Chapter 284-180 WAC
HEALTH CARE BENEFIT MANAGERS

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WAC

SUBCHAPTER A
GENERAL PROVISIONS

284-180-110 Purpose.
284-180-120 Applicability and scope.
284-180-130 Definitions.
284-180-150 Severability.

SUBCHAPTER B
REGISTRATION AND RENEWAL

284-180-210 Registration and renewal fees.
284-180-220 Health care benefit manager registration.
284-180-230 Health care benefit manager renewal.
284-180-240 Providing and updating registration information.

SUBCHAPTER C
RECORDS AND NOTICES

284-180-310 Health care benefit manager records.
284-180-320 Deadline to provide copies of records.
284-180-325 Required notices.

SUBCHAPTER D
CONTRACT FILINGS

284-180-405 Definitions in this subchapter.
284-180-411 Purpose of this subchapter.
284-180-415 Scope of this subchapter.
284-180-421 Filing instructions that are incorporated into this subchapter.
284-180-425 General health care benefit management form filing rules.
284-180-431 The commissioner may reject filings.
284-180-435 Filing authorization rules.
284-180-441 Rules for responding to an objection letter.
284-180-445 Rules for revised or replaced forms.
284-180-450 Effective date rules.
284-180-455 Carrier filings related to health care benefit managers.
284-180-460 Health care benefit manager filings.
284-180-465 Self-funded group health plan opt-in.

SUBCHAPTER E
APPEALS

284-180-500 Applicability and scope.
284-180-501 Pharmacy reimbursement.
284-180-505 Appeals by network pharmacies to health care benefit managers who provide pharmacy benefit management services.
284-180-507 Appeals by network pharmacies to health care benefit managers who provide pharmacy benefit management services.
284-180-510 Computation of time.
284-180-515 Use of brief adjudicative proceedings for appeals by network pharmacies to the commissioner.
284-180-517 Use of brief adjudicative proceedings for appeals by network pharmacies to the commissioner.
284-180-520 Appeals by network pharmacies to the commissioner.
284-180-522 Appeals by network pharmacies to the commissioner.
284-180-530 Review of initial orders from brief adjudicative proceedings.
284-180-540 General procedures governing brief adjudicative proceedings before the commissioner.

SUBCHAPTER F
ENROLLEES' ACCESS TO NETWORK PHARMACIES

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

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-180-140 Computation of time. [Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-140, filed 12/20/16, effective 1/1/17.] Decodified by WSR 21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900. Recodified as § 284-180-510.

284-180-330 Actions that may result in a fine. [Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-330, filed 12/20/16, effective 1/1/17.] Repealed by WSR 21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900.

284-180-340 When a violation is knowing and willful. [Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-340, filed 12/20/16, effective 1/1/17.] Repealed by WSR

21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900.

284-180-400 Appeals by network pharmacies to health care benefit managers who provide pharmacy benefit management services. [Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-400, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-400, filed 12/20/16, effective 1/1/17.] Amended and decodified by WSR 21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900. Recodified as § 284-180-505.

284-180-410 Use of brief adjudicative proceedings for appeals by network pharmacies to the commissioner. [Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-410, filed 12/20/16, effective 1/1/17.] Amended and decodified by WSR 21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900. Recodified as § 284-180-515.

284-180-420 Appeals by network pharmacies to the commissioner. [Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-420, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-420, filed 12/20/16, effective 1/1/17.] Amended and decodified by WSR 21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900. Recodified as § 284-180-520.

284-180-430 Review of initial orders from brief adjudicative proceedings. [Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-430, filed 12/20/16, effective 1/1/17.] Amended and decodified by WSR 21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900. Recodified as § 284-180-530.

284-180-440 General procedures governing brief adjudicative proceedings before the commissioner. [Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-440, filed 12/20/16, effective 1/1/17.] Decodified by WSR 21-02-034, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900. Recodified as § 284-180-540.

SUBCHAPTER A
GENERAL PROVISIONS

WAC 284-180-110 Purpose. (1) The purpose of this chapter is to establish uniform regulatory standards for health care benefit managers including, but not limited to, the processes and procedures for registration of health care benefit managers by the office of the insurance commissioner (commissioner).

