HOUSE BILL 163
Committee Substitute Favorable 4/1/25

Short Title: Pharmacy Benefits Manager Provisions. (Public)

Sponsors:

Referred to:

February 24, 2025

A BILL TO BE ENTITLED

AN ACT TO REGULATE THE USE OF SPREAD PRICING AND CONCESSIONS BY PHARMACY BENEFITS MANAGERS, TO ESTABLISH UNIFORM STANDARDS FOR THE TREATMENT OF SPECIALTY PHARMACY ACCREDITATION BY PHARMACY BENEFITS MANAGERS, TO CLARIFY THE RIGHT TO A PHARMACY OF CHOICE, AND TO STRENGTHEN THE PROTECTIONS PROVIDED TO PHARMACIES DURING AUDITS.

The General Assembly of North Carolina enacts:

PART I. REGULATE THE USE OF SPREAD PRICING AND CONCESSIONS SUCH AS FEES AND REBATES BY PHARMACY BENEFITS MANAGERS AND ESTABLISH UNIFORM STANDARDS FOR THE TREATMENT OF ACCREDITING SPECIALTY PHARMACIES BY PHARMACY BENEFITS MANAGERS

SECTION 1.1. Article 56A of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-56A-6. Protection against spread pricing.**

A pharmacy benefits manager shall not charge an insurer offering a health benefit plan a price for a prescription drug that differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacy or pharmacist for providing pharmacist services under that same health benefit plan."

SECTION 1.2.(a) G.S. 58-56A-1 reads as rewritten:

"**§ 58-56A-1. Definitions.**

The following definitions apply in this Article:

…

(4a) Concession. – A reduction in the cost of a prescription drug that a pharmacy benefits manager negotiates with a drug manufacturer or wholesale distributor. A concession includes fees, discounts, rebates, or other reductions in the cost to the pharmacy benefits manager. A concession does not include a bona fide service or administrative fee.

(4b) Reserved for future codification purposes.

(4c) Generic equivalent. – A drug that meets all of the following criteria:

a. Has an identical amount of the same active ingredients in the same dosage form as a non-generic drug.

b. Meets applicable standards of strength, quality, and purity according to the United States Pharmacopeia or other nationally recognized compendium.

c. If administered in the same amount as a non-generic drug, provides comparable therapeutic effects.

This term does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the Administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

…

(5a) High-deductible health plan. – As defined under the Internal Revenue Code.

…

(9a) National average drug acquisition cost. – The publicly available, most current pharmacy acquisition cost benchmark published by the Centers for Medicare and Medicaid Services (CMS), which reflects the average price that retail community pharmacies pay to acquire prescription drugs from wholesalers, excluding rebates and discounts.

…

(16a) Section 223. – Section 223 of the Internal Revenue Code or its equivalent.

(16b) Specialty drug. – Either of the following prescription medications:

a. A medication that is subject to restricted distribution by the United States Food and Drug Administration.

b. A medication used to treat complex or chronic conditions that requires special handling, provider coordination, or patient education.

(16c) Specialty pharmacy accreditation. – A certification granted by an independent, nationally recognized accrediting organization that evaluates a pharmacy's compliance with quality, safety, and service standards for handling, dispensing, and managing specialty medications. The accreditation may be issued by the Utilization Review Accreditation Commission (URAC), Accreditation Commission for Health Care (ACHC), the Joint Commission, their successors, or any similar nationally recognized accrediting organization.

…."

SECTION 1.2.(b) G.S. 58-56A-4 reads as rewritten:

"**§ 58-56A-4. Pharmacy and pharmacist protections.**

(a) ~~A pharmacy benefits manager may only charge fees or otherwise hold a pharmacy responsible for a fee relating to the adjudication of a claim if the fee is reported on the remittance advice of the adjudicated claim or is set out in contract between the pharmacy benefits manager and the pharmacy. No fee or adjustment for the receipt and processing of a claim, or otherwise related to the adjudication of a claim, shall be charged without a justification on the remittance advice or as set out in contract and agreed upon by the pharmacy or pharmacist for each adjustment or fee. This section shall not apply with respect to claims under an employee benefit plan under the Employee Retirement Income Security Act of 1974 or Medicare Part D.~~A pharmacy benefits manager shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim.

