SB 478-FN - AS INTRODUCED

2026 SESSION

26-2037
05/08

SENATE BILL ***478-FN***

AN ACT relative to strengthening prescription drug affordability and pharmacy benefits manager accountability.

SPONSORS: Sen. McGough, Dist 11; Sen. Gannon, Dist 23; Sen. Rosenwald, Dist 13; Sen. Pearl, Dist 17; Sen. Birdsell, Dist 19; Sen. Innis, Dist 7; Rep. W. MacDonald, Rock. 16; Rep. Miles, Hills. 12; Rep. Potucek, Rock. 13; Rep. L. Walsh, Rock. 15; Rep. Cole, Hills. 26

COMMITTEE: Health and Human Services

ANALYSIS

This bill regulates prescription drug costs and increases transparency and accountability by banning spread pricing, adopting pass through pricing, and ensuring all manufacturer rebates go toward lowering premiums or point-of sale costs. The bill also bans retroactive fees on clean claims, requires timely access to pricing lists, allows audits to prevent misuse, and prioritizes lowest net cost drugs.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

26-2037
05/08

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty-Six

AN ACT relative to strengthening prescription drug affordability and pharmacy benefits manager accountability.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Statement of Purpose.

The general court finds that prescription drug affordability is essential to public health and that aligning incentives among manufacturers, pharmacy benefit managers (PBMs), health carriers, pharmacies, hospitals, and patients can reduce list-price inflation pressures, lower consumer out-of-pocket costs, and moderate premiums. The purpose of this act is to enhance transparency to the New Hampshire insurance department (NHID) while protecting competitively sensitive information, delink PBM compensation from drug prices in state-administered plans and make a delinked, pass-through option broadly available to employers, assure fair, competitive pharmacy networks without retroactive claim recoupments, protect 340B safety-net care from discriminatory reimbursement, promote clinically driven formularies with clear exceptions pathways, expand access to biosimilars and other lower-net-cost therapies, and offer consumers optional monthly out-of-pocket smoothing.

2 Pharmacy Benefits Managers; Definitions. Amend RSA 402-N:1 is repealed and reenacted to read as follows:

402-N:1 Definitions.

In this chapter:

I. "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(a) Receiving payments for pharmacist services.

(b) Making payments to pharmacists or pharmacies for pharmacist services.

II. "Commissioner" means the commissioner of the insurance department.

III. "Health carrier" means "health carrier" as defined in RSA 420-J:3, XXIII.

IV. "Pharmacist" means an individual licensed as a pharmacist by the pharmacy board.

V. "Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

VI. "Pharmacy" means the place licensed by the pharmacy board in which drugs, chemicals, medicines, prescriptions, and poisons are compounded, dispensed, or sold at retail.

VII. “Health plan” means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

VIII. "Insurer" means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C. section 300gg-91, or any state or local governmental employer plan.

IX. "Person" includes a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision or agency.

X. "Pharmacy benefit management fee" means a fee that covers the cost of providing one or more pharmacy benefit management services and that does not exceed the value of the service or services actually performed by the pharmacy benefit manager.

XI. "Pharmacy benefit management service" means:

(a) Negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;

(b) Managing any aspect of a prescription drug benefit, including but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs, managing or providing data relating to the prescription drug benefit, or the provision of services related thereto;

(c) Performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting, or billing service; and

(d) Such other services as the department may define in rules adopted under RSA 541-A.

XII. "Pharmacy benefit manager" means any person that, pursuant to a written agreement with an insurer or health plan, either directly or indirectly, provides one or more pharmacy benefit management services on behalf of the insurer or health plan, and any agent, contractor, intermediary, affiliate, subsidiary, or related entity of such person who facilitates, provides, directs, or oversees the provision of the pharmacy benefit management services.

XIII. "Rebate" means:

(a) Negotiated price concessions including but not limited to base price concessions, whether described as a "rebate" or otherwise, and reasonable estimates of any price protection rebates and performance-based price concessions that may accrue directly or indirectly to the insurer or health plan during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug, and

(b) Reasonable estimates of any negotiated price concessions, fees and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the insurer or health plan and serve to reduce the insurer or health plan's liabilities for a prescription drug.