(2) This chapter applies to all health care benefit managers except as otherwise expressly provided in this chapter. Health care benefit managers are responsible for compliance with the provisions of this chapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the health care benefit manager, or acting pursuant to health care benefit manager standards or requirements. Carriers remain responsible for activities of health care benefit managers conducted on their behalf. A carrier may not offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a health care benefit manager or other person acting on behalf of or at the direction of a health care benefit manager.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-110, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-110, filed 12/20/16, effective 1/1/17.]

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 health care benefit managers providing services exclusively to, or acting exclusively on behalf of:

(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.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-120, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-120, filed 12/18/24, effective 1/18/25; WSR 21-02-034, § 284-180-120, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-120, filed 12/20/16, effective 1/1/17.]

WAC 284-180-130 Definitions. Except as defined in other subchapters 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.

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

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

(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.

(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.

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

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

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

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

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

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

(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.

(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.

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

(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.

(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.

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

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

(25) As used in RCW 48.200.310, "other conditions" means conditions a pharmacy benefit manager applies to a covered person that di-

rectly 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.

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

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

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

(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.

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

(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.

(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.

(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.

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

(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.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-130, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-130, filed 12/18/24, effective 1/18/25; WSR 21-02-034, § 284-180-130, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-130, filed 12/20/16, effective 1/1/17.]

WAC 284-180-150 Severability. If any provision of this chapter or its application to any person or circumstances is held invalid, the remainder of the chapter or its application of the provision to other persons or circumstances is not affected.

[Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-150, filed 12/20/16, effective 1/1/17.]

SUBCHAPTER B
REGISTRATION AND RENEWAL

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 $500.

(3) For the renewal fee, the commissioner will charge a proportional share of the annual cost of the insurance commissioner's renew-

al 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 $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.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-210, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-210, filed 12/18/24, effective 1/18/25. Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-210, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-210, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-210, filed 12/20/16, effective 1/1/17.]

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 $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.

(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 serv-

ices on behalf of health carriers, employee benefits programs, or medicaid managed care programs must register under this section.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-220, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-220, filed 12/18/24, effective 1/18/25. Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-220, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-220, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-220, filed 12/20/16, effective 1/1/17.]

WAC 284-180-230 Health care benefit manager renewal. (1) Health care benefit managers must annually renew their registration and pay their renewal fee as required by RCW 48.200.030. Registration renewal must be submitted through the commissioner's electronic system, which is available at www.insurance.wa.gov.

(2) Health care benefit managers renewing their registrations must, no later than March 1st of each year, submit an electronic renewal report and supporting documents for approval to include:

(a) Their Washington state annual gross income for health care benefit manager business for the previous calendar year, broken down by Washington state annual gross income received from each contracted entity, whether a carrier or another health care benefit manager, that has made payments to the health care benefit manager for services provided to covered persons in Washington state during the previous calendar year; and

(b) Any additional information, including supporting documents, as required by the commissioner.

(3) Health care benefit managers may not amend their Washington state annual gross income report for the previous year later than April 15th, of the submission year.

(4) On or before June 1st of each year, the commissioner will calculate and set the renewal fees for the next July 1st through June 30th fiscal year. Invoices for the renewal fees and electronic payments will be available through the insurance commissioner's electronic filing and payment center. Renewal fee payments are due by July 15th of each year.

(5) The renewal application is not complete until the commissioner receives the complete renewal report, supporting documentation if required by the commissioner, and the payment of the invoiced renewal fee.

(6) Upon successful completion, the health care benefit manager will receive notice of approval of the renewal application from the commissioner.

(7) Failure to timely submit a completed renewal report and fee may result in a delayed renewal or nonrenewal in addition to potential violations if a health care benefit manager provides services without being registered.

(8) Each renewed registration is valid for one fiscal year from July 1st through June 30th fiscal year.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-230, filed 12/18/24, effective 1/18/25. Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-230, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-230, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-230, filed 12/20/16, effective 1/1/17.]

