OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Patty Kuderer - Insurance Commissioner

As required by

The Washington State Administrative Procedures Act

Chapter 34.05 RCW

Matter No. **R 2025-11**

CONCISE EXPLANATORY STATEMENT; RESPONSIVENESS SUMMARY; RULE DEVELOPMENT PROCESS; AND IMPLEMENTATION PLAN

Relating to the adoption of

# Health Care Benefit Managers

**December 24, 2025**

TABLE OF CONTENTS


| | | |
|---|---|---|
| Section 1 | Introduction | p. 3 |
| Section 2 | Reasons for adopting the rule | p. 3 |
| Section 3 | Rule development process | p. 3 |
| Section 4 | Differences between proposed and final rule | p. 4 |
| Section 5 | Responsiveness summary | p. 5 |
| Section 6 | Implementation plan | p. 33 |
| Appendix A | Hearing Summary | p. 35 |

## Section 1: Introduction

Revised Code of Washington (RCW) 34.05.325(6) requires the Office of the Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES shall:

1. Identify the OIC's reasons for adopting the rule;
2. Describe differences between the proposed rule and the final rule (other than editing changes) and the reasons for the differences; and
3. Summarize and respond to all comments received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the OIC's reasoning in not incorporating the change requested by the comment; and
4. Be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

## Section 2: Reasons for Adopting the Rule

The CR-103 (final rule) implements provisions of E2SSB 5213 (Chapter 242, Laws of 2024, codified at RCW 48.200) that go into effect January 1, 2026. This law regulates the business practices of health care benefit managers (HCBMs), including pharmacy benefit managers (PBMs).

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

## Section 3: Rule Development Process

OIC filed the CR-101 (preproposal statement of inquiry) for this rulemaking with the Washington State Register on July 22, 2025 (WSR 25-15-143). The comment period for the CR-101 closed on August 22, 2025. OIC received two comment letters on the CR-101.

OIC released a prepublication draft of this rule on September 24, 2025. The comment period for this draft closed on October 3, 2025. OIC received six comment letters on this draft.

OIC held a public interested parties meeting regarding the first prepublication draft on October 1, 2025.

OIC filed the proposed rule (CR-102) on November 4, 2025 (WSR 25-22-093). The comment period for the CR-102 closed on December 11, 2025. OIC received 11 comment letters on the CR-102.

OIC held a public hearing on the proposed rule text on December 10, 2025. The hearing was administered by Nico Janssen, Senior Health Policy Analyst, as a virtual meeting. Testimony was presented by:

- Matthew Sinnott, Willamette Dental
- LuGina Mendez-Harper, Prime Therapeutics
- Jenny Arnold, Washington State Pharmacy Association

OIC filed the final rule (CR-103) with the Code Reviser on December 24, 2025, and the rule will become effective on January 24, 2025.

## Section 4: Differences Between Proposed and Final Rule

OIC made the following changes between the proposed and final rule:

1. In the definition of "contract price" at WAC 284-180-130(4), OIC changed the first sentence to replace the word "price" with the word "amount" and added "fees for a pharmacist's professional services that are not related to the ingredient cost of the drug" at the end of the last sentence.

2. In the definition of "other conditions" at WAC 284-180-130(25), OIC replaced the reference to the "board of pharmacy" with the technically correct reference to the "pharmacy quality assurance commission."

3. In the definition of "require or coerce" at WAC 284-180-130(33), OIC made three changes. OIC replaced "an enrollee" with "a covered person." In addition, OIC replaced "their representative, or an entity under contract with" with "or a person acting on behalf of a pharmacy benefit manager,…" Last, OIC removed the phrase "when a network pharmacy that is not owned by or affiliated with a pharmacy benefit manager is also available to the covered person" from the definition. The final rule's definition of "require or coerce" now reads—

   "(33) As used in RCW 48.200.310, "require or coerce" means an action by a pharmacy benefit manager or a person acting on behalf of a pharmacy benefit manager, to compel or force a covered person to use only a pharmacy benefit managers' owned or affiliated pharmacy."

4. In WAC 284-180-501(2), OIC re-ordered the second sentence as new subsection (a), removed "For purposes of this subsection," changed "price" to "amount," and created new subsections (b) and (c), which state—

"(b) The pharmacy benefit manager's reimbursement amount to a network pharmacy excludes adjustments, denials, or reversals of prescription drug claims due to a network pharmacy submitting the original claim fraudulently or as the result of a pharmacy audit conducted in accordance with RCW 48.200.220.

(c) The term "contract price" has the meaning given in WAC 284-170-130."

5. In WAC 284-180-522(5)(g), OIC removed "with the approval of the presiding officer."

6. Regarding the scope of "new prescriptions" in WAC 284-180-550(2)(b), OIC re-ordered the subsection and created new subsections (ii) and (iii) to exclude—

"(ii) Prescriptions for which the only change is a difference in the dosage; and

(iii) Prescriptions for which the only change is substitution between a brand and generic drug. This subsection does not exempt substitution between a biological and biosimilar drug, including an interchangeable biosimilar drug, from the requirement for a pharmacy benefit manager to obtain affirmative authorization in this subsection."

7. In WAC 284-180-505(4), OIC re-wrote the subsection to read—

"For new prescriptions that are issued after January 1, 2026, a pharmacy benefit manager must receive affirmative authorization from a covered person to receive a prescription drug through a mail order pharmacy before a mail order pharmacy fills a prescription prescribed to the covered person."

8. In WAC 284-180-505(4), OIC added a new subsection (e) which reads—

"The responsibility to obtain a covered person's affirmative authorization under this subsection applies only to pharmacy benefit managers. This subsection does not create a new obligation on the part of a pharmacy or other health care provider or facility to obtain affirmative authorization from a covered person."

## Section 5: Responsiveness Summary

OIC received a total of 19 comments regarding R 2025-11, inclusive of the CR-101, prepublication draft, and CR-102. The following section of this CES summarizes the comments by topic and WAC section. It then provides OIC's responses to the comments and whether changes were made in the rule language at any point in the rulemaking process.

The OIC received comments from:

1. Association of Washington Health Plans
2. Cambia Health Solutions
3. Pharmaceutical Care Management Association
4. Premera Blue Cross
5. Washington Association for Community Health
6. Washington State Pharmacy Association
7. Whole Health Pharmacy
8. Melissa Johnson
9. Melissa Hansen
10. Jessica Knapick
11. Jill McClellan
12. National Association of Specialty Pharmacy
13. Navitus
14. Prime Therapeutics
15. Willamette Dental

| Comment | Response |
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| **General comments** | |
| Multiple commentors asserted that the underlying statute (E2SSB 5213, codified at RCW 48.200) does not support provisions of OIC's proposed rule.<br><br>One of these commentors voiced concern with various provisions of the proposed rule because specific language in the proposed rule did not appear in the underlying statute.<br><br>Commentors' concerns about OIC's authority with respect to individual WAC sections and subsections of the final rule are addressed separately in this summary. | RCW 48.02.060 and RCW 48.200.900 are the statutory authorities for adoption of this rule.<br><br>RCW 48.02.060(1) states that "The commissioner has the authority expressly conferred upon him or her by or reasonably implied from the provisions of this code."<br><br>RCW 48.200.900 states that "the insurance commissioner may adopt any rules necessary to implement this act."<br><br>The OIC may conduct rulemaking to "fill in the gaps" in legislation if such rulemaking is "necessary to the effectuation of a general statutory scheme." *Hama Hama Co. v. Shorelines Hearings Bd*., 85 Wn.2d 441, 448 (1975).<br><br>This final rule effectuates the Legislature's general statutory scheme to bring greater transparency and accountability to the business practices of HCBMs and PBMs. |
| A commentor stated that pharmacists are eager for E2SSB 5213 to take | OIC appreciates this comment. |

