

August 25, 2025

The Honorable Lori M. Chavez-DeRemer
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: Reforming Pharmacy Benefit Manager (PBM) Compensation Practices

Dear Secretary Chavez-DeRemer,

Pursuant to President Trump's Executive Order issued on April 15, 2025, Lowering Drug Prices by Once Again Putting Americans First, the DOL has been tasked with implementing measures to reduce prescription drug costs. On behalf of the National Community Pharmacists Association (NCPA) and the over 18,900 independent community pharmacies we represent, we write today concerning the work you are focused on pertaining to this Executive Order and proposed regulations under the Employee Retirement Income Security Act (ERISA) § 408(b)(2)(B) to enhance transparency of PBM compensation.

NCPA is pleased to submit these comments on the important topic of PBM compensation and fee disclosure. As pharmacists, our members serve on the front lines of patient care and on a daily basis field questions from patients about the costs of their prescription medications. Most patients seem to assume that we, as pharmacists, determine the cost of prescription medications to patients. Very few patients are aware of the role that PBMs play in determining virtually all aspects of their prescription drug benefit. For example, PBMs set the price of a patient's drug at the point of sale, how much a patient's coinsurance will be, which pharmacies are in-network, which drugs are on formulary, how much a pharmacy will be reimbursed, and which drugs community pharmacies can dispense.

In addition, health plan sponsors and fiduciaries may have minimal knowledge of the breadth of PBM revenue streams and the ins- and- outs of PBM contracting and auditing. We feel that knowledge of this type is critical for plan sponsors and fiduciaries that are responsible for safeguarding the assets of a plan and protecting the rights of the beneficiaries. **To put it simply, PBMs continue to create significant barriers for employer-sponsored health plans and the patients they serve via opaque pricing practices, restrictive drug formularies, and specialty drug steering, driving up costs while limiting access to essential medications. Under ERISA, the DOL has the authority to intervene.**

PBMs serve as the "middleman" in virtually all prescription drug transactions in the United States. They are able to leverage the number of beneficiaries in a particular plan in order to negotiate lucrative rebates from pharmaceutical manufacturers. They also formulate pharmacy provider networks that will supply or dispense these drugs to the plans' beneficiaries and in turn charge the plan sponsor for these products. The amount that the PBM pays the pharmacy for dispensing the drug to the plan beneficiary is rarely the same amount that the PBM "charges" the plan for the same drug. Typically, the PBM "marks up" the cost of the drug, charging the plan more than the pharmacy is reimbursed, keeping the

difference as profit for the PBM. This is especially true when the drug is dispensed by a PBM-owned pharmacy.

It is precisely compensation such as these hidden spread amounts that need to be disclosed in some way to plan sponsors or plan fiduciaries. This type of information—about the vast sums of money that PBMs are making by virtue of the drug spend of a particular plan—should be readily available to a plan. If plan sponsors or fiduciaries have a clearer picture about the amount of money that is being made by their vendor by virtue of handling the plan’s business—this may provide them with a greater ability to negotiate competitive contracts with these vendors in the first place. PBM compensation models create concerns about potential conflicts of interest. PBMs do earn more revenue for higher-cost drugs, so they prioritize coverage of those drugs, which increases out of pocket costs for patients. The lack of transparency in these arrangements enables PBMs to exploit complex pricing structures and hidden fees, ultimately raising costs.

PBMs obscure their actual earnings, so it is essential for DOL to define what constitutes “reasonable” compensation. To protect patients and ensure fair practices, the DOL should:

- **Require full transparency from PBMs in their dealings with ERISA-covered plans, including clear disclosures of pricing structures, rebates, and compensation arrangements.**
- **Establish safeguards against excessive PBM compensation, particularly by limiting such compensation to bona fide service fees.**
- **Define acceptable compensation standards that separate PBM revenue from drug list prices—for example, banning percentage-based fees that scale with drug list prices.**

Transparency measures would strengthen ERISA’s regulatory framework, but the DOL has broader authority to enact more substantive reforms. It should use this authority to regulate how PBMs are compensated by plan fiduciaries, addressing the systemic incentives that inflate drug costs for employers and beneficiaries. Specifically, the DOL should regulate compensation arrangements between plan fiduciaries and PBMs that are retained by a plan fiduciary to manage or administer a group health plan’s prescription drug benefits. The DOL should also ensure that compensation structures between PBMs and brokers are made transparent to plans. If a broker has financial ties to a PBM, their advice may not be aligned with the employers’ best interests.

