ALSTON & BIRD

HEALTH & WELFARE PLAN LUNCH GROUP

March 5, 2026

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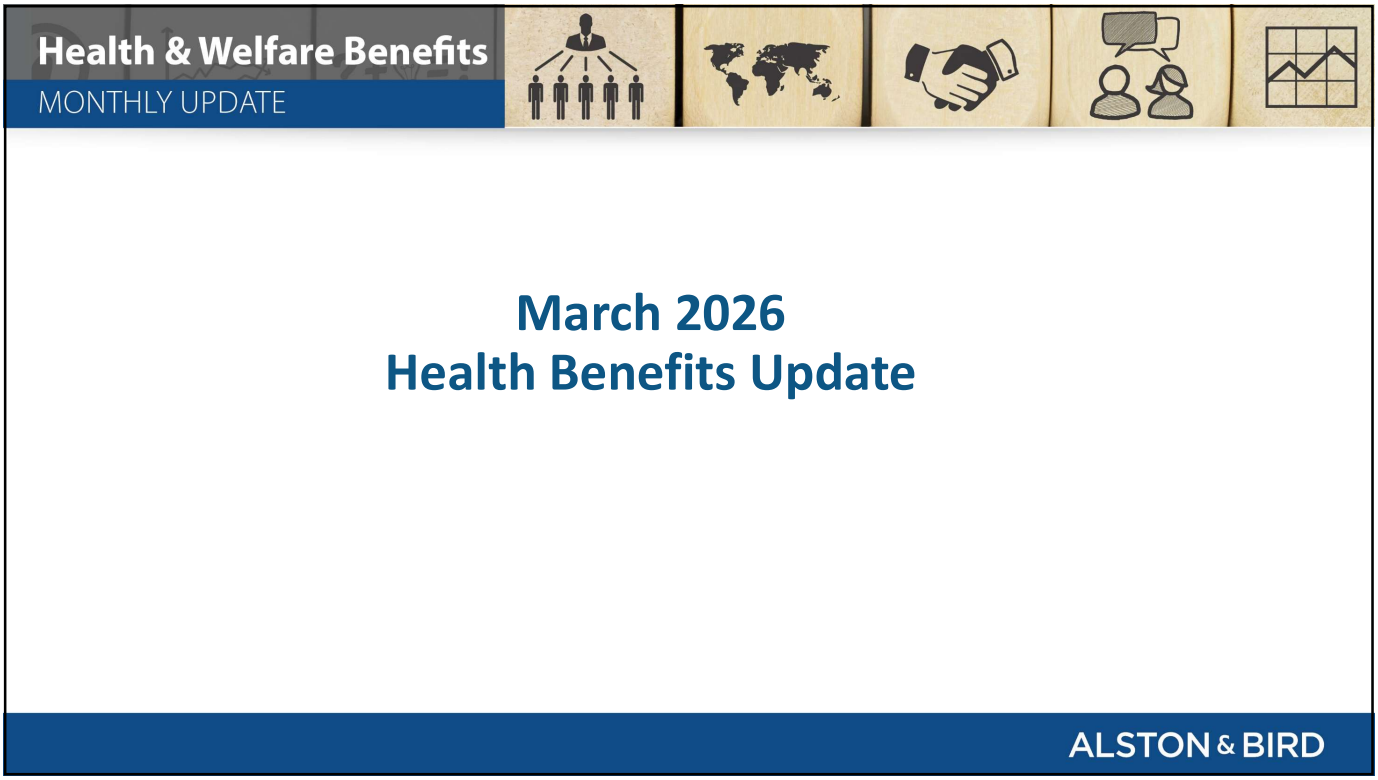

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March 2026 Agenda

- Federal Legislation and Regulations
- Transparency for PBMs and Health Plan Service Providers
- Litigation Update
- Grab bag

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Regs and Legs

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Published in the Federal Register