WAC 284-180-240 Providing and updating registration information. (1) When registering, a health care benefit manager must submit with its application an affidavit affirming the application's accuracy. An application for registering as a health care benefit manager must include:

(a) The legal name as well as any additional names that it uses to conduct business;

(b) The names of persons and entities with any ownership or controlling interests, including stockholders, officers and directors, or limited liability company members, managers and officers in the health care benefit manager, and the identity of any entity for which the health care benefit manager has a controlling interest;

(c) A list of tax identification numbers and business licenses and registrations that are active;

(d) Identifying any areas of specialty, such as a pharmacy benefit management, radiology benefit management, laboratory benefit management, mental health care benefit management, or any other areas of specialty identified in the application;

(e) A copy of the health care benefit manager's certificate of registration with the Washington state secretary of state;

(f) Contact information for communications regarding registration, renewal and oversight activities, to include name of the contact person, address, phone number, and valid email address;

(g) Name and contact information for the person the health care benefit manager has designated as responsible for compliance with state and federal laws to include name of the contact person, address, phone number, and valid email address;

(h) Identify if the health care benefit manager has committed any violations in this or any state or been the subject of an order from any federal or state agency or court; and

(i) Any additional information requested by the commissioner.

(2) Registered health care benefit managers must provide any material change in the information filed with the commissioner.

(a) This information includes, but is not limited to:

(i) Any additional names that the health care benefit manager uses to conduct business; and

(ii) The contact's name and email address for official communications between the commissioner and the health care benefit manager as required in subsection (1)(f) of this section.

(b) Any change in the information provided to obtain, renew, nonrenew, or surrender a registration as a health care benefit manager is a material change and must be reported to the commissioner within 30 days of the change.

(c) Any amendments to its annual renewal reports including the reported annual gross income must be reported to the commissioner no later than May 31st. Amended annual renewal reports may be accepted after review by the commissioner.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-240, filed 12/18/24, effective 1/18/25. Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 23-23-141 (Matter R 2023-06), § 284-180-240, filed 11/20/23, effective 12/21/23. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-240, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-240, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-240, filed 12/20/16, effective 1/1/17.]

SUBCHAPTER C
RECORDS AND NOTICES

WAC 284-180-310 Health care benefit manager records. (1) Health care benefit managers must maintain all records for a period of seven years from the date of creation and make them available to the commissioner upon request. Records include, but are not limited to:

(a) Registration and renewal materials that health care benefit managers submit to the commissioner to request registration and renewal; and

(b) Health care benefit managers that engage in pharmacy benefit management must also maintain information about appeals under chapter 48.200 RCW.

(2) These materials are subject to review by the commissioner's representatives.

(3) The commissioner may require health care benefit managers to provide copies of records.

(4) When the commissioner requests copies of records for inspection, health care benefit managers must transmit these documents as directed by the commissioner.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-310, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-310, filed 12/20/16, effective 1/1/17.]

WAC 284-180-320 Deadline to provide copies of records. (1) If the commissioner requests records for inspection for a purpose other than to resolve an appeal under RCW 48.200.280, a health care benefit manager must make the records available to the commissioner within fifteen business days from the date on the written request. If the commissioner grants a written extension, then the records are due by the date indicated on the extension.

(2) Upon receipt of any inquiry from the commissioner concerning a complaint, every health care benefit manager must furnish the com-

missioner with an adequate response to the inquiry within fifteen business days after receipt of the commissioner's inquiry using the commissioner's electronic company complaint system.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-320, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-320, filed 12/20/16, effective 1/1/17.]

WAC 284-180-325 Required notices. (1) Carriers must post on their website information that identifies each health care benefit manager contracted with the carrier, either directly or indirectly through subcontracting with a health care benefit manager or other entity, and identify the services provided by each health care benefit manager. The information must be visually prominent and easily located on the carriers' website with a link from the web page utilized for enrollees. The carrier is required to update the information on their website within 30 business days of any change, such as addition or removal of a health care benefit manager or a change in the services provided by a health care benefit manager.

(2) Carriers must notify enrollees in writing and at least annually, including at plan enrollment and renewal, of each health care benefit manager contracted with the carrier to provide any health care benefit management services, either directly or indirectly through subcontracting with a health care benefit manager or other entity. For example, written notices include disclosure in the policy or member handbook. This notice must identify the website address where enrollees can view an updated listing of all health care benefit managers utilized by the carrier.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-325, filed 12/18/24, effective 1/18/25; WSR 21-02-034, § 284-180-325, filed 12/29/20, effective 1/1/22.]

