



VIA ELECTRONIC SUBMISSION

April 15, 2026

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

Re: Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure (File Code: RIN 1210-AB37)

Dear Assistant Secretary Aronowitz:

The Peterson Center on Healthcare (the Center) appreciates the opportunity to submit comments on the Improving Transparency Into Pharmacy Benefit Manager (PBM) Fee Disclosure proposed rule. We thank the Department for taking meaningful steps to impose important new transparency requirements on third-party vendor partners to employers in the pharmacy benefits space, and we encourage the Department to extend the rule to also encompass medical benefits disclosures as well.

The Center is a nonprofit, nonpartisan organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. We are working to create a more efficient and effective healthcare system in the United States and believe that unlocking healthcare data will increase market competition by delivering better information about prices, spending, utilization, and outcomes, which can improve patient care and reduce spending.

One of the Center’s major focus areas is equipping employers with the data they need to be more effective purchasers and managers of healthcare benefits for their employees. Employers purchase healthcare coverage for half of all Americans, at an average annual cost of nearly \$27,000 for family coverage in 2025—about \$20,000 of which is paid by employers, with the remainder coming from employees’ paychecks.¹ These high costs are largely driven by provider prices: even a 1 percentage point increase in hospital prices leads to lower incomes, job losses, and higher unemployment claims in that market, with disproportionate effects on lower- and middle-income workers.² Research, while limited, suggests that self-insured employers’ opaque and unfavorable contract terms with Third-Party Administrators (TPAs),

¹ 2025 Employer Health Benefits Survey. KFF. October 22, 2025. <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>

² Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics*. 2019;134(1):51-107. <https://academic.oup.com/qje/article-abstract/134/1/51/5090426>

Pharmacy Benefit Managers (PBMs), and owners of the provider network are shifting costs to employers without their knowledge or consent.^{3,4,5}

The Center has a long track record of work to advance transparency and the use of pricing information to empower employers to improve their return-on-investment on healthcare spending.⁶ We have consistently advocated for greater transparency in prescription drug pricing over the past three years, primarily through improvements to Transparency in Coverage (TiC) reporting requirements and increased compliance.⁷ As such, we appreciate the Department's efforts to improve transparency of fees, billing, and payment for prescription drugs through this proposed rule. Given that medical benefit spend represents approximately 70 percent of total annual healthcare spending by employers, compared to the 30 percent spent on prescription drugs,⁸ we believe that understanding the full range of compensation incentives for both medical and pharmacy benefits will help employers become better purchasers of healthcare for their employees, and as discussed more fully below, help employer health plan sponsors satisfy their fiduciary duties under the Employee Retirement Income Security Act (ERISA).

With respect to this last point, we have become increasingly aware of non-price factors that impede employers from satisfying their fiduciary duties as healthcare purchasers. A prime example is the lack of visibility into the compensation streams and incentives that often drive the billing and payment practices of TPAs, including but not limited to PBMs. TPAs, PBMs, and owners of provider networks (i.e., entities that possess and control a health plan's pricing information and "rent" their provider network to a self-insured employer for a fee) have strong financial and competitive incentives to keep their income streams hidden and inaccessible. To mitigate the existing information asymmetry in contract negotiations between employers and TPAs, PBMs, or owners of the provider network, employers must have unencumbered access not only to information about the compensation received by these entities, but also to complete and accurate pricing information and claims data in a format that is easy to analyze.