(a1) A pharmacy benefits manager shall not do any of the following:

(1) Reimburse a pharmacy or pharmacist for a prescription drug in an amount less than the national average drug acquisition cost for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee. For purposes of this subsection, a "professional dispensing fee" means an amount equal to or higher than the fee-for-service professional drug dispensing fee calculated using the reimbursement methodology described in the North Carolina Medicaid State Plan.

(2) Reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the amount the pharmacy benefits manager reimburses itself or an affiliate for the same prescription drug or pharmacy.
(3) Base pharmacy reimbursement for prescription drugs on patient outcomes, scores, or metrics.
(4) Impose a point-of-sale or retroactive fee on a pharmacist, pharmacy, or insured.
(5) Derive any revenue from a pharmacist, pharmacy, or insured in connection with performing pharmacy benefits management services.
(6) Receive deductibles or copayments.
(7) Directly or indirectly divert, transfer, or otherwise redirect any prescription drug claims submitted by a pharmacy or pharmacist to any third-party discount card program, cash discount program, or any other non-insurance adjudication platform.
(8) Use pharmacy benefits manager policy documents which are incorporated into a pharmacy agreement, including, but not limited to, provider manuals, administrative guidelines, operational policies, ancillary documents, claims processing rules, and/or audit and compliance procedures, to materially change, alter, or modify the pharmacy agreement, to modify, limit, or negate reimbursement rates, payment terms, or other financial obligations, or introduce material changes to the definitions of brand and generic drugs, claims adjudication, audit process, or contractual rights of the pharmacy or pharmacist.

…

(c) A pharmacy or pharmacist shall not be prohibited by a pharmacy benefits manager from dispensing any prescription ~~drug, including specialty drugs dispensed by a credentialed and accredited pharmacy,~~ drug allowed to be dispensed under a license to practice pharmacy under Article 4A of Chapter 90 of the General Statutes.

(c1) A pharmacy or pharmacist shall not be prohibited by a pharmacy benefits manager from dispensing any specialty drug allowed to be dispensed under a license to practice pharmacy under Article 4A of Chapter 90 of the General Statutes if the pharmacist or pharmacy obtains specialty pharmacy accreditation.

…

(e) A claim for pharmacist services may not be retroactively denied or reduced after adjudication of the claim unless any of the following apply:

…

~~(5) The adjustments were part of an attempt to limit overpayment recovery efforts by a pharmacy benefits manager.~~

…

(g) A pharmacy benefits manager may not prohibit a pharmacy or pharmacist that dispenses a pharmaceutical product from, nor may a pharmacy benefits manager penalize the pharmacy or pharmacist for, informing an individual about the cost of the pharmaceutical product, the amount in reimbursement that the pharmacy or pharmacist receives for dispensing the pharmaceutical product, the cost and clinical efficacy of a less expensive alternative to the pharmaceutical product, or any difference between the cost to the individual under the individual's pharmacy benefits plan or program and the cost to the individual if the individual purchases the pharmaceutical product without making a claim for benefits under the individual's pharmacy benefits plan or program."

SECTION 1.2.(c) G.S. 58-56A-15 reads as rewritten:

"**§ 58-56A-15. Pharmacy benefits manager networks.**

(a) A pharmacy benefits manager shall not deny the right ~~to~~ of any properly licensed pharmacist or pharmacy to participate in a retail pharmacy network on the same terms and conditions of other similarly situated participants in the network.

(a1) A pharmacy benefits manager shall not require multiple specialty pharmacy accreditations as a prerequisite for participation in a retail pharmacy network that dispenses specialty drugs and shall not deny the right of any properly licensed pharmacist or pharmacy that has a specialty drug accreditation to participate in a retail pharmacy network that includes network participants that dispense specialty drugs on the same terms and conditions of other similarly situated participants in the network.

…

(d) A pharmacy benefits manager shall not charge a pharmacist or pharmacy a fee related to participation in a retail pharmacy network."