XIV. "Related entity" means:

(a) Any entity, whether foreign or domestic, that is a member of any controlled group of corporations, as defined in section 1563(a) of the Internal Revenue Code, except that "50 percent" shall be substituted for "80 percent" wherever the latter percentage appears in such code, of which a pharmacy benefit manager is a member; or

(b) Any of the following persons or entities that are treated as a related entity to the extent provided in rules adopted by the commissioner:

(1) A person other than a corporation that is treated under such rules as a related entity of a pharmacy benefit manager, or

(2) A person or entity that is treated under such rules as affiliated with a pharmacy benefit manager in cases where the pharmacy benefit manager is a person other than a corporation.

3 Pharmacy Benefits Managers; Rulemaking; Penalties. RSA 402-N:2 is repealed and reenacted to read as follows:

402-N:2 Registration to do Business; Rulemaking; Penalties.

I. The commissioner shall adopt rules, pursuant to RSA 541-A, to implement this act, including standardized reporting formats, confidentiality protections, audit standards, and enforcement.

II. Penalties under RSA 402-N shall remain administrative and proportionate. No private right of action is created.

4 New Section; Employer Choice and State Plan Alignment. Amend RSA 402-N by inserting after section 2 the following new section:

402-N:2-a Employer Choice and State Plan Alignment.

I. No pharmacy benefit manager may derive income from pharmacy benefit management services provided to an insurer or health plan in this state except for income derived from pharmacy benefit management fees. The amount of any pharmacy benefit management fees must be set forth in the agreement between the pharmacy benefit manager and the insurer or health plan.

II. Pharmacy benefit management fees charged by or paid to a pharmacy benefit manager from an insurer or health plan shall not be directly or indirectly based or contingent upon:

(a) The acquisition cost or any other price metric of a drug;

(b) The amount of savings, rebates, or other fees charged, realized, or collected by or generated based on the activity of the pharmacy benefit manager; or

(c) The amount of premiums, deductibles, or other cost-sharing or fees charged, realized, or collected by the pharmacy benefit manager from patients or other persons on behalf of a patient.

III. Annually by December 31, each pharmacy benefit manager operating in the state must certify to the commissioner that it has fully and completely complied with the requirements of this section throughout the prior calendar year. Such certification must be signed by the chief executive officer or chief financial officer of the pharmacy benefit manager.

IV. In addition to any other civil or criminal penalty authorized by law, a violation of this section shall be punishable by the department through a civil monetary penalty not to exceed $1,000 per claim.

5 New Paragraphs; Provider Contract Standards for Pharmacy Benefits Managers. Amend RSA 402-N:3 by inserting after paragraph III the following new paragraphs:

I. A PBM shall not assess retroactive fees, recoupments, or "DIR"-like adjustments on clean claims after adjudication, except for fraud, waste, abuse, or data corrections identified within 60 days and subject to appeal.

II. PBMs shall provide pharmacies with timely access to maximum allowable cost (MAC) lists and an electronic appeal pathway with determinations within 7 business days. MAC lists shall be updated at least every 7 days when pricing changes exceed specified thresholds.

III. A PBM shall not require the use of a mail-order or affiliated pharmacy when a network retail or health-system pharmacy offers the same net cost and can meet clinically appropriate dispensing requirements, provided that specialty drug safety, cold-chain, and REMS requirements are met.

IV. Gag clauses are prohibited. Pharmacists may disclose the lowest cost legally available to the patient at the point of sale.

6 New Section; 340B Non-Discrimination. Amend RSA 402-N by inserting after section 3 the following new section:

402-N:3-a 340B Non-Discrimination.

I. A PBM or carrier shall not reimburse a 340B covered entity or its contract pharmacy at a lower rate solely due to 340B status, require unique modifiers outside of federal or state standards, or otherwise impose terms that discriminate against 340B participation.

II. This section does not prohibit reasonable auditing necessary to prevent duplicate discounts or diversion, and insurance department may establish a standard claims identifier to facilitate compliance consistent with federal law and privacy protections.