³ Handorf K., Monahan C, Watts K. Third-Party Administrators – The Middlemen Of Self-Funded Health Insurance. Health Affairs Forefront. May 16, 2025. <https://www.healthaffairs.org/content/forefront/third-party-administrators-middlemen-self-funded-health-insurance>

⁴ Montgomery E. The Role of Third-Party Administrators in Health Insurance Coverage. Arkansas Center for Health Improvement. October 28, 2025. <https://achi.net/publications/the-role-of-third-party-administrators-in-health-insurance-coverage/>

⁵ Transparent Open Networks. Health Rosetta. <https://healthrosetta.org/health-rosetta/transparent-open-networks/>

⁶ Center Responds to HHS, Treasury, and Labor Proposed Rule on Transparency in Coverage Data Reporting. Peterson Center on Healthcare. March 3, 2026. <https://petersonhealthcare.org/news/center-responds-to-hhs-treasury-and-labor-proposed-rule-on-tic-data-reporting/>

⁷ Unlocking Healthcare's Black Box: Why Trump's New Transparency Order Matters for Employers and Consumers. Peterson Center on Healthcare. March 24, 2025. <https://petersonhealthcare.org/news/why-new-transparency-order-matters-for-employers-consumers/>

⁸ Business Group on Health Survey Reveals Almost 8% in Projected Health Care Trend for 2025. Business Group on Health. August 20, 2025. <https://www.businessgrouphealth.org/newsroom/news-and-press-releases/press-releases/2025-employer-health-care-strategy-survey>

Our work and the work of our grantees have highlighted systemic failures in both TiC data completeness and employer claims data access.^{9,10} We funded the Purchaser Business Group on Health (PBGH) to test the use of TiC and Hospital Price Transparency data—combined with claims and quality and safety data—to inform employer healthcare purchasing decisions, but participating employers faced challenges obtaining their claims data from TPAs.¹¹ Furthermore, in 2026, the State of Indiana compared published price transparency data to actual claims payments and found only a 21 percent match between payer-published TiC data and commercial claims from the state’s All Payer Claims Database.¹² These inconsistencies make it all the more difficult to ascertain the source of truth for how payment is flowing between entities.

Add in the complexity of compensation streams and financial incentives paid to TPAs, PBMs, and even owners of provider networks, and compensation disclosures represent a material missing piece of the puzzle that employers need access to in order to make prudent decisions about the cost of covered benefits and how best to manage their healthcare spend. In addition, as the Department notes, employers still face barriers to accessing their claims data that would enable them to better understand their actual spending, improve their negotiations, and deliver savings to their employees. **Transparency requirements about the terms, conditions, and incentives under which TPAs, PBMs, and other vendors operate are imperative to allow employers to make the most informed health benefits purchasing decisions for their employees.**

We appreciate the opportunity to share insights and learnings from our work and the work of our grantees. Our enclosed comments largely pertain to the extension of this regulation to TPAs and owners of the provider network administering medical benefits, as well as to securing greater claims data access. Our recommendations have the ultimate goals of equipping self-insured employers with the information they need to select and monitor their vendor partners more prudently (including by reducing potential conflicts of interest) and to negotiate more effectively.

Specifically, we recommend that the Department:

1. Extend the compensation disclosure requirements to include other service providers, such TPAs and owners of provider networks, who contract with self-insured group health plans for the provision and administration of medical benefits.
2. Expand the scope of the regulation to increase employer access to claims data, which could include classifying claims data as “compensation” to increase disclosure and data-

⁹ Muhlestein D, Pathak Y. Price Transparency With Gaps: Assessing the Completeness of Payer Transparency in Coverage Data. *American Journal of Managed Care*. 2025;31(Spec. No. 15):SP1121-SP1127.

<https://www.ajmc.com/view/price-transparency-with-gaps-assessing-the-completeness-of-payer-transparency-in-coverage-data>

¹⁰ Muhlestein D. High prevalence of ghost rates in transparency in coverage data. *Health Affairs Scholar*. 2025;3(11):qxaf212. <https://academic.oup.com/healthaffairsscholar/article/3/11/qxaf212/8321476>

¹¹ Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers. Purchaser Business Group on Health. October 6, 2025. <https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/>

¹² Sachdev G, Lambert H. Re: Response to Executive Order 25-21 Increasing Freedom and Opportunity for Hoosiers by Improving Price Transparency in Healthcare. Indiana Department of Insurance. January 21, 2026. <https://www.in.gov/gov/files/EO-25-21-Memo,-Executive-Summary,-and-Study.pdf>

sharing, and clarifying that the proposed information-sharing requirement in Section 7.4 applies to a plan's pricing and health claims data under the Gag Clause Prohibition (i.e., under ERISA section 724).

