



April 15, 2026

Daniel Aronwitz
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Re: RIN 1210-AB37, Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure

Dear Secretary Aronwitz:

Aimed Alliance is a non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. Aimed Alliance applauds the Trump Administration's efforts to lower prescription drug prices by putting Americans first and addressing under-regulated and opaque pharmacy benefit manager (PBM) practices.

Aimed Alliance supports the many disclosure requirements included in the proposed rule. Accurate information that allows plan sponsors and employers to more clearly understand their prescription drug costs is essential to ensuring they act as prudent fiduciaries as required under ERISA. To strengthen these proposed reporting requirements, Aimed Alliance also urges the Department of Labor (DOL) to require (1) disclosure of benefit utilization savings; (2) clarification that third-party programs not directly affiliated with PBMs are subject to these requirements; and (3) prohibit the use of discriminatory QALYs.

I. Require Reporting of Drug Utilization Management Savings

Aimed Alliance applauds the DOL's proposed rule for recognizing the large role PBMs play in determining which drugs will be covered as part of a health plan's prescription drug benefits. Critically, the proposed rule recognizes that policies like step therapy and non-medical switching may be utilized when a PBM will benefit financially from a drug substitution.¹ Not only can this steer payers to higher-cost drugs, but it can also be detrimental to the consumer's health when a patient has previously tried and failed the medication or is stable on their current treatment. These delays can result in patients experiencing disease progression, relapse, or other negative health consequences.² For employers, worsening health conditions can result in increased hospitalizations and emergency room visits, which are higher-cost expenditures for plans. As

¹ Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure, 91 Fed. Reg. 4348 at 3.10 (Jan. 30, 2026).

² Aimed Alliance, *New York Step Therapy Reform*, <https://aimedalliance.org/new-york-step-therapy-reform/>.

such, patients and employers are both better positioned when treatment decisions are left between patients and their health care providers.

For these reasons, Aamed Alliance strongly supports the proposed rule requirements that entities disclose if they have a conflict of interest and any incentives to impose step-therapy requirements. Aamed Alliance urges DOL to amend this provision to also apply to non-medical switching requirements, as non-medical switching policies are also often tied to rebate-based incentives and not based on the consumer's health care needs.

Finally, to ensure employers and plan sponsors adequately understand the cost of benefit utilization policies like step therapy, Aamed Alliance also urges the DOL to require entities to disclose any plan savings derived from the use of step therapy. PBMs often allege that step therapy is a necessary tool to help employers save on prescription drug costs; however, PBMs are rarely asked to quantify those savings. Fortunately, some states have started to require PBMs and plans to report this information, and the data is enlightening.³ For example, Connecticut's 2024 Report Card found that savings derived from non-prior authorization utilization management tools, like step therapy, were less than \$5 per member per month.⁴ This calculation does not reconcile the costs the plan experienced as a result of these policies, such as hospitalizations or disease progression. Importantly, this same report found that some plans were not deriving any savings from these policies, and some plans actually lost money imposing these utilization management protocols.⁵

As such, requiring plans to disclose if there are actual savings derived from step therapy is an important tool in understanding if this utilization management policy is in the best interest of patients and employers, or if it is solely in the interest of a PBM's profitability.

II. Expand the Definition of PBM Services to Include Alternative Funding Programs

Aamed Alliance applauds the proposed rule's requirement that reporting and disclosure requirements apply to PBMs and entities conducting PBM services, irrespective of how these entities self-identify. Aamed Alliance supports the proposed list of "pharmacy benefit manager services" under section 1.4.1 and urges an additional bullet to be added to include alternative funding program (AFP) practices.

³ Aamed Alliance, *2025 State Report: Step Therapy, Oversight, & Patient Access* (Jun. 2025), https://aamedalliance.org/wp-content/uploads/2025/06/AA-2025StateReport_June_2025.pdf.

⁴ Conn. Ins. Dep't, *2024 Consumer Report Card on Health Insurance Carriers in Connecticut* (2024), <https://portal.ct.gov/cid/-/media/cid/reports/consumer-report-card/2024-consumerreportcard.pdf?rev=94d0c6b1e170408b974006006dbe6751&hash=81474DB06393007646988C1A5C55116F>.

