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April 15, 2026

The Honorable Daniel Aronowitz
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure (RIN 1210–AB37)

Dear Assistant Secretary Aronowitz:

We are pleased to provide our comments on the Proposed Rule by the Department of Labor (Department) entitled, "Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure"¹ (Proposed Rule). The Proposed Rule is a significant step forward that incorporates several ideas to increase transparency that were previously included in legislation supported by Democrats on the Committee on Education and Workforce (Committee). We encourage the Department to move forward with these aspects of the Proposed Rule, while taking additional action to further strengthen its provisions to lower costs for workers and their families.

The Department Should Expand the Application of the Proposed Rule to Improve Transparency Beyond Pharmacy Benefit Manager Services

The Proposed Rule applies critical fee disclosure requirements to pharmacy benefit manager (PBM) service providers of group health plans pursuant to the Department's authority under the *Employee Retirement Income Security Act* (ERISA).² This is a long overdue reform that has previously been proposed by the Advisory Council on Employee Welfare and Pension Benefit

¹ Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure, 91 Fed. Reg. 4,348 (Jan. 30, 2026), <https://www.govinfo.gov/content/pkg/FR-2026-01-30/pdf/2026-01907.pdf> (hereinafter Proposed Rule).

² Pub. L. No. 93-406 (1974).

Plans (ERISA Advisory Council),³ bipartisan leaders of the Committee,⁴ and Committee Democrats in legislation that would codify similar requirements.⁵ As the Department discusses,⁶ there is clear regulatory authority under subparagraphs (A) and (B) of section 408(b)(2) and section 505 of ERISA⁷ to take action in this area. Additionally, the Department’s authority is supported by the longstanding precedent of similar disclosures that apply to retirement plans.⁸

However, while the Department correctly ensures that a broad range of entities will provide disclosures to responsible plan fiduciaries—regardless of whether such entities are themselves “pharmacy benefit managers”⁹—the Proposed Rule falls short in its narrow focus on pharmacy benefits. Group health plans contract with a vast range of other service providers whose opaque compensation models and business practices raise costs for both workers and employers, and ERISA requires fiduciaries to prudently select and oversee these entities. For example, hospital, physician, behavioral health, and other benefits managed by third party administrators (TPAs) present similar potential for conflicts of interests and overpayments as PBM service providers.¹⁰ Additionally, as we have previously documented for the Department,¹¹ other middlemen such as claims repricers operate under a shroud of secrecy that leads to higher costs and often outrageous bills for workers and their families.¹² Moving forward, we encourage the Department to examine legislation such as H.R. 2041, the *Hidden Fee Disclosure Act*,¹³ to develop tailored, ongoing disclosure requirements for middlemen such as TPAs that are not limited to prescription drug benefits.

The Department Should Take Action to Clarify that All Covered Service Providers Provide Statutorily-Required Disclosures under Section 408(b)(2)(B) of ERISA

In addition to expanding the application of the Proposed Rule’s disclosure requirements to other service providers and middlemen, the Department should take steps to implement the recent clarification of the meaning of “covered service provider” that was recently enacted in the *Consolidated Appropriations Act, 2026*¹⁴ (CAA 2026). As Committee Democrats recently

³ Advisory Council on Employee Welfare and Pension Benefit Plans, *Report to the Honorable Thomas E. Perez, United States Secretary of Labor, PBM Compensation and Fee Disclosure* (Nov. 2024), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebasa/about-us/erisa-advisory-council/pbm-compensation-disclosure-report-2014.pdf>.

⁴ Letter from Rep. Robert C. “Bobby” Scott and Rep. Virginia Foxx to the Hon. Lisa M. Gomez, Asst. Sec’y, Emp. Benefits Sec. Admin., U.S. Dep’t of Lab. (Dec. 14, 2022), https://democrats-edworkforce.house.gov/imo/media/doc/bipartisan_scott-foxx_letter_to_ebsa_re_health_transparency.pdf.

⁵ Hidden Fee Disclosure Act of 2025, H.R. 2041, 119th Cong. (Mar. 11, 2025).

⁶ Proposed Rule at 4,373.

⁷ 29 U.S.C. §§ 1108(b)(2)(A), (B), and 1135.

⁸ 29 C.F.R. § 2550.408b-2.

⁹ Proposed Rule at 4,360.

¹⁰ See, e.g., Christine Monahan, *Questionable Conduct: Allegations Against Insurers Acting as Third-Party Administrators* (Mar. 24, 2023), <https://chir.georgetown.edu/questionable-conduct-allegations-insurers-acting-third-party-administrators/>.

¹¹ Letter from Rep. Robert C. “Bobby” Scott, Rep. Mark DeSaulnier to the Hon. Lisa M. Gomez, Asst. Sec’y, Emp. Benefits Sec. Admin., U.S. Dep’t of Lab. (Aug. 20, 2024), https://democrats-edworkforce.house.gov/imo/media/doc/scott_desaulnier_letter_to_dol_re_multiplan.pdf.