SECTION 1.3. Article 56A of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-56A-22. Reporting.**

(a) Effective May 1, 2026, and quarterly thereafter, every pharmacy benefits manager licensed in this State shall file a report with the Commissioner that contains all of the following information for the applicable time period:

(1) The aggregate wholesale acquisition costs to the pharmacy benefits manager from manufacturers or wholesale distributors for each therapeutic category of drugs covered under each health benefit plan offered by all insurers that contract with the pharmacy benefits manager, net of all concessions, direct or indirect, from all sources.

(2) The aggregate amount of the concessions that the pharmacy benefits manager received from all drug manufacturers or wholesale distributors for each insurer contracting with the pharmacy benefits manager, detailed by each health benefit plan offered by the insurer. In reporting the aggregate amount of the rebates, the pharmacy benefits manager shall include any utilization discounts it receives from a manufacturer or wholesale distributor.

(3) The aggregate amount of all concessions that the pharmacy benefits manager received.

(4) All concessions received by the pharmacy benefits manager from all manufacturers or wholesale distributors that were not passed on by the pharmacy benefits manager to an insurer contracting with the pharmacy benefits manager or other clients of the pharmacy benefits manager.

(b) The information contained in the report required by this section shall be confidential by law and privileged, shall not be considered a public record under either G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible into evidence in any private civil action. The Commissioner is authorized to use this information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(c) Effective August 1, 2026, and annually thereafter, the Commissioner shall prepare a report based on the information received under this section. The report shall aggregate data and shall not contain information that would cause financial, competitive, or proprietary harm to any individual pharmacy benefits manager. The Commissioner shall post the report required by this subsection on the Department's website."

SECTION 1.4. This Part becomes effective October 1, 2025, and applies to contracts issued, renewed, or amended on or after that date.

PART II. CLARIFY HEALTH BENEFIT PLAN BENEFICIARY'S RIGHT TO A PHARMACY OF CHOICE AND MAKE TECHNICAL CORRECTIONS AND UPDATES TO STATUTES DEALING WITH THESE CONSUMER PROTECTIONS

SECTION 2.1. G.S. 58-51-37 reads as rewritten:

"**§ 58-51-37. Pharmacy of choice.**

~~(a) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of North Carolina. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall apply to pharmacy benefits managers with respect to 340B covered entities and 340B contract pharmacies, as defined in G.S. 58-56A-1. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses, and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and to enrollees of its health benefit plan; provided, however, this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services. This section shall not apply to any federal program, clinical trial program, hospital or other health care facility licensed pursuant to Chapter 131E or Chapter 122C of the General Statutes, when dispensing prescription drugs to its patients.~~

(b) ~~As used~~ Definitions. – The following definitions apply in this section:

(1) ~~"Copayment" means a~~ Copayment. – A type of cost sharing ~~whereby insured or covered persons~~ requiring insureds to pay a specified predetermined amount per unit of service with ~~their~~ the insurer paying the remainder of the charge. The copayment is incurred at the time the service is used. The copayment may be a fixed or variable amount.

(2) ~~"Contract provider" means a~~ Contract provider. – A pharmacy granted the right to provide prescription drugs and pharmacy services according to the terms of the insurer.

(3) ~~"Health benefit plan" is as that term is~~ Health benefit plan. – As defined in ~~G.S. 58-50-110(11).~~G.S. 58-3-167.

(4) ~~"Insurer" means any entity that provides or offers a health benefit plan.~~Insured. – Any individual covered by a health benefit plan.

(4a) Insurer. – As defined in G.S. 58-3-167.

(5) ~~"Pharmacy" means a~~ Pharmacy. – A pharmacy registered with the North Carolina Board of Pharmacy.

(b1) Applicability. – This section applies to insurers offering health benefit plans that include prescription drug or pharmacy benefits. This section shall also apply to pharmacy benefits managers in the same way that it applies to insurers with respect to 340B covered entities and 340B contract pharmacies, as defined in G.S. 58-56A-1. This section does not apply to any federal program or clinical trial program.

(c) Health Benefit Plan Terms. – The terms of a health benefit plan shall ~~not:~~not do any of the following:

(1) Prohibit or limit a resident of this State, who is eligible for reimbursement for pharmacy services as ~~a participant or beneficiary of a health benefit plan,~~ an insured, from selecting a pharmacy of his or her choice when the pharmacy has agreed to participate in the health benefit plan according to the terms offered by the ~~insurer;~~insurer.