7 New Paragraphs; Prescription Drugs; Formulary Integrity; Biosimilars; Patient Protections. Amend RSA 402-N:4 by inserting after paragraph II the following new paragraphs:

III. Pharmacy benefits managers shall support formulary placement based on evidence-based clinical criteria and lowest net cost, including rebates and all price concessions.

IV. Formularies shall provide parity access for biosimilars. A plan shall place the product with the lowest net cost, reference or biosimilar, on the preferred tier with the lowest applicable member cost-sharing.

V.(a) Electronic prior authorization shall be offered and decisions rendered within 48 hours for urgent requests and 5 calendar days otherwise.

(b) A clear exception process shall allow bypass of step therapy where the patient is stable on current therapy, where prior therapies are contraindicated, or where delay risks serious harm.

(c) Clinical criteria shall be posted publicly and updated at least semi-annually.

VI. For fully insured plans, carriers shall either:

(a) Cap member cost-sharing for insulin at no more than $30 per 30-day supply; or

(b) Apply point-of-sale reductions sufficient to achieve an average member out-of-pocket cost not exceeding $30, with the approach disclosed in rate filings.

8 New Section; Confidential Transparency to NHID; Public Aggregates. Amend RSA 402-N by inserting after section 6 the following new section:

402-N:6-a Confidential Transparency to Insurance Department; Public Aggregates.

I. Annual Filings. PBMs and carriers shall file with insurance department, in a commissioner-prescribed confidential format, the following for the prior calendar year, attributable to New Hampshire lives:

(a) The aggregate dollar amount of all rebates that pharmacy benefit manager received from all pharmaceutical manufacturers;

(b) The aggregate dollar amount of all administrative fees that the pharmacy benefit manager received;

(c) The aggregate dollar amount of all insurer administrative service fees that the pharmacy benefit manager received;

(d) The aggregate dollar amount of all rebates that the pharmacy benefit manager received from all pharmaceutical manufacturers and did not pass through to health plans or insurers;

(e) The aggregate dollar amount of all administrative fees that the pharmacy benefit manager received from all pharmaceutical manufacturers and did not pass through to health plans or insurers;

(f) The aggregate retained rebate percentage; and

(g) Across all of the pharmacy benefit manager's contractual or other relationships with all health plans or insurers, the highest aggregate retained rebate percentage, the lowest aggregate retained rebate percentage, and the mean aggregate retained rebate percentage.

II. The department shall publish in a timely manner the information that it receives under paragraph I on a publicly available website, provided that such information shall be made available in a form that does not directly or indirectly disclose the identity of a specific health plan or the identity of a specific manufacturer, the prices charged for specific drugs or classes of drugs, or the amount of any rebates provided for specific drugs or classes of drugs.

III. The pharmacy benefit manager and the department shall not directly or indirectly publish or otherwise disclose any information that would reveal the identity of a specific health plan

or manufacturer, the prices charged for a specific drug or class of drugs, the amount of any rebates provided for a specific drug or class of drugs, the manufacturer, or that would otherwise have the potential to compromise the financial, competitive, or proprietary nature of the information. Any such information shall be protected from disclosure as confidential and proprietary information, shall not be regarded as a public record under RSA 91-A. A pharmacy benefit manager shall impose the confidentiality protections and requirements of this section on any agent or downstream third party that performs health care or administrative services on behalf of the pharmacy benefit manager that may receive or have access to rebate related information.

9 New Sections; Consumer Out-of-Pocket Smoothing Option; Duty of Good Faith and Loyalty to Plan Sponsor. Amend RSA 402-N by inserting after section 6-a the following new sections:

402-N:6-b Consumer Out-of-Pocket Smoothing Option.

I. Carriers shall offer to all enrollees an interest-free, monthly out-of-pocket smoothing option that allows members to distribute high pharmacy cost-sharing evenly across the plan year, with reasonable safeguards for delinquency, portability, and mid-year enrollment changes.

II. Carriers shall disclose this option at enrollment and via member portals.

402-N:6-c Duty of Care.