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| effect and be fully implemented in Washington to address unfair and deceptive PBM practices. The commentor stated that they hope the proposed rule will give OIC the necessary authority for effective oversight, regulation, and enforcement of PBM activities. | |
| Responding to the preproposal statement of inquiry, a commentor voiced support for additional OIC rulemaking on HCBMs, saying that community health centers continue to experience pressures on pharmacy operations due to lack of transparency of PBM practices and strong enforcement is needed to ensure parity of reimbursement for Washington pharmacies. | OIC appreciates this comment. |
| A commentor asked to provide PBMs with 90 days to implement the changes in the proposed rule. | OIC did not make any changes to the final rule in response to this request. This request was outside the scope of the rule.<br><br>OIC assumes the commentor is asking for a 90-day delay in the effective date of the final rule.<br><br>E2SSB 5213 was signed into law on March 25, 2024. The PBM industry has had since that date to read the statute and begin preparing for the requirements that are effective January 1, 2026.<br><br>On December 18, 2024, OIC adopted a final rule (R 2024-02) implementing and providing guidance on provisions of E2SSB 5213, including provisions going into effect January 1, 2026. This final rule was effective January 18, 2025. The PBM industry has had since that date to prepare for implementation of the requirements in that final rule.<br><br>OIC filed the proposed rule pertaining to this CES (R 2025-11) on November 4, 2025. The requirements associated with this final rule comply with the Administrative Procedure Act and give affected entities reasonable time and guidance to comply. |

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| | OIC refers the commentors to the "implementation plan" section of this CES for more detail as to how OIC will work with affected entities toward compliance with the requirements of this rule. |
| **WAC 284-180-120 – Applicability and scope** | |
| Two commentors asked OIC to explain the interpretation and application of the word 'exclusively' in WAC 284-180-120(3) of the prepublication draft and proposed rule.<br><br>One of the commentors asked how this provision impacts the scope of requirements for HCBMs interacting with self-funded plans.<br><br>Another of the commentors voiced concern that the provision would mean that PBMs providing services to all types of health insurance (including Medicare and Medicaid) would be subject to the rule. | OIC did not make a change to the final rule as the result of this comment. However, OIC provides the clarifications below to the commentor, as the questions pertain to language in the final rule.<br><br>Recently, HCBMs have asked OIC whether they must register as an HCBM if they provide services to or act on behalf of a self-funded group health plan.<br><br>To provide guidance on this question in a timely fashion before notice-and-comment rulemaking could be completed, OIC released a technical assistance advisory (2025-02) in September 2025, which is incorporated into WAC 284-180-120(3) and other provisions of this final rule.<br><br>HCBMs that provide services to or act on behalf of a health carrier or employee benefits program (PEBB/SEBB Uniform Medical Plan) must register with OIC and follow applicable requirements of RCW 48.200 *even if* the HCBM *also provides* HCBM services to or acts on behalf of a self-funded group health plan. Put another way, the fact that an HCBM acts on behalf of a self-funded group health plan *does not* exempt the HCBM from registration *if the HCBM also* provides services to a health carrier or employee benefits program. Below are two illustrative examples of this difference:<br>Example #1: An HCBM provides HCBM services for self-funded employer group health plans and fully-insured health plans. The health care benefit manager must register with OIC because it provides health care benefit manager services to fully-insured health plans.<br><br>Example #2: An HCBM provides HCBM services *exclusively* to self-funded employer |

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| | group health plans other than employee benefit programs as defined in RCW 48.200.020(4) (PEBB/SEBB Uniform Medical Plan). The HCBM is not required to register with OIC.<br><br>Under RCW 48.200 and WAC 284-180, PBMs are a subset of HCBMs with a distinct definition and requirements. Hence, several requirements in these chapters apply only to PBMs but not to other types of HCBMs.<br><br>Nothing in WAC 284-120(3) of the final rule changes federal ERISA or Medicare preemption laws with respect to a PBM's conduct on behalf of ERISA self-funded group health plans or Medicare Advantage/Part D plans. As described in detail in WAC 284-180-465(5) of the final rule, a PBM's conduct specific to an ERISA self-funded group health plan is only subject to RCW 48.200 when such plan opts into RCW 48.200.280, 48.200.310, and 48.200.320. As provided in RCW 48.200.330, OIC does not have enforcement authority with respect to a PBM's conduct on behalf of a self-funded group health plan that has opted into the state laws referenced above. |
| Two commentors asked that WAC 284-180-120 of the prepublication draft and proposed rule be amended by adding a new subsection stating:<br><br>"Health care services contractors, as defined in RCW 48.44.010, where the health care benefit manager is itself a provider, group of providers, or an Affiliate of the health care services contractor that is exclusively contracted with such health care services contractor for services defined in RCW 48.200.020(5)(a)."<br><br>The commentor stated that the Legislature did not intend to apply HCBM requirements to this type of entity. | OIC did not make the requested change.<br><br>Existing regulation at WAC 284-180-210(5)(a) states:<br><br>"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."<br><br>The definition of "carrier" in RCW 48.200.020 uses the definition in RCW 48.43.005, which includes "health care services contractor."<br><br>Although RCW 48.200.020(5)(c) excludes "health care service contractors" from the definition of an HCBM, it does *not* exclude an HCBM that is an affiliate of the health care service contractor and is exclusively contracted with that health care service contractor. |

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| | The definition of "health care benefit manager" in RCW 48.200.020(5)(a) applies to the entity as described by the commentor. The Legislature chose not to exempt this specific type of entity in RCW 48.200. |
| **WAC 284-180-130 – Definitions** | |
| In both the prepublication draft and proposed rule, multiple commentors asked for changes to or removal of the definition of "contract price."<br><br>Several commentors stated that "contract price" is an erroneous term because there is no one "price" paid by a PBM for a specific drug; rather, amounts paid to pharmacies vary based on pre-established lists and formulas that change frequently.<br><br>One of the commentors requested that the proposed rule's definition be changed to expressly exclude "other fees, such as drug or vaccine administration fees," in addition to dispensing fees, which the proposed rule already excluded from the definition. | OIC made two changes in the final rule's definition of "contract price" in response to these comments. However, OIC did not adopt all of the commentor's requested changes or deletions.<br><br>As background, OIC notes that the Legislature used the term "contract price" in RCW 48.200.310(1)(a). OIC has authority to define the term "contract price" in the final rule to effectuate the Legislature's intent. RCW 48.200.310(1)(a) prohibits the practice of PBM "spread pricing" to bring greater transparency to PBM business practices.<br><br>OIC revised the first sentence of WAC 284-180-130(4) to replace the word "price" with the word "amount." This change responds to commentors' concerns about the word "price" being inaccurate. OIC's understanding is that PBMs often charge insurers for prescription drugs based on fluid, predetermined formulas (such as WAC, NADAC, MAC), discounts, and other factors, rather than using a set "price."<br><br>In the final rule OIC added language to the definition that excludes "fees for a pharmacist's professional services that are not related to the ingredient cost of the drug." This change avoids confusion about what fees are excluded in addition to "dispensing fees."<br><br>These technical changes add precision to an existing definition in the proposed rule so that affected organizations can better understand the proposed rule's meaning. The technical changes do not substantially vary from the definition in the proposed rule. |