(2) Deny a pharmacy the opportunity to participate as a contract provider under a health benefit plan if the pharmacy agrees to provide pharmacy services that meet the terms and requirements, including terms of reimbursement, of the insurer under ~~a~~ that health benefit ~~plan, provided that if~~ plan. If the pharmacy is offered the opportunity to ~~participate,~~ participate as a contract provider, it

must participate or no provisions of ~~G.S. 58-51-37~~ this section shall ~~apply;~~apply.

(3) Impose upon ~~a beneficiary of pharmacy services under a health benefit plan~~ an insured any copayment, fee, or condition that is not equally imposed upon all ~~beneficiaries~~ insureds in the same benefit category, class, or copayment level under the health benefit plan when receiving services from a contract ~~provider;~~provider.

(4) Impose a monetary advantage or penalty under a health benefit plan that would affect ~~a beneficiary's~~ an insured's choice of ~~pharmacy. Monetary advantage or penalty includes~~ pharmacy, including a higher copayment, a reduction in reimbursement for services, or the promotion of one participating pharmacy over another by these methods.

(5) Reduce allowable reimbursement for pharmacy services to ~~a beneficiary under a health benefit plan~~ an insured because the ~~beneficiary~~ insured selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage ~~area; or~~area.

(6) Require ~~a beneficiary,~~ an insured, as a condition of payment or reimbursement, to purchase pharmacy products or services, including prescription drugs, exclusively through a mail-order pharmacy.

(7) Impose upon an insured any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to the purchase of pharmacy services or products, including prescription drugs, from any pharmacy that is more costly or more restrictive than that which would be imposed upon the insured if the same services or products were purchased from either a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail-order service.

(d) Use of Agent. – A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent, or owner, may not waive, discount, rebate, or distort a copayment of any ~~insurer, policy, or plan,~~ insurer or health benefit plan or ~~a beneficiary's~~ an insured's coinsurance portion of ~~a~~ prescription drug coverage or reimbursement ~~and if~~ of a prescription drug. If a pharmacy, by or through a pharmacist's ~~acting~~ action on its behalf as its employee, ~~agent~~ agent, or owner, provides a pharmacy service to an ~~enrollee of a health benefit plan~~ insured that meets the terms and requirements of the insurer under a health benefit plan, then the pharmacy shall provide its pharmacy services to all ~~enrollees of~~ individuals covered under that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection ~~shall be~~ is a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the North Carolina Board of Pharmacy pursuant to G.S. 90-85.38.

(e) Offer to Participate. – At least 60 days before the effective date of any health benefit plan ~~providing reimbursement to North Carolina residents~~ coverage for prescription ~~drugs, which~~ drugs that restricts pharmacy participation, the ~~entity~~ insurer providing the health benefit plan shall ~~notify, in writing,~~ provide a written notification and offer to all pharmacies within the geographical coverage area of the health benefit ~~plan, and offer to the pharmacies~~ plan the opportunity to participate in the health benefit plan. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The ~~entity providing the health benefit plan~~ insurer shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform ~~the beneficiaries of the plan~~ insureds of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their

participation to their customers through a means acceptable to the pharmacy and the ~~entity providing the health benefit plans.~~ insurer. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the State.

(f) Rebates and Marketing Incentives. – If rebates or marketing incentives are allowed to pharmacies or other dispensing entities providing pharmaceutical services or benefits under a health benefit plan, these rebates or marketing incentives shall be offered on an equal basis to all pharmacies and other dispensing entities providing services or benefits under ~~a~~ the health benefit plan when pharmacy services, including prescription drugs, are purchased in the same volume and under the same terms of payment. Nothing in this section shall prevent a pharmaceutical manufacturer or wholesale distributor of pharmaceutical products from providing special prices, marketing incentives, rebates, or discounts to different purchasers not prohibited by federal and State antitrust laws.