I. In this section, the following terms shall have the following meanings:

(a) "Enrollee" means any individual entitled to coverage of health care services from an insurer.

(b) "Health care service" means an item or service furnished to any individual for the purpose of preventing, diagnosing, alleviating, curing, or healing human illness, injury or physical disability.

(c) "Health plan" means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(d) "Insurer" means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C. section 300gg-91, or any state or local governmental employer plan.

(e) "Person" includes a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision or agency.

(f) "Pharmacy benefit management fee" means a fee that covers the cost of providing one or more pharmacy benefit management services and that does not exceed the value of the service or services actually performed by the pharmacy benefit manager.

(g) "Pharmacy benefit management service" means:

(1) Negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;

(2) Managing any aspect of a prescription drug benefit, including but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs, managing or providing data relating to the prescription drug benefit, or the provision of services related thereto;

(3) Performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting, or billing service; and

(4) Such other services as the department may define in regulation.

(h) "Pharmacy benefit manager" means any person that, pursuant to a written agreement with an insurer or health plan, either directly or indirectly, provides one or more pharmacy benefit management services on behalf of the insurer or health plan, and any agent, contractor, intermediary, affiliate, subsidiary, or related entity of such person who facilitates, provides, directs, or oversees the provision of the pharmacy benefit management services.

(i) "Pharmacy benefit manager duty" means a duty and obligation to perform pharmacy benefit management services with care, skill, prudence, diligence, fairness, transparency, and professionalism, and for the best interests of the enrollee, the health plan, and the provider, as consistent with the requirements of this section and any regulations that may be adopted to implement this section.

(j) "Provider" means an individual or entity that furnishes, provides, dispenses, or administers one or more units of a prescription drug.

(k) "Related entity" means:

(1) Any entity, whether foreign or domestic, that is a member of any controlled group of corporations (as defined in section 1563(a) of the Internal Revenue Code, except that "50 percent" shall be substituted for "80 percent" wherever the latter percentage appears in such code) of which a pharmacy benefit manager is a member; or

(b) Any of the following persons or entities that are treated as a related entity to the extent provided in rules adopted by the commissioner:

(1) A person other than a corporation that is treated under such rules as a related entity of a pharmacy benefit manager, or

(2) A person or entity that is treated under such rules as affiliated with a pharmacy benefit manager in cases where the pharmacy benefit manager is a person other than a corporation.

(l) "Spread pricing" means any amount retained, charged, or claimed by a pharmacy benefit manager including rebates in excess of the ingredient cost for a dispensed prescription drug plus dispensing fee paid directly or indirectly to any pharmacy, pharmacist, or other provider on behalf of the health plan, less any pharmacy benefit management fees.

II. A pharmacy benefit manager shall owe the pharmacy benefit manager duty to any enrollee, health plan, or provider that receives pharmacy benefit management services from the pharmacy benefit manager or that furnishes, covers, receives, or is administered a unit of a prescription drug for which the pharmacy benefit manager has provided pharmacy benefit management services.

(a) The pharmacy benefit manager duty owed to enrollees shall include duties of care and good faith and fair dealing. The department shall adopt regulations defining the scope of the duties owed to enrollees, including by obligating pharmacy benefit managers to provide all pharmacy benefit management services related to formulary design, utilization management, and grievances and appeals in a transparent manner to enrollees that is consistent with the best interest of enrollees and to disclose all conflicts of interest to enrollees.

(b) The pharmacy benefit manager duty owed to health plans shall include duties of care and good faith and fair dealing. The department shall adopt rules under RSA 541-A defining the scope of the duties owed to health plans, including by obligating pharmacy benefit managers to provide transparency to health plans about amounts charged or claimed by the pharmacy benefit manager in a manner that is adequate to identify all instances of spread pricing and to disclose all conflicts of interest to health plans.

(c) The pharmacy benefit manager duty owed to providers shall include duties of care and good faith and fair dealing. The department shall adopt rules under RSA 541-A defining the scope of the duties owed to providers, including by obligating pharmacy benefit managers to provide transparency to providers about amounts charged or claimed by the pharmacy benefit manager in a manner that is adequate to identify all instances of spread pricing and to disclose all conflicts of interest to providers.