3. Apply the explicit and thorough protections of audit rights articulated in this proposed rule to other service providers such as TPAs and owners of provider networks involved in the administration of medical benefits, and ensure employers have access to health claims data.

We welcome opportunities to support the Department on any of the topics addressed in this letter. For questions or follow-up, please contact Mairin Mancino, Vice President, Policy at mmancino@petersonhealthcare.org and Natalie Joyce, Vice President of Advocacy at njoyce@petersonsolutions.org.

Sincerely,



Caroline Pearson

Executive Director, Peterson Center on Healthcare

D. Description of the Proposed Regulation

1.3. Covered Service Providers – Proposed Paragraph (c) 91 Fed. Reg. 4358-4359 (Jan. 30, 2026)

The Department proposes two types of covered service providers that would be subject to the disclosure and related audit obligations set forth in this regulation: “(i) providers of pharmacy benefit management services (as defined in paragraph (d) of the proposal) and (ii) providers of advice, recommendations, or referrals regarding pharmacy benefit management services who are themselves providers of pharmacy benefit management services or their affiliates.” The Department acknowledges that self-insured employers have other service providers that provide services that may not be considered providers of “brokerage services” or “consulting” for purposes of ERISA section 408(b)(2)(B). These service providers include TPAs, insurers, and others involved in the administration of self-insured group health plans’ medical claims, such as for hospital stays, surgeries, and chronic treatment. Stakeholders have indicated that group health plan fiduciaries may not have access to all claims data, payments to providers, and fee and pricing data that could enable negotiation for cost savings to group health plans and participants. The Department seeks comment on whether the proposed requirements should be expanded to cover additional service providers, and whether additional disclosures should be considered.

We support the expansion of these proposed requirements and strongly recommend that the Department extend these compensation disclosure and audit requirements to all service providers, including TPAs, owners of the provider networks, brokers, consultants, and any other entities involved in the administration of the group health plans’ medical claims. Fiduciary duties apply across the entire plan—not only to pharmacy benefits—and many service providers beyond PBMs control critical data needed by fiduciaries. Including the full range of vendor partners providing services to self-insured group health plans is essential to furthering the Department’s goal of positioning employers to more prudently choose and monitor the companies they hire to manage their employees’ health benefits. This information would enable employers to compare contracts and payments across all relevant service providers, improve their negotiating positions over pricing and contractual terms, and mitigate conflicts of interest through more informed vendor selection and contracting. With greater visibility into how money flows among the entities they contract with, employers could ensure their “plan assets” are being spent appropriately.

We emphasize that Congress always intended to require TPAs to furnish to a plan fiduciary a 408(b)(2)(B) Compensation Disclosure, evidenced by a letter sent to the Department by the Chair and Ranking Member of the House Education and Workforce Committee on December 14, 2022.¹³ This original intent was recently confirmed through the

¹³ In the letter, the Chair and Ranking Member state: “Specifically, we encourage EBSA [Employee Benefits Security Administration] to issue guidance clarifying that the compensation disclosure requirements of CAA Division BB, Title II, Section 202 fully apply to covered service providers performing any of the activities enumerated in the statute, including pharmacy benefit management, third party administration, and other consulting services. Such guidance is not only consistent with congressional intent, but it also greatly assists plan fiduciaries in ensuring that the

Consolidated Appropriations Act (CAA) of 2026, in which Congress amended ERISA section 408(b)(2)(B)'s Compensation Disclosure requirements to apply more expansively to any entity providing the "types" of services enumerated in the statute's "list of services."¹⁴ This clarification explicitly includes TPAs, making this proposed rule and comment request particularly timely and aligned. The Department could consider further effectuating Congress' intent by using this proposed regulation as a template to develop and release regulations that would require TPAs to disclose the "direct compensation" and "indirect compensation" they receive when providing services to self-insured health plan.

