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House Passes HR 7148, Advancing New PBM Transparency and Compensation Rules

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On January 22, the U.S. House of Representatives passed on a bipartisan basis HR 7148, the Consolidated Appropriations Act, 2026 (HR 7148). If it also wins passage in the Senate, the bill would, among other Trump administration priorities, impose new rules and requirements for pharmacy benefit managers (PBMs) and pharmacy benefit administration more generally. As with prior federal legislative proposals, HR 7148 attempts to bring more transparency to the administration of pharmacy benefits for both fully insured and self-funded groups and would impose enhanced transparency requirements for PBMs contracting with Medicare Part D prescription drug plans PDP sponsors. Specifically, among other requirements, HR 7148 proposes the following new rules and regulations impacting PBM arrangements:

1. PBM Rebate Pass-Through and Compensation Disclosures for ERISA Fully Insured and Self-Funded Plan: Mandates 100% pass-through of rebates and expands the definition of "covered service provider" beyond brokers and consultants, resulting in a PBM (and other entities supporting group health plans) being subject to the ERISA compensation disclosure rules.

Effective Date: This provision would be effective for contracts entered into, extended, or renewed for plan years beginning on or after 30 months after the date of the enactment of the change.

Section 6702 of HR 7148 provides for an amendment to Section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), as follows:

- Requires entities providing "pharmacy benefit management services"[1] to pass through 100% of rebates, fees, alternative discounts, and other remuneration to the group health plan or group health plan insurance issuer. Failure to provide for the 100% pass-through after the effective date results in the contract not being considered "reasonable" under ERISA Section 408(b)(2)(B), thus giving rise to prohibited transaction penalties imposed on the parties to such PBM client contract.
- Expands the definition of "covered service provider" in ERISA's compensation disclosures applicable to group health plans to include *all* service providers to group health plans, including PBMs, third-party administrators (TPAs), and any other entity providing services to group health plans. ERISA Section 408(b)(2)(B) requires a "covered service provider" to provide a disclosure of all direct and indirect compensation received by the service provider to the group health plan sponsor prior to entering into, extending, or renewing the contract in order for such arrangement to be considered "reasonable" and not violate the prohibited transaction provisions of ERISA.[2]

2. PBM Reporting Obligations for Fully Insured and Self-Funded Group Health Plans: Requires entities providing "pharmacy benefit management services"[3] to provide reports to certain self-funded plan sponsors and

health insurers, as well as summary reports that can be disclosed to their participants or beneficiaries.

Effective Date: This provision would be effective for contracts entered into, extended, or renewed for plan years beginning on or after 30 months after the date of the enactment of the change to applicable coordinating statutes in the Public Health Service Act (PHSA), ERISA and the Internal Revenue Code, as amended (IRC).

Section 6701 of HR 7148 would amend Section 2799A-11 of the PHSA, Section 726 of ERISA, and Section 9826 of the IRC to include a substantial additional report to be provided by a PBM to its group health plan clients over and above those required by the Consolidated Appropriations Act of 2021 (CAA 2021).[4] The PBM must provide the group health plan with a semi-annual report (quarterly upon request, or annually for self-funded large plan opt-in) that includes:

- A summary document for purposes of assisting such plans with selecting PBM services that include certain required information (such as estimated net price, cost per claim, etc.) to be specified by the Tri-Agencies in guidance.
- A summary document that can be provided to participants and beneficiaries upon request to assist participants/beneficiaries in better understanding the group health plan coverage or benefits, that provides aggregate information, and that states that participants and beneficiaries may request specific, claims-level information from the group health plan or health insurance issuer. The required content of such participant/beneficiary document will be specified by the Tri-Agencies in guidance.
- Extensive disclosures about the prescription drug coverage that has been provided during the reporting period, such as information regarding drugs covered by such plan or coverage during such reporting period (such as total net spending); amounts paid directly or indirectly in rebates, fees, etc. to certain third parties; an explanation of benefit designs that encourage or require participants to use affiliate pharmacies; and total gross spending on all drugs under the plan or coverage during the reporting period.
- In addition to the above information, for large self-funded group health plans only[5], the report also must include[6] a list of and information about drugs for which a claim was filed; a list of and information about each therapeutic class for which a claim was filed; information relating to all drugs for which gross spending was more than $10,000 during the reporting period, or, if that results in less than 50 drugs, the top 50 prescriptions with the highest spending or for which the group health plan paid more than $10,000 in the reporting period; and an explanation of any plan design features that encourage participants to use affiliate pharmacies.

