Compliance Watch

PROVANT

PBM Transparency Rules Advance as HIPAA Updates Trigger New Participant Notice Deadlines

February 2026

In the News

Federal PBM Reforms Are Here

Federal changes are coming for group health plans with respect to their contracts with Pharmacy Benefit Managers (PBMs). Following are three recent developments:

- A **proposed rule** requiring all size self-insured ERISA plan years on or after July 1, 2026, to secure and evaluate:
  - PBM compensation disclosures with estimates of all non-transparent compensation before a contract or agreement begins each year, and
  - A semiannual explanation for any overages of 5% or more.
- A **new law** effective for plan years on or after August 3, 2028, requiring:
  - Detailed PBM reporting for all large group health plans (100+),
  - New PBM notices and summaries for all size health plans, and
  - Pass-through of all non-transparent PBM compensation in all size ERISA contracts.
- A **Federal Trade Commission (FTC) settlement** in which the large PBM, Express Scripts, agreed to implement a number of business changes that impact employer group health plans.

Applies To: All employers sponsoring prescription drug coverage will experience an impact in some way, directly or indirectly, including a new employee notice requirement coming in late 2028. ERISA plans have fiduciary obligations to ensure PBM compensation disclosures and summaries are provided and evaluated. Governmental, tribal, or church plans are exempt from ERISA but are subject to some of the reporting and disclosure requirements imposed by the new law.

Go Deeper:

Read more about these new reforms in recent Alerts:

- PBM Compensation Proposed Rule
- New Law Imposes New Requirements on PBMs

More information about the FTC settlement with Express Scripts is found on the FTC's website. The FTC is undertaking similar enforcement action against Caremark Rx and OptumRx.

Penalties for Non-Compliance:

For changes to ERISA plans, fiduciaries have an obligation to review compensation and contracts for reasonableness to avoid engaging in a prohibited transaction. The new law's

WHAT'S NEW

- **PBM transparency rules proposed** — Annual compensation disclosures may be required starting in 2026.
- **HIPAA notices updated** — Revised privacy notices must be distributed by April 16.
- **CHIP notice refreshed** — January 2026 update should be included in enrollment materials.
- **RxDC reporting underway** — Watch for carrier surveys ahead of the June 1 deadline.

TAKEAWAY

Prescription drug plan oversight is shifting from a cost-management exercise to a fiduciary compliance responsibility, requiring employers to formally evaluate PBM compensation arrangements and disclosures in the coming years.

notice requirement, going into effect in late 2028 for all size employers regardless of ERISA status, imposes a $10,000 per day penalty for failing to provide the required notice.

Practical Impact to Employers

The intent of these changes is to provide employers greater transparency into their PBM contracts and compensation. So, it is prudent to start establishing procedures for how these disclosures will be evaluated by the plan's fiduciaries for reasonableness and potential conflicts of interest. The new notice requirement can be part of the standard notices employers routinely provide, but this is the largest penalty seen thus far for failing to provide a specific notice.

Updated HIPAA Notice of Privacy Practices Now Available

On Friday, February 13, Health and Human Services (HHS) published a revised model HIPAA Notice of Privacy Practices (NPP) that incorporates newly required language related to Substance Use Disorder (SUD) records as required under 42 CFR Part 2 ("Part 2"). This update reflects the alignment of Part 2 with HIPAA as required by the CARES Act, and it introduces new patient rights and redisclosure limitations related to certain SUD records that must reflect in all compliant NPPs as of February 16, 2026.

As required under HIPAA, Covered Entities have 60 days from the date of any material change to their NPP to distribute to all plan participants. For example, a Plan that incorporates the new HHS language into their own NPP as of February 16, 2026, must distribute to participants on or before April 16, 2026.

