



# PROPOSED RULE MAKING

**CR-102 (June 2024)**  
**(Implements RCW 34.05.320)**  
Do **NOT** use for expedited rule making

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FILED

**DATE: November 04, 2025**  
**TIME: 1:50 PM**

**WSR 25-22-093**

**Agency:** Office of the Insurance Commissioner Insurance Commissioner Matter R 2025-11

- Original Notice**
- Supplemental Notice to WSR** \_\_\_\_\_
- Continuance of WSR** \_\_\_\_\_

- Preproposal Statement of Inquiry was filed as WSR 25-15-143 ; or**
- Expedited Rule Making--Proposed notice was filed as WSR \_\_\_\_\_; or**
- Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**
- Proposal is exempt under RCW \_\_\_\_\_.**

**Title of rule and other identifying information:** (describe subject) Health care benefit managers

**Hearing location(s):**

<b>Date:</b>	<b>Time:</b>	<b>Location:</b> (be specific)	<b>Comment:</b>
December 10, 2025	10 a.m. Pacific Time	Virtual meeting (Zoom) Detailed information for attending this meeting is posted on the OIC website:  https://www.insurance.wa.gov/laws-rules/legislation-and-rulemaking/rulemaking/health-care-benefit-managers-r-2025-11	Written comments are due to the OIC by 11:59 p.m. on December 11, 2025. Written comments should be emailed to <a href="mailto:rulescoordinator@oic.wa.gov">rulescoordinator@oic.wa.gov</a>

**Date of intended adoption:** December 16, 2025 (Note: This is **NOT** the **effective** date)

<b>Submit written comments to:</b>	<b>Assistance for persons with disabilities:</b>
Name Rules Coordinator Address P.O. Box 40255, Olympia, WA 98504-0255 Email rulescoordinator@oic.wa.gov Fax 360-586-3109 Other TTY: 360-586-0241 Beginning (date and time) November 4, 2025 at 12:00 am Pacific Time By (date and time) <u>December 11, 2025 at 11:59 p.m.</u> Pacific Time	Contact Rules Coordinator Phone 360-725-7171 Fax 360-586-3109 TTY 360-586-0241 Email rules coordinator@oic.wa.gov Other By (date) <u>December 9, 2025 by 5:00 p.m. Pacific Time</u>

**Purpose of the proposal and its anticipated effects, including any changes in existing rules:** The proposed rule implements provisions of E2SSB 5213 (Chapter 242, Laws of 2024) that go into effect January 1, 2026. This law regulates the business practices of health care benefit managers, including pharmacy benefit managers.

The proposed rule allows the Office of the Insurance Commissioner (OIC) to continue effective oversight of health care benefit managers. The proposed rule ensures that affected entities understand their rights and obligations under these new provisions.

**Reasons supporting proposal:** Revisions to current rules are necessary to effectuate the statute.

**Statutory authority for adoption:** RCW 48.200.900; RCW 48.02.060

**Statute being implemented:** RCW 48.200

**Is rule necessary because of a:**

Federal Law?  Yes  No

Federal Court Decision?  Yes  No

State Court Decision?  Yes  No

If yes, CITATION:

**Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:**

**Name of proponent:** (person or organization) Patty Kuderer, Insurance Commissioner  
**Type of proponent:**  Private.  Public.  Governmental.

**Name of agency personnel responsible for:**

	Name	Office Location	Phone
Drafting	Nico Janssen	P.O. Box 40255, Olympia WA 98504-0255	360-725-7171
Implementation	Sandy Ray and Todd Lovshin	P.O. Box 40255, Olympia WA 98504-0255	360-725-7000
Enforcement	Sofia Pasarow	P.O. Box 40255, Olympia WA 98504-0255	360-725-7000

**Is a school district fiscal impact statement required under [RCW 28A.305.135](#)?**  Yes  No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

Name  
Address  
Phone  
Fax  
TTY  
Email  
Other

**Is a cost-benefit analysis required under [RCW 34.05.328](#)?**

Yes: A preliminary cost-benefit analysis may be obtained by contacting:  
Name Simon Casson  
Address PO Box 40255, Olympia, WA 98504-0255  
Phone 360-725-7038  
Fax 360-586-3109  
TTY  
Email rulescoordinator@oic.wa.gov  
Other

No: Please explain:

**Regulatory Fairness Act and Small Business Economic Impact Statement**  
Note: The [Governor's Office for Regulatory Innovation and Assistance \(ORIA\)](#) provides support in completing this part.

**(1) Identification of exemptions:**  
This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see [chapter 19.85 RCW](#)). For additional information on exemptions, consult the [exemption guide published by ORIA](#). Please check the box for any applicable exemption(s):

This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.061](#) because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.  
Citation and description:

This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by [RCW 34.05.313](#) before filing the notice of this proposed rule.

This rule proposal, or portions of the proposal, is exempt under the provisions of [RCW 15.65.570\(2\)](#) because it was adopted by a referendum.

This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.025\(3\)](#). Check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> <a href="#">RCW 34.05.310</a> (4)(b)<br>(Internal government operations)        | <input checked="" type="checkbox"/> <a href="#">RCW 34.05.310</a> (4)(e)<br>(Dictated by statute)   |
| <input checked="" type="checkbox"/> <a href="#">RCW 34.05.310</a> (4)(c)<br>(Incorporation by reference) | <input type="checkbox"/> <a href="#">RCW 34.05.310</a> (4)(f)<br>(Set or adjust fees)   |
| <input type="checkbox"/> <a href="#">RCW 34.05.310</a> (4)(d)<br>(Correct or clarify language)           | <input type="checkbox"/> <a href="#">RCW 34.05.310</a> (4)(g)<br>(i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit) |

This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.025\(4\)](#). (Does not affect small businesses).

This rule proposal, or portions of the proposal, is exempt under RCW \_\_\_\_\_.

Explanation of how the above exemption(s) applies to the proposed rule:

Portions of the proposal are exempt from requirements of the Regulatory Fairness Act. The following table identifies rule sections or portions of rule sections that have been determined exempt based on the exemptions provided in RCW 34.05.310

**Table 1: SBEIS Exempt Sections**

WAC Section and Title	Description of Adopted Changes	Rationale for Exemption Determination
WAC 284-180-501 Pharmacy reimbursement.	Incorporating state statute without material change. This section directly aligns with RCW 48.200.310 without any material changes.	RCW 34.05.310(4)(c)

OIC determined that health carriers, HCBMs and pharmacies are impacted by the implementation of this rule. Based on 2024 Washington state Employment Security Department (ESD) Covered Employment data, health carriers are not considered small businesses, as they have on average 95 employees per firm (7,445 total employees in WA / 78 average number of firms in WA). A small business is defined as a business entity, including a sole proprietorship, corporation, partnership, or other legal entity, that is owned and operated independently from all other businesses, and that has fifty or fewer employees (RCW 19.85.020).

**(2) Scope of exemptions:** *Check one.*

- The rule proposal: Is fully exempt. (*Skip section 3.*) Exemptions identified above apply to all portions of the rule proposal.
- The rule proposal: Is partially exempt. (*Complete section 3.*) The exemptions identified above apply to portions of the rule proposal, but less than the entire rule proposal. Provide details here (consider using [this template from ORIA](#)): See Table 1 above.
- The rule proposal: Is not exempt. (*Complete section 3.*) No exemptions were identified above.