⁵ *Id.*

AFPs are third-party companies that partner with employer-sponsored health plans to manage some of the health plans' prescription drug benefits.⁶ Critically, AFPs are managing *covered prescription drug benefits*. When a health plan partners with an AFP, the health plan automatically denies coverage for the enrollee's prescription medication. The AFP then steps in and obtains the enrollee's personal information, such as household size and annual income, to determine the type of third-party financial assistance the plan enrollee may be eligible for. AFPs primarily focus on determining if an enrollee is eligible for a manufacturer's patient assistance program, charitable assistance program, or importation from an international pharmacy. However, if the enrollee is not eligible for any part of the AFP, then the prescription is sent back to the health plan for coverage, and the medication is covered like a regular pharmacy benefit.⁷ These programs are harmful to consumers, who can experience delays for over two months before being able to access their treatments.⁸

These for-profit companies are often misleading and identify themselves as "patient advocates," making it difficult for consumers to discern their true priorities.⁹ This misnomer classification can also make it difficult for regulatory authorities to identify the laws and regulations these companies are subject to. This challenge is compounded by the fact that some AFPs are not directly affiliated with a PBM. Even in the absence of such affiliation, AFPs are instrumental in causing plans to adopt benefit designs that steer certain prescription drugs to their programs. Therefore, to ensure AFPs are subject to the requirements of this regulation, as they are playing a role in establishing and maintaining prescription drug formularies, Aimerd Alliance urges DOL to add the following bullet to the PBM services list:

- Establishing or maintaining prescription drug formularies that require beneficiaries to apply to third-party programs, such as manufacturer patient assistance programs, copay assistance programs, or international pharmacies, with or without a direct PBM affiliation;

Aimerd Alliance believes this addition will provide employers greater transparency into these third-party program practices and incentives and allow employers to determine whether these programs act in the best interest of the plan and its beneficiaries.

III. QALY Evaluation Metrics Should Not Be Adopted

Aimerd Alliance reiterates its longstanding recommendation against relying on quality-adjusted life year (QALY) measures to evaluate any treatment. The use of QALY measures to evaluate the value of a treatment raises significant ethical concerns. QALY measures put a price

⁶ Aimerd Alliance has an extensive number of resources on AFPs, available at: [Alternative Funding Programs - Aimerd Alliance](#).

⁷ Aimerd Alliance, *Alternative Funding Programs*, <https://aimerdalliance.org/alternative-funding-programs/>.

⁸ William B. Wong et al., *A Descriptive Survey of Patient Experiences and Access to Specialty Medicines with Alternative Funding Programs*, 30 J. MANAGED CARE & SPECIALTY PHARMACY 1308 (2024).

⁹ Aimerd Alliance, *Response to Payer Matrix* (Aug. 17, 2023), https://aimerdalliance.org/wp-content/uploads/2023/08/Response-to-Payer-Matrix_Final-8.17.23.pdf.

tag on the value of human life that merely reflects the individual's diagnosis and deems those with chronic, debilitating, and rare conditions to be worth less than those with common conditions. They treat individuals' lives and health as a commodity and ignore patients' and practitioners' individualized concepts of the value of treatment. QALYs are often used to justify coverage limitations and utilization management policies, such as prior authorization and step therapy programs, that prevent individuals from obtaining treatments that are most appropriate for their individualized needs. Such policies can be unethical and inconsistent with standards of care, interfere with the patient-doctor relationship, and result in significant delays to prescribed treatments. For these reasons, Aimed Alliance recommends against using QALYs.

IV. Conclusion

Aimed Alliance appreciates the opportunity to comment on the proposed rule and the Trump Administration's continued commitment to lowering prescription drug prices for consumers. If you have any questions regarding this comment, please contact us at avantrees@aimedalliance.org.

Sincerely,

Ashira Vantrees, Esq.
Director of Legal Strategy & Advocacy