SUBCHAPTER D
CONTRACT FILINGS

WAC 284-180-405 Definitions in this subchapter. The definitions in this section apply throughout this subchapter.

(1) "Complete filing" means a package of information containing forms, supporting information, documents and exhibits submitted to the commissioner electronically using the system for electronic rate and form filing (SERFF).

(2) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(3) "Filer" means:

(a) A person, organization or other entity that files forms or rates with the commissioner for a carrier or health care benefit manager; or

(b) A person employed by a carrier or heath care benefit manager to file under this chapter.

(4) "Health care benefit management contract form" or "contract" or "form" means any written agreement describing the rights and re-

sponsibilities of the parties, such as carriers, health care benefit managers, providers, pharmacy, pharmacy services administration organization, and employee benefit program conforming to chapter 48.200 RCW and this chapter including:

(a) All forms that are part of the contract; and

(b) All amendments to the contract.

(5) "NAIC" means the National Association of Insurance Commissioners.

(6) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation, or other information; or

(b) Explains errors or omissions in the filing.

(7) "SERFF" means the system for electronic rate and form filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule, and form filings electronically to the commissioner.

(8) "Type of insurance" or "TOI" means a specific type of health care coverage listed in the *Uniform Life, Accident and Health, Annuity and Credit Coding Matrix* published by the NAIC and available at www.naic.org.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-405, filed 12/18/24, effective 1/18/25; WSR 21-02-034, § 284-180-405, filed 12/29/20, effective 1/1/22.]

WAC 284-180-411 Purpose of this subchapter. The purpose of this subchapter is to:

(1) Adopt processes and procedures for filers to use when submitting electronic forms and rates to the commissioner by way of SERFF.

(2) Designate SERFF as the method by which filers, including carriers and health care benefit managers, must submit all health care benefit management contract forms to the commissioner.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-411, filed 12/18/24, effective 1/18/25; WSR 21-02-034, § 284-180-411, filed 12/29/20, effective 1/1/22.]

WAC 284-180-415 Scope of this subchapter. This subchapter applies to all carriers and health care benefit managers that must file forms under chapter 48.200 RCW.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-415, filed 12/29/20, effective 1/1/22.]

WAC 284-180-421 Filing instructions that are incorporated into this subchapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF website into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* available within the SERFF application; and

(2) The *Washington State SERFF Health Care Benefit Management General Filing Instructions* posted on the commissioner's website (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-421, filed 12/29/20, effective 1/1/22.]

WAC 284-180-425 General health care benefit management form filing rules. (1) Each health care benefit management contract form and contract amendment form filing must be submitted to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must:

(i) Be attached to the form schedule; and

(ii) Have a unique identifying number and a way to distinguish it from other versions of the same form.

(b) Filers must send all written correspondence related to a form filing in SERFF.

(2) All filed forms must be legible for both the commissioner's review and retention as a nonpublic record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.

(3) Filers must submit complete filings that comply with the *SERFF Industry Manual* available within the SERFF application and the *Washington State SERFF Health Care Benefit Management General Filing Instructions*, as revised from time to time and posted on the commissioner's website (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-425, filed 12/29/20, effective 1/1/22.]

WAC 284-180-431 The commissioner may reject filings. (1) The commissioner may reject and close any filing that does not comply with this subchapter. If the commissioner rejects a filing, the filer has not filed forms with the commissioner.

(2) If the commissioner rejects a filing and the filer resubmits it as a new filing, the date filed will be the date the commissioner receives and accepts the new filing.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-431, filed 12/29/20, effective 1/1/22.]

WAC 284-180-435 Filing authorization rules. A carrier or health care benefit manager may authorize a third-party filer to file forms or rates on its behalf. For the purposes of this section, a "third-party filer" means a person or entity in the business of providing regulatory compliance services.

(1) If a carrier or health care benefit manager delegates filing authority to a third-party filer, each filing must include a letter as supporting documentation signed by an officer of the carrier or health care benefit manager authorizing the third-party filer to make filings on behalf of the carrier or health care benefit manager.