¹² Chris Hamby, *Congress Asks Regulators About ‘Troubling’ Health Insurance Tactics*, N.Y. Times (Aug. 21, 2024), <https://www.nytimes.com/2024/08/21/us/congress-multiplan-health-insurance-medical-bills.html>.

¹³ H.R. 2041, 119th Cong. (Mar. 11, 2025)

¹⁴ Pub. L. No. 119-75, div. J, tit. VII, § 6702(c) (2026).

informed the Department,¹⁵ Congress took this action to ensure that stakeholders understood the application of fee disclosure requirements for “covered service providers” by (1) ensuring a broader understanding of the term “brokerage services” and (2) amending the statute’s reference to “consulting” to read as follows:

(BB) **Other services**, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), **including any of the following**: plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third-party administration services, or consulting services related to any such services.¹⁶

The plain meaning of this provision requires responsible plan fiduciaries to receive written compensation disclosures at the time of entering or renewing a contract or arrangement with any of the enumerated “covered service providers.”¹⁷ This ensures the law is understood in a manner consistent with the original intent of Congress¹⁸ in enacting this provision in the *Consolidated Appropriations Act, 2021*.¹⁹ Because this clarification was enacted following the Department’s issuance of the Proposed Rule, the final rule should acknowledge the application of the statutorily-mandated disclosure obligations of all “covered service providers” and ensure that this provision is operationalized.

The Definition of “Covered Plan” Under the Proposed Rule Must Include Fully Insured Group Health Plans

The Department seeks comments on whether the definition of “covered plan” under the Proposed Rule should be expanded to include fully insured group health plans.²⁰ We urge the Department to take this action. Although the majority of participants and beneficiaries in ERISA-covered group health plans receive health benefits through a self-funded plan, more than 46 million receive benefits through a fully insured plan.²¹ The duties of an ERISA fiduciary to ensure the reasonableness of compensation for service providers for group health plans does not distinguish between those that are self-funded and those that are fully insured, and without the disclosures described in the Proposed Rule, fiduciaries of fully insured plans will struggle to prudently select

¹⁵ Letter from Rep. Robert C. “Bobby” Scott, Rep. Mark DeSaulnier, and Rep. Joe Courtney to the Hon. Daniel Aronowitz, Asst. Sec’y, Emp. Benefits Sec. Admin., U.S. Dep’t of Lab. (Mar. 26, 2026), https://democrats-edworkforce.house.gov/imo/media/doc/scott_desaulnier_courtney_letter_to_ebsa_re_covered_service_providers1.pdf.

¹⁶ 29 U.S.C. § 1108(b)(2)(B) (emphasis added).

¹⁷ *Id.*

¹⁸ Scott and Foxx, *supra* note 4.

¹⁹ Pub. L. No. 116-260, div. BB, tit. II, § 202 (2020).

²⁰ Proposed Rule at 4,358.

²¹ Emp. Benefits Sec. Admin., U.S. Dep’t of Lab., Health Insurance Coverage Bulletin (Aug. 30, 2024) at 46, <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2023.pdf>.

and monitor PBM service providers. Congress recognized the importance of this in enacting recent requirements of the CAA 2026, which makes PBM reports available to insured group health plans.²²

Additionally, the proffered reason of the Department for excluding these plans from the Proposed Rule is not compelling. Specifically, the Department states that:

[R]esponsible plan fiduciaries may focus on different considerations when contracting with an insurance company for health insurance coverage that integrates prescription drug coverage, as opposed to self-funding medical care and contracting for pharmacy benefit management services. Specifically, the Department questions whether responsible plan fiduciaries responsible for procuring fully insured health insurance policy would find the specific disclosures proposed in the regulation sufficiently useful when they are negotiating more comprehensive health insurance coverage as to justify the costs associated with the disclosures.

This conclusion is inconsistent with the facts on the ground. As the Department later notes,²³ many TPAs that contract with self-funded plans often integrate their health benefits with the pharmacy benefit management services provided. Yet, the Proposed Rule does not provide an exception for TPAs of self-insured plans that integrate medical and pharmaceutical benefits. Additionally, to the extent the Department's stated concern is founded, it could also be resolved by ensuring that the Proposed Rule's disclosure requirements apply broadly to the compensation received by all TPAs and other service providers and are not simply limited to PBM services (see above).

