandating 100% pass-through of rebates and restricting compensation to BFSFs, the law shifts PBM revenue streams toward transparent, flat-fee arrangements for services actually performed.

PBMs will need to renegotiate contracts with plan sponsors, manufacturers, and pharmacies and may seek to offset lost rebate revenue by increasing administrative fees or developing new value added services, which must be fully disclosed and justified as reasonable under ERISA and BFSF standards. Implementation challenges may include potential PBM resistance to flat-fee models, leading to contract disputes or delays; litigation over “fair market value” definitions.²⁴

Pharmacy Models: In the Medicaid market, the law restricts spread pricing and requires pass-through models. While CAA 2026 does not limit PBMs’ use of spread pricing or affiliated pharmacy business models in the commercial market, the transparency and reporting requirements—combined with the 100% pass-through mandate—are expected to significantly curtail such practices.²⁵

Affiliated Pharmacy Models: PBMs’ use of affiliated pharmacies remains under scrutiny, with new reporting requirements mandating disclosure of benefit design features that steer utilization and detailed data on reimbursement and dispensing activity. CMS oversight of essential retail pharmacies and AWP contract standards is

intended to prevent anticompetitive practices and preserve pharmacy access and are expected to increase scrutiny of benefit designs that steer utilization toward PBM-affiliated pharmacies, particularly where such designs may disadvantage unaffiliated community pharmacies or restrict patient choice.²⁶

Market Consolidation and Competition: The shift toward transparent, fee-based models may accelerate market consolidation, as smaller PBMs will face increased compliance costs and operational complexity. However, the reforms also create opportunities for new entrants and alternative PBM models.²⁷

Implications for Retail and Community Pharmacy Reimbursement

CAA 2026 introduces several provisions that are designed to address long-standing concerns regarding opaque PBM practices and their effect on pharmacy financial viability and patient access.

Enhanced Transparency Into Reimbursement: PBMs must disclose reimbursement rates, spread pricing, and drug-level dispensing data.²⁸

Strengthened Network Access Protections: The law bolsters AWP protections in Medicare Part D, requiring plan sponsors to include any pharmacy meeting standard contract terms in their network. CMS is further directed to define reasonable and relevant contract terms to ensure fair participation.²⁹

Support for Essential and Community Pharmacies: New oversight of “essential retail pharmacies” aims to preserve beneficiary access and address pharmacy deserts in rural and urban markets. This oversight includes annual reporting on reimbursement, network participation, and cost-sharing trends.³⁰

Antiretaliation and Complaint Pathways: To ensure that pharmacies can safely report PBM contract violations, the law prohibits PBMs from retaliating against entities that report non-compliance and establishes formal complaint pathways.³¹

New Audit and Redress Avenues: Plan fiduciaries’ access to independent audits of PBM reimbursement and rebate records provides new avenues for redress and negotiation in contract disputes.³²

Medicaid Spread Pricing Restrictions: In align-

ment with recent state reforms, the law restricts spread pricing in Medicaid and mandates the use of pass-through models.³³

State Law Preemption and Ongoing Litigation

Recent federal court decisions have clarified the scope of ERISA and Medicare Part D preemption, but legal uncertainty remains in the commercial market. CAA 2026 does not preempt existing state PBM laws, but the expanded federal framework may prompt litigation over the boundaries of state and federal authority, particularly in areas such as spread pricing, pharmacy network adequacy, and reimbursement standards.³⁴

Conclusion

CAA 2026 represents the most consequential federal intervention in PBM regulation to date, establishing a transparent, auditable, service based framework across the commercial market and Medicare Part D. By mandating full rebate pass through, imposing strict BFSF standards, and establishing expansive reporting and audit requirements, the law fundamentally reshapes how PBMs interact with plan sponsors, pharmacies, manufacturers, and federal regulators.

These reforms are expected to accelerate the industry's shift toward predictable, fee-based compensation models while heightening fiduciary exposure for arrangements that fail to meet the statute's transparency and disclosure obligations.

For pharmacies, the new federal architecture offers meaningful opportunities to challenge underreimbursement, reduce anticompetitive steering, and strengthen their position in contract negotiations. At the same time, the transition will require careful navigation of evolving regulatory guidance, new data-reporting structures, and shifting PBM business strategies. As the DOL, HHS, and Treasury begin issuing implementing regulations and enforcement activity ramps up, the practical contours of the law will continue to take shape. Stakeholders that proactively realign contracts, compliance programs, and operational workflows ahead of the 2028–2029 implementation cycle will be best positioned to mitigate risk, preserve flexibility, and capitalize on the increased transparency and accountability that CAA 2026 is designed to deliver. ■

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REFERENCES

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