(2) The carrier or health care benefit manager may not delegate responsibility for the content of a filing to a third-party filer. The commissioner considers errors and omissions made by the third-party

filer to be errors and omissions of the carrier or health care benefit manager.

(3) If a third-party filer has a pattern of making filings that do not comply with this chapter, the commissioner may reject a delegation of filing authority.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-435, filed 12/29/20, effective 1/1/22.]

WAC 284-180-441 Rules for responding to an objection letter. An objection letter may ask the filer to revise a noncompliant form or provide clarification or additional information. The objection letter will state the reason(s) for the objection, including relevant case law, statutes, and rules. Filers must:

(1) Provide a complete response to an objection letter. A complete response must include a separate response to each objection, and if appropriate:

(a) A description of changes proposed to noncompliant forms, and a replacement form attached to the form schedule; or

(b) Revised exhibits and supporting documentation.

(2) Respond to the commissioner in a timely manner designated by the commissioner in the objection letter.

(3) Failure to timely respond to an objection is a violation.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-441, filed 12/29/20, effective 1/1/22.]

WAC 284-180-445 Rules for revised or replaced forms. If a carrier or health care benefit manager files a revised or replaced form, the filer must provide the supporting documentation described below:

(1) If a form is revised due to an objection(s) from the commissioner, the filer must provide a detailed explanation of all material changes to the replaced form.

(2) If a form is replaced with a new version, the filer must submit an exhibit that marks and identifies each change or revision to the replaced form using one of these methods:

(a) A draft form that strikes through deletions and underlines additions or changes in the form;

(b) A draft form that includes comments in the margins explaining the changes in the form; or

(c) A side-by-side comparison of current and proposed language.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-445, filed 12/29/20, effective 1/1/22.]

WAC 284-180-450 Effective date rules. (1) Filers must include a common implementation date for all forms submitted in a filing.

(2) Filers may submit a request to change the implementation date of a filing as a note to reviewer.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-450, filed 12/29/20, effective 1/1/22.]

WAC 284-180-455 Carrier filings related to health care benefit managers. (1)(a) A carrier must file all contracts and contract amendments between a health care benefit manager and a carrier within 30 days following the effective date of the contract or contract amendment.

(b) To meet its obligations under RCW 48.200.050(5), a carrier must, for any health care benefit manager that provides services to or acts on behalf of the carrier and is not directly contracted with the carrier:

(i) File all contracts to provide health care benefit management services to or on behalf of a carrier such as, but not limited to, health care benefit management services contracts that result from a carrier contracting with a health care benefit manager who then contracts or subcontracts with another health care benefit manager; or

(ii) Identify all contracts to provide health care benefit management services to or on behalf of the carrier, ensure that contracted health care benefit managers have filed all required contracts with the commissioner, whether the health care benefit manager is directly or indirectly contracted with the carrier, as required in RCW 48.200.040 and WAC 284-180-460, and submit to the commissioner, as required by the "Washington State SERFF Carrier Provider Agreement and HCBM Contract Filing General Instructions," as a supporting document to the carrier's filings, a list of all health care benefit manager contracts. The list must include the SERFF tracker identifier for each contract.

(2) If a carrier negotiates, amends, or modifies a contract or a compensation agreement that deviates from a previously filed contract, then the carrier must file that negotiated, amended, or modified contract or agreement with the commissioner within 30 days following the effective date. The commissioner must receive the filings electronically in accordance with this subchapter.

(3) Carriers must maintain health care benefit manager contracts at its principal place of business in the state, or the carrier must have access to all contracts and provide copies to facilitate regulatory review upon 20 days prior written notice from the commissioner.

(4) Nothing in this section relieves the carrier of the responsibility detailed in WAC 284-170-280 (3)(b) to ensure that all contracts are current and signed if the carrier utilizes a health care benefit manager's providers and those providers are listed in the network filed for approval with the commissioner.

(5) If a carrier enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the carrier must file the reimbursement agreement with the commissioner within 30 days following the effective date of the reimbursement agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the carrier that the agreement is disapproved within 30 days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.