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| | OIC addresses commentors' related concerns about WAC 284-180-501(2) of the proposed rule ("spread pricing") under that section of this responsiveness summary. |
| Regarding the definition of "drug" and "prescription drug" in WAC 284-180-130(9) of the prepublication draft, a commentor said these terms are already defined in state law and there is no mention of these terms in the underlying statute. The interested party asked OIC to give its justification and authority to define these terms. | OIC changed the proposed rule to define "drug" as having the same meaning as RCW 18.64.011(15).This change was in part informed by the commentor's concern that definitions already exist in state law. This change is retained in the final rule.<br><br>OIC consulted with the pharmacy quality assurance commission, which acts as the state board of pharmacy, to understand the scope and definition of "drug" and "prescription drug" and conducted research into this issue. OIC determined that aligning the definition with existing state law was appropriate.<br><br>OIC refers the commentor to the "general" section of this summary to explain OIC's authority. |
| Multiple commentors asked OIC to change or remove the definition of "local network pharmacy" in both the prepublication draft and proposed rule.<br><br>These commentors stated that:<br>(a) The definition does not appear in the underlying statute;<br><br>(b) The statute only mentions "network pharmacy," and has no mention of location; and/or<br><br>(c) OIC does not have authority to adopt the definition. | OIC did not make the requested changes in either the proposed or final rule.<br><br>OIC refers the commentor to the "general" section of this summary to explain OIC's authority to adopt the final rule.<br><br>The commentors' assertion that "E2SSB 5213 from 2024 refers to network pharmacies without any mention of location" is inaccurate. Sec. 7 of E2SSB 5213 (codified at RCW 48.200.310) uses the term "local network pharmacies."<br><br>The word "local" reasonably implies a location that is in proximity to the covered person. This reading is supported by the Legislature's clear intent to give covered persons more choice in where they receive a drug when a mail order delivery is delayed or arrives in an unusable condition (see RCW 48.200.310(3)).<br><br>Further, the use of "reasonable proximity" to an enrollee's business or residence is aligned with OIC's existing network access (network adequacy) rules for health plans, which contain similar language. |

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| Multiple commentors requested changes or removal of the definition of "other conditions" in both the prepublication draft and final rule.<br><br>One commentor suggested that the proposed rule's mention of "board of pharmacy" be replaced with "pharmacy quality assurance commission," which is the correct updated name for the same entity.<br><br>One commentor stated that the terms in the definition contemplate concepts considered and rejected by the Legislature.<br><br>Multiple commentors read the definition to prohibit PBMs from rejecting unjustified refills of opioids, creating patient safety risks.<br><br>One commentor asked OIC to remove specific examples of practices from the definition.<br><br>In addition, an interested organization contacted OIC with an inquiry that raised the question of whether RCW 48.200.310(2)(a) requires a PBM to apply the same enrollee cost-sharing for all network pharmacies. | OIC made a technical change to replace the reference to the "board of pharmacy" with the correct "pharmacy quality assurance commission" at the request of one of the commentors. The entity is the same; the change shows the entity's updated name. The change does not substantially vary from the proposed rule.<br><br>OIC did not make the other commentors' requested changes to this definition.<br><br>OIC is defining the term "other conditions" to effectuate RCW 48.200.310(2)(a), under which a PBM shall "Apply the same utilization review, fees, days allowance, and other conditions upon a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the pharmacy benefit manager's pharmacy network, including mail order pharmacies;"<br><br>Because the Legislature did not define "other conditions," and that term is not specific, OIC is defining it in the final rule.<br><br>The final rule defines "other conditions" to mean—<br><br>"…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 pharmacy quality assurance commission."<br><br>RCW 48.200.310(2)(a) and this definition require a PBM to apply *"the same"* conditions to covered persons across network pharmacies, including a mail order pharmacy. These provisions mean that if a PBM applies a particular |

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| | utilization review, fee, days allowance, or other condition to a covered person at one of its network pharmacies – including an owned or affiliated pharmacy -- those same terms must also apply to the PBM's other network pharmacies (including independent retail pharmacies).<br><br>The commentors' reading that the final rule would prevent a PBM's rejection of unjustified early refills for opioids is inaccurate. The statute and final rule allow a PBM to reject an unjustified early refill of an opioid *unless the PBM allows such unjustified early refills at one of its network pharmacies (such as a mail order pharmacy).* Hence, the statutory provision and this final rule ensure "the same" PBM treatment of pharmacies in these practices.<br><br>OIC retained the illustrative examples of practices under "other conditions" in the final rule; OIC concluded that listing such examples is appropriate to help inform affected entities. Listing such examples is common in both Title 48 RCW and Title 284 WAC (Statutory and regulatory titles related to OIC authority and responsibilities).<br><br>In response to commentors' concerns, OIC notes that the statutory and final rule provisions mentioned above *do not* prohibit a PBM from applying different enrollee cost-sharing amounts across different network pharmacies. During the legislature's consideration of SB 5213, which resulted in RCW 48.200.310(2)(a), one of the earlier versions of the bill language would have required the same cost-sharing amounts to be applied across all network pharmacies (Sec. 7(2)(a) of engrossed second substitute). In the enacted version of the bill, the Legislature removed that provision.<br><br>OIC refers the commentors to the "general" section of this summary to explain OIC's authority to adopt the final rule. |
| Multiple commentors asked OIC to change, remove, or explain the definition of "require or coerce" in the prepublication draft and proposed rule. | OIC made some, but not all, of these commentors' requested changes. As described below, OIC did not accept commentors' request to make an exception |

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| Commentors requested that OIC –<br><br>(a) Remove the prepublication draft's examples of practices that would "require or coerce" a covered person to use a PBM-owned or affiliated pharmacy, including notifications representing pharmacy options to exclude non-PBM owned or affiliated network pharmacies. This commentor raised First Amendment (free speech) concerns about these examples.<br><br>(b) Accommodate specialty pharmacy networks that may only contain PBM-owned or affiliated specialty pharmacies.<br><br>The commentors stated that the prepublication draft and proposed rule definitions are unsupported by E2SSB 5213 and go beyond OIC's authority. | for PBM-owned or affiliated specialty pharmacy networks.<br><br>As background, the "require or coerce" definition effectuates RCW 48.200.310(1)(c), which states that a PBM may not "require or coerce a patient to use their owned or affiliated pharmacies."<br><br>OIC made a change in the proposed rule, retained in the final rule, to remove a list of specific examples in the definition through which a PBM would represent pharmacy networks to promote or encourage such pharmacies.<br><br>This change aligned the proposed rule's definition with the limitation of "require or coerce" in the statutory provision.<br><br>In the final rule, OIC revised the definition of "require or coerce" at WAC 284-180-130(33) by making three changes.<br><br>OIC replaced "an enrollee" with "a covered person."<br><br>OIC replaced "their representative, or an entity under contract with" with "or a person acting on behalf of a [pharmacy benefit manager]."<br><br>Finally, OIC removed the phrase "when a network pharmacy that is not owned by or affiliated with a pharmacy benefit manager is also available to the covered person" from the definition. The final rule's definition now reads—<br><br>"(33) As used in RCW 48.200.310, "require or coerce" means an action by a pharmacy benefit manager or a person acting on behalf of a pharmacy benefit manager, to compel or force a covered person to use only a pharmacy benefit managers' owned or affiliated pharmacy."<br><br>The replacement of "an enrollee" with "a covered person" aligns the definition with the statutory term "covered person" for consistency. |

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| | The replacement of "their representative, or an entity under contract with" with "or a person acting on behalf of [a pharmacy benefit manager]" clarifies the proposed rule's definition and conforms to the statutory provision.<br><br>The deletion of "when a network pharmacy that is not owned by or affiliated with a pharmacy benefit manager is also available to the covered person" is necessary to align with the clear language of RCW 48.200.310(1)(c), which states that a PBM may not "require or coerce a patient to use their owned or affiliated pharmacies."<br><br>RCW 48.200.310(1)(c) makes no exception or accommodation for scenarios in which a PBM-owned or affiliated network pharmacy, such as a specialty pharmacy, is the only one in the PBM's network where a particular prescription may be filled. In considering the statute and legislative history (as discussed with respect to specialty pharmacies under the section on WAC 284-180-550 of this responsiveness summary), OIC concludes that revision of the proposed rule language is necessary.<br><br>OIC refers the commentors to the "general" section of this summary to explain OIC's authority to adopt the final rule and provides the following, specific explanations regarding its authority and interpretation for this definition. |
| Several commentors requested changes to or deletion of the definition of "unusable condition" in comments on the prepublication draft and proposed rule.<br><br>The commentors asked OIC to change the language so that the determination of "unusable condition" is reserved for the pharmacist in charge of the dispensing mail order pharmacy and not a pharmacist at a local network pharmacy. | OIC did not make the commentors' requested changes in the final rule.<br><br>This definition effectuates RCW 48.200.310(3)(a)(ii). That provision requires that if a covered person is using a mail order pharmacy, the PBM shall allow for dispensing at a local network pharmacy "if the prescription arrives in an unusable condition;"<br><br>RCW 48.200.310(3)(a)(ii) reflects the Legislature's stated concern that PBMs may place patients in PBM-owned mail order pharmacies without their knowledge and |