**(3) Small business economic impact statement:** *Complete this section if any portion is not exempt.*

If any portion of the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

- No Briefly summarize the agency's minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor costs.

***A brief description of the proposed rule including the current situation/rule, followed by the history of the issue and why the proposed rule is needed. A description of the probable compliance requirements and the kinds of professional services that a small business is likely to need in order to comply with the proposed rule.***

Engrossed Second Substitute Senate Bill (E2SSB) 5213 (Chapter 242, Laws of 2024) was signed into law on March 25, 2024. E2SSB 5213 amends state law (chapter 48.200 RCW) concerning the business practices of health care benefit managers (HCBMs) and pharmacy benefit managers (PBMs, which are a type of HCBM). The law's provisions address, among other issues, PBM reimbursement to pharmacies for dispensing prescription drugs; consumer access to mail order and retail pharmacies; consumer out-of-pocket costs for prescription drugs; HCBM registration and reporting; and oversight authority of the Office of the Insurance Commissioner (OIC) regarding HCBM registration and operations. Sections 1,2,3,4,6,10 and 11 of E2SSB 5213 took effect June 6, 2024. These sections are codified in RCW 48.200.020, 48.200.030, 48.200.050, 48.200.210, 48.200.300, and 41.05.017, respectively. Sections 5, 7,8, and 9 will take effect January 1, 2026. These sections are codified in RCW 48.200.280, 48.200.310, 48.200.320, and 48.200.330, respectively.

On December 18, 2024, the Commissioner adopted a rule (R 2024-02, WSR 25-02-024) implementing E2SSB 5213 and updating then-existing HCBM regulations. This rule amended chapter 284-180 Washington Administrative Code (WAC) and was effective January 18, 2025. To reflect E2SSB 5213's multiple effective dates, this rule amended certain WAC sections such that they expire December 31, 2025, and added new WAC sections that go into effect January 1, 2026.

Rulemaking regarding HCBMs is necessary to further implement the provisions of E2SSB 5213 that go into effect on January 1, 2026 and ensure that affected entities understand their rights and obligations under these new provisions. In addition, rulemaking to update other HCBM regulations outside the scope of E2SSB 5213 is necessary to ensure OIC can effectively oversee HCBMs. In this proposed rule (CR-102), OIC is revising Chapter 284-180 WAC to accomplish these goals. The OIC was unable to definitively determine whether HCBMs should be classified as large businesses (more than 50 employees). The OIC used the North American Industry Classification System (NAICS) code 524292, "Pharmacy benefit management and other third-party administration of insurance and pension funds," to estimate the number of employees per firm. However, this NAICS code includes entities in addition to HCBMs and PBMs, as it captures third-party administrators of insurance and pension funds; accordingly, the code could misrepresent the true average firm sizes of HCBMs and PBMs.

Additionally, the OIC reviewed evidence suggesting that a small number of large PBM firms dominate the PBM market in Washington state and nationally. The Washington state Health Care Authority's report *Drug Price Transparency Program Annual Report 2023*<sup>1</sup> found that "the top four PBMs in Washington account for approximately 99 percent of the total dollar value of prescription drug claims, with the top two accounting for 68% of statewide dollars." This report also found that the bottom 10 PBMs account for just 1 percent of Washington's PBM market. The Federal Trade Commission (FTC)'s 2024 report titled *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*<sup>2</sup> found that a few large, integrated firms dominate the pharmacy benefit management market in the United States. The FTC report stated: "Over the past two decades, the PBM industry has undergone substantial change as a result of horizontal consolidation and vertical integration. The top three PBMs processed nearly 80 percent of the approximately 6.6 billion prescriptions dispensed by U.S. pharmacies in 2023, while the top six PBMs processed more than 90 percent. All of the top six PBMs are vertically integrated downstream, operating their own mail order and specialty pharmacies, while one PBM owns and operates the largest chain of retail pharmacies in the nation. Pharmacies affiliated with the three largest PBMs now account for nearly 70 percent of all specialty drug revenue." OIC did not find evidence suggesting that the concentration of the PBM market in Washington state is substantially different than these national trends. Hence, OIC assumes that none of the small number of dominant PBM firms in Washington are small businesses.

There is evidence to suggest that, in addition to PBMs specifically, many HCBMs are part of large and vertically integrated businesses. As one example, the U.S. House of Representatives' Committee on Energy and Commerce found that Change Healthcare, a subsidiary of UnitedHealth Group that performs HCBM functions nationally and in Washington state, "acts as a clearing house for 15 billion medical claims each year – accounting for nearly 40 percent of all claims."<sup>3</sup>

Although these findings indicate that most of Washington state's HCBM and PBM market is made up of large businesses, OIC acknowledges that there may also be a subset of firms providing HCBM and PBM services who are small businesses. Because of this, the OIC assumed that HCBMs are classified as small businesses for purposes of this analysis.

OIC also considered the impact of this rule on small pharmacies. The NAIC's system classifies pharmacies as having an average of 38 employees under code 456110 – pharmacies and drug retailers. The proposed rule amends WAC 284-180-507 to clarify the effective date of the expanded appeals process for small pharmacies regarding reimbursements by PBMs. However, OIC concluded that this rule provision does not constitute a cost to small businesses. First, the small pharmacy appeals process is voluntary on the part of pharmacies. Second, the proposed rule amendment to WAC 284-180-507 does not constitute a new cost to small businesses by clarifying an effective date.

This analysis evaluates the cost of compliance and any potential impacts on revenue associated with the proposed rule. Impacts on small businesses are discussed in sections 4 and 5, and steps to reduce the impacts to small businesses are discussed in section 6.

Parts of this analysis refer to HCBMs while others reference PBMs. Under RCW 48.200.020, PBMs are considered a type of HCBM. All PBMs are therefore considered HCBMs, but not all HCBMs are considered PBMs. Chapter 48.200 RCW and E2SSB 5213 include provisions that apply to all HCBMs and provisions that only apply to pharmacy benefit managers.

***Identification and summary of which businesses are required to comply with the adopted rule using the North American Industry Classification System (NAICS).***

***SBEIS Table 2. Summary of Businesses Required to comply to the Adopted Rule***

<sup>1</sup>Washington State Health Care Authority, *Drug Price Transparency Annual Report* (Olympia, WA: Washington State Health Care Authority, 2023), <https://www.hca.wa.gov/assets/billers-and-providers/drug-price-transparency-annual-report-2023.pdf>.

<sup>2</sup>Federal Trade Commission, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, July 2024, <https://www.ftc.gov/reports/pharmacy-benefit-managers-report>.

<sup>3</sup>United States House of Representatives, Committee on Energy and Commerce, *What We Learned: Change Healthcare Cyber Attack*, May 2024, <https://energycommerce.house.gov/posts/what-we-learned-change-healthcare-cyber-attack>

NAICS Code	NAICS Business Description	Estimated number of firms in WA	Minor Cost Threshold
524292	Pharmacy Benefit Management and Other Third Party Administration of Insurance and Pension Funds	167	\$28,510.46
456110	Pharmacies and Drug Retailers	290	Redacted (unknown)
524114	Direct Health and Medical Insurance Carriers	78	\$298,214.06

The number of HCBMs in Washington is determined from the list of entities that have registered with the OIC. To conduct business in Washington, an HCBM must register with the Commissioner and annually renew the registration ([RCW 48.200.030](#)). HCBMs are a subset of the businesses included in the NAICS code 524292, which includes third party administration of insurance and pension funds.

