State PBM Reform Inventory

Updated October 2026

New Hampshire

Issue	Summary	Citation
Licensing/Registration	A person or organization shall not establish or operate as a PBM in this state for health benefit plans without registering with the Insurance Commissioner. A PBM must file an application or renewal form established by the commissioner, as well as a non-refundable fee of not more than $500 annually.	N.H. Rev. Stat. Ann. § 402-N:2
Reporting Requirements	Each PBM shall submit an annual or quarterly report to the commissioner containing a list of health benefit plans it administered and the rebates it collected from pharmaceutical manufacturers that were attributable to patient utilization in the state of New Hampshire during the prior calendar year. The report submitted to the commissioner shall include the following information: • The aggregate number of rebates and total value received by the PBM; • The aggregate number of rebates and total value distributed to the appropriate health care insurer; • The aggregate number of rebates and total value passed on to an insured of each health care insurer at the point of sale that reduced the insured's applicable deductible, copayment, coinsurance, or other cost-sharing amount; • The individual and aggregate amount paid by the health care insurer to the PBM for pharmacist services itemized by pharmacy, by product (at the unique NDC level), and by goods and services; and • The individual and aggregate amount a PBM paid for pharmacist services itemized by pharmacy, by product, and by goods and services. Beginning March 1, 2025, and annually thereafter, an insurer shall file with the commissioner a report in the manner and form determined by the commissioner demonstrating the manner in which the insurer and/or its contracted entity for pharmacy benefit services has complied with the rebate pass-	N.H. Rev. Stat. Ann. § 402-N:6; N.H. Rev Stat § 415-A:7

	through requirements. The report shall include at least the following: • An attestation that all discounts and rebates received by health insurers were used to reduce costs for policyholders; • If a portion of rebates were remitted to the insurer, provide an explanation of how rebates were used to reduce policyholder premiums; • A description of how rebates were remitted in the individual, small, and large group market; and • A description of the methodology employed to calculate the estimated rebate amount. Note: All above reporting requirements do not apply to contracts with Medicaid, Medicaid MCOs, Ryan White HIV/AIDS Program administered by the department of health and human services, or self- funded plans such as the state employee health benefit plan.	
PBM Income	**Rebate Pass-Through:** All rebates remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to an insurer, or to a PBM under contract with an insurer, related to its prescription drug benefits shall be remitted in the following ways: • At least 50% of all rebates shall be emitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular or specific prescription drug; and • The remainder of the rebates shall be remitted to the insurer and shall be applied by the insurer to offset the premium for covered persons.	N.H. Rev Stat § 415-A:7
Pharmacy Contracting	**MAC Pricing:** All contracts between a carrier or PBM and a contracted pharmacy shall include: • The sources used by the PBM to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the carrier or PBM. • A process to appeal, investigate, and resolve disputes regarding the MAC pricing. The process shall include the following provisions:	N.H. Rev. Stat. § 402-N:3

	○ A provision granting the contracted pharmacy or pharmacist at least 30 business days following the initial claim to file an appeal; ○ A provision requiring the carrier or PBM to investigate and resolve the appeal within 30 business days; ○ A provision requires that, if the appeal is denied, the carrier or PBM shall: ▪ Provide the reason for the denial; and ▪ Identify the NDC of a drug product that may be purchased by contracted pharmacies at a price at or below the MAC; and ○ A provision requires that, if an appeal is granted, the carrier or PBM shall, within 30 business days after granting the appeal: ▪ Make the change in the MAC; and ▪ Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question. • For every drug for which the PBM establishes a MAC to determine the drug product reimbursement, the PBM shall: ○ Include in the contract with the pharmacy information identifying the national drug pricing compendia or sources used to obtain the drug price data. ○ Make available to a contracted pharmacy the actual MAC for each drug. ○ Review and make necessary adjustments to the MAC for every drug for which the price has changed at least every 14 days.	
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A PBM or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less. **Copay Cap:** Each insurer that provides coverage for prescription insulin drugs shall cap the total amount that a covered person is required to pay for each covered insulin drug prescription at an amount not to exceed $30 for each 30-day supply of each insulin prescription. The maximum $30 copayment for each 30-day supply of each covered insulin drug prescription shall apply when an original prescription is dispensed as	N.H. Rev. Stat. § 402-N:4; N.H. Rev. Stat. § 415:6-e

	well as when refills of the prescription are dispensed, including early refills. Coverage for prescription insulin drugs shall not be subject to any deductible.	