- Employee or Independent Contractor Status under the Fair Labor Standards Act, Family and Medical Leave Act, and Migrant and Seasonal Agricultural Worker Protection Act (DOL-WHD), Notice of Proposed Rule published on 2/27/2026, Comment deadline 4/28/26
- Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (HHS-CMS), RFI published on 2/27/2026, Comment deadline 3/30/26
- Requirement to Provide Paper Statements in Certain Cases-Amendments to Electronic Disclosure Safe Harbors (DOL-EBSA), Proposed Rule published on 2/25/2026. Comment due by 4/17/26.
- HHS Notice of Benefit and Payment Parameters for 2027 (HHS-CMS), Proposed Rule published 2/11/26; Comments due by 3/13/26
- Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure (DOL-EBSA), Proposed Rule published on 1/30/26; Comments due 4/15/26 (extended)
- Update to the Women's Preventive Services Guidelines (HHS-HRSA), Notice published on 1/5/26
- Delinquent Filer Voluntary Compliance Program (DOL-EBSA), Notice published on 12/30/25
- Transparency in Coverage (HHS-CMS, TREAS-IRS, DOL-EBSA), Proposed Rule published on 12/23/25

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At the Office of Management and Budget (OMB)

These proposed rules are under review at OMB and are not yet publicly available:

- Final Rule: **Independent Dispute Resolution Operations**, rec'd 1/29/2026 (HHS-CMS)
- Proposed Rule: **Fiduciary Duties in Selecting Designated Investment Alternatives**, rec'd 1/13/2026 (DOL-EBSA)
- Final Rule: **Administrative Simplification: Adoption of Standards for Health Care Attachment Transactions and Electronic Signatures (CMS-0053)**, rec'd 1/9/2026 (HHS-CMS)

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Proposed Legislation

- S.3549 **(H.R.6837)- PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act:** To amend the Employee Retirement Income Security Act of 1974 to ensure that pharmacy benefit managers are considered fiduciaries, and for other purposes. Introduced 12/17/2025.
- **Appropriations Committee releases Consolidated Appropriations Act, 2026** : Increasing funding for mental health and substance use treatment and prevention. For a summary related to DOL, HHS, and related agencies appropriations, click here.
- S.3097 **– Health Information Privacy Reform Act ("HIPRA"):** The press release states that the legislation is aimed at protecting "Americans' private health data by expanding health privacy protections to account for new technologies that are not currently required to have privacy protections, such as smartwatches and health apps." Introduced 11/4/2025 by Bill Cassidy (R-LA).

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Transparency for PBMs and Health Plan Service Providers

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Service Provider Fees

- There has always been a requirement under §408(b)(2) of ERISA that "no more than reasonable compensation" be paid to a service provider to fall within the prohibited transaction exemption.
- For brokers and consultants, CAA 2021 incorporated into §408(b)(2) a ***very*** detailed list of required disclosures for both direct and indirect compensation.

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Health Plan Oversight Reforms (CAA 2026)

- Key components:
  - Expanded fee disclosure requirements for ERISA health plan service providers
    - Fee disclosures required for nearly all ERISA health plan service providers (effective Feb. 3, 2026)
    - Covers ERISA-covered group health plans which includes excepted benefits like stand alone dental and vision, Health FSAs, certain EAPs as well as HRAs
  - Explicitly added PBMs to prohibited transaction statute (effective Feb. 3, 2026)
  - Pharmacy Benefit Manager transparency reforms
    - New reporting requirements for PBM (effective 2028-2029)
    - Mandatory rebate pass-through (effective 2028-2029)

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Expanded Fee Disclosure Requirements

- "Clarification of Covered Service Provider" – Section 6702(c) of the CAA
- Amended definition of covered service provider under ERISA § 408(b)(2):
  - **(AA)** ~~Brokerage services.~~ Services (including brokerage 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), provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.
  - **(BB)** ~~Consulting~~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.

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Expanded Fee Disclosure Requirements

- **Effective immediately:**
  - Applicable to contracts entered into or renewed after February 3, 2026
- Expands compensation disclosure requirements to include compensation received by nearly all plan service providers and their affiliates and subcontractors.
  - Previously, group health plans were required to receive compensation disclosures from **brokers** and **consultants**.
- Now, the definition has been expanded to include nearly all service providers including third-party administrators, PBMs, stop-loss carriers, and ancillary vendors providing medical management, disease management, and employee assistance program services.