3. Compensation Disclosures and Reporting Obligations for Medicare Part D Prescription Drug Program: Requires PBMs contracting with PDP sponsors to only accept “bona fide service fees” from drug companies and to pass through all rebates received from drug manufacturers to the PDP sponsors, report information to PDP sponsors, and allow PDP sponsors to audit the PBMs at least annually.

Effective Date: Plan years beginning on or after January 1, 2028.

Section 6224 of HR 7148 would amend Section 1860D-12 of the Social Security Act and introduce additional reporting requirements and obligations that go beyond the current requirements that were introduced by the Affordable Care Act. Some key additions include:

- Requires the PBM agreement with a PDP sponsor to provide:
  - PBMs can only receive “bona fide service fees” from drug manufacturers, which explicitly excludes payments in connection with utilization of part D drugs.
  - Requires the PBM or its affiliate, as applicable, to reimburse the PDP sponsor for any civil money penalty imposed on the PDP sponsor as a result of the failure of the PBM or its affiliate to comply with these new

obligations to be added under Social Security Act Section 1860D-12(h)(1) (such as the bona fide service fees limitation on compensation and reporting obligations), as well as punitive remedies for breach of contract for failure to comply with the requirements under Social Security Act Section 1860D-12(h)(1).

- The PDP sponsor would have the right to audit the PBM at least once a year.
- The PBM would be required to provide a written explanation of the contract/agreement with drug manufacturers that provides for rebates, discounts, payments, or financial incentives related to one or more Part D drugs to the PDP sponsor.
- No later than July 1 following each plan year, PBMs would be required to provide an annual report to the PDP sponsor and the Secretary of Health and Human Services (HHS). The report must include, for example, a list of all drugs covered by the plan that were dispensed; total spending on covered part D drugs; an explanation of any plan design features that encourage participants to use affiliate pharmacies; and a list of all affiliates of the PBM.
- Arrangements between the PBM and PDP sponsors would be subject to review by the Secretary of HHS to ensure the remuneration received by the PBM is consistent with fair market value. Any amounts received in violation of the requirements of the new law are subject to disgorgement to the PDP sponsor, which then must disgorge such amounts to the Secretary of HHS.
  - PBMs must enter into a written contract with any affiliates under which the affiliate shall identify and disgorge any prohibited remuneration, and the PBM must attest to the Secretary of HHS that such contracts are in effect.

The Senate is expected to take action on HR 7148 this week and, if this bill passes the Senate without changes, it could become law by the end of the week. With bipartisan Senate support, which has been apparent, HR 7148 still could be passed easily despite growing congressional concerns over the other government funding bill, HR 7147 (Department of Homeland Security Appropriations Act, 2026) that contains funding for ICE, border security, and other DHS initiatives.

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[1] The term “pharmacy benefit management services” is undefined in HR 7148.

[2] The Consolidated Appropriations Act of 2021 (CAA 2021) amended ERISA Section 408(b)(2)(B) to require compensation disclosures only by “brokers” and “consultants” and defines the activities of such parties in a way that would not apply to most PBMs and many other service providers to group health plans, such as third party or claims administrators.

[3] The term “pharmacy benefit management services” is undefined in the amendment.

[4] CAA 2021 required group health plan sponsors to annually report certain health plan information to the Tri-Agencies[4], including data relating to the top 50 costliest and most frequently used drugs and certain rebate information related to drugs covered by the plan.

[5] This provision applies to group health plans sponsored by a “specified large employer” (100 or more employees on business days during prior year and at least 1 employee on first day of plan year) or a “specified large plan” (union or multiple employer welfare arrangement covering 100 or more participants on business days during prior year).

[6] Large self-funded group health plans are permitted to allow the PBM to provide all required disclosures on an annual basis instead of semi-annually (or quarterly).

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