III. Where there is a conflict between the pharmacy benefit manager duties owed under this section, the pharmacy benefit manager duty owed to an enrollee shall be primary over the duty owed to any other party, and the pharmacy benefit manager duty owed to a provider shall be primary over the duty owed to a health plan.

IV. A person who is aggrieved by a violation of this section may bring a civil action before a state court of competent jurisdiction against a pharmacy benefit manager.

10 Preemption; Severability. RSA 402-N:9 is repealed and reenacted to read as follows:

402-N:6-d Preemption; Construction.

I. This chapter is intended to regulate insurance and PBM practices within the state to the maximum extent permitted by federal law, consistent with prevailing United States Supreme Court precedent.

II. If any section, provision, or portion of this chapter, including any condition or prerequisite to any action or determination thereunder, is for any reason held to be illegal or invalid, this illegality or invalidity shall not affect the remainder thereof or any other section, provision, or

portion of this chapter, including any condition or prerequisite to any action or determination thereunder, which shall be construed and enforced and applied as if such illegal or invalid portion were not contained therein.

11 Applicability. RSA 402-N:2-a, as inserted by section 4 of this act shall apply to contracts issued or renewed on or after January 1, 2027.

12 Effective Date.

I. Sections 5-10 of this act shall take effect January 1, 2027.

II. The remainder of this act shall take effect upon its passage.

LBA
26-2037
Revised 12/30/25

SB 478-FN- FISCAL NOTE
AS INTRODUCED

AN ACT relative to strengthening prescription drug affordability and pharmacy benefits manager accountability.

FISCAL IMPACT:

Estimated State Impact				
	FY 2026	**FY 2027**	**FY 2028**	**FY 2029**
Revenue	$0	Indeterminable Decrease (not provided by agency)	Indeterminable Decrease (not provided by agency)	Indeterminable Decrease (not provided by agency)
Revenue Fund(s)	General Fund			
Expenditures*	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source(s)	General Fund, Highway Fund, and Various Agency Funds			
Appropriations*	$0	$0	$0	$0
Funding Source(s)	None			

***Expenditure = Cost of bill** ***Appropriation = Authorized funding to cover cost of bill**

Estimated Political Subdivision Impact				
	FY 2026	**FY 2027**	**FY 2028**	**FY 2029**
County Revenue	$0	$0	$0	$0
County Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Local Revenue	$0	$0	$0	$0
Local Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

The Office of Legislative Budget Assistant is unable to provide a complete fiscal note for this bill, as introduced, as it is awaiting information from the Department of Administrative Services. The Department was originally contacted on 11/14/25 and again on 12/22/25 for a fiscal note worksheet. When completed, a revised fiscal note will be forwarded to the Senate Clerk's Office.

METHODOLOGY:

This bill regulates prescription drug costs and increases transparency and accountability by banning spread pricing, adopting pass through pricing, and ensuring all manufacturer rebates go toward lowering premiums or point-of sale costs. The bill also bans retroactive fees on clean claims, requires timely access to pricing lists, allows audits to prevent misuse, and prioritizes lowest net cost drugs.

The Insurance Department states eliminating the annual pharmacy benefit manager renewal fee would result in a revenue decrease of approximately $3,400 per year, which the Department considers de minimus. The Department states this bill would prohibit pharmacy benefit managers from retaining manufacturer rebates and instead require those amounts to be passed through to insurers or plan members. In calendar year 2024, total rebate value across licensed pharmacy benefit managers was approximately $222,407,749. The Department assumes that some portion of this value may reduce future insurance premiums however, the extent of any cost reduction on Insurance Premium Tax revenue is indeterminable at this time. To the extent premiums change counties and municipalities who purchase health insurance could see a change in their expenditures.

To the extent this bill impacts pharmacy benefit management practices or pharmacy benefit contracts applicable to the State Employee Health Benefit Plan, the state would experience a corresponding fiscal impact.

AGENCIES CONTACTED:

Insurance Department and Department of Administrative Services