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Form and Timing of Fee Disclosure

- Information to be disclosed:
  - Description of services provided
  - Statement of fiduciary status (if applicable)
  - A Description of…
    - All direct and indirect compensation
    - Method and manner of compensation
    - Compensation paid among and between affiliates
  - Any compensation expected in the event of termination
- Timing
  - Initial disclosure must be provided reasonably in advance of the date a contract is entered into, extended or renewed.
  - Modifications must be disclosed as soon as practicable but no later than 60 days from the date the service provider is informed of the change.

Considerations

- Is the entity (or subcontractor or affiliate) receiving any direct or indirect compensation?
  - Query: Finders fees, incentives, etc.
  - Query: Marketing fees
  - Query: interchange revenue
- Is the service provided to or for the plan?
  - Query: Stop loss provided to employer
  - Query: Fees for settlor services provided to the employer
  - Others?

Disclosure

- Take Aways/Action Items for plan administrators and other plan fiduciaries
  - Identify all service providers (including subcontractors and affiliates) with respect to any group health plan.
  - Determine whether any service provider receives any direct compensation and the amount of that compensation.
  - If known, determine whether the service provider receives any indirect compensation and the amount of that compensation.
  - Be prepared to make a demand to any covered service provider who has not provided adequate disclosure.
  - Establish and document that requests made and that a responsible fiduciary actually reviews the disclosures and determines that the compensation is reasonable.

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Disclosure

- Take Aways/Action Items for health plan service providers
  - Identify all ERISA group health plans where services are provided.
  - Determine all sources of direct and indirect compensation to service provider.
  - Determine whether direct and indirect compensation meets the $$ threshold.
  - Design and format (and presumably automate) the disclosures to include the required information for timely delivery.

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Prohibited Transactions

- Contracts between a health plan and service provider, including a PBM, are considered "an indirect furnishing of goods, services, or facilities…" under the prohibited transaction statute.
- To qualify for the exemption under this section, compensation paid to the service provider must be **reasonable**.
- This portion of the statute is effective as of Feb. 3, 2026.

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PBM Transparency Reforms

- Reporting Requirements (Section 6701 of CAA)
  - Requires PBMs to submit reports at least every six months (or quarterly upon request) with detailed information about drug costs, spending, rebates, discounts, and statistics about the total number of claims and participants.
  - Effective: August 3, 2028
    - For most plans based on a calendar year, the effective date will be January 1, 2029.
      - Effective date is "for plan years beginning on or after 30 months after date of enactment…"
  - Secretary of Labor must undertake rulemaking within 18 months to specify format for required reporting and other regulations necessary for implementation.

Reporting Requirements

- Required information for large plans (100 or more participants) or large employers (100 or more employees)
  - Detailed information about all drugs for which a claim is filed, including average cost, amount paid to PBM, amount paid to pharmacy, any difference between those amounts, unit cost, total out of pocket spending, rebates to the plan and to the PBM, and more.
  - Similar information about each therapeutic class for which a claim was filed, including total gross spending, net spending, average spending for all drugs, and total out-of-pocket spending.
  - A list of all drugs with spending exceeding $10,000 or top 50 drugs with highest spending
  - Information about drugs dispensed by affiliated pharmacies

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Reporting Requirements (all plans)

- Summary documents tailored for the plan and available to participants upon request
- For drugs covered by the plan, total net spending and amount received in rebates or total renumeration for drugs
- Amounts paid directly or indirectly to any brokerage firms, brokers, consultants, or advisors for any referrals, consideration of, or retention of a plan's business to a PBM
- Explanation of any benefit design parameters to encourage use of affiliate pharmacies
- Total gross spending on all drugs under the plan

Enforcement

- Statute provides penalties of up to $10,000 per date for late reporting and up to $100,000 for knowingly providing false information

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Disclosures to Participants

- Plan administrator requirements:
  - Must provide annual written notice to participants about the reporting requirements.
  - Must provide summary document to participants upon request.
  - Participants may request claims-level information on the difference between the cost of a drug and the amount paid to a PBM.

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Rebate Pass-Through Requirement

- PBMs must pass through 100% of rebate, fees, alternative discounts, and other renumeration to the plan or issuer.
- Otherwise, the compensation under the contract is presumptively unreasonable.
- This applies to PBM contracts entered into, renewed, or extended for plan years beginning on or after August 3, 2028.