**WAC 284-180-120 Applicability and scope.**

**Description:**

This amended section of the proposed rule clarifies which HCBMs Chapter 284-180 WAC applies to.

**Cost(s):**

There are no direct compliance costs imposed on the impacted entities from this amended section.

**WAC 284-180-130 Definitions.**

**Description:**

This amended section adds definitions for terms used in statute (RCW 48.200) and throughout chapter 284-180. Defined terms include “contract price,” “drug” or “prescription drug,” “local network pharmacy,” “other conditions,” “require or coerce,” and “unusable condition.”

**Cost(s):**

There are no direct compliance costs imposed on the impacted entities from this amended section. The added definitions ensure clarity throughout the chapter.

**WAC 284-180-210 Registration and renewal fees.**

**Description:**

This amended section of the proposed rule increases the initial registration fee for HCBMs from \$200 to \$500. It also increases the annual minimum renewal fee from \$500 to \$750. The renewal fees are set based on a proportional share of each HCBM’s Washington state annual gross income as reported to OIC. In the rule language, OIC proposes \$750 as the minimum annual renewal amount. RCW 48.200.030 requires OIC to set each registration fee “in an amount that ensures the registration, renewal, and oversight activities are self-supporting.” These fee increases are necessary to ensure OIC’s HCBM-related registration, renewal, and oversight activities are appropriately funded as the statute requires.

**Cost(s):**

The increased registration and renewal fees for HCBMs represent the direct compliance costs associated with this section. Under the proposed rule, each HCBM must pay an additional \$300 to initially register, and an additional \$250, at a minimum, to renew their registration annually.

In addition to the fixed dollar registration and minimum renewal fees, OIC collects a proportion of each HCBM’s annual gross income as part of the renewal fee structure. OIC has designed this fee structure to be progressive ensuring that smaller HCBMs operating in Washington are not disproportionately impacted by the fees. For example, under this structure, a small HCBM in Washington state may only be responsible for the initial registration and minimum renewal fees, whereas a large HCBM with substantial gross income in Washington state will fund a larger share of the fees. For this analysis, the OIC uses the minimum registration and renewal fees to determine the cost to HCBMs. The calculation of the renewal fee based on the HCBM’s gross income is not set in rule.

For cost calculations, the OIC determined the average annual cost for registered HCBMs using the minimum renewal rate and the registration rate. The combined annual cost, including both the registration and renewal fee, is calculated based on how many HCBMs were new registrants compared to how many existing HCBMs renewed in 2024. In 2024, approximately 17% of registered HCBMs were new registrants.

*Table 3: Cost calculations of proposed rule for registration and renewal increases*

Rule version	Initial registration cost per HCBM	Annual minimum renewal cost per HCBM	Combined annual cost per HCBM
Current rule	\$200	\$500	\$449
Proposed rule	\$500	\$750	\$707.50

<b>Cost change</b>	\$300	\$250	<b>\$258.50</b>
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The combined average cost using the minimum renewal amount is \$258.50 per HCBM.

**WAC 284-180-220 Health care benefit manager registration.**

**Description:**

This section of the proposed rule references the updated registration fee of \$500 (which was explained in the previous section relating to WAC 284-180-210). Amendments to this section also clarify which HCBMs must register with the OIC. Specifically, the proposed rule clarifies that HCBMs that provide services to a self-funded group health plan (SFGHP) and also provide services to a health carrier or employee benefits program must register. Similar requirements apply specifically to PBMs. This amended language is clarifying in nature and does not change the underlying requirement of who is required to register. To the extent that HCBMs and PBMs have been interpreting this section to exempt them from registration, this clarification may result in additional HCBMs registering with OIC.

**Cost(s):**

There is no direct cost associated with this section of the proposed rule, as it does not change the underlying requirement but merely clarifies which entities must register with the OIC. However, depending on how the current rule has been interpreted, there may be an average annual cost of \$707.50 (the combined annual cost per HCBM under the proposed rule calculated in the previous section). This cost is not explicitly captured in this analysis, as it is considered to be a clarification of the existing requirement.

**WAC 284-180-465 Self-funded group health plan opt-in.**

**Description:**

This amended section clarifies the requirements for a PBM providing services to or acting on behalf of a self-funded group health plan that elects to participate (“opting in.”) This opt-in is not required. New subsection 5 describes the PBM’s obligations in the case of a self-funded group health plan opting into RCW 48.200.280, 48.200.310, and 48.200.320.

**Cost(s):**

There are no direct compliance costs imposed on impacted entities from this amended section. Participation in the opt-in is voluntary.

**WAC 284-180-517 Use of brief adjudicative proceedings for appeals by network pharmacies to the commissioner.**

**Description:**

This section amends subsection 1 to include “drugs” in addition to “multisource generic drugs” regarding the appeals process for drugs subject to predetermined reimbursement costs.

**Cost(s):**

There are no substantive direct compliance costs imposed on impacted entities from this amended section. This change implements a clear statutory requirement.

**WAC 284-180-522 Appeals by network pharmacies to the commissioner.**

**Description:**

This amended section requires a network pharmacy to include an email address as a part of the petition for an appeal. The petition already requires the basis for the appeal, the network pharmacy’s business address, mailing address, documents supporting the appeal, and any additional information the commissioner may require.

**Cost(s):**

This amended section does include an additional requirement for network pharmacies to include an email address as a part of their petition for an appeal. However, the OIC has determined there is no associated cost with providing this information. The inclusion of the email address will ensure that the submitting network pharmacy can be easily contacted regarding their petition.

**WAC 284-180-550 Enrollee rights and pharmacy benefit manager obligations – Mail order and retail pharmacies.**

**Description:**

This new section of the proposed rule defines terms relevant to the section, aligns existing regulations with statutory requirements, and clarifies terms, requirements and processes clearly directed in statute. Subsections 1 and 2 define the terms “issued” and “new prescription.” Subsection 3 aligns with RCW 48.200.310(2)(b) and clarifies the meaning of “primarily

engaged.” Subsection 4 aligns with RCW 48.200.310(2)(c) and clarifies the process and requirements for the affirmative authorization required in statute. Subsection 5 aligns with RCW 48.200.310(3). This subsection also clarifies the meaning of the term “easily and timely access” regarding pharmacy counseling, which is a statutory requirement.

**Cost(s):**

There may be a minor cost associated with the creation of an affirmative authorization form by the PBM for enrollees to access mail-order prescriptions. Because this authorization may be in an electronic or non-written form, the OIC assumes a minimal associated compliance cost.

The OIC makes the following assumptions for PBMs to create an affirmative authorization form for enrollees:

- If authorization is written, it takes an office support staff member 1 hour to format and edit the form. It takes a legal professional 2 hours to draft and revise the form. It takes an IT staff member 3 hours to create the electronic form.
- The labor rate for a secretary is \$67.82 per hour. The labor rate for a lawyer is \$169.28. The labor rate for a computer programmer is \$134.95.
- Estimated one-time cost = (1 x \$67.82) + (2 x \$169.28) + (3 x \$134.95) = **\$811.23**

**Summary of all Cost(s):**

WAC Section and Title	Probable Cost (or Cost Range)
284-180-210 Registration and renewal fees.	\$258.50
284-180-550 Enrollee rights and pharmacy benefit manager obligations.	\$811.23
<b>Total Cost:</b>	<b>\$1,096.73</b>

The above summary details the quantifiable costs associated with this proposed rule.