(6) Health care benefit manager contracts and compensation agreements must clearly set forth the carrier provider networks and applicable compensation agreements associated with those networks so that

the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-455, filed 12/18/24, effective 1/18/25; WSR 21-02-034, § 284-180-455, filed 12/29/20, effective 1/1/22.]

WAC 284-180-460 Health care benefit manager filings. (1) A health care benefit manager must file all contracts and contract amendments between the health care benefit manager and a health carrier, provider, pharmacy, pharmacy services administration organization, or other health care benefit manager entered into directly or indirectly in support of a contract with a carrier or employee benefits program within 30 days following the effective date of the contract or contract amendment. Contracts that must be filed by a health care benefit manager shall include all contracts to provide health care benefit management services to or on behalf of the carrier, whether the health care benefit manager is directly or indirectly contracted with the carrier such as, but not limited to, health care benefit management services contracts that result from a carrier contracting with a health care benefit manager who then contracts or subcontracts with another health care benefit manager.

(2) If a health care benefit manager negotiates, amends, or modifies a contract or a compensation agreement that deviates from a filed agreement, then the health care benefit manager must file that negotiated, amended, or modified contract or agreement with the commissioner within 30 days following the effective date. The commissioner must receive the filings electronically in accordance with this chapter.

(3) Contracts or contract amendments that were executed prior to July 23, 2023, and remain in force, must be filed with the commissioner no later than 60 days following July 23, 2023.

(4) A health care benefit manager must maintain health care benefit management contracts at its principal place of business in the state, or the health care benefit manager must have access to all contracts and provide copies to facilitate regulatory review upon 20 days prior written notice from the commissioner.

(5) Health care benefit manager contracts and compensation agreements must clearly set forth provider network names and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-460, filed 12/18/24, effective 1/18/25. Statutory Authority: RCW 48.02.060, 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900. WSR 23-24-034 (Matter R 2023-07), § 284-180-460, filed 11/30/23, effective 1/1/24. Statutory Authority:

RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-460, filed 12/29/20, effective 1/1/22.]

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.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-465, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-465, filed 12/18/24, effective 1/18/25.]

SUBCHAPTER E
APPEALS

WAC 284-180-500 Applicability and scope. This subchapter applies to pharmacy benefit managers as defined in RCW 48.200.020.

(1) Specifically, this subchapter applies to the actions of pharmacy benefit managers regarding contracts with pharmacies on behalf of a carrier, employee benefits program, or medicaid managed care program in regard to:

(a) Fully insured health plans; and

(b) Medicaid managed care plans. However, the appeal requirements of RCW 48.200.280 do not apply to medicaid managed care plans.

(2) This subchapter does not apply to:

(a) The actions of pharmacy benefit managers contracting with third-party administrators to administer prescription drug benefits for self-funded group health plans or union plans, unless a self-funded group health plan or union plan governed by the provisions of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.) has elected to participate in RCW 48.200.280, 48.200.310, and 48.200.320 under WAC 284-180-465; and

(b) The actions of pharmacy benefit managers contracting to administer prescription drug benefits for medicare plans.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-500, filed 12/18/24, effective 1/18/25; WSR 21-02-034, § 284-180-500, filed 12/29/20, effective 1/1/22.]

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.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-501, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-501, filed 12/18/24, effective 1/18/25.]

WAC 284-180-505 Appeals by network pharmacies to health care benefit managers who provide pharmacy benefit management services. A network pharmacy may appeal a reimbursement to a health care benefit manager providing pharmacy benefit management services (first tier appeal) if the reimbursement for the drug is less than the net amount the network pharmacy paid to the supplier of the drug and the claim was adjudicated by the pharmacy benefit manager within the past 90 days. "Network pharmacy" has the meaning set forth in RCW 48.200.280. "Pharmacy benefit manager" is a health care benefit manager that offers pharmacy benefit management services and has the meaning set forth in RCW 48.200.020. A pharmacy benefit manager must process the network pharmacy's appeal as follows:

(1) 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, then 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 this subsection and documentation or information described in subsection (2) of this section, or of a request for or 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.

(2) The pharmacy benefit manager must reconsider the reimbursement. A pharmacy benefit manager's review process must provide the network pharmacy or its representatives with the 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 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 net 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.

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.