(g) ~~Any entity or insurer providing a health benefit plan is subject to G.S. 58-2-70.~~ Violations of This Section. – It shall be a violation of this section for any insurer to provide any health benefit plan providing coverage for pharmaceutical services or products to residents of this State that does not conform to the provisions of this section. A violation of this section shall subject the ~~entity providing a health benefit plan~~ insurer to the sanctions of revocation, suspension, or refusal to renew license in the discretion of the Commissioner pursuant to G.S. 58-3-100. A violation of this section creates a civil cause of action for damages or injunctive relief in favor of any person or pharmacy aggrieved by the violation.

~~(h) A violation of this section creates a civil cause of action for damages or injunctive relief in favor of any person or pharmacy aggrieved by the violation.~~

(i) Approval by Commissioner. – The Commissioner shall not approve any health benefit plan providing pharmaceutical services ~~which~~ that does not conform to this section.

(j) Provisions to the Contrary Void. – Any provision in a health benefit plan which is executed, delivered, or renewed, or otherwise contracted for in this State that is contrary to any provision of this section shall, to the extent of the conflict, be void.

(k) ~~It shall be a violation of this section for any insurer or any person to provide any health benefit plan providing for pharmaceutical services to residents of this State that does not conform to the provisions of this section.~~

(*l*) Certain Lock-In Programs. – An insurer's use of a lock-in program developed pursuant to G.S. 58-51-37.1 or G.S. 108A-68.2 is not a violation of this section."

SECTION 2.2. G.S. 58-56A-3 reads as rewritten:

"**§ 58-56A-3. Consumer protections.**

…

(b1) A pharmacy benefits manager shall not prohibit a pharmacist or pharmacy from charging a minimal shipping and handling fee to the insured for a mailed or delivered prescription if the pharmacist or pharmacy discloses all of the following to the insured before delivery:

(1) The fee will be charged.

(2) The fee may not be reimbursed by the health benefit plan, insurer, or pharmacy benefits manager.

~~(3) The charge is specifically agreed to by the health benefit plan or pharmacy benefits manager~~.

(c) A pharmacy benefits manager shall not charge, or attempt to collect from, an insured a copayment that exceeds the total submitted charges by the network pharmacy.

(c1) When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, the insurer or pharmacy benefits manager shall include any amounts paid by the insured, or on the insured's behalf, for a prescription that is ~~either:~~either of the following:

(1) Without an AB-rated generic equivalent.

(2) With an AB-rated generic equivalent if the insured has obtained authorization for the drug through any of the following:
a. Prior authorization from the insurer or pharmacy benefits manager.
b. A step therapy protocol.
c. The exception or appeal process of the insurer or pharmacy benefits manager.

This subsection shall not apply to an insured covered by a high deductible health ~~plan, as that term is defined in section 223 of the Internal Revenue Code,~~ plan, if its application would render the insured ineligible for a health savings account under section 223 unless (i) the insured has satisfied the minimum deductible under section 223 or (ii) the prescription qualifies as preventive care under section 223.

~~(c2) For purposes of this section, the term "generic equivalent" means a drug that has an identical amount of the same active ingredients in the same dosage form; meets applicable standards of strength, quality, and purity according to the United States Pharmacopeia or other nationally recognized compendium; and which, if administered in the same amount, would provide comparable therapeutic effects. The term "generic equivalent" does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the Administration's most recent publication of approved drug products with therapeutic equivalence evaluations.~~

(c3) When calculating an insured's out-of-pocket cost for a covered prescription drug, a pharmacy benefits manager shall base the calculation on the net price of the prescription drug after taking into account all concessions associated with that prescription drug that the pharmacy benefits manager has received or will receive. The current retail price shall not be used when calculating an insured's out-of-pocket cost for a prescription drug if the pharmacy benefits manager has received, is receiving, or will receive any concessions associated with that particular prescription drug.

(d) Any contract for the provision of a network to deliver health care services between a pharmacy benefits manager and insurer shall be made available for review by the Department.

(e) Repealed by Session Laws 2021-161, s. 1(b), effective October 1, 2021, and applicable to any contracts entered into, renewed, or amended on or after that date.

(f) A pharmacy benefits manager shall not prohibit an insured's selection of a pharmacy or pharmacist with respect to any pharmacy or pharmacist that has agreed to participate as a provider in a health benefit plan's network according to the terms offered by the insurer."