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| Another commentor asked OIC not to make the requested change because a mail order pharmacist may not be readily available for consultation to help the patient.<br><br>The commentors stated that the prepublication draft and proposed rule definitions are unsupported by E2SSB 5213 and exceed OIC's authority. | "remove patients' choice in how they want to obtain their drugs…" (see testimony of Senators Short and Kuderer at February 3, 2024 Senate Health and Long-Term Care hearing on SB 5213). When an enrollee's mail order drug arrives in an unusable condition, the clear wording of the statute allows for a local network pharmacy to dispense the drug.<br><br>Requiring that only the pharmacist in charge of the dispensing mail order pharmacy have authority to decide whether the drug arrived in an "unusable condition" could weaken the statutory provision's intent to give patients choice in where they receive a prescription drug. A mail order pharmacist may not be readily available to consult with the patient to make this decision and will not have the drug as delivered in their possession. For PBM-owned or affiliated mail order pharmacies, keeping the decision in vertically integrated entities could create an incentive against allowing the patient to receive their prescription at a competing, non-vertically integrated retail pharmacy.<br><br>The final rule allows, but does not require, a local network pharmacy's pharmacist to decide whether a drug arrived in an "unusable condition." This language reflects the Legislature's clearly stated aim to prevent PBM practices that reduce patient choice of pharmacy and supports patient safety.<br><br>OIC refers the commentors to the "general" section of this summary to explain OIC's authority to adopt the final rule. |
| **WAC 284-180-210—Registration and renewal fees**<br><br>A commentor voiced support for the registration and renewal fee increases in the proposed rule. The commentor requested that OIC charge a proportional fee based on a company's income. The commentor suggested that the proportional fee be 10% of the HCBM's income. | OIC appreciates this comment.<br><br>RCW 48.200.030(2)(b) requires that OIC set HCBM registration and registration renewal fees in "an amount that ensures the registration, renewal, and oversight activities are self-supporting."<br><br>OIC currently charges HCBMs a registration fee and a minimum registration renewal fee, which both use fixed amounts. The proposed rule and final rule increase those |

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| | fees to meet the Legislature's requirement that OIC's HCBM work be self-supporting.<br><br>OIC charges HCBMs a registration renewal fee that is a proportional share of the HCBM's Washington state annual gross income – meaning that the HCBMs with greater revenue in Washington state pay more than those with lower revenue (WAC 284-180-210(3). This proportional fee uses a "factor" to set the percentage of an HCBM's Washington state annual gross income. OIC can update this "factor" as needed to support HCBM activities; the factor is provided annually to registering HCBMs, as part of the annual HCBM registration process. |
| **WAC 284-180-220 – Health care benefit manager registration** | |
| In the prepublication draft, a commentor asked OIC to explain its intent regarding WAC 284-180-220(5). The commentor read the provision to require third party administrators to register as a health care benefit manager. | OIC did not make a change in either the proposed or final rule as the result of this comment.<br><br>WAC 284-180-220 does not create a new obligation for any entity other than an HCBM or PBM, as those terms are defined in statute and rule, to register with OIC. OIC would refer the commentor to RCW 48.200.020 and WAC 284-180-120 and -130 for clarity regarding the definition of HCBM or PBM. This provision clarifies that PBMs that provide services to self-funded group health plan *and also* to carriers, PEBB/SEBB or Medicaid MCOs must register with OIC.<br><br>See the comment and response regarding WAC 284-180-120 in this summary for a related response as to registration requirements for HCBMs and PBMs. |
| **WAC 284-180-310—Health care benefit manager records** | |
| Responding to the proposed rule, a commentor asked OIC to clarify WAC 284-180-310 as to whether HCBM records containing protected health information (PHI) must be retained by an HCBM for 7 years in addition to registration and renewal records. | OIC did not make the commentors' requested change in the final rule.<br><br>The seven-year retention period for "all transactions," which may include PHI, is a reasonable requirement that allows OIC to conduct appropriate HCBM oversight and enforcement activities. RCW 48.37.080 provides that all information obtained by |

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| The commentor asked OIC to change the final rule to exempt PHI records, with two different suggestions for language changes. | OIC as part of its market conduct enforcement activities is confidential and not subject to public disclosure. This includes PHI. In addition, RCW 48.02.068 provides that all nonpublic PHI obtained by, disclosed to, or in the custody of the commissioner, regardless of the form or medium, is confidential and is not subject to public disclosure under RCW 42.56. |
| **WAC 284-180-465 – Self-funded group health plan opt-in** | |
| In comments to the prepublication draft and proposed rule, an interested party asked OIC to clarify in rule or otherwise explain several questions about timing, operations, and scope of the self-funded group health plan opt-in right under WAC 284-180-465, including –<br><br>(a) Whether OIC has made the opt in form available or when it will be available;<br><br>(b) Whether the opt-in right covers self-funded group health plans with indirect contractual relationships with a PBM; and<br><br>(c) Whether OIC has enforcement authority over PBMs pursuant to contracts with non-ERISA self-funded group health plans. | OIC did not make changes in the final rule as the result of the comments but responds to several of the commentor's questions here.<br><br>On question (a), in November 2025, OIC made available an online opt-in and attestation form for ERISA self-funded group health plans to participate in certain provisions of E2SSB 52313. The webpage and form are available here: https://www.insurance.wa.gov/about-us/current-initiatives/protections-surprise-medical-billing/pharmacy-benefit-manager-self-funded-group-health-plan-opt. OIC has met the statutory and regulatory requirements of the opt-in provision by making the attestation process available and making a list of participating self-funded group health plans publicly available. OIC has shared information regarding this option to several self-funded employer organizations.<br><br>On question (b), OIC interprets RCW 48.200.330 to allow ERISA self-funded group health plans, regardless of whether they are directly or indirectly contracted with a PBM, to participate in and be bound by the opt-in provisions related to their PBM's conduct on the plan's behalf. This reflects the Legislature's intent regarding the opt-in process, which is modeled on the Balance Billing Protection Act, to give self-funded group health plans an opportunity to opt-into these new consumer protections. Prohibiting an ERISA self-funded group health plan from participating because it is not directly contracted with a PBM would weaken this intent. |

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| | RCW 48.200 and WAC 284-180 do *not* broadly apply to a PBM's conduct on behalf of a self-funded group health plan. Instead, the applicability of RCW 48.200 RCW and WAC 284-180 is limited to those provisions of law referenced in RCW 48.200.330.Non-ERISA governed self-funded group health plans (such as local government plans) cannot opt into E2SSB 5213 due to limiting language of the statute.<br><br>As provided in RCW 48.200.330, OIC does not have enforcement authority related to a PBM's conduct pursuant to a contract with either an ERISA self-funded group health plan or a non-ERISA self-funded group health plan. |
| **WAC 284-180-501 – Pharmacy reimbursement** | |
| Multiple interested organizations commented on WAC 284-180-501(2) in the prepublication draft and proposed rule.<br><br>Several commentors asked that OIC remove or change the second sentence of WAC 284-180-501(2), which references post-sale or post-invoice adjustments. Commentors stated this language would prohibit reconciliations due to performance-based contracts, recoupments permitted by Washington state's pharmacy audit statute, and findings of waste, fraud, and abuse.<br><br>One commentor stated that the above request was not necessary because an existing state statute (RCW 48.200.280(l)) already addresses these scenarios. The commentor stated that PBMs have long used retroactive quality payment adjustments to "claw back" funds from pharmacies without transparent standards, clear metrics or goals. | OIC made several technical changes in this provision of the final rule. These changes address some, but not all, of the commentors' requests.<br><br>WAC 284-180-501(2) effectuates RCW 48.200.310(1)(a), which states that a PBM may not—<br><br>"Reimburse a network pharmacy an amount less than the contract price between the pharmacy benefit manager and the insurer, third-party payor, or the prescription drug purchasing consortium the pharmacy benefit manager has contracted with;"<br><br>This provision prohibits a PBM practice widely known as "spread pricing." This provision reflects the Legislature's stated concern regarding spread pricing's lack of transparency and potential to raise drug costs (see testimony of bill sponsors, Senators Short and Kuderer, at February 3, 2024 Senate Health and Long-Term Care hearing on SB 5213).<br><br>A wide array of organizations, including employers, insurers, pharmacies, drug manufacturers, regulators, Congress, and consumers have raised concerns regarding PBM's use of "spread pricing." Among these organizations' concerns are spread pricing's |

