Senate Health and Human Services
March 4, 2026
2026-1047s
07/09

Amendment to SB 665-FN

Amend the title of the bill by replacing it with the following:

AN ACT relative to pharmacy benefits managers and managed care laws.

Amend the bill by replacing all after the enacting clause with the following:

1 Pharmacy Benefits Managers; Definitions. Amend RSA 402-N:1, VIII to read as follows:

VIII.(a) "Pharmacy benefits manager" means a person, business, or other entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager ***or licensed health insurer***, that, pursuant to a contract with a health carrier, manages the prescription drug coverage provided by the health carrier ***for health coverage as defined in RSA 420-G:2, IX***, including, but not limited to, providing claims processing services for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudication of grievances or appeals related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

(b) "Pharmacy benefits manager" shall not include any:

(1) Health care facility licensed in this state;

(2) Health care professional licensed in this state;

(3) Consultant who only provides advice as to the selection or performance of a pharmacy benefits manager; ***or***

(4) Service provided to the Centers for Medicare and Medicaid Services[~~; or~~]**.**

[~~(5) Health insurer licensed in this state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds.~~]

2 Pharmacy Benefits Managers; Registration to do Business; Rulemaking; Penalties. Amend RSA 402-N:2, III to read as follows:

III. If the commissioner finds after notice and hearing that any person has violated any provision of this chapter, or [~~rules adopted pursuant to this chapter~~] ***insurance laws of this state***, the commissioner may order:

(a) [~~For each separate violation, a penalty in the amount of $2,500~~] ***An administrative fine not to exceed $10,000 per violation. Each day of non-compliance shall be considered a separate violation***.

(b) Revocation or suspension of the pharmacy benefits manager registration.

3 New Section; Written Agreements. Amend RSA 402-N by inserting after section 2 the following new section:

402-N:2-a. Written Agreement.

I. No pharmacy benefits manager shall act as such without a written agreement between the pharmacy benefits manager and the health carrier. The written agreement shall be retained as part of the official records of both the health carrier and the pharmacy benefits manager for the duration of the agreement and for 5 years thereafter. The agreement shall contain all provisions required by this chapter, except insofar as those requirements do not apply to the functions performed by the pharmacy benefits manager.

II. The written agreement shall include the following:

(a) A statement of duties that the pharmacy benefits manager is expected to perform on behalf of the health carrier.

(b) A statement that the pharmacy benefits manager has a fiduciary duty to health carrier.

(c) A statement that the pharmacy benefits manager shall maintain and make available to the health carrier complete books and records of all transactions performed on behalf of the health carrier.

(d) The instructions for how the pharmacy benefits manager will undertake the duties delegated by the health carrier.

III. In cases in which pharmacy benefits manager administers benefits for more than 100 covered lives in New Hampshire on behalf of the health carrier, the health carrier shall, at least semi-annually, conduct an on-site or virtual audit of the operations of the pharmacy benefits manager.

4 Pharmacy Benefits Manager Reporting. RSA 402-N:6 is repealed and reenacted to read as follows:

402-N:6 Pharmacy Benefits Manager Reporting.

I. Each pharmacy benefits manager shall submit to the commissioner semi-annually a report 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, at a minimum, include the following information:

(a) The aggregate dollar amount spent on drugs prior to rebates;

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

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

(d) The aggregate dollar amount of all health carrier administrative service fees that the pharmacy benefit manager received;

(e) 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 health carriers;

(f) 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 health carriers;

(g) The aggregate retained rebate percentage; and

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

II. Information reported to the commissioner pursuant to this section shall be confidential and protected from disclosure under the commissioner's examination authority and shall not be considered a public record subject to disclosure under RSA 91-A. Based on this reporting, the commissioner shall make public aggregated data on the overall amount of rebates collected on behalf of covered persons in the state, but shall not release data that identifies a specific health carrier or pharmacy benefit manager.

III. The commissioner shall prescribe the format of the report and procedure for filing the report. Any forms, templates, or guidance regarding the report required by the section shall be exempt from the requirements of RSA 541-A.

IV. This section shall not apply to data related to Medicaid, the Medicaid Care Management program, the Ryan White HIV/AIDS program administered by the department of health and human services, self-funded plans, the state employee health benefit plan, or any other plan outside the jurisdiction of the commissioner.

5 Pharmacy Benefits Managers; Authority to Examine and Directly Bill Pharmacy Benefits Managers for Examinations. RSA 402-N:7 is repealed and reenacted to read as follows:

402-N:7 Authority to Examine and Directly Bill Pharmacy Benefits Managers for Examinations.

I. The acts of the pharmacy benefits manager shall be considered the acts of the health carrier on whose behalf it is acting. A pharmacy benefits manager may be examined as if it were the health carrier pursuant to RSA 400-A:37 and the commissioner may directly bill a pharmacy benefits manager for the costs of any examination.

II. The commissioner may investigate the acts of a pharmacy benefits manager pursuant to RSA 400-A:16.

III. The pharmacy benefits manager shall make all records and books of account available to the examiners or consultants and shall otherwise facilitate the performance of the examination or investigation.

6 New Section; Pharmacy Benefits Manager; Legislative Intent. Amend RSA 402-N by inserting after section 1 the following new section:

402-N:1-a Legislative Intent. This chapter is enacted for the purpose of regulating insurance and pharmacy benefits manager practices within the state to the maximum extent permitted by federal law, consistent with prevailing United States Supreme Court precedent.