***Analysis on if the proposed rule may impose more than minor costs for businesses in the industry. Includes a summary of how the costs were calculated.***

The estimated impacts of the proposed rule on identified small businesses are determined to not impose more than minor costs. The table below shows the identified small businesses by their NAICS codes, their associated minor cost thresholds, and the estimated cost of the proposed rule.

Industry NAICS code	NAICS code title	Number of firms in WA	Avg employees per firm in WA	Minor cost threshold	Estimated cost of rule
524292	Pharmacy Benefit Management and Other Third Party Administration of Insurance and Pension Funds	167	32	\$28,510.46	\$1,096.73
456110	Pharmacies and drug retailers	290	34	NA	\$0

**Additional steps OIC has taken to lessen impacts**

Several steps were taken during the rulemaking process to reduce costs to comply with the proposed rule:

- In the [prepublication draft](#), OIC proposed raising the minimum renewal fee from \$500 to \$1,000. In the proposed rule, OIC proposes raising the minimum renewal fee to \$750, representing a lower fee increase. This change reduces the potential small business cost.
- In the [prepublication draft](#), OIC proposed requiring PBMs to ensure that patients have easy and timely access to prescription drug counseling by a pharmacist that includes in-person, video or telephonic assistance in real time that is available from 9 am-5 pm pacific time every day, including weekends and holidays. In the proposed rule, OIC removed the requirement for holidays and the requirement that pharmacy counseling be available in-person, through video, or telephonically in real time. This change could reduce the potential compliance cost for small PBMs.

Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses and a small business economic impact statement is required. Insert the required small business economic impact statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name Rules Coordinator  
Address PO Box 40255, Olympia, WA 98504-0255  
Phone 360-725-7171  
Fax 360-586-3109  
TTY  
Email rulescoordinator@oic.wa.gov  
Other

<b>Date:</b> November 4, 2025	<b>Signature:</b> 
<b>Name:</b> Patty Kuderer	
<b>Title:</b> Insurance Commissioner	

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-120 Applicability and scope.** (1) This chapter applies to:

(a) Health care benefit managers as defined in RCW 48.200.020, and health carriers who contract with health care benefit managers; and

(b) Pharmacy benefit managers who contract with pharmacies on behalf of health carriers, medicaid managed care organizations, and employee benefits programs as defined in RCW 48.200.020.

(2) Effective January 1, 2026, RCW 48.200.280, 48.200.310, and 48.200.320 and WAC 284-180-500, 284-180-507, 284-180-517, and 284-180-522 apply to self-funded group health plans that have elected to participate under RCW 48.200.330.

(3) This chapter does not apply to (~~the actions of~~) health care benefit managers providing services exclusively to, or acting exclusively on behalf of (~~medicare supplement or medicare advantage plans~~):

(a) Self-funded group health plans, other than an employee benefit program as defined in RCW 48.200.020 or with respect to compliance with RCW 48.200.280, 48.200.310, and 48.200.320, a self-funded group health plan that has elected to participate under RCW 48.200.330;

(b) Medicare supplement plans;

(c) Medicare advantage plans;

(d) Medicare Part D prescription drug plans;

(e) Medicaid, except that pharmacy benefit managers that contract with pharmacies on behalf of medicaid managed care plans are subject to chapter 48.200 RCW and this chapter;

(f) Children's health insurance program plans;

(g) Discount plans;

(h) Union plans, other than a union plan that is a self-funded group health plan that has elected to participate under RCW 48.43.330 with respect to compliance with RCW 48.200.280, 48.200.310, and 48.200.320; and

(i) Plans that provide monetary payment, such as income replacement disability plans or life insurance accelerated benefits, unless these plans provide coverage for health care services, drugs, or supplies.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-130 Definitions.** Except as defined in other sub-chapters and unless the context requires otherwise, the following definitions apply throughout this chapter:

(1) "Affiliate" or "affiliated employer" has the same meaning as the definition of affiliate or affiliated employer in RCW 48.200.020.

(2) "Annual gross income" means the sum of all amounts paid during a calendar year by any entities with which a health care benefit manager has contracted for the provision of health care benefit management services in Washington state.

(3) "Certification" has the same meaning as the definition of certification in RCW 48.43.005.

(4) "Contract price" means the price a pharmacy benefit manager charges a carrier, insurer, third-party payor, or prescription drug purchasing consortium for a drug, pursuant to a contract between the pharmacy benefit manager and the carrier, insurer, third-party payor, or prescription drug consortium. "Contract price" does not include a pharmacy's dispensing fee.

(5) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, such as through ownership of voting securities, membership rights, or by contract.

~~((5))~~ (6) "Corporate umbrella" means an arrangement consisting of, but not limited to, subsidiaries and affiliates operating under common ownership or control.

~~((6))~~ (7) "Covered person" has the same meaning as in RCW 48.43.005.

~~((7))~~ (8) As used in RCW 48.200.020 and 48.200.280, "credentialing" means the collection, verification, and assessment of whether a health care provider meets relevant licensing, education, and training requirements.

~~((8))~~ (9) "Drug" has the same meaning as in RCW 18.64.011(15).

(10) "Employee benefits programs" has the same meaning as the definition of employee benefits program in RCW 48.200.020.

~~((9))~~ (11) "Generally available for purchase" means available for purchase by multiple pharmacies within the state of Washington from national or regional wholesalers.

~~((10))~~ (12) "Health care benefit manager" has the same meaning as the definition of health care benefit manager in RCW 48.200.020.

~~((11))~~ (13) "Health care provider" or "provider" has the same meaning as the definition of health care provider in RCW 48.43.005.

~~((12))~~ (14) "Health care services" has the same meaning as the definition of health care services in RCW 48.43.005.

~~((13))~~ (15) "Health carrier" or "carrier" has the same meaning as the definition of health carrier in RCW 48.43.005.

~~((14))~~ (16) "Laboratory benefit manager" has the same meaning as the definition of laboratory benefit manager in RCW 48.43.020.

~~((15))~~ (17) Effective January 1, 2026, "list" has the same meaning as the definition of list in RCW 48.200.280, as amended by section 5, chapter 242, Laws of 2024.

~~((16))~~ (18) "Local network pharmacy" means a network pharmacy with a physical retail location that is within a reasonable proximity of the enrollee's business or residence. "Local network pharmacy" does not include mail order pharmacies owned by or affiliated with a pharmacy benefit manager.

(19) "Mail order pharmacy" has the same meaning as the definition of mail order pharmacy in RCW 48.200.020.

~~((17))~~ (20) "Mental health benefit manager" has the same meaning as the definition of mental health benefit manager in RCW 48.200.020.

~~((18))~~ (21) Effective January 1, 2026, "multiple source drug" has the same meaning as the definition of multiple source drug in RCW 48.200.280, as amended by section 5, chapter 242, Laws of 2024.

~~((19))~~ (22) "Net amount" means the invoice price that the pharmacy paid to the supplier for a prescription drug that it dispensed, plus any taxes, fees or other costs, minus the amount of all discounts and other cost reductions attributable to the drug.

~~((20))~~ (23) "Network" has the same meaning as the definition of network in RCW 48.200.020.

~~((21))~~ (24) "Network pharmacy" has the same meaning as the definition of network pharmacy in RCW 48.200.280.

