



# RULE-MAKING ORDER PERMANENT RULE ONLY

## CR-103P (October 2017) (Implements RCW 34.05.360)

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STATE OF WASHINGTON  
FILED

DATE: December 24, 2025

TIME: 11:37 AM

WSR 26-01-215

Agency: Office of the Insurance Commissioner

Insurance Commissioner Matter R 2025-11

**Effective date of rule:**

**Permanent Rules**

- 31 days after filing.
- Other (specify) \_\_\_\_\_ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

- Yes  No If Yes, explain:

**Purpose:** The 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.

**Citation of rules affected by this order:**

New: WAC 284-180-550  
 Repealed: none  
 Amended: WAC 284-180-120; WAC 284-180-130; WAC 284-180-210; WAC 284-180-220; WAC 284-180-465; WAC 284-180-501; WAC 284-180-507; WAC 284-180-517; WAC 284-180-522  
 Suspended: none

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

**Other authority:**

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 25-22-093 on November 4, 2025 (date).

Describe any changes other than editing from proposed to adopted version: OIC made the following changes:

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 “board of pharmacy” with “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.”

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Rules Coordinator

Address: PO Box 40260 Olympia, WA 98504

Phone: 360-725-7000

Fax:

TTY:

Email: [rulescoordinator@oic.wa.gov](mailto:rulescoordinator@oic.wa.gov)

Web site:

Other:

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

Federal statute:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Federal rules or standards:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Recently enacted state statutes:	New	<u>1</u>	Amended	9	Repealed	<u>0</u>

**The number of sections adopted at the request of a nongovernmental entity:**

New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
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**The number of sections adopted on the agency's own initiative:**

New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	<u>0</u>	Amended	0	Repealed	<u>0</u>
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**The number of sections adopted using:**

Negotiated rule making:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Pilot rule making:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Other alternative rule making:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>

**Date Adopted:** December 24, 2025

**Name:** Patty Kuderer

**Title:** Insurance Commissioner

**Signature:**



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 amount 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 or fees for a pharmacist's professional services that are not related to the ingredient cost of the drug.

(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 pharmacy quality assurance commission.

(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 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.

(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:

(a) The pharmacy benefit manager's reimbursement amount to a network pharmacy includes post-sale or post-invoice adjustments the pharmacy benefit manager makes that affect the amount paid for a drug including, but not limited to, fees, discounts, reconciliations, or assessments.

(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 284-180-130.

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.

**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 officer 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:

(i) Refills or continuations of existing prescriptions by the prescribing health care provider that ordered the original prescription under the same pharmacy benefit manager;

(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.

(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 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.

(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.

(e) 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.

(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.