Protection for "innocent plan fiduciaries"

- Fiduciary may be shielded from a fiduciary breach under the prohibited transaction statute if:
  - 1) The fiduciary did not know the service provider failed to make remittances and reasonably believed such amounts were remitted,
  - 2) The Fiduciary requests remittance in writing upon discovering a failure to remit such amounts, and
  - 3) If the service provider fails to comply with a written request within 90 days, the fiduciary notifies the Secretary of this failure.
- This is not an exception from the fiduciary duties of prudence and duty to monitor the service provider.

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Litigation Update

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Cases to Watch

- GLP-1 Coverage: 1st Circuit determined that failure to cover weight loss medications by an insurer for obese participants is not disability discrimination under ACA § 1557 or the ADA.
- Tobacco Surcharges: Is an ERISA § 104(b) document request headed your way?
- Ghost Networks: SD NY dismissed with prejudice complaint against an insurer under NY state law over alleged inaccuracies in provider directory.
- State PBM Laws: Self-funded plan reporting preempted?

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Grab Bag

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HIPAA

- Notice of Privacy Practices
  - February 16, 2026: deadline to update NPP for HIPAA Part 2
  - HIPAA Part 2/Substance Use Disorder Update Model Language is published here.

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San Francisco Health Care Security Ordinance

- April 1 – The 2025 Annual Reporting Form (ARF Form) will be available at Health Care Security Ordinance | SF.gov
- May 1 - Deadline to Submit ARF Form
- REMEMBER: Beginning in April 2026, unused funds accounts dormant for 3 years will **"be permanently reverted to the City and County of San Francisco".** Visit Employer FAQ - San Francisco City Option for more information.

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Q1 Deadlines

- Privacy breaches affecting less than 500 must be reported w/in 60 days of the end of the calendar year in which the breach was discovered.
- Notice of creditable coverage to CMS due within 60 days after the beginning date of the plan year.
- HCSO Top-Off calculation and payment: March 2.
- 2025 Form 1095-C to individuals:
  - For automatic furnishing: Jan. 31, but regulations allow automatic 30-day extension (generally March 2). Applies to Federal, RI and NJ.
  - New Alternate furnishing manner (Federal only): The statement is timely furnished if provided to the individual no later than the later of January 31, 2026, or 30 days after the date of the request.

Q1 Deadlines (continued)

Alternate Manner for Furnishing Form 1095-C.

- To use the alternative manner of furnishing statements, the following conditions must be met:
- Provide clear and conspicuous notice, in a location on its website that is reasonably accessible to all responsible individuals, stating that individuals may receive a copy of their statement upon request.
- Use plain, non-technical terms and with letters of a font size large enough, including any visual clues or graphical figures, to call to a viewer's attention that the information pertains to tax statements reporting that individuals had health coverage.
- Notice must include an email address, a physical address to which a request for a statement may be sent, and a telephone number that individuals may use to contact the employer with any questions.
- Timely posted, which for tax year 2025 is by March 2, 2026, and retained until October 15 of the filing year.
- Furnished to the individual no later than the later of January 31, 2026, or 30 days after the date of the request.
- See Instructions for Forms 1094-C and 1095-C (2025) for more information.

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Signed, Sealed…and Delivered? New Rule Clarifies the Effect of a Postmark

- **Final Rule:** Postmarks and Postal Possession, published n Fed. Reg. on 11/24/2025.
- Section 608.11.3 of the Final Rule states that "[t]he presence of a postmark confirms that the Postal Service accepted custody of a mailpiece, and that the mailpiece was in the possession of the Postal Service on the identified date. However […] the postmark date does not necessarily indicate the first day that the Postal Service had possession of the mailpiece." (Emphasis added.) Rather, the postmark date "shows the date of the first automated processing operation performed on a mailpiece or, alternately, the date when a mailpiece was accepted at a retail unit."
- Current Statutory language under IRC Section 7502(a)(1): "[i]f any return, claim, statement, or other document required to be filed, or payment required to be made, […]is delivered by the United States mail to the agency, officer or office […] *the date of the United States postmark stamped on the cover* […] *shall be deemed to be the date of delivery or date of payment*."
- The Final Rule was not intended to "change any existing postal operations or postmarking practices, but [was] instead intended to improve public understanding of postmarks and their relationship to the date of mailing."

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Questions