SECTION 2.3. G.S. 58-56A-50(c) is repealed.

SECTION 2.4. This Part becomes effective October 1, 2025, and applies to contracts issued, renewed, or amended on or after that date.

PART III. STRENGTHEN PHARMACY AUDIT PROTECTIONS

SECTION 3.1. G.S. 90-85.50 reads as rewritten:

"**§ 90-85.50. Declaration of pharmacy rights during audit.**

(a) The following definitions apply in this Article:

(1) ~~"Pharmacy" means a~~ Pharmacy. – A person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A.

(2) ~~"Responsible party" means the~~ Responsible party. – The entity responsible for payment of claims for health care services other than (i) the individual to whom the health care services were rendered or (ii) that individual's guardian or legal representative.

(b) Notwithstanding any other provision of law, whenever a managed care company, insurance company, third-party payer, or any entity that represents a responsible party conducts an audit of the records of a pharmacy, the pharmacy has a right to all of the following:

…

(8) ~~If an audit is conducted for a reason other than described in subdivision (6) of this subsection, the audit is limited to 100 selected prescriptions.~~Unless the audit is for reasons described in subdivision (6) of this subsection, the following audit restrictions shall apply to audits conducted by a pharmacy benefits manager:

a. A retail pharmacy may only be audited once per calendar quarter.

b. The audit is restricted to the lesser of (i) one-tenth of one percent (0.1%) of the number of total prescription fills processed through the pharmacy benefits manager for that retail pharmacy in a calendar year or (ii) 50 prescription fills processed through the pharmacy benefits manager for that pharmacy in a calendar year.

(9) If an audit reveals the necessity for a review of additional claims, ~~to have~~ then the pharmacy may request the audit be conducted on ~~site.~~site and is entitled to written notice of the basis of the claims, including a specific description of any suspected fraud or abuse, at least 14 days prior to any additional audit.

…."

SECTION 3.2. G.S. 90-85.52 reads as rewritten:

"**§ 90-85.52. Pharmacy audit recoupments.**

…

(a1) Prior to any recoupment, the entity conducting the audit shall provide the pharmacy with a summary describing the total recoupment amount and the approximate date, within a seven-day window, on which the recoupment will be assessed. This summary shall be accompanied by payment summaries or electronic remittance advices documenting any disputed funds, charges, or other penalties.

…."

SECTION 3.3. G.S. 90-85.53 reads as rewritten:

"**§ 90-85.53. Applicability.**

(a) This Article does not apply to any audit, review, or investigation that involves alleged Medicaid fraud, Medicaid abuse, insurance fraud, or other criminal fraud or misrepresentation.

(b) This Article applies to an audit of a pharmacy or pharmacist conducted by a pharmacy benefits manager, insurer, or third-party administrator and is enforceable against these entities by the Commissioner of Insurance under G.S. 58-56A-25."

SECTION 3.4. G.S. 58-56A-25 is amended by adding a new subsection to read:

"(d) The provisions of Article 4C of Chapter 90 of the General Statutes apply to an audit of a pharmacy or pharmacist conducted by a pharmacy benefits manager, insurer, or third-party administrator and are enforceable by the Commissioner."

SECTION 3.5. This Part becomes effective October 1, 2025, and applies to audits initiated on or after that date.

PART IV. CLARIFYING "HEALTH BENEFIT PLAN" DOES NOT INCLUDE LOCAL GOVERNMENT PLANS

SECTION 4. G.S. 58-3-167 reads as rewritten:

"**§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.**

(a) As used in this section:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does

not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any plan implemented or administered by the State Health Plan for Teachers and State Employees. "Health benefit plan" does not mean any plan consisting of one or more of any combination of benefits described in G.S. 58-68-25(b). "Health benefit plan" does not mean any self-funded plan implemented or administered by a local government.

…."

PART V. RULEMAKING AUTHORITY AND EFFECTIVE DATE

SECTION 5.1.(a) The Commissioner may adopt temporary rules to implement Part I and Part II of this act.

SECTION 5.1.(b) The North Carolina Board of Pharmacy may adopt temporary rules to implement Part III of this act.

SECTION 5.2. Except as otherwise provided, this act is effective when it becomes law.