~~((22))~~ (25) As used in RCW 48.200.310, "other conditions" means conditions a pharmacy benefit manager applies to a covered person that directly affect the covered person's access to and convenience of receiving a covered prescription drug. "Other conditions" include, but are not limited to, the frequency at which an enrollee may receive a prescription refill and the duration of the refill, restrictions on the type of provider that must order the prescription, and restrictions on a network pharmacy's preparation or dispensing of a medication other than those established by the Washington state board of pharmacy.

(26) "Oversight activities" includes all work done by the commissioner to ensure that the requirements of chapter 48.200 RCW are properly followed and in fulfilling its duties as required under chapter 48.200 RCW.

~~((23))~~ (27) "Person" has the same meaning as the definition of person in RCW 48.200.020.

~~((24))~~ (28) "Pharmacy benefit manager" has the same meaning as the definition of pharmacy benefit manager in RCW 48.200.020.

~~((25))~~ (29) "Pharmacy network" has the same meaning as the definition of pharmacy network in RCW 48.200.020.

~~((26))~~ (30) "Predetermined reimbursement cost" means maximum allowable cost, maximum allowable cost list, or any other benchmark price utilized by the pharmacy benefit manager, including the basis of the methodology and sources utilized to determine drug or multisource generic drug reimbursement amounts. However, dispensing fees are not included in the calculation of predetermined reimbursement costs for drugs or multisource generic drugs.

~~((27))~~ (31) "Radiology benefit manager" has the same meaning as the definition of radiology benefit manager in RCW 48.200.020.

~~((28))~~ (32) "Readily available for purchase" means manufactured supply is held in stock and available for order by more than one pharmacy in Washington state when such pharmacies are not under the same corporate umbrella.

~~((29))~~ (33) As used in RCW 48.200.310, "require or coerce" means an action by a pharmacy benefit manager, their representative, or an entity under contract with a pharmacy benefit manager, to compel or force an enrollee to use only a pharmacy benefit managers' owned or affiliated pharmacy when a network pharmacy that is not owned by or affiliated with a pharmacy benefit manager is also available to the covered person.

(34) (a) Through December 31, 2025, "retaliate" means action, or the implied or stated threat of action, to decrease reimbursement or to terminate, suspend, cancel or limit a pharmacy's participation in a pharmacy benefit manager's provider network solely or in part because the pharmacy has filed or intends to file an appeal under RCW 48.200.280.

(b) Effective January 1, 2026, "retaliate" means action, or the implied or stated threat of action, to cancel, restrict, or refuse to renew or offer a contract to a pharmacy, to decrease reimbursement or to terminate, suspend, cancel or limit a pharmacy's participation in a pharmacy benefit manager's provider network solely or in part because the pharmacy has:

(i) Filed or intends to file an appeal under RCW 48.200.280;

(ii) Disclosed information in a court, in an administrative hearing, or legislative hearing, if the pharmacist or pharmacy has a good faith belief that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation; or

(iii) Disclosed information to a government or law enforcement agency, if the pharmacist or pharmacy has a good faith belief that the disclosed information is evidence of a violation of a state or federal law, rule, or regulation.

~~((30))~~ (35) "Union plan" means an employee welfare benefit plan governed by the provisions of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.) in which an employee organization participates and that exists for the purpose, in whole or in part, of dealing with employers concerning an employee welfare benefit plan.

~~((31))~~ (36) "Unsatisfied" means that the network pharmacy did not receive the reimbursement that it requested at the first tier appeal.

~~((32))~~ (37) As used in RCW 48.200.310, "unusable condition" means a condition in which a prescription drug arrives to an enrollee in a manner that renders the prescription drug ineffective or unsafe for the enrollee to use as prescribed. "Unusable condition" includes, but is not limited to, prescription drugs that are:

(a) Above or below the temperature required for safe and effective use;

(b) Open, tampered with, or showing physical damage; or

(c) Incompatible with electronic or other devices that must be paired with the prescription drug for its effective and safe use, resulting in the prescription drug being unusable.

(38) "Utilization review" has the same meaning as the definition of utilization review in RCW 48.43.005.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-210 Registration and renewal fees.** (1) The commissioner must establish fees for registration and renewal in an amount that ensures the program for the registration, renewal, and oversight activities of the health care benefit managers is self-supporting. Each health care benefit manager must contribute a sufficient amount to the commissioner's regulatory account to pay for the reasonable costs, including overhead, of regulating health care benefit managers.

(2) The initial registration fee is \$~~((200))~~ 500.

(3) For the renewal fee, the commissioner will charge a proportional share of the annual cost of the insurance commissioner's renewal and oversight activities of health care benefit managers. Each health care benefit managers' proportional share of the program annual operating costs will be based on their Washington state annual gross income of their health care benefit manager business for the previous calendar year. The renewal fee is \$~~((500))~~ 750, at a minimum, and may increase based on a proportional share of each health care benefit manager's Washington state annual gross income as reported to the insurance commissioner.

(4) If an unexpended balance of health care benefit manager registration and renewal funds remain in the insurance commissioner's

regulatory account at the close of a fiscal year, the commissioner will carry the unexpended funds forward and use them to reduce future renewal fees.

(5) Carriers are exempt from the definition of health care benefit manager under RCW 48.200.020.

(a) An entity that is owned or controlled by a holding company that owns or controls a carrier is not exempt from registration as a health care benefit manager.

(b) Under RCW 48.200.050, when a carrier, i.e., "carrier A," acts as a health care benefit manager for another carrier, i.e., "carrier B," carrier B is responsible for the conduct of carrier A with respect to its action as a health care benefit manager on carrier B's behalf.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-220 Health care benefit manager registration.** (1) Beginning January 1, 2022, and thereafter, to conduct business in this state, health care benefit managers must have an approved registration with the commissioner as required in RCW 48.200.030 and 48.200.300. The registration application is not complete until the commissioner receives the complete registration form, any supporting documentation required by the commissioner, and the ~~\$(200)~~ 500 registration fee.

(2) Health care benefit managers must apply for registration using the commissioner's electronic system, which is available at [www.insurance.wa.gov](http://www.insurance.wa.gov).

(3) The registration period is valid from the date of approval of registration through June 30th of the same fiscal year.

(4) A health care benefit manager that provides services to, or acts on behalf of, a self-funded group health plan and also provides services to, or acts on behalf of, a health carrier or employee benefits program must register under this section.

(5) A pharmacy benefit manager that contracts with pharmacies or contracts to provide any pharmacy benefit management services on behalf of a self-funded group health plan and also contracts with pharmacies or contracts to provide any pharmacy benefit management services on behalf of health carriers, employee benefits programs, or medicaid managed care programs must register under this section.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-465 Self-funded group health plan opt-in.** (1)(a) A self-funded group health plan governed by the provisions of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.) that elects under RCW 48.200.330 to participate in RCW 48.200.280, 48.200.310, and 48.200.320 shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. Election decisions are effective beginning January 1, 2026. The completed form must include an attestation that the self-funded group health plan has elected to participate in and be bound by

RCW 48.200.280, 48.200.310, and 48.200.320 and rules adopted to implement those sections of law. If the form is completed by the self-funded group health plan, the plan must inform any entity that administers the plan of their election to participate. The form will be posted on the commissioner's public website for use by self-funded group health plans.

(b) A pharmacy benefit manager may not, by contract or otherwise, prohibit a self-funded group health plan from electing to participate under RCW 48.200.330.