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| | effects on employer prescription drug spending, retail pharmacy closures, transparency, formulary placement for higher-cost drugs, PBM market concentration, and vertical integration (for example, see Federal Trade Commission, 2024; KFF, 2025; U.S. House Oversight and Government Reform Committee, 2023; National Alliance of Healthcare Purchaser Coalitions, 2024; National Community Pharmacists Association, 2025; PhRMA, 2025; National Academy for State Health Policy, 2022).<br><br>The statutory spread pricing provision in RCW 48.200.310(1)(a) does not define "contract price" nor the reimbursement amount to a network pharmacy that are critical to the determination of the payment "spread." These concepts should be defined to effectuate legislative intent.<br><br>OIC defines "contract price" in WAC 284-180-130 of the final rule and answers comments in that section of this summary.<br><br>For the PBM's reimbursement amount to a network pharmacy, WAC 284-180-501(2) of the proposed rule clarifies that this amount includes "post-sale or post-invoice adjustments the [PBM] makes that affect the price paid for a drug, including, but not limited to, fees, discounts, reconciliations, or assessments." This language reflects OIC's understanding, based on public comment and on the previously cited links, that PBMs often adjust drug reimbursement amounts to pharmacies after a claim has been adjudicated, for a variety of reasons. Because of this common practice, limiting the spread pricing prohibition to the initial drug reimbursement amount could allow PBMs to use various retroactive adjustments as a way to effectively create a "spread" on a drug while seemingly complying with the Legislature's ban on spread pricing. The rule language is needed to effectuate the statute banning spread pricing and the Legislature's stated goal to rein in fees charged to pharmacies (see legislator testimony cited earlier). |

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| | The language of WAC 284-180-502 of the proposed and final rule also conforms to a statutory provision outside of E2SSB 5213 (RCW 48.200.280(l)), which states that a PBM—<br><br>"…may not directly or indirectly retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated," unless "the original claim was submitted fraudulently," or "the denial or reduction is the result of a pharmacy audit conducted in accordance with RCW 48.200.220;"<br><br>If OIC agreed to commentors' request to exclude post-sale or post-sale adjustments in the calculation of "spread pricing," that exemption could conflict with RCW 48.200.280(l) by effectively allowing adjustments that may be construed as retroactive claim reductions or denials.<br><br>OIC did make a technical change in the final rule to ensure that WAC 284-180-501(2) of the final rule conforms to the aforementioned RCW 48.200.280(l). This change responds in part to commentors' request that the final rule allow for a PBM to deny claims that are submitted fraudulently by a pharmacy or adjust drug reimbursement due to a pharmacy audit properly conducted under existing state law.<br><br>Because that statute (RCW 48.200.280(l)) effectively allows retroactive claims adjustments related to fraud and pharmacy audits, OIC revised the final rule language at WAC 284-180-501(2) by adding subsection (b), which provides that:<br><br>"The pharmacy benefit manager's reimbursement amount to a network pharmacy excludes adjustments, denials, or reversals of prescription drug claims due to a network pharmacy submitting the original claim fraudulently or as the result of a pharmacy audit conducted in accordance with RCW 48.200.220." |

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| | This technical change aligns with statute and delineates between allowed and prohibited forms of PBM "adjustments," "denials" and "reversals" as part of the ban on spread pricing.<br><br>OIC made several other technical changes to WAC 284-180-501(2) of the final rule to:<br><br>1. Create subsection (c) to make clear that "contract price" has the meaning given in WAC 284-180-130.<br><br>2. Change the reference from "price" to "amount" within subsection (a).<br><br>3. Remove the word "any" from subsection (a).<br><br>4. Remove "for purposes of this subsection" from subsection (a).<br><br>These four technical changes do not substantially vary from the proposed rule and do not change the effect of the rule. |
| **WAC 284-180-507 -- Appeals by network pharmacies to health care benefit managers who provide pharmacy benefit management services** | |
| Responding to the proposed rule, two commentors stated that WAC 284-180-507 was not included in the prepublication draft and it was their first opportunity to provide feedback. These commentors requested changes to:<br><br>1. Add "on the date of the claim or claims that are subject to the appeal" in subsection (4);<br><br>2. Remove the second sentence of subsection (9);<br><br>3. Remove the requirement in subsection (12) for an HCBM providing PBM services to identify a PBM employee who is a single point of contact for pharmacy appeals and include the name of the contact person. | OIC did not make the requested changes in the final rule.<br><br>OIC notes that WAC 284-180-507 is an existing section that has been effective since January 18, 2025. OIC rulemaking matter R 2024-02 established this rule; accordingly, the existing language in the rule underwent notice-and-rulemaking under the Administrative Procedures Act.<br><br>The only amendatory language that this rulemaking (R 2025-11) proposes to the section is an effective date clarification in the first sentence of subsection (a)(1).<br><br>OIC did not make the commentors' suggestions for substantive changes to the section because the requested changes were either not supported in statute or were not necessary. |

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| Several organizations commented on existing rule language in WAC 284-180-507(1)(a) pertaining to the time period a network pharmacy has to appeal a claim to a PBM after a claim has been adjudicated. OIC did not amend this language in either the prepublication draft or the proposed rule. These comments were made to the proposed rule.<br><br>One comment supported the existing language giving network pharmacies 90 days after claim adjudication to appeal (a "lookback" period of 90 days).<br><br>One comment requested that the "lookback period" be shorter.<br><br>One comment requested that the "lookback period" be longer. | OIC did not make commentors' requested changes in the final rule.<br><br>The issue commentors raise is in the scope of the rulemaking because it is a provision included in WAC 284-180. However, OIC did not address the issue at any stage of the rulemaking because OIC did not believe a change was necessary. WAC 284-180-507 was the subject of 2024 rulemaking, with an opportunity for review and comment at that time. OIC concluded that the existing requirements, which were the subject of significant comment and discussion during its previous rulemaking, continue to be appropriate. |
| One commentor asked OIC to change WAC 284-180-507 in an appropriate place to require that a PBM respond to a pharmacy appeal within 72 hours. | The issue the commentor raises is in the scope of the rulemaking because it is a provision included in WAC 284-180. However, as noted above, this provision was subject to significant comment during OIC's 2024 rulemaking. The current rule language continues to be appropriate. |
| Two commentors asked OIC to change WAC 284-180-507(4)(c)(i) to add "on the date of the claim or claims that are subject to the appeal" in the last sentence after the word "paid." Commentors stated this change would ensure integrity of the appeals process. | The language the commentor cites is not new to this rulemaking; it was effective on January 18, 2025 as part of OIC rulemaking R 2024-02 and under the Administrative Procedures Act.<br><br>OIC did not make the requested change in the final rule. OIC did not address this issue at any stage of the current rulemaking and concluded that the change was not necessary to effectuate the network pharmacy appeals process. |
| Two commentors asked OIC to change WAC 284-180-507(7) to add "at the pharmaceutical manufacturer's list price" in the second to last sentence of the subsection. Commentors felt the change would correct an inaccurate description. | The language the commentor cites is not new to this rulemaking; it was adopted on January 18, 2025 as part of OIC rulemaking R 2024-02 and underwent a notice and comment process under the Administrative Procedures Act.<br><br>OIC did not make the requested change in the final rule. OIC did not address this issue |