7 Managed Care Law; Provider Contract Standards. Amend RSA 420-J:8, XV to read as follows:

XV.(a) All contracts between a carrier or pharmacy benefit manager and a contracted pharmacy shall include:

(1) The sources used by the pharmacy benefit manager to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the carrier or pharmacy benefit manager.

(2) A process to appeal, investigate, and resolve disputes regarding the maximum allowable cost pricing. The process shall include the following provisions:

(A) A provision granting the contracted pharmacy or pharmacist at least 30 business days following the initial claim to file an appeal;

(B) A provision requiring the carrier or pharmacy benefit manager to investigate and resolve the appeal within 30 business days;

(C) A provision requiring that, if the appeal is denied, the carrier or pharmacy benefit manager shall:

(i) Provide the reason for the denial; and

(ii) Identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost; and

(D) A provision requiring that, if an appeal is granted, the carrier or pharmacy benefits manager shall within 30 business days after granting the appeal:

(i) Make the change in the maximum allowable cost; and

(ii) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question.

(3) All claims adjudications, appeals, and utilization review processes shall comply with the requirements of RSA 420-J and rules promulgated thereunder.

(b) For every drug for which the ***health carrier or*** pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the ***health carrier or*** pharmacy benefit manager shall:

(1) Include in the contract with the pharmacy information identifying the national drug pricing compendia or sources used to obtain the drug price data.

(2) Make available to a contracted pharmacy the actual maximum allowable cost for each drug.

(3) Review and make necessary adjustments to the maximum allowable cost for every drug for which the price has changed at least every 14 days.

(c) [Repealed.]

(d) [Repealed.]

(e) Grant at least 7 days' advance notice of the initial on-site audit for each audit cycle. A pharmacy that requests an additional 7 days prior to the commencement of an audit shall be granted 7 additional days.

8 Managed Care Law; Prescription Drugs. Amend RSA 420-J:7-b, III-IV to read as follows:

III. Every health plan that provides prescription drug benefits shall provide written notice in a conspicuous font and size to covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free telephone number through which a covered person can request additional information. For purposes of this paragraph, covered persons affected by deletions to the plan list or plan formulary shall include those covered persons for whom the health plan has provided coverage for the deleted prescription drugs during the 12-month period immediately prior to the deletion. Upon notification to covered persons, the health benefit plan shall allow at least [~~45~~] ***60*** days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the federal Food and Drug Administration has determined that a prescription drug on the health benefit plan's formulary is unsafe. For purposes of this section, "conspicuous font and size" shall mean a font that is at least [~~12~~] ***14*** point in size and in an easily legible font. If a covered person avails himself or herself of the exception process as outlined in 420-J:7-b, II, the medication shall be covered by the health plan until there is a resolution of the exception process. ***Any denial of an exceptions request shall be considered an adverse determination.***

IV. Every health benefit plan that provides prescription drug benefits shall maintain, as part of its records, all of the following information, which shall be made available to the commissioner upon request:

(a) [~~the~~] ***The*** complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over the other drugs.

(b) Documentation regarding any changes to the formulary including the date the formulary was changed and the reason for the change.

(c) The complete maximum allowable cost list for each pharmacy subject to the maximum allowable cost list.

(d) Documentation regarding any changes to the maximum allowable cost list including, but not limited to, the date the maximum allowable cost list was changed and when impacted pharmacies were notified of the change.

9 Managed Care Law; Retroactive Denials Prohibited; Exceptions. Amend RSA 420-J:8-b, III to read as follows:

III. A health carrier shall notify a health care provider at least 15 days in advance of the imposition of any retroactive denials of previously paid claims. The health care provider shall have 6 months from the date of notification under this paragraph to determine whether the insured has other appropriate insurance, which was in effect on the date of service. Notwithstanding the contractual terms between the health carrier and provider, the health carrier shall allow for the submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage. ***If the health care provider files an appeal within 15 days of the date of the notice by the health carrier, the recoupment of the previously paid claim shall occur only after the appeal and external review process has concluded.***

10 New Subparagraphs; Standards for Accident and Health Insurance; Establishing Excess Cost Sharing. Amend RSA 415-A:7, I by inserting after subparagraph (b) the following new subparagraphs:

(c) "Pharmacy benefits manager" means "pharmacy benefits manager" as defined in RSA 402-N:1, VIII.

(d) "Spread pricing" means the model of drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for drugs, and the contracted price for the drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for the drugs, pharmacist services, or drug and dispensing fees.

11 Standards for Accident and Health Insurance; Establishing Excess Cost Sharing. Amend RSA 415-A:7, IV(b) to read as follows:

(b) A civil fine not to exceed [~~$2,500~~] ***$10,000*** may be imposed for each violation. Repeated ***or continuing*** violations of the same provision shall constitute separate civil offenses.

12 New Paragraphs; Standards for Accident and Health Insurance; Establishing Excess Cost Sharing. Amend RSA 415-A:7 by inserting after paragraph V the following new paragraphs:

VI. An insurer providing health coverage as defined in RSA 420-G:2, IX to a group shall disclose at the time the plan is sold how rebates will be treated in accordance with this section and, if a pharmacy benefits manager is used to administer the prescription drug benefit, whether spread pricing is used to compensate the pharmacy benefits manager.

VII. Nothing in this section shall prohibit the use of spread pricing.

13 Effective Date. This act shall take effect January 1, 2027.

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AMENDED ANALYSIS

This bill:

I. Requires written agreement to be formed between pharmacy benefits managers and health carriers before benefits managers can operate.

II. Amends pharmacy benefits manager reporting and examination requirements.

III. Raises the value of the maximum administrative fine that can be levied for violations of the state's pharmacy benefits manger laws.