(2) A self-funded group health plan election to participate is for a full year. The plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

(3) A self-funded group health plan's election occurs on an annual basis. On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the commissioner receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least 15 days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

(4) A self-funded plan operated by an out-of-state employer that has at least one employee who resides in Washington state may elect to participate in pharmacy benefit manager regulation as provided in RCW 48.200.330 on behalf of their Washington state resident employees and dependents. If a self-funded group health plan established by a Washington state employer has elected under RCW 48.200.330 to participate in RCW 48.200.280, 48.200.310, and 48.200.320 and has employees that reside in other states, those employees are protected by RCW 48.200.330 in RCW 48.200.280, 48.200.310, and 48.200.320 when filling a prescription ordered by a provider in Washington state or at a pharmacy located in Washington state.

(5) A pharmacy benefit manager providing services to or acting on behalf of a self-funded group health plan that elects to participate under this section must comply with RCW 48.200.280, 48.200.310, and 48.200.320 related to the pharmacy benefit manager's conduct specific to the participating self-funded group health plan. The pharmacy benefit manager is not subject to other provisions of chapter 48.200 RCW for its conduct specific to the participating self-funded group health plan. This subsection does not relieve a pharmacy benefit manager of its duty to register under chapter 48.200 RCW or this chapter if, in addition to providing services to or acting on behalf of an opted-in self-funded group health plan, the pharmacy benefit manager provides pharmacy benefit management services to or acts on behalf of a carrier, employee benefits program, or medicaid managed care organization.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-501 Pharmacy reimbursement.** (1) A pharmacy benefit manager may not reimburse a pharmacy in the state an amount less than the amount the pharmacy benefit manager reimburses an affiliate for

dispensing the same prescription drug as dispensed by the pharmacy, calculated on a per unit basis.

(2) A pharmacy benefit manager may not reimburse a network pharmacy an amount less than the contract price between the pharmacy benefit manager and the carrier, insurer, third-party payor, or prescription drug purchasing consortium the pharmacy benefit manager has contracted with for a drug. For purposes of this subsection, the pharmacy benefit manager's reimbursement amount to a network pharmacy includes any post-sale or post-invoice adjustments the pharmacy benefit manager makes that affect the price paid for a drug including, but not limited to, fees, discounts, reconciliations, or assessments.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-507 Appeals by network pharmacies to health care benefit managers who provide pharmacy benefit management services.**

(1)(a) For claims adjudicated on or after January 1, 2026, a network pharmacy, or its representative, may appeal the reimbursement amount for a drug to a health care benefit manager providing pharmacy benefit management services (first tier appeal) if the reimbursement amount for the drug is less than the net amount the network pharmacy paid to the supplier of the drug and the claim was adjudicated within the past 90 days.

(b) If a pharmacy is represented by a pharmacy services administrative organization, or other entity, the contract between the pharmacy benefit manager and the pharmacy must allow the pharmacy services administrative organization or other entity to use the appeal process included in the contract between the pharmacy benefit manager and the pharmacy. The pharmacy benefit manager must meet all statutory, regulatory, and contractual requirements when reviewing an appeal submitted by a representative on behalf of a pharmacy.

(c) A pharmacy services administrative organization may submit an appeal to a pharmacy benefit manager on behalf of multiple pharmacies if:

(i) The claims that are the subject of the appeal are for the same prescription drug; and

(ii) The pharmacies on whose behalf the claims are submitted are members of the pharmacy services administrative organization; and

(iii) The pharmacy benefit manager has contracts with the pharmacies on whose behalf the pharmacy services administrative organization is submitting the claims.

(2) Before a pharmacy files an appeal pursuant to this section, upon request by a pharmacy or pharmacist, a pharmacy benefit manager must provide, within four business days of receiving the request, a current and accurate list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans and for self-funded group health plans that have elected under RCW 48.200.330 to participate in RCW 48.200.280, 48.200.310, and 48.200.320 with which the pharmacy benefit manager either has a current contract or had a contract that has been terminated within the past 12 months to provide pharmacy benefit management services.

(3) A pharmacy benefit manager must process the network pharmacy's appeal as follows:

A pharmacy benefit manager must include language in the pharmacy provider contract and on the pharmacy benefit manager's website fully describing the right to appeal under RCW 48.200.280. If the health care benefit manager provides other health care benefit management services in addition to pharmacy benefit management services, this information must be under an easily located page that is specific to pharmacy services. The description must include, but is not limited to:

(a) Contact information, including:

(i) A telephone number by which the pharmacy may contact the pharmacy benefit manager between 9 a.m. and 5 p.m. Pacific Time Zone Monday through Friday, except national holidays, and speak with an individual responsible for processing appeals;

(ii) A fax number that a network pharmacy can use to submit information regarding an appeal; and

(iii) An email address or a link to a secure online portal that a network pharmacy can use to submit information regarding an appeal. If the pharmacy benefit manager chooses to use a link to a secure online portal to satisfy the requirement of this subsection, the contract must include explicit and clear instructions as to how a pharmacy can gain access to the portal. Submission by a pharmacy of an appeal that includes the claim adjudication date or dates consistent with subsection (1) of this section and documentation or information described in subsection (4) of this section, or of a request for information regarding an appeal, to the email address or secure online portal included in the contract under this subsection must be accepted by the pharmacy benefit manager as a valid submission.

(b) A detailed description of the actions that a network pharmacy must take to file an appeal; and

(c) A detailed summary of each step in the pharmacy benefit manager's appeals process.

(4) The pharmacy benefit manager must reconsider the reimbursement amount. A pharmacy benefit manager's review process must provide the network pharmacy or its representatives with an opportunity to submit information to the pharmacy benefit manager including, but not limited to, documents or written comments. Documents or information that may be submitted by a network pharmacy or their representative to show that the reimbursement amount paid by a pharmacy benefit manager is less than the net amount that the network pharmacy paid to the supplier of the drug include, but are not limited to:

(a) An image of information from the network pharmacy's wholesale ordering system;

(b) Other documentation showing the amount paid by the network pharmacy; or

(c) An attestation by the network pharmacy that:

(i) The reimbursement amount paid by a pharmacy benefit manager is less than the net amount that the network pharmacy paid to the supplier of the drug; and

(ii) Describes the due diligence the network pharmacy undertook to procure the drug at the most favorable amount for the pharmacy, taking into consideration whether the pharmacy has fewer than 15 retail outlets within the state of Washington under its corporate umbrella and whether the network pharmacy's contract with a wholesaler or secondary supplier restricts disclosure of the amount paid to the wholesaler or secondary supplier for the drug.

(5) The pharmacy benefit manager must review and investigate the reimbursement and consider all information submitted by the network pharmacy or its representatives prior to issuing a decision.

(6) The pharmacy benefit manager must complete the appeal within 30 calendar days from the time the network pharmacy submits the appeal. If the network pharmacy does not receive the pharmacy benefit manager's decision within that time frame, then the appeal is deemed denied.

(7) The pharmacy benefit manager must uphold the appeal of a network pharmacy with fewer than 15 retail outlets within the state of Washington, under its corporate umbrella, if the pharmacy demonstrates that they are unable to purchase therapeutically equivalent interchangeable product from a supplier doing business in the state of Washington at the pharmacy benefit manager's list price. "Therapeutically equivalent" is defined in RCW 69.41.110.

(8) (a) If the pharmacy benefit manager denies the network pharmacy's appeal, the pharmacy benefit manager must provide the network pharmacy with a reason for the denial, the national drug code, and price of a drug that has been purchased by other network pharmacies located in the state of Washington at a price less than or equal to the reimbursement cost for the drug and the name of at least one wholesaler or supplier from which the drug was available for purchase at that price on the date of the claim or claims that are subject of the appeal.