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| | at any stage of the current rulemaking and concluded that the change was not needed. |
| In response to the prepublication draft, a commentor asked OIC to change WAC 284-180-507 in several ways to make it easier for small pharmacies to appeal reimbursements to PBMs, including:<br><br>1. That OIC take over the "tier 1" appeals process, which currently is between a pharmacy and a PBM.<br><br>2. That OIC speed up its complaint response and enforcement timelines and hire a pharmacist with experience in medication billing and purchasing. | OIC did not make changes to the proposed or final rule as the result of these requests.<br><br>OIC does not have statutory authority to move the "tier 1" appeals process from a PBM to the OIC. RCW 48.200.280 sets a specific process by which pharmacies appeal PBM reimbursement amounts. The first, or "tier 1" appeal must be to a PBM.<br><br>OIC appreciates the commentors' concern about OIC's complaint response and enforcement timeliness. OIC continues efforts to improve its PBM oversight. |
| Responding to the CR-101, a commentor asked that OIC make various changes to WAC 284-180-507 to clarify that reimbursement adjustments resulting from a successful appeal should apply to all claims for the affected patient, and preferably to all claims at that pharmacy for that medication, both retrospectively to the date the appeal was filed and for 90 days going forward. The commentor asked that this requirement be incorporated into WAC 284-180-522(3) as well regarding "tier 2" appeals. | OIC did not make the requested change in the prepublication draft, proposed rule, or final rule.<br><br>The Legislature's statutory scheme in RCW 48.200.280(3) applies pharmacy appeals to "a drug." This singular application is reflected throughout the section as well as WAC 284-180. OIC concludes that it lacks statutory authority to make the change requested.<br><br>WAC 284-180-507(1)(c), which is existing regulation not amended in this rulemaking, allows a pharmacy services administrative organization (PSAO) to submit an appeal to a PBM on behalf of multiple pharmacies if certain conditions are met. In this case, PSAOs must still submit the necessary information to support each appeal. This change, effective January 1, 2026, may ease the administrative burden on pharmacies for submitting appeals. |
| **WAC 284-180-517—Use of brief adjudicative proceedings for appeals by network pharmacies to the commissioner.** | |
| Responding to the CR-101, a commentor asked OIC to change WAC 280-180-517 to remove references to predetermined and multisource drugs, saying that this | OIC made a change in the prepublication draft, retained in the proposed rule and final rule, to accept this request. In WAC 284-180-517(1) OIC added "or drugs" |

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| language is now erroneous because pharmacies may appeal all underpaid medication claims beginning January 1, 2026. | after "multisource generic drugs." This inclusion reflects the statutory change in RCW 48.200 expanding small pharmacies' appeal rights beginning January 1, 2026. |
| **WAC 284-180-550—Enrollee rights and pharmacy benefit manager obligations—Mail order and retail pharmacies.** | |
| Multiple commentors requested that WAC 284-180-550(4) be changed to exempt drugs filled by specialty pharmacies from the requirement that a PBM receive affirmative authorization from a covered person before filling prescriptions through a mail order pharmacy.<br><br>Commentors voiced concern that the prepublication draft and proposed rule's language would create patient safety risks and care disruptions for patients needing specialty drugs.<br><br>Relatedly, some commentors stated that the detailed requirements of WAC 284-180-505(4) are unsupported in statute and overly burdensome to implement, which could cause delays for patients receiving prescription drugs. | OIC did not make the commentors' requested changes in the final rule.<br><br>WAC 284-180-550(4) and (5) of the final rule effectuate RCW 48.200.310(2)(c), which states that a PBM shall—<br><br>"For new prescriptions issued after January 1, 2026, receive affirmative authorization from a covered person before filling prescriptions through a mail order pharmacy."<br><br>This provision does not provide any exemption for mail order specialty pharmacies, nor is there any exemption for specialty pharmacies within the statutory definition of "mail order pharmacy" in RCW 48.200.020(10).<br><br>In public testimony on E2SSB 5213, several interested parties asked the Legislature to exempt specialty mail order pharmacies from the affirmative authorization requirements in Sec. 7 of the bill (now codified at RCW 48.200.310) (see public testimony in the House Health Care & Wellness Committee public hearing on February 20, 2024, as reflected in the February 29, 2024 House bill report). The Legislature rejected the request. The enacted legislation provides no such exemption.<br><br>OIC does not have statutory authority to exempt mail order specialty pharmacies from the statutory affirmative authorization requirements, by rule or otherwise. |
| A commentor asked that WAC 284-180-550(4) distinguish between PBM-owned or affiliated mail order | OIC did not make the requested change in the final rule. |

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| pharmacies and independent, or non-PBM owned or affiliated pharmacies. | RCW 48.200.310(2)(c) applies to mail order pharmacies and does not distinguish between those that are PBM-owned or affiliated and those that are not. OIC does not have statutory authority to require that only PBM-owned or affiliated pharmacies comply with this requirement. |
| Multiple commentors asked for changes, deletions, or clarification as to how WAC 284-180-550(4) would affect obligations by PBMs, pharmacists, and health care providers to obtain affirmative authorization for use of a mail order pharmacy.<br><br>Some of these organizations stated that pharmacies – not PBMs – fill prescriptions, meaning that the rule language would not be feasible to implement. Relatedly, some of the organizations stated that enrollees already "authorize" a drug to be filled through a mail order pharmacy because they request that option from their prescribing health care provider, suggesting that the affirmative authorization requirement is unnecessary.<br><br>One commentor stated that the proposed rule's language as to the obligations of these entities would allow for a workable system of requiring affirmative authorization. | OIC made technical changes that address some, but not all, of these concerns.<br><br>As explained above, WAC 284-180-550 is meant to effectuate RCW 48.200.310(2)(c), which states that a PBM shall—<br><br>"For new prescriptions issued after January 1, 2026, receive affirmative authorization from a covered person before filling prescriptions through a mail order pharmacy."<br><br>The clear language of the statute places a mandate on PBMs, and only PBMs, to receive affirmative authorization before "filling" prescriptions through mail order pharmacies. As to commentors' concerns that PBMs cannot obtain this authorization, or that enrollees already inherently give permission to fill drugs at a mail order pharmacy, the statute makes no exceptions for those scenarios, and therefore OIC has no authority to circumvent this clear PBM requirement through rule.<br><br>To some commentors' concerns regarding which entities would need to receive affirmative authorization, the clear language of the statute places that mandate on PBMs without mentioning any other entities. This language reflects the Legislature's stated intent to give patients greater choice of pharmacies and reflects the Legislature's concern that patients are being placed into mail order pharmacies without their knowledge or consent (see previously cited public hearings and testimony of bill sponsors).<br><br>Having said this, OIC also recognizes that the language of the proposed rule lacked clarity in delineating the obligations of PBMs |

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| | versus the obligations of pharmacies or health care providers in the affirmative authorization requirements. The proposed rule language could have left ambiguity as to whether entities other than a PBM must receive affirmative authorization from consumers.<br><br>Therefore, OIC made two technical changes in the final rule language to clarity the proposed rule's meaning and ensure the rule language conforms to statute.<br><br>WAC 284-180-505(4) of the proposed rule now reads—<br><br>"For new prescriptions that are issued after January 1, 2026, a pharmacy benefit manager must receive affirmative authorization from a covered person to receive a prescription drug through a mail order pharmacy before a mail order pharmacy fills a prescription prescribed to the covered person."<br><br>This technical change effectuates the statute's language, and intent, by ensuring that a PBM cannot circumvent the requirement to obtain affirmative authorization.<br><br>OIC added WAC 284-505(4)(e), which states:<br><br>"The responsibility to obtain a covered person's affirmative authorization under this subsection applies only to pharmacy benefit managers. This subsection does not create a new obligation on the part of a pharmacy or other health care provider or facility to obtain affirmative authorization from a covered person."<br><br>This technical change follows the statute's clear language placing the mandate on the PBM without creating a new requirement for entities other than a PBM.<br><br>Removing or significantly altering the Legislature's requirement that a PBM must |

