State PBM Reform Inventory

Updated October 2026

North Carolina

Issue	Summary	Citation
Licensing/Registration	A person or organization may not establish or operate as a PBM for health benefit plans in this State without obtaining a license from the Commissioner of the Department of Insurance. The Commissioner shall develop an application for licensure to operate in this State as a PBM and may charge an initial application fee of $2,000 and an annual renewal fee of $1,500.	N.C. Gen. Stat. § 58-56A-2
Reporting Requirements	No later than May 1 of every year, all PBMs shall report to the Commissioner all the following information regarding prescription drug benefits specific to insurers within the State: • The aggregate amount of rebates that the PBM received from all drug manufacturers or wholesale distributors by therapeutic category; • The aggregated amount of difference between the amount paid by the health benefit plan for prescription drugs and the amount paid to pharmacies for claims paid under the health benefit plan, including point-of-sale and retroactive charges; • The spread between the aggregate amount paid to pharmacies for prescription drugs and the aggregate amount charged to insurers for prescription drugs; • A list of all pharmacies that are under common control or ownership of the PBM; • The aggregated amount of any differences between what the PBM reimburses or charges affiliated retail pharmacies and non- affiliated retail pharmacies; • The aggregate amount of all fees or other assessments, including point-of-sales or retroactive charges, that are imposed on contracted, preferred, or in-network pharmacies. Retroactive charges shall not include any funds recouped from an audit that complies with §58-50-8; and • The highest, lowest, and mean aggregate percentages for retained rebates by the PBM.	N.C. Gen. Stat. § 58-56A-22; N.C. Gen. Stat. §58-56A-6

	Beginning March 31, 2026, and quarterly thereafter, any PBM that conducts spread pricing shall report to applicable contracted insurers the aggregate difference between the price charged by the insurer and the price paid to the pharmacy for each drug where there is a difference in price. Any insurer who receives a spread pricing report from a PBM shall make that report available on its website and to any employers who have purchased a health benefit plan from the insurer.	
PBM Income	**Rebate Pass-Through:** Starting January 1, 2027, when calculating an insured's defined cost-sharing for a covered prescription drug at the point of sale, an insurer offering a health benefit plan or a PBM shall base the calculation on the price of the prescription drug after taking into account all rebates associated with that prescription drug. The price of the prescription drug shall be reduced by an amount equal to 90% of all rebates received, or to be received, in conjunction with the dispensing or administration of the prescription drug.	N.C. Gen. Stat. § 58-3-182; N.C. Gen. Stat. § 58-56A-3
Pharmacy Contracting	**Minimum Reimbursement:** No PBM contract may require an independent pharmacy or any pharmacy in a pharmacy desert, as defined in §58-51-37, to accept reimbursement for providing a covered prescription drug, device, or service at a rate less than the acquisition cost. **Patient Steering:** An insurer or PBM shall not: • Prohibit or limit an insured from selecting a pharmacy of the insured's choice when the pharmacy has agreed to participate in the health benefit plan; • Impose upon an insured any copayment, fee, or condition that is not equally imposed upon all insureds in the same benefit category, class, or copayment level under the benefit plan when receiving services from a contract provider; • Impose a monetary advantage or penalty that would affect an insured's choice of pharmacy, including higher copayment, a reduction in reimbursement for services, or the promotion of one contract provider over another. Prohibition of monetary advantages shall not apply to monetary advantages imposed upon a pharmacy located in	N.C. Gen. Stat. § 58-56A-4(g); N.C. Gen. Stat. § 58-51-37; N.C. Gen. Stat. § 58-56A-3; N.C. Gen. Stat. § 58-56A-20; N.C. Gen. Stat. § 58-56A-5

	a pharmacy desert or in a country with a population under 20,000; • Reduce reimbursement for pharmacy services to an insured because the insured selects a pharmacy of their choice; or • Require an insured to purchase pharmacy products or services exclusively through a mail-order pharmacy. A PBM shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount that the PBM reimburses a PBM affiliate for providing the same pharmacist services or same prescription drug. In determining the amount of the reimbursement for the purposes of this section, the amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number and shall reflect all drug manufacturer's rebates, all direct and indirect administrative fees, and any other cost-savings or discounts that may be given related to the drug or services. **MAC Pricing:** To place a prescription drug on the MAC price list, the drug must be available for purchase by pharmacies in North Carolina from national or regional wholesalers, must not be obsolete, and must meet one of the following conditions: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or • The drug has a "NR" or "NA" rating, or a similar rating, by a nationally recognized reference. A PBM shall adjust or remove the MAC price for a prescription drug to remain consistent with changes in the national marketplace for prescription drugs. A review of the MAC prices for removal or modification shall be completed at least once every 7 business days, and any removal or modification shall occur within 7 business days of the review. A PBM shall provide a means by which the contracted pharmacies may promptly review current prices in an electronic, print, or telephonic format within 1 business day of the removal or modification. Dispensing fees shall not be included in the calculation of MAC prices.	

	A PBM shall establish an administrative appeals procedure by which a contracted pharmacy or pharmacist, or a designee, may appeal the provider's reimbursement for a prescription drug subject to MAC pricing if the amount of reimbursement for the drug is less than the net amount that the network provider paid to the suppliers of the drug. The reasonable administrative appeal procedure must include the following: • A dedicated telephone number and email address or website for the purpose of submitting administrative appeals; • The ability to submit an administrative appeal regarding the pharmacy benefits plan or program directly to the PBM or through a pharmacy service administrative organization if the pharmacy service administrative organization has a contract with the PBM that allows for the submission of appeals; • No less than 10 calendar days after the applicable prescription fill date to file an administrative appeal; • A period of no more than 10 calendar days after receipt of notice of the filing of the administrative appeal by the PBM for a decision to be made on the appeal; • A requirement that if an appeal is upheld, then, within 10 calendar days of the decision, the PBM shall notify the appellant of the decision, apply the change in the MAC effective as of the date the appeal was resolved and make the change effective for all similarly situated pharmacies or pharmacists, and permit the appellant to reverse and rebill the claim that was appealed; and • A requirement that if the appeal is denied, then, within 10 calendar days of the decision, the PBM shall notify the appellant of the decision, provide the reason for the denial, the NDC of the drug, and the names of the national or regional wholesalers operating in the state.	
Patient Cost-Sharing	**Copay Adjustment Programs:** When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, the insurer or PBM shall include any amounts paid by the insured, or on the insured's behalf, for a prescription that is either: • Without an AB-rated generic equivalent.	N.C. Gen. Stat. § 58-56A-3

	• 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 PBM;
	  ○ A step therapy protocol; or
	  ○ The exception or appeal process of the insurer or PBM.
	
	This subsection shall not apply to an insured covered by a high-deductible health plan if its application would render the insured ineligible for a health savings account unless the insured has satisfied the minimum deductible or the prescription qualifies as preventive care.
	
	Maximum Cost-Sharing Levels:
	A PBM shall not charge, or attempt to collect from, an insured, a copayment that exceeds the total submitted charges by the network pharmacy.
	
	Note: see PBM Income section for rules regarding point-of-sale rebate pass-throughs.	