The DOL’s authority to address these behaviors is extensive. DOL regulations could dictate that the abusive compensation structures described above would not be reasonable compensation as contemplated by ERISA. PBMs are considered “parties in interest” under ERISA and therefore must adhere to restrictions on prohibited transactions. They may only provide services under arrangements deemed reasonable, with reasonable compensation. In 2012, new DOL rules required service providers to disclose compensation details in pension plan contracts. Unfortunately, similar requirements for health plans have not been issued, despite prior hearings in which NCPA participated, highlighting the need for such disclosures.

Additional regulations specify that compensation must be evaluated based on context and must not be excessive under IRS standards for business expenses. When issuing proposed rules under the Executive Order, the DOL should also revise its definition of reasonable compensation.

The DOL should use the opportunity created by President Trump’s Executive Order to eliminate PBMs’ perverse financial incentives that drive up health care costs by promulgating comprehensive PBM compensation parameters. PBMs exist in large, complex, vertically integrated corporate structures, so DOL’s regulations should frame its regulations around the functional purpose of PBMs. Specifically, the DOL should define the term “pharmacy benefit manager” to encompass any entity (including affiliates or agents) that administers prescription drug benefits, negotiates drug prices on behalf of a health plan, or negotiates rebates or fees with a manufacturer.

As PBMs have partnered with other prescription drug supply chain entities to create new revenue streams in an increasingly vertically integrated business environment, it is important to ensure that the definition of a PBM is broad enough to encompass new revenue streams and business activities.

Additionally, the DOL should mandate that PBM service agreements qualify as reasonable only if compensation is strictly limited to bona fide service fees. These fees must reflect fair market value for actual services rendered, be expressed as flat dollar amounts, and must not be tied (directly or indirectly) to drug prices, rebates, or other financial incentives.

Given the DOL’s authority and the documented practices of PBMs that obscure and inflate compensation, new regulations are justified. These rules should build on the Executive Order’s minimum requirements by stipulating that only bona fide service fees qualify as reasonable compensation.

NCPA has long been in favor of extending proposed regulations that would require fee disclosures for PBMs. In 2010, we also advocated for the disclosure of all “direct and indirect compensation” in light of the fact that much, if not the majority of, the compensation that PBMs receive is in the form of indirect compensation—typically in the form of manufacturer rebates, discounts, credits, fees, grants and chargebacks. Many government agencies and third-party payors have filed many high-profile lawsuits against major PBMs alleging a variety of inappropriate business schemes, including fraud, kickbacks, overcharges and breach of fiduciary duty to plan sponsors. These lawsuits have resulted in fines and settlements being paid by some of the largest for-profit PBMs.

There is a growing recognition of the value of transparency in healthcare—specifically PBM transparency. Federal law dictates that PBMs that serve any of the state insurance exchanges and Part D plans disclose certain information to the Secretary of HHS and to the plan sponsors. Under the Medicare Modernization Act (MMA), Part D plans are already required to disclose to the Secretary the manufacturer rebates and price concessions for the purposes of determining whether the plans are passing through the direct and indirect price concessions that they negotiate. There is no legitimate reason to limit the ability to obtain transparency to only government programs. All plan beneficiaries should be able to reap the benefits of similar fiduciary protections, regardless of the size of their plan sponsor.

The Pharmaceutical Care Management Association (PCMA) has testified in the past about concerns that that if any disclosures are required, such transparency would somehow encourage “tacit collusion” on the part of the pharmaceutical manufacturers. However, for an ERISA plan fiduciary to make the most informed purchasing decisions in a free market environment, more – and not less information – is

essential. Such specious arguments about collusion are simply a red herring. The PBM disclosures required of those PBMs that serve state exchanges and Part D are accompanied by a confidentiality provision—and require confidentiality on the part of HHS and of the plans themselves—something that could easily be added to any disclosure requirement contemplated for PBMs serving ERISA plans.

In conclusion, NCPA urges the DOL to finalize strong, enforceable rules that bring much needed accountability and transparency to the PBM sector. Please contact me if you have any questions at ronna.hauser@ncpa.org

Sincerely,



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SVP Policy & Pharmacy Affairs