(b) If the pharmacy benefit manager bases its denial on the fact that one or more of the claims that are the subject of the appeal is not subject to RCW 48.200.280 and this chapter, it must provide documentation clearly indicating that the plan to which the claim relates is a self-funded group health plan that has not opted in under RCW 48.200.330, is a medicare plan, or is otherwise not subject to RCW 48.200.280 and this chapter.

(9) If the pharmacy benefit manager upholds the network pharmacy's appeal, the pharmacy benefit manager must make a reasonable adjustment no later than one day after the date of the determination. The commissioner will presume that a reasonable adjustment applied prospectively for a period of at least 90 days from the date of an upheld appeal is not a knowing or willful violation of chapter 48.200 RCW under RCW 48.200.290. If a therapeutically equivalent interchangeable product becomes available during the period that a reasonable adjustment is in effect, the adjustment may reflect the cost of that product from the date it becomes available to the end of the prospective reasonable adjustment period. If the request for an adjustment is from a critical access pharmacy, as defined by the state health care authority by rule for purpose related to the prescription drug purchasing consortium established under RCW 70.14.060, any such adjustment shall apply only to such pharmacies.

(10) If otherwise qualified, the following may file an appeal with a pharmacy benefit manager:

(a) Persons who are natural persons representing themselves;

(b) Attorneys at law duly qualified and entitled to practice in the courts of the state of Washington;

(c) Attorneys at law entitled to practice before the highest court of record of any other state, if attorneys licensed in Washington are permitted to appear before the courts of such other state in a representative capacity, and if not otherwise prohibited by state law;

(d) Public officials in their official capacity;

(e) A duly authorized director, officer, or full-time employee of an individual firm, association, partnership, or corporation who appears for such firm, association, partnership, or corporation;

(f) Partners, joint venturers or trustees representing their respective partnerships, joint ventures, or trusts; and

(g) Other persons designated by a person to whom the proceedings apply.

(11) A pharmacy benefit manager's response to an appeal submitted by a Washington small pharmacy that is denied, partially reimbursed, or untimely must include written documentation or notice to identify the exact corporate entity that received and processed the appeal. Such information must include, but is not limited to, the corporate entity's full and complete name, taxpayer identification number, and number assigned by the office of the insurance commissioner.

(12) Health care benefit managers providing pharmacy benefit management services must identify a pharmacy benefit manager employee who is the single point of contact for appeals, and must include the address, phone number, name of the contact person, and valid email address. This includes completing and submitting the form that the commissioner makes available for this purpose at [www.insurance.wa.gov](http://www.insurance.wa.gov).

(13) This section is effective January 1, 2026.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-517 Use of brief adjudicative proceedings for appeals by network pharmacies to the commissioner.** (1) The commissioner has adopted the procedure for brief adjudicative proceedings provided in RCW 34.05.482 through 34.05.494 for actions involving a network pharmacy's appeal of a pharmacy benefit manager's reimbursement for a drug subject to predetermined reimbursement costs for multisource generic drugs or drugs (reimbursement). WAC 284-180-500 through 284-180-540 describe the procedures for how the commissioner processes a network pharmacy's appeal (second tier appeal) of the pharmacy benefit manager's decision in the first tier appeal through a brief adjudicative proceeding.

This rule does not apply to adjudicative proceedings under WAC 284-02-070, including converted brief adjudicative proceedings.

(2) This section is effective January 1, 2026.

AMENDATORY SECTION (Amending WSR 25-02-024, filed 12/18/24, effective 1/18/25)

**WAC 284-180-522 Appeals by network pharmacies to the commissioner.** The following procedure applies to brief adjudicative proceedings before the commissioner for actions involving a network pharmacy's appeal of a pharmacy benefit manager's decision in a first tier appeal regarding reimbursement for a drug, unless the matter is converted to a formal proceeding as provided in WAC 284-180-540(3).

(1) **Grounds for appeal.** A network pharmacy or its representative may appeal a pharmacy benefit manager's decision to the commissioner if it meets all the following requirements:

(a) The pharmacy benefit manager's decision must have denied the network pharmacy's appeal, or the network pharmacy must be unsatisfied with the outcome of its appeal to the pharmacy benefit manager;

(b) The network pharmacy must request review of the pharmacy benefit manager's decision by submitting a petition at <https://www.insurance.wa.gov> according to the filing instructions.

The petition for review must include:

(i) The network pharmacy's basis for appealing the pharmacy benefit manager's decision in the first tier appeal;

(ii) The network pharmacy's business address (~~and~~), mailing address, and email address; and

(iii) Documents supporting the appeal;

(c) Documents supporting the appeal include:

(i) The documents from the first tier review, including the documents that the pharmacy submitted to the pharmacy benefit manager as well as the documents that the pharmacy benefit manager provided to the pharmacy in response to the first tier review, if any (if the pharmacy benefit manager has not issued a decision on the first tier appeal in a timely manner, a signed attestation to that fact must be submitted by the appealing pharmacy);

(ii) Documentation evidencing the net amount paid for the drug by the small pharmacy;

(iii) If the first-tier appeal was denied by the pharmacy benefit manager because a therapeutically equivalent drug was available in the state of Washington at a price less than or equal to the reimbursement cost for the drug and documentation provided by the pharmacy benefit manager evidencing the national drug code of the therapeutically equivalent drug; and

(iv) Any additional information that the commissioner may require;

(d) The network pharmacy must file the petition for review with the commissioner within 30 days of receipt of the pharmacy benefit manager's decision or within 30 days after the deadline for the pharmacy benefit manager's deadline for responding to the first tier appeal;

(e) The network pharmacy making the appeal must have less than 15 retail outlets within the state of Washington under its corporate umbrella. The petition for review that the network pharmacy submits to the commissioner must include a signed attestation that this requirement is satisfied; and

(f) Electronic signatures and electronic records may be used to facilitate electronic transactions consistent with the Uniform Electronic Transactions Act chapter 1.80 RCW.

(2) **Time frames governing appeals to the commissioner.** The commissioner must complete the appeal within 30 calendar days of the receipt of the network pharmacy's complete petition for review. A complete petition for review means that all requirements under subsection (1) of this section have been satisfied, including the submission of all required documents and documentation. An appeal before the commissioner is deemed complete when a presiding officer issues an initial order on behalf of the commissioner to both the network pharmacy and pharmacy benefit manager under subsection (8) of this section. Within seven calendar days of the resolution of a dispute, the presiding of-

ficer shall provide a copy of the initial order to both the network pharmacy and pharmacy benefit manager.

(3) **Relief the commissioner may provide.** The commissioner, by and through a presiding officer or reviewing officer, may enter an order directing the pharmacy benefit manager to make an adjustment to the disputed claim, denying the network pharmacy's appeal, issuing civil penalties pursuant to RCW 48.200.290, or taking other actions deemed fair and equitable.