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| | obtain affirmative authorization as described above would require a statutory change. |
| Responding to the prepublication draft, a commentor asked OIC to remove a requirement that affirmative authorization for use of a mail order pharmacy be "written." The commentor stated that the underlying statute does not support the requirement. | OIC made a change in the proposed rule, retained in the final rule, removing the explicit requirement for affirmative authorization to be "written." OIC acknowledged that communication in these instances may be verbal.<br><br>However, to ensure accountability for compliance with this requirement, OIC added language in the proposed rule, retained in the final rule, to require that a PBM retain records of such affirmative authorization and allow a patient to opt-out of mail order, to ensure that patient choice is honored. |
| Several commentors asked for changes to, removal of, or explanation for the definition of "new prescription" within WAC 284-180-505(2) of the prepublication draft and proposed rule.<br><br>These commentors believed the definitions were too rigid and failed to understand what a "new prescription" is. Commentors asked that the definition exempt multiple prescribers within a health system or group practice writing the same prescription, dosage changes, generic/brand substitution, and health plan or PBM changes, from the requirement to receive a separate affirmative authorization. | In the final rule, OIC made a technical change in response to some, but not all, of the commentors' concerns.<br><br>OIC's technical change in the final rule re-orders the subsections of WAC 284-180-505(2)(b) to add that "new prescription" excludes—<br><br>"(ii) Prescriptions for which the only change is a difference in the dosage; and<br><br>(iii) Prescriptions for which the only change is substitution between a brand and generic drug. This subsection does not exempt substitution between a biological and biosimilar drug, including an interchangeable biosimilar drug, from the requirement for a pharmacy benefit manager to obtain affirmative authorization in this subsection."<br><br>This technical change does not alter the proposed rule's effect but does clarify its meaning by explicitly exempting circumstances that OIC determined do not constitute "new prescriptions" (dosage differences and substitution between a brand and generic drug). In these cases, OIC determined that it is appropriate to not require a PBM to obtain separate affirmative authorization for use of a mail order pharmacy. |

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| | OIC did not grant several commentors' requests to exclude substitutions from biologics to biosimilars or interchangeable biosimilars, nor refills by a different prescriber from the scope of "new prescription." OIC concluded that granting these changes would run counter to the statutory language and intent to give patients a meaningful right to opt-in (through affirmative authorization) when there is a "new prescription." These circumstances would constitute a change to the patient's prescription warranting a new affirmative authorization. |
| Several commentors ask that OIC change, remove, or explain the meaning of the definition of "easy and timely access" to mail order pharmacist counseling. These comments concern WAC 284-180-505(5) of the prepublication draft and proposed rule.<br><br>Commentors stated that the proposed rule's requirement for mail order pharmacist counseling availability from 9:00 am to 5:00 pm pacific time, as well as online counseling instructions, would hold mail order pharmacies to a different standard than other pharmacies and exceed OIC's authority. | OIC made a change in the proposed rule, retained in the final rule, in response to part of this concern.<br><br>The prepublication draft defined "easy and timely access" to include—<br><br>"The ability for an enrollee to receive in-person, video or telephonic assistance in real time from an individual pharmacist if the enrollee requests such consultation. To fulfill this requirement, the pharmacy benefit manager must make in-person, video or telephonic assistance available from, at a minimum, 8 am – 5 pm pacific time every day, including weekends and holidays."<br><br>After researching pharmacy counseling practices and considering the commentors' concerns, OIC revised the proposed rule to instead define "easy and timely access" to mean that—<br><br>"…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."<br><br>The statute reflects the Legislature's stated concern, as well as concerns from interested organizations who testified during E2SSB 5213's public hearings, that mail order pharmacies *do not* have comparable |

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| | availability and counseling services compared to retail (brick and mortar) pharmacies (see previously cited links to bill sponsor testimony, public hearing testimony, and bill reports). The Legislature used the term "easy and timely access," but did not define that term; it was therefore appropriate for OIC to define the term in rule.<br><br>OIC's change in the proposed rule, retained in the final rule, creates reasonable parity between mail order pharmacy counseling availability and retail pharmacy counseling availability so that patients may access "easy and timely" counseling when issues with prescriptions arise. OIC notes that by definition, mail order pharmacies have no in-person pharmacist available for a patient to visit during normal business hours; this in-person counseling option is generally available at retail pharmacies. Patients must call or communicate remotely with a mail order pharmacist. |
| Responding to WAC 284-180-505(3) of the prepublication draft and proposed rule, multiple commentors voiced concern with the requirement that a "network pharmacy that is not primarily engaged in dispensing prescription drugs to enrollees 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 pharmacies."<br><br>Commentors questioned OIC's authority for making this change and said the change was arbitrary. | OIC did not make a change to the proposed or final rule in response to these comments.<br><br>In WAC 284-180-505(3), OIC is effectuating RCW 48.200.310(2)(b), which states that a PBM shall—<br><br>"Permit the covered person to receive delivery or mail order of a prescription drug through any network pharmacy that is not primarily engaged in dispensing prescription drugs to patients through the mail or common carrier;"<br><br>The Legislature did not define what "primarily engaged" means; OIC has authority, and it is appropriate, to clarify the scope of this term. It is reasonable to establish a percentage threshold in this case to avoid confusion about what "primarily engaged" means. |
| A commentor asked that WAC 284-180-505(3) of the prepublication draft and proposed rule be changed to reflect the purpose of the underlying statute to require that PBMs allow for | OIC made a change in the proposed rule, retained in the final rule, in response to this comment.<br><br>The prepublication draft required that a PBM "must ensure that an enrollee may |

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| enrollee choice as to mail order pharmacies. | 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."<br><br>OIC changed the proposed rule to replace "must ensure" to "must permit."<br><br>OIC acknowledged the statute's use of "must permit" and its different meaning than "must ensure." |
| A commentor asked OIC to clarify whether the scope of "issued" in WAC 284-180-505(1) of the prepublication draft includes a pharmacist. | OIC did not make a change to the proposed or final rule due to this comment.<br><br>WAC 284-180-130 defines "health care provider" using the statutory definition of that term in RCW 48.43.005. This is a broad definition that encompasses pharmacists. |
| **Comments outside the scope of rulemaking** | |
| The following comments pertain to requirements of current law that two commentors believe are not being enforced, and/or that PBMs are not following. Broadly speaking, the commenters would like OIC to address these concerns in rule and explain how OIC is enforcing current law, including investigating PBMs and issuing penalties. These provisions include:<br><br>WAC 284-180-501 and RCW 48.200.280(2)(k) – parity of pharmacy reimbursement and<br><br>WAC 284-180-507(3)(a) and (12) – accurate contact information for appeals<br><br>WAC 284-180-507(4) – proof for an appeal<br><br>WAC 284-180-507(8)(a) and (8)(b) – denial of appeals.<br><br>CW 48.200.210(3) and RCW 48.200.220 (11) – clerical errors | Generally speaking, these comments are not related to the scope of the final rule but rather enforcement of RCW 48.200 and WAC 284-180. Hence, OIC did not include language in the final rule that speaks to OIC's processes to enforce these provisions.<br><br>If a pharmacist believes that a PBM is in violation of the provisions in RCW 48.200, the pharmacist may file a complaint using OIC's complaint portal: https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status<br><br>OIC has modified its complaint portal to provide an option to note issues related specifically to PBMs. Under RCW 48.200.050, OIC is required to respond to and investigate complaints related to the conduct of health care benefit managers.<br><br>OIC also received an appropriation in the 2025 biennial operating budget to contract for clinical consulting services, including pharmacy expertise. OIC is pursuing that opportunity at the time of this rulemaking. |