With regards to additional disclosures, we also recommend expanding the scope of the regulation to include claims data for all medical and pharmacy benefits (i.e., transaction-level access to claims and pricing data across the full transaction chain). Employers need their claims data to understand and control their own spending and their employees' costs. Although the CAA of 2021 established a prohibition on gag clauses in ERISA (i.e., contractual terms that restrict a plan sponsor's ability to obtain or share provider cost, quality, or claims data), the Department of Labor implemented guidance that left an opening for TPAs and owners of provider networks to continue to hinder access to claims data.¹⁵

For example, in our pilot project with PBGH, one large employer incurred an 11 month wait for the TPA to provide access to its claims data so that the employer could proceed with the price and quality benchmarking exercise. Ambiguity surrounding the "reasonable restrictions" that may be placed on public disclosure represents another barrier employers face in accessing their claims data and fulfilling their fiduciary obligations. Increasing employers' access to claims data would enhance their ability to assess the reasonableness of the compensation (including all compensation streams) in light of services actually being provided, and to better track the flow of money between related parties in order to reduce potential conflicts of interest—one of the Department's stated goals for this regulation. To address these challenges more broadly, we encourage the Department to issue guidance that expressly prohibits TPAs and owners of a provider network from restricting employers from accessing their health plan's claims data, and to identify specific practices that violate the prohibition on gag clauses to prevent inappropriate interpretations of the guidance.

compensation paid is reasonable and that service providers are free of conflicts of interest that could result in higher health care costs for both workers and employers...For example, a group health plan may contract with a third-party administrator or a pharmacy benefit manager (PBM) who is responsible for designing the plan by developing a provider network or a prescription drug formulary; such service providers may also implement the plan design by processing claims, maintaining records, and negotiating reimbursement rates. Covered service providers engaging in any of these activities as part of a contract or arrangement with a covered group health plan are providing "consulting" services, and as such are subject to the law's disclosure requirements."

Letter from Rep. Robert C. "Bobby" Scott and Rep. Virginia Foxx to the Honorable Lisa M. Gomez, Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor. House Education and Workforce Committee. December 14, 2022. https://democrats-edworkforce.house.gov/imo/media/doc/bipartisan_scott-foxx_letter_to_ebsa_re_health_transparency.pdf

¹⁴ Section 6702 of the Consolidated Appropriations Act of 2026. 119th United States Congress. February 3, 2026. <https://www.congress.gov/bill/119th-congress/house-bill/7148/text>

¹⁵ FAQs About Consolidated Appropriations Act, 2021 Implementation Part 57. Department of Labor, Department of Health and Human Services, Treasury Department. February 23, 2023. <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-57.pdf>

The Department could also explore whether it is reasonable to classify claims data as “compensation” for purposes of ERISA section 408(b)(2)(B). These data are akin to a receipt for purchasing medical and pharmacy items and services and represent an exchange of the employer’s claims data for the TPA’s services. Claims data generated by self-insured health plans is widely recognized as a valuable commercial asset. TPAs commonly derive economic benefit from their employer partners’ claims data by: 1) selling the claims data to databases and datasets, and 2) leveraging the claims data to negotiate better rates with providers, build provider networks, and then “rent” their provider networks to self-insured plans or other third-party intermediaries for a fee. These economic benefits, which would not exist but for the existence of the self-insured employer and its plan participants, suggests that there is an argument supporting classifying claims data as a form of “compensation” in this relationship, which therefore must be disclosed to the plan fiduciary in a 408(b)(2)(B) Compensation Disclosure.