(4) **Notice.** If the presiding officer under the use of discretion chooses to conduct an oral hearing, the presiding officer will set the time and place of the hearing. Written notice shall be served upon both the network pharmacy and pharmacy benefit manager at least seven days before the date of the hearing. Service is to be made pursuant to WAC 284-180-440(2). The notice must include:

(a) The names and addresses of each party to whom the proceedings apply and, if known, the names and addresses of any representatives of such parties;

(b) The official file or other reference number and name of the proceeding, if applicable;

(c) The name, official title, mailing address, and telephone number of the presiding officer, if known;

(d) A statement of the time, place, and nature of the proceeding;

(e) A statement of the legal authority and jurisdiction under which the hearing is to be held;

(f) A reference to the particular sections of the statutes or rules involved;

(g) A short and plain statement of the matters asserted by the network pharmacy against the pharmacy benefit manager and the potential action to be taken; and

(h) A statement that if either party fails to attend or participate in a hearing, the hearing can proceed and the presiding or reviewing officer may take adverse action against that party.

(5) **Appearance and practice at a brief adjudicative proceeding.** The right to practice before the commissioner in a brief adjudicative proceeding is limited to:

(a) Persons who are natural persons representing themselves;

(b) Attorneys at law duly qualified and entitled to practice in the courts of the state of Washington;

(c) Attorneys at law entitled to practice before the highest court of record of any other state, if attorneys licensed in Washington are permitted to appear before the courts of such other state in a representative capacity, and if not otherwise prohibited by state law;

(d) Public officials in their official capacity;

(e) A duly authorized director, officer, or full-time employee of an individual firm, association, partnership, or corporation who appears for such firm, association, partnership, or corporation;

(f) Partners, joint venturers or trustees representing their respective partnerships, joint ventures, or trusts; and

(g) Other persons designated by a person to whom the proceedings apply with the approval of the presiding officer.

In the event a proceeding is converted from a brief adjudicative proceeding to a formal proceeding, representation is limited to the provisions of law and RCW 34.05.428.

(6) **Method of response.** Upon receipt of any inquiry from the commissioner concerning a network pharmacy's appeal of a pharmacy benefit manager's decision in the first tier appeal regarding reimbursement

for a drug, pharmacy benefit managers must respond to the commissioner using the commissioner's electronic pharmacy appeals system.

(7) **Hearings by telephone.** If the presiding officer chooses to conduct a hearing, then the presiding officer may choose to conduct the hearing telephonically. The conversation will be recorded and will be part of the record of the hearing.

(8) **Presiding officer.**

(a) Per RCW 34.05.485, the presiding officer may be the commissioner, one or more other persons designated by the commissioner per RCW 48.02.100, or one or more other administrative law judges employed by the office of administrative hearings. The commissioner's choice of presiding officer is entirely discretionary and subject to change at any time. However, it must not violate RCW 34.05.425 or 34.05.458.

(b) The presiding officer shall conduct the proceeding in a just and fair manner. Before taking action, the presiding officer shall provide both parties the opportunity to be informed of the presiding officer's position on the pending matter and to explain their views of the matter. During the course of the proceedings before the presiding officer, the parties may present all relevant information.

(c) The presiding officer may request additional evidence from either party at any time during review of the initial order. After the presiding officer requests evidence from a party, the party has seven days after service of the request to supply the evidence to the presiding officer, unless the presiding officer, under the use of discretion, allows additional time to submit the evidence.

(d) The presiding officer has all authority granted under chapter 34.05 RCW.

(9) **Entry of orders.**

(a) When the presiding officer issues a decision, the presiding officer shall briefly state the basis and legal authority for the decision. Within 10 days of issuing the decision, the presiding officer shall serve upon the parties the initial order, as well as information regarding any administrative review that may be available before the commissioner. The presiding officer's issuance of a decision within the 10-day time frame satisfies the seven day requirement in subsection (2) of this section.

(b) The initial order consists of the decision and the brief written statement of the basis and legal authority. The initial order will become a final order if neither party requests a review as provided in WAC 284-180-530(1).

(10) **Filing instructions.** When a small pharmacy or a pharmacy benefit manager provides information to the commissioner regarding appeals under WAC 284-180-520, the small pharmacy or pharmacy benefit manager must follow the commissioner's filing instructions, which are available at [www.insurance.wa.gov](http://www.insurance.wa.gov).

(11) This section is effective January 1, 2026.

## SUBCHAPTER F

## ENROLLEES' ACCESS TO NETWORK PHARMACIES

### NEW SECTION

**WAC 284-180-550 Enrollee rights and pharmacy benefit manager obligations—Mail order and retail pharmacies.** (1) For purposes of this section, "issued" means ordered by a prescribing health care provider.

(2) (a) For purposes of this section, "new prescription" means:

(i) A prescription that is ordered for the first time by a health care provider; or

(ii) A prescription that is ordered for the first time following a covered person receiving a prescription under a new health plan, employee benefits program, or medicaid managed care organization.

(b) "New prescription" excludes refills or continuations of existing prescriptions by the prescribing health care provider that ordered the original prescription under the same pharmacy benefit manager.

(3) A pharmacy benefit manager must permit a covered person to receive delivery of a prescription drug through the mail or common carrier from any network pharmacy that is not primarily engaged in dispensing prescription drugs to enrollees through the mail or common carrier. For purposes of this section, a network pharmacy not primarily engaged in dispensing prescription drugs through the mail or common carrier is one that receives less than 50 percent of the total value of its annual prescription drug reimbursements, excluding dispensing fees, from mail order prescriptions.

(4) For new prescriptions that are issued after January 1, 2026, a pharmacy benefit manager may not fill or cause to be filled an enrollee's prescription through a mail order pharmacy until the enrollee provides affirmative authorization under this section to receive a prescription drug through a mail order pharmacy.

(a) Affirmative authorization for use of a mail order pharmacy offered to an enrollee must be included in the pharmacy benefit manager's records, including the date upon which the authorization was given, the means by which authorization was obtained, and the individual that obtained the authorization from the covered person.

(b) The authorization form, or the individual obtaining the authorization from the covered person, if it is obtained by other means, must clearly state the purpose of the authorization and the enrollee's right to have each new prescription filled at a network pharmacy other than a mail order pharmacy under RCW 48.200.310 and this section.

(c) If the affirmative authorization is in a written form, it must be a separate and distinct paper or electronic document that is not combined with other enrollee communications. It must be printed or displayed in at least 12 point font. The enrollee must clearly sign or acknowledge their consent on the form, in writing or by e-signature. The date of the enrollee's signature must be included on the form.

(d) A pharmacy benefit manager must permit a covered person to rescind the covered person's affirmative authorization at any time. The pharmacy benefit manager must provide instructions and information regarding the right to rescind authorization on the pharmacy benefit

manager's website and incorporate such instructions and information in the required communications under (b) and (c) of this subsection.

(5) If an enrollee uses a mail order pharmacy to receive a prescription drug through the mail or common carrier, the pharmacy benefit manager shall:

(a) Allow a prescription drug to be dispensed to the enrollee at a local network pharmacy if:

(i) The prescription drug's delivery is delayed by more than one calendar day after the original delivery date promised by the mail order pharmacy; or

(ii) The prescription drug arrives to the enrollee in an unusable condition as that term is defined in WAC 284-180-130. A pharmacist acting on behalf of a local network pharmacy may determine whether a drug arrives in an unusable condition.

(b) Ensure that patients have easy and timely access to prescription drug counseling by a pharmacist. For purposes of this subsection and RCW 48.200.310, "easy and timely access" means that pharmacist counseling is available to the patient by phone from 9:00 a.m. to 5:00 p.m. Pacific time every day except holidays, at a minimum, and that this phone number and other pharmacist counseling instructions are made available to the patient and prominently displayed on the pharmacy benefit manager's website.