Applies To:

- Employers sponsoring a fully insured medical, dental, or vision plan that includes claims analytics drill-down data feeds or other access to Protected Health Information (PHI).
- Employers sponsoring a self-insured medical plan to include a level-funded plan, FSA, HRA, or ICHRA, as well as those sponsoring a self-funded dental or vision plan. The requirement also includes any carve-out/bolt-on benefit which is not fully insured and must be "integrated" with the employer's medical plan (telemedicine, fertility, Rx carve-out, etc.).
  (Note, only a self-insured, self-administered health plan with fewer than 50 eligible employees is exempt from HIPAA Privacy & Security rules and NPP.)

Go Deeper:

Read more in the recent Alert: Updated Model HIPAA Notice of Privacy Practices Now Available.
(Note, the updated model NPP did not include language warning individuals who authorize a disclosure of the risks of redisclosure. It appears that was not added to the model NPP because it is included in the updated model notice for health care providers.)

Model Employer CHIP Notice Updated:

The Department of Labor (DOL) has updated the Model Employer Children's Health Insurance Plan (CHIP) Notice as of Jan 29, 2026.

Applies To: All size employers sponsoring any type of medical plan in which employees pay part of the premium, with employees living in a state with a Medicaid and/or CHIP premium assistance subsidy.

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Go Deeper:

An employer must provide the Employer CHIP Notice to employees eligible for the employer's medical plan who reside in a state with a premium assistance subsidy, regardless of the employer's location.

A model notice is available in English and Spanish. The notice is updated at the end of January and July each year reflecting when states make changes to phone, email, and website information.

For the **January 2026 update, Louisiana made changes** to its website, email, phone, fax, and mailing address.

Employers sponsoring a group health plan should provide the CHIP notice with other health plan eligibility materials, such as new hire and annual open enrollment materials.

Penalties for Non-Compliance:

Employers who fail to provide the Employer CHIP Notice to employees in premium assistance states may face a penalty of up to $145 per person per day. The Model Employer CHIP Notice is considered a safe harbor way to meet the notice language requirements. While the employer is permitted to remove from the notice any states in which employees do not reside, keep in mind that if they eventually hire anyone in such a state, they need to add that state back to the notice.

Practical Impact to Employers:

While the model notice usually includes an expiration date that goes fairly far into the future, the intent of the notice is to ensure employees understand how to reach out to a state to inquire about and apply for premium assistance. To that end, it is strongly recommended employers always grab the latest updated version of the model notice to incorporate into plan materials for new hires and for open enrollment.

On the Horizon

RxDC Surveys Are Here, Respond Promptly

As in prior years, most carriers/TPAs, in partnership with PBMs, will submit required RxDC reporting for their group health plan clients since they have the detailed prescription drug claims data. However, carriers/TPAs do not know how much employees paid vs. how much the employer paid for the prior calendar year's health coverage. So, they must ask the employer for that information each year. Employers should be vigilant for the questionnaire and respond promptly to meet the carrier/TPA's deadline.

Applies To: All size employers sponsoring a group medical plan and prescription drug benefit that is not an Individual Coverage Health Reimbursement Arrangement (ICHRA).

Go Deeper:

To comply with the RxDC reporting requirement, employers must rely heavily on their claims administrators because these service providers possess the detailed claims data. Typically, the claims administrator or carrier facilitates the full reporting but requests key information from the employer about three months before the June 1st annual deadline. The carrier/TPA primarily needs to know how much the employer paid vs. how much participants paid (including COBRA participants) for the previous calendar year's medical/Rx coverage (even if the plan does not operate on a calendar year).

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If self-funded, the premium "equivalent" for the reporting requirement is actual fixed costs plus actual claims. Choose either incurred claims or paid claims for the calendar year (stick with that choice every year), less stop-loss rebates and pharmacy rebates retained by the plan.
Any gaps in submissions should be addressed by either the employer submitting the missing data themselves via the government's HIOS system or by engaging a third-party vendor to assist with coordinating submissions.

Employer plan sponsors, especially self-funded health plan sponsors, should continue to take necessary steps to prepare for the June 1st deadline. Find helpful information on CMS's RxDC webpage.