6. Right to Audit – Proposed Paragraph (j) 91 Fed. Reg. 4370-4371 (Jan. 30, 2026)

If finalized, this regulation would establish the right for self-insured group health plans to audit their covered service providers providing “pharmacy benefit management services” at least once per year. The Department proposes to prohibit the service provider from placing limits on the period of the audit, the location of the audit, and the number of records that the plan/plan sponsor can review during the audit. The Department would also prohibit a covered service provider from charging the plan a fee for any information and records associated with the audit, and the plan would maintain the right to select an auditor of its choosing. We fully support this proposal and recommend that the Department specify that audit rights cover actual prices paid, rather than rebate summaries or estimates.

In the spirit of our previous comments, we suggest extending audit rights to all TPAs, owners of the provider networks, and other vendors that are considered “covered service providers” under ERISA section 408(b)(2)(B), and to ensure that the employer gains access to the information they need to conduct a rigorous, independent audit to fulfill its fiduciary duties—which includes claims data. Without access to a complete and accurate claims dataset, employers cannot perform critical plan management functions that are necessary to satisfy their fiduciary duties, including:

- Verifying whether incurred claims are being paid correctly
- Identifying and recovering improper payments and overpayments
- Detecting fraud, waste, abuse, and improper billing practices
- Analyzing utilization patterns and cost drivers to manage healthcare costs
- Making prudent procurement, contracting, and plan design decisions

Therefore, to increase the utility and validity of these audits, the Department should facilitate self-insured employers’ ability to obtain all the pertinent information they need to ensure “plan assets” are being used for the benefit of their employees.

7.4. Confidentiality Agreements *91 Fed. Reg. 4372 (Jan. 30, 2026)*

The Department is proposing to prohibit a covered service provider and its affiliates, agents, and subcontractors from imposing restrictions on the self-insured group health plan's use of the disclosed compensation information, including a prohibition against restricting the plan's ability to share the disclosed compensation information with other third-party service providers for quality control and other fiduciary-related purposes. However, the proposal includes an exception to allow confidentiality agreements to prevent redisclosure to fourth parties.

The Department has articulated a goal of achieving maximal price transparency systemwide so that every dollar is traceable and every contract is easily understood. We commend the Department for acknowledging the role that confidentiality agreements have played in obfuscating critical information plan sponsors need to satisfy their fiduciary obligations. Given the success service providers historically have had in leveraging confidentiality agreements to block access to plan data, **we encourage the Department (1) to remain focused on advancing its policy goal of fulfilling systemwide transparency and (2) to make sure that the design of this policy—particularly the exception to allow confidentiality agreements to prevent redisclosures—does not create a backdoor way of obstructing data access or introduce other unintended consequences that would impede progress towards this goal.** Moreover, the Department should not permit service providers to create information barriers that inhibit research and insights that can restore market function and lower healthcare costs for employers and their employees.

We also encourage the Department to clarify that this same proposed information-sharing requirement applies to a plan's pricing and health claims data under the Gag Clause Prohibition (i.e., ERISA section 724). While the Department has issued Frequently Asked Questions (FAQs) (on February 23, 2023¹⁶ and again on January 14, 2025¹⁷) explaining how the Gag Clause Prohibition should be interpreted and applied in practice, our employer partners continue to report that the owners of provider networks are blocking employers' access to pricing and health claims data, including through confidentiality agreements.¹⁸ We urge the Department to take a more comprehensive approach to enforcing this provision across all aspects of the administration of a health plan, including gaining access to pricing and claims data and sharing this information with specified plan service providers.

¹⁶ FAQs About Consolidated Appropriations Act, 2021 Implementation Part 57. Department of Labor, Department of Health and Human Services, Treasury Department. February 23, 2023.

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-57.pdf>

¹⁷ FAQs About Consolidated Appropriations Act, 2021 Implementation Part 69. Department of Labor, Department of Health and Human Services, Treasury Department, Office of Personnel Management. January 14, 2025.

<https://www.cms.gov/files/document/faqs-part-69.pdf>

¹⁸ Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers. Purchaser Business Group on Health. October 6, 2025. <https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/>