The Department Should Take Steps to Protect the Privacy of Patient Health Data

Although transparency is essential to the administration of group health plans, the sharing of price and payment data inherently raises the risk of sensitive information being accessed and utilized in a manner that could be harmful to plan participants and beneficiaries. While the Proposed Rule does not require the submission of claims-level data or other personally identifiable information to responsible plan fiduciaries, we are nonetheless concerned that the Department has seemingly not taken any privacy considerations into account. This is especially troubling as the Department seeks comments from stakeholders that could potentially expand the scope of reporting requirements to include sensitive health information.²⁴ Moving forward, we urge the Department to exercise extreme caution to ensure that data is used only for the exclusive benefit of plan participants and beneficiaries and that employers and other actors do not discriminate or retaliate against individuals for their receipt of benefits under their health plans.

In considering potential guardrails in the final rule, the Department should consult the privacy protections included in section 726 of ERISA,²⁵ recently enacted as part of the CAA 2026. In

²² Pub. L. No. 119-75, div. J, tit. VII, § 6701, 6702 (2026).

²³ Proposed Rule at 4,359.

²⁴ *Id.*

²⁵ 29 U.S.C. § 1185.

developing these requirements, Congress took care to minimize the risk of potential harm to participants and beneficiaries as a result of the sharing of prescription drug information. The final rule could be strengthened by ensuring that similar and, if needed, additional protections are included to address potential privacy concerns. For example: (1) reports from PBMs are to be submitted directly to health plans²⁶ rather than to plan fiduciaries because a “health plan” is a Covered Entity²⁷ under regulations implementing the *Health Insurance Portability and Accountability Act of 1996*²⁸ (HIPAA); (2) the risk of potentially identifiable information being traced back to an individual employee is reduced by limiting the sharing of drug-level and claim-level data only to plans sponsored by large employers (i.e., those with at least 100 or more employees)²⁹ or plans that meet the statutory definition of specified large plans (i.e., those with at least 100 or more participants)³⁰; and (3) the legislation requires compliance with core privacy and security requirements, including the HIPAA Privacy Rule and Security Rule and imposes an affirmative obligation on plan sponsors to comply with 45 C.F.R. 164.504(f).³¹ This list is not exhaustive, as additional privacy protections may also be needed, such as clearer requirements to fiduciaries and service providers that data must only be used for the exclusive benefit of plan participants. In developing guardrails, the Department should consult with the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services to ensure that all necessary actions are taken to protect the privacy of plan participants and beneficiaries.

The Department Should Not Undermine the Proposed Rule in Any Effort to Harmonize Disclosure Requirements With Section 6701 of the CAA 2026

Finally, as the Department moves forward with a final rule, it may be necessary to address the interaction between the Proposed Rule and recent changes enacted under the CAA 2026, particularly the new reporting requirements under section 726 of ERISA.³² However, in doing so, the Department should not accommodate industry requests to withdraw, weaken, or otherwise undermine the Proposed Rule.³³

The Proposed Rule is substantially different from, and in certain ways stronger than, the reporting obligations under section 726 of ERISA in a number of respects. First, the content of the disclosures under the Proposed Rule includes useful information not provided by section 726’s reports, such as a description of services provided to the plan, information directly addressing PBM’s incentives regarding formulary placement, and whether PBMs are operating as a fiduciary on behalf of the plan. Moreover, the information presented through the Proposed Rule is provided to plans at the time of signing or renewing a contract and is more readily actionable for plan fiduciaries than the data provided under section 726. This is particularly beneficial to mid-sized and smaller plans that lack the sophistication and resources to understand

²⁶ 29 U.S.C. § 1185(b).

²⁷ 45 C.F.R. § 160.103.

²⁸ Pub. L. No. 104-191 (1996).

²⁹ 29 U.S.C. § 1185(e)(8).

³⁰ 29 U.S.C. § 1185(e)(9).

³¹ 29 U.S.C. § 1185(b)(4)(B)(ii).

³² 29 U.S.C. § 1185.

³³ See, e.g., Press Release, PCMA, After Enactment of PBM Reform, PCMA Urges DOL to Rescind Duplicative Proposed Rule (Mar. 19, 2026), <https://www.pcmanet.org/press-releases/pcma-urges-dol-to-rescind-duplicative-proposed-rule/03/19/2026/>.

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the vast amount of information reported under section 726. Additionally, the Proposed Rule directly links the receipt of its disclosures to the duty of fiduciaries to prudently select and monitor their service providers, ensuring the data is actually used to lower costs and reduce conflicts of interest that harm participants and beneficiaries.

To the extent the Department takes steps to address concerns of duplicative reporting requirements, the Department should limit changes to those necessary to assist service providers in providing reports in a manner that minimizes duplication, while still ensuring both provisions fully apply to all relevant parties.

Thank you for your consideration of these comments. We urge the Department to move forward swiftly to strengthen the Proposed Rule and to ensure it fully benefits workers and their families.

Sincerely,



ROBERT C. "BOBBY" SCOTT
Ranking Member



MARK DESAULNIER
Ranking Member
Subcommittee on Health, Employment, Labor, and
Pensions