HOUSE BILL 163:
Pharmacy Benefits Manager Provisions.

2025-2026 General Assembly

Committee:	House Regulatory Reform. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	April 15, 2025
Introduced by:	Reps. Rhyne, Blackwell, Huneycutt, Lowery	**Prepared by:**	Aaron McGlothlin* Committee Counsel
Analysis of:	PCS to Second Edition H163-CSCC-4		

OVERVIEW: The PCS to H163 would require pharmacy benefits managers (PBMs) to reimburse pharmacies at certain rates and report drug acquisition and concession amounts to the Insurance Commissioner. It would prohibit PBMs from imposing some fees, changing reimbursement rates, and preventing pharmacies from discussing lower-cost options with patients. It would also make pharmacy choice provisions applicable to PBMs, increase audit notice requirements to pharmacies, and reduce the frequency and scope of most audits. Finally, it would make technical changes throughout the Pharmacy Benefits Management Act and clarify that the provisions applicable to health benefit plans in the Insurance chapter of the General Statutes do not apply to self-funded insurance plans run by local governments.

BILL ANALYSIS:

Part I of the bill would add definitions for "concession," "generic equivalent", "high-deductible health plan," "national average drug acquisition cost," "Section 223," "specialty drug," and "specialty pharmacy" to the list of definitions in the Pharmacy Benefits Management Act (Article 56A of Chapter 58 [Insurance]).

It would also prohibit PBMs from doing the following:

- Charging insurers a different price than the PBM pays a pharmacy for the same drug.
- Reimbursing pharmacies for a drug in an amount less than the cost bench established by the Centers for Medicare and Medicaid Services (CMS) or less than the amount the PBM reimburses itself or affiliate pharmacies for the same drug.
- Basing reimbursement for drugs on patient outcomes, scores, or metrics.
- Imposing point-of-sale or retroactive fees on pharmacies or charging fees related to participation in a pharmacy network.
- Receive revenue from pharmacies or insured for performing PBM services.
- Receive proceeds from cost-sharing.
- Transfer claims for reimbursement from pharmacies to discount programs.
- Use policy documents to materially change reimbursement rates or other financial obligations.

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- Prevent specialty pharmacies from dispensing specialty drugs or requiring multiple specialty accreditations to join specialty drug networks.
- Prevent pharmacies from informing customers about lower-cost drugs.

Finally, Part I would require PBMs to report the following information to the Insurance Commissioner every quarter:

- The net aggregate wholesale acquisition costs for each class of drugs.
- The aggregate amount of all concessions received from drug manufacturers or wholesale distributors.

The Commissioner must prepare an annual report based on this information.

Part I would be effective October 1, 2025, and apply to insurance contracts issued, renewed, or amended on or after that date.

Part II of the bill would make the pharmacy of choice provisions of G.S. 58-51-37 that apply to insurers also apply to PBMs and PBM interactions with 340B covered entities. These provisions would prohibit PBMs from doing the following:

- Preventing insureds from selecting their pharmacy of choice.
- Preventing pharmacies who accept network terms from becoming in-network providers.
- Selectively imposing cost-sharing on insureds.
- Reducing reimbursement to in-network pharmacies.
- Imposing cost-sharing requirements that are greater than those that would be charged for use of a mail-order pharmacy.
- Not notifying all area pharmacies about the opportunity to participate in a pharmacy network.
- Not providing rebates on an equal basis.

Part II would also extend the consumer protections in G.S. 58-56A-3 to prohibit PBMs from preventing insureds' selection of a preferred in-network pharmacy. Pharmacies would no longer be required to inform insureds that the pharmacy and insurer agreed to a shipping fee before charging that fee for mail-order prescriptions. PBMs would be required to base an insured's out-of-pocket payment calculation on the net price of the drug after all concessions.

Finally, Part II would make technical changes to G.S. 58-51-37, G.S. 58-56A-3.

Part II would be effective October 1, 2025, and apply to insurance contracts issued, renewed, or amended on or after that date.

Part III would limit PBM audits of pharmacies to one time per quarter and a limited number of prescriptions in most cases. If the initial audit turns up information requiring additional audits, the pharmacy must be given written notice of the suspected fraud or abuse and may have the audit conducted on site. If the pharmacy is going to be assessed with a refund to the PBM as a result of the audit, the pharmacy must receive notice, within a seven-day window, of the date the assessment will be levied. Violations of the audit procedures may be enforced by the Insurance Commissioner.

Part III would be effective October 1, 2025, and apply to audits conducted on or after that date.

Part IV would clarify that the provisions of Chapter 58 (Insurance) applicable to health benefit plans do not apply to self-funded plans offered by local governments.

Part V would give the Insurance Commissioner and the Board of Pharmacy the authority to adopt rules necessary to implement the provisions of this act.

EFFECTIVE DATE: Except as otherwise provided, this act is effective when it becomes law.

** Jason Moran-Bates, staff attorney with the Legislative Analysis Division, substantially contributed to this Summary.*