

December 10, 2025

**SUBMITTED ELECTRONICALLY VIA: [rulescoordinator@oic.wa.gov](mailto:rulescoordinator@oic.wa.gov)**

Commissioner Patty Kuderer  
Washington State Officer of the Insurance Commissioner  
P.O. Box 40255  
Olympia, WA 98504

**RE: R 2025-11 Health Care Benefit Managers**

Dear Commissioner Kuderer,

On behalf of Navitus Health Solutions, LLC (“Navitus”), we appreciate the opportunity to provide feedback on the proposed rule, and the Washington State Office of the Insurance Commissioner’s (“OIC”) willingness to engage stakeholders throughout the rulemaking process. We also recognize the OIC’s stated efforts to ensure that the rules implementing E2SSB 5213 provide clear guidance so that affected entities understand their rights and obligations under these new provisions.

By way of background, Navitus is a transparent, pass-through PBM formed over two decades ago as an alternative to the traditional PBM model. Today, Navitus is co-owned by SSM Health Care Corporation – a-not-for-profit health system – and Costco Wholesale. We serve more than 18 million lives across all 50 states, including 550,000 Washingtonians through a range of health plan products, including commercial/employer, individual, small group, Exchange, Medicare, and Medicaid plans. We are privileged to work with Moda Health, ArrayRx, and several other partners throughout Washington. The term pass-through means that we pass through to our clients the payments that we receive from drug manufacturers and/or the group purchasing organization, with whom we participate as a nonowner. We have never engaged in spread; meaning that what we pay the pharmacy is what we charge the client.

Below is a summary of Navitus' comments, recommendations, and requests for clarifications.

## SUBCHAPTER F – ENROLLEES' ACCESS TO NETWORK PHARMACIES

WAC 284-180-550 Enrollee rights and PBM obligations—Mail order and retail pharmacies.

### (2) "New Prescription"

We respectfully request that the OIC narrow the definition of 'new prescription' to ensure that it applies only to prescriptions that materially diverge from existing treatments or that are issued for a new condition. Switching between brand and generic products, substituting a biosimilar, or making minor dosage adjustments are part of standard clinical practice and should not be deemed a 'new prescription' as this could inadvertently disrupt continuity of care. Further, the definition may unintentionally classify long-standing, stable therapies as 'new' simply because an enrollee changes health plans or PBMs. A more practical definition, focused on the true intent of initiating new therapy, would help ensure continuity of care and avoid unnecessary delays in patient access to essential medications.

We request that the definition of 'new prescription' under section (2)(a) be revised. The interpretation that every prescription written by a different provider is considered "new" fails to account for common clinical situations—such as a patient seeing another provider during an absence or for other routine reasons. This approach could unnecessarily delay patient access to needed medications.

### (4)

We are concerned about the operational and patient-access challenges posed by subsection (4), which requires PBMs to obtain "affirmative authorization" from each covered person before filling any new prescription through a mail-order pharmacy. In practice, providers often send prescriptions to mail-order pharmacies at the patient's request or the patient contacts the mail-order pharmacy via web portal or phone to fill scripts. Patients generally do not contact the PBM directly. Therefore, if the PBM must acquire an attestation for each "new prescription" an additional step is now added to the process of filling a prescription. Requiring patients to contact the PBM to confirm their expressed preference could create unnecessary delays in treatment—particularly for chronic, time-sensitive, or specialty medications.

Further, PBM clients choose their own mail-order pharmacies. Not all mail-order pharmacies are affiliated with a PBM or health insurer. Therefore, a PBM cannot force a mail-order pharmacy to provide them with records of any attestation. To ensure that PBMs have the necessary attestation, they may need to put a hold on filling a prescription until they speak directly to the patient, which, as stated above, delays care. In general, a patient is affirmatively selecting the mail-order pharmacy and acknowledging a desire to fill their prescription. We respectfully request that the OIC consider allowing a disclosure of an affirmative acknowledgment with required language at open enrollment as sufficient attestation.

Additionally, this provision requires PBMs to maintain documentation of affirmative authorization, including the date, method, and individual who obtained consent. However, it does not specify how long these records must be retained or whether they should follow existing state or federal standards. We respectfully request that the department consider limiting the retention period to 3 years.

Thank you for your leadership and for your careful consideration of this request.

Respectfully,



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