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| RCW 48.200.280(2)(h) – deceptive and misleading information<br><br>RCW 48.200.280(I) – indirect or direct retroactive fees<br><br>RCW 48.200.290 – enforcement, disputes, and civil penalties<br><br>RCW 48.200.280(2)(i) – fees | |
| Responding to the prepublication draft, a commentor asked OIC to explain its comment period that ran from September 24, 2025 to October 3, 2025, which was shorter than the prepublication draft comment periods in the OIC's 2024 HCBM rulemaking (R 2024-02). | OIC did not make changes in the proposed or final rule in response to this comment as the requests were outside the scope of rule language.<br><br>OIC is conducting this notice-and-comment rulemaking in compliance with the Administrative Procedure Act.<br><br>The release of a prepublication draft is not required by the Administrative Procedure Act, nor is there any set period for comments established in statute or rule related to prepublication drafts. OIC released the prepublication draft and held an open interested parties meeting on that draft to receive feedback from interested organizations before releasing a proposed rule (CR-102).<br><br>In this rulemaking, OIC has afforded the commentor and all interested organizations the opportunity to comment as required by the Administrative Procedure Act, and additional opportunities not required by state law. This included a one-month comment period on the preproposal statement of inquiry (CR-101), a one-month comment period on the proposed rule (CR-102), a 10-day comment period for the prepublication draft, an open interested parties meeting, and a public hearing. |

## Section 6: Implementation Plan

### A. Implementation and enforcement of the rule.

As described below, implementation of the rule will occur through numerous activities at OIC. The Legal Division will rely on this rule when determining

whether to initiate an investigation of an HCBM and in determining whether enforcement action is appropriate. The Company Supervision Division will rely on the rule in the HCBM registration and renewal process. The Consumer Protection Division will continue to respond to consumer complaints related to HCBMs. Through these activities, OIC will monitor the impact of rule implementation.

**B. How the Agency intends to inform and educate affected persons about the rule.**

OIC Policy staff will distribute the final rule and this Concise Explanatory Statement (CES) to all interested parties by posting and sharing the documents through the OIC's standard rulemaking listserv. The OIC Policy Division will post the CR-103 documents on the OIC's website.

| Type of Inquiry | Division |
|---|---|
| **Consumer assistance** | Consumer Advocacy Program |
| **Rule content** | Policy Division |
| **Authority for rules** | Legal Division |
| **Enforcement of rule** | Legal Division |
| **HCBM registration and renewal** | Company Supervision Division |

**C. How the Agency intends to promote and assist voluntary compliance for this rule.**

OIC will respond to inquiries from entities that plan to act or are acting as HCBMs in Washington state. The OIC will provide these entities with an opportunity to fully understand and comply with these rules. OIC also stands ready to meet with organizations representing carriers, HCBMs, PBMs, pharmacies, consumer groups and others to respond to questions and share perspectives on implementation of the rule.

**D. How the Agency intends to evaluate whether the rule achieves the purpose for which it was adopted.**

The goal of the laws implemented through this rulemaking is to "protect and promote the health, safety, and welfare of Washington residents by establishing standards for regulatory oversight of health care benefit managers." See RCW 48.200.010(3). OIC will monitor HCBM registrations, renewals, filings, and consumer and pharmacy complaints. OIC will review the outcome of HCBM-related investigations undertaken pursuant to this rule.

**Appendix A**

**CR-102 Public Hearing Summary**

**Summarizing Memorandum**
**To: Patty Kuderer, Insurance Commissioner**
**From: Nico Janssen, Presiding Official, Hearing on Rulemaking**

**Matter No. R 2025-11**

**Topic of Rulemaking:** Health care benefit managers

This memorandum summarizes the hearing on the above-named rulemaking, held on December 10, 2025 at 10 a.m. Pacific Time on Zoom, over which I presided in your stead.

The following agency personnel were present:

- Joyce Brake
- Jennifer Kreitler
- Remy McKnight
- Eric Villar
- Julia Hinrichs
- Heather Shimoji
- Jason Carr

**In attendance and testifying:**

**Testified:**
- LuGina Mendez-Harper, Prime Therapeutics
- Jenny Arnold, Washington State Pharmacy Association
- Matthew Sinnott, Willamette Dental

**Attended:**
- Annabel Lyons
- Benjamin Schaefer
- Brooke Rademacher
- Christina Mojica
- Courtney Taylor
- Dedi Little
- Denyse Bayer
- Edwin Chen
- Elizabeth Kerr
- Eric Dodsley

- Eric Villar
- Gary Swearingen
- Heather Chapman
- Jane Douthit
- Jeff Gingold
- Jenny Arnold
- Jessica Rowlett Jessica Rowlett
- Jessica Schrimpf
- Judy Lonteen
- Justin Aycock
- Katherine Lamb
- Katrina Jackson
- Kristina Berger
- LaKesha Bradley
- LuGina Mendez-Harper
- Matthew Sinnott
- Megan Kochenderfer
- Melanie Anderson
- Robyn Crosson
- Samantha Skinner
- Shannon Kubesh

**Contents of the presentations made at hearing:**

- LuGina Mendez-Harper (Prime Therapeutics) acknowledged that developing rules on this subject is complicated and difficult; however, she requested numerous changes to the CR-102 relevant to several WAC sections and topics, including:

    - WAC 284-180-505's treatment of specialty pharmacies with respect to the statute and rule's requirement that a PBM receive affirmative authorization before filling a prescription drug through a mail order pharmacy, as well as the administrative processes that will be required by this provision and the potential for patient safety or care disruption issues arising from these requirements.

    - Concerns with WAC 284-180-130's definitions, including "new prescription," "unusable condition," "require or coerce," and "contract price," and how the rule should address situations in which the only PBM-contracted specialty pharmacy is a PBM-owned or affiliated pharmacy.

    - WAC 284-180-501's treatment of post-invoice and post-service reconciliations as part of the parameters of "spread pricing." The

commentor requested that this language and/or WAC 284-180-501(2) allow for PBM adjustments or denials due to findings of fraud, waste, and abuse or due to pharmacy audits.

- That WAC 284-180-5107's allowance of pharmacies to appeal a PBM reimbursement up to 90 days after the claim was adjudicated is excessive and should be reduced.

- In general, the commentor asked that OIC change the proposed rule to adhere to the commentor's understanding of the intent of the underlying statute.

- Jenny Arnold (Washington State Pharmacy Association) testified with appreciation for the CR-102 language, suggested several changes, and stated that:

  - WAC 284-180-130's definition of "other conditions" should replace "board of pharmacy" with "pharmacy quality assurance commission"

  - The goal of the "local network pharmacy" language in RCW 48.200.310 was to allow emergency fills at local nearby pharmacies, and OIC need not change the definition in the proposed rule.

  - Regarding WAC 284-180-130's definition of "unusable condition," she appreciates the specialized knowledge that a pharmacist in charge of a mail order pharmacy would have; however, she is concerned that the mail order pharmacist would be readily available in the case of emergency refills.

  - She agreed with Ms. Mendez-Harper that findings of fraud, waste, and abuse should be permitted, and that this was what pharmacy audit allowed in current law was designed to collect. Hence, existing statute (RCW 48.200.280(l) already addresses this issue.

  - WAC 284-180-507's allowance of a pharmacy to appeal a PBM reimbursement up to 90 days after claim adjudication is not excessive and could be expanded further.

- Matthew Sinnott (Willamette Dental) requested that OIC change WAC 284-180-120 to exempt a particular type of entity from being an HCBM, specifically where the health care benefit manager is itself a provider, group of providers, or an affiliate of the health care services contractor that is exclusively contracted with such health care services contractor for services. The

commentor stated that the Legislature did not intend to apply HCBM requirements onto this type of entity.

**The hearing was adjourned.**

*SIGNED this 10th day of December, 2025*

*Nico Janssen*
*Presiding Official*