HHS Updates Penalties and 2027 Out-of-Pocket Limits

Each year, HHS publishes indexing for penalties and non-grandfathered out-of-pocket (OOP) maximums. The newest numbers published provide:

For 2026:

- Increased HIPAA penalties ranging from $145 to $73,011; to a calendar year cap of $2,190,294
- $1,443 per failure to provide a Summary of Benefits and Coverage (SBC)
- $11,823 per failure to comply with Medicare Secondary Payer rules

For 2027:

- Non-grandfathered in-network OOP limits increase to $12,000 per person, $24,000 per family, which are up from $10,600/$21,200 in 2026
- §4980H(a) penalty of $3,780 ($315.00/mo), up from $3,340 ($278.33/mo) in 2026
- §4980H(b) penalty of $5,670 ($472.50/mo), up from $5,010 ($417.50/mo) in 2026

Applies To:

- Employers of all sizes may be subject to potential penalties for HIPAA, SBC, MSP, and OOP violations.
- §4980H penalties apply to Applicable Large Employers (ALEs), which are those averaging 50 or more full-time and equivalent employees the previous calendar year, including rules that require combining counts within a Controlled Group or Affiliated Service Group of employers under common ownership or control.

Under the Radar

Federal Benefits Enforcement Priorities for 2026

The Employee Benefits Security Administration (EBSA) is the division of the Department of Labor (DOL) focused on enforcing laws and rules pertaining to employee benefits, particularly under the Employee Retirement Income Security Act (ERISA). Each year the EBSA publishes a list of the enforcement priorities for which they dedicate department funds to investigate and resolve. While the list for 2026 mainly focuses on retirement plans, other focus areas include cybersecurity, barriers to mental health parity, and surprise billing, along with a continued commitment to protecting employers and employees impacted by fraud, mismanagement, or insolvency of abusive Multiple Employer Welfare Arrangements (MEWAs).

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Applies To: Employers sponsoring benefits subject to ERISA. Only employers sponsoring governmental, tribal, or church plans are exempt from ERISA.

Go Deeper:

The EBSA allocates money each year to spend on enforcement initiatives and attempts to concentrate regulatory and investigative resources on areas needing particular attention each year. Most years focus on retirement benefits and 2026 is no different, but there are some employee benefits focus areas, including:

Cybersecurity

- Electronic transactions and communications abound in benefits, and "system hardening" is a theme for 2026.
- This is separate from HIPAA security enforced by the Office of Civil Rights (OCR).

Barriers to Mental Health and Substance use Disorder (MH/SUD) Parity

- An ongoing issue for over a decade, with the latest barriers being access to in-network care (see Kaiser's recent $30 million FTC settlement regarding this issue) and how MH/SUD care is determined as medically necessary.
- Most complaints the last few years are regarding applied behavioral analysis therapy for autism spectrum disorder, eating disorder treatments and medication-assisted treatment for opioid use disorder.

Surprise Billing

- Primarily handled by carriers and third-party administrators on behalf of employers.
- Millions of disputes flood the Independent Dispute Resolution (IDR) system and about 80% of those resolve in favor of the health care provider and against the health plan.
- This is a concern for plan fiduciaries, as it means the plan is repeatedly paying much more than it has deemed reasonable for the care provided and may need more involvement in ensuring strict adherence to IDR processes and documentation.

Abusive MEWAs

- Many organizations implement and promote "association health plans" or other arrangements where employers share benefits even when they are not in a family of companies together under a high percentage of common ownership or control.
- While such arrangements are possible in many states, there are generally strict state rules to follow, and those rules are often not followed by many sponsors of these arrangements.
- Non-compliance with MEWA rules means no accountability to the government, and can eventually translate to mismanagement or fraud to the point of insolvency of the MEWA.

Practical Impact to Employers:

Compliance with various federal and state laws governing benefits is paramount to ensure the employer and plan participants are protected. The DOL's enforcement priorities give employers insight into compliance areas the DOL is actively working through. Violations can result in complaints, litigation, audits, investigations, penalties, and more.

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