State PBM Reform Inventory

Updated October 2026

New Mexico

Issue	Summary	Citation
Licensing/Registration	A person shall not operate as a PBM unless licensed by the Superintendent of Insurance. PBMs must renew their license annually. An initial application and a renewal application for licensure as a PBM shall be made on a form and in a manner provided for by the superintendent.	NM Stat § 59A-61-3
Reporting Requirements	N/A	
PBM Income	**Rebate Pass-Through:** Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer. Any rebate amount shall be counted toward the insured's out- of-pocket prescription drug costs.	NM Stat § 13-7-47
Pharmacy Contracting	**MAC Pricing:** A PBM shall determine a reimbursement amount for a generic drug based on objective and verifiable sources. A PBM shall reimburse a pharmacy an amount no less than the amount that the PBM reimburses a PBM affiliate in the same network for providing the same or equivalent service. A PBM using MAC pricing may place a drug on an MAC list if the drug: • Is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; • Is available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and • Is a drug with no fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version	NM Stat § 59A-61-4 NM Stat § 13-7-47

	of the FDA's approved drug products with therapeutic equivalence evaluations, also known as the "orange book".
	
	A PBM using MAC pricing shall:
	• Upon a network pharmacy's request, provide that network pharmacy with the sources used to determine the MAC pricing for the MAC list specific to that provider;
	• Review and update MAC price information at least once every 7 business days to reflect any modification of MAC pricing;
	• Establish and maintain a process for eliminating products from the MAC list or modifying MAC prices in at least 7 business days to remain consistent with pricing changes and product availability in the marketplace;
	• Provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:
	  ○ Directly to the PBM; or
	  ○ Through a PSAO;
	• Provide an appeals process that, at a minimum, includes the following:
	  ○ A dedicated telephone number and electronic mail address or website for the purpose of submitting appeals;
	  ○ the ability to submit an appeal directly to the PBM; and
	  ○ the allowance of at least 21 business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount;
	• Grant an appeal if the PBM fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within 14 business days after the PBM receives the appeal;
	• If an appeal is granted, notify the challenging pharmacy and its PSAO, if any, that the appeal is granted and make the change in the MAC effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the claim or claims that formed the basis of the appeal;
	• When an appeal is denied, provide the challenging pharmacy and its PSAO, if any, the NDC number and	

	supplier that has the product available for purchase in New Mexico at or below the MAC; • Within 1 business day of granting or denying a network pharmacy's appeal, notify all network pharmacies of the decision; • Upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; and • Provide for each of its network pharmacy providers and the superintendent a process and mechanism to readily access the MAC list specific to that provider. **Patient Steering:** Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for: • Prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or • Administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.	
Patient Cost-Sharing	**Copay Cap:** The amount an individual with diabetes may be required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is not to exceed $25 per 30-day supply. Group health care coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall cap the amount an insured is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative at an amount not to exceed a total of $25 per 30-day supply and shall provide coverage for individuals with diabetes as required by law for each health care insurer. **Copay Accumulator Programs:** When calculating an enrollee's cost-sharing obligation for covered prescription drugs, pursuant to group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act, the insurer shall credit	NM Stat § 59A-22-41; NM Stat § 13-7-25; NM Stat § 13-7-47

	the enrollee for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim. These provisions do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans, tax- favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law. **Maximum Cost-Sharing Levels:** Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the: • Applicable cost-sharing amount for the prescription drug; • Amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts; • Total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or • Value of the rebate from the manufacturer provided to the insurer or its PBM for the prescribed drug.	