(3) 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.

(4) 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(7).

(5)(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 predetermined reimbursement cost for the multisource generic 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. "Multisource generic drug" has the same meaning as the definition of "multisource generic drug" in RCW 48.200.280.

(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 are 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.

(6) 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 reasonable adjustment must include, at a minimum, payment of the claim or claims at issue at the net amount paid by the pharmacy to the supplier of the drug. 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.

(7) 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.

(8) 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.

(9) Health care benefit managers providing pharmacy benefit management services benefit managers 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.

(10) This section expires December 31, 2025.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-505, filed 12/18/24, effective 1/18/25; WSR 21-02-034, amended and recodified as § 284-180-505, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-400, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-400, filed 12/20/16, effective 1/1/17.]

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.

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

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-507, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-507, filed 12/18/24, effective 1/18/25.]

WAC 284-180-510 Computation of time. In computing any period of time prescribed by this rule, the commissioner:

(1) Will not count the first day;

(2) Will count the last day, unless the last day is a weekend or a state legal holiday; and

(3) Will count the next day that is not a weekend or a state legal holiday as the last day if the last day is a weekend or a state legal holiday.

[Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, recodified as § 284-180-510, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, § 284-180-140, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-140, filed 12/20/16, effective 1/1/17.]

WAC 284-180-515 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 (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 expires December 31, 2025.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-515, filed 12/18/24, effective 1/18/25. Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 22-23-069 (Matter R 2022-07), § 284-180-515, filed 11/10/22, effective 12/11/22. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, amended and recodified as § 284-180-515, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-410, filed 12/20/16, effective 1/1/17.]

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.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-517, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-517, filed 12/18/24, effective 1/18/25.]

WAC 284-180-520 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 subject to predetermined reimbursement costs for multisource generic drugs, 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 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

(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 predetermined reimbursement cost for the multisource generic 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 subject to predetermined reimbursement costs for multisource generic drugs, 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.

(11) This section expires December 31, 2025.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 25-02-024 (Matter R 2024-02), s 284-180-520, filed 12/18/24, effective 1/18/25. Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 22-23-069 (Matter R 2022-07), § 284-180-520, filed 11/10/22, effective 12/11/22. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, amended and recodified as § 284-180-520, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.02.220 and chapter 19.340 RCW. WSR 18-13-023, § 284-180-420, filed 6/8/18, effective 7/9/18. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-420, filed 12/20/16, effective 1/1/17.]

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, 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.

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 pre-

siding 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.

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

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-522, filed 12/24/25, effective 1/24/26; WSR 25-02-024 (Matter R 2024-02), s 284-180-522, filed 12/18/24, effective 1/18/25.]

WAC 284-180-530 Review of initial orders from brief adjudicative proceedings. The following procedure applies to the commissioner's review of a brief adjudicative proceeding conducted pursuant to WAC 284-180-520, unless the matter is converted to a formal proceeding as provided in WAC 284-180-540(4).

(1) **Request for review of initial order.** A party to a brief adjudicative proceeding under WAC 284-180-520 may request review of the initial order by filing a written petition for review with the commissioner within 21 days after service of the initial order is received or deemed to be received by the party. A form for this purpose is available at www.insurance.wa.gov. The request for review must be submitted electronically.

(a) When making a petition for review of the initial order, the petitioner must submit to the reviewing officer any evidence or written material relevant to the matter that the party wishes the reviewing officer to consider.

(b) The commissioner may, on its own motion, conduct an administrative review of the initial order as provided for in RCW 34.05.491.

(2) **Reviewing officer.** The commissioner shall appoint a reviewing officer who satisfies the requirements of RCW 34.05.491(2). The reviewing officer shall:

(a) Make such determination as may appear to be just and lawful;

(b) Provide both the network pharmacy and the pharmacy benefit manager an opportunity to explain their positions on the matter; and

(c) Make any inquiries necessary to determine whether the proceeding should be converted to a formal adjudicative proceeding. The review is governed by the brief adjudicative procedures of chapter

34.05 RCW and this rule, or WAC 284-02-070 in the event a brief adjudicative hearing is converted to a formal adjudicative proceeding. The reviewing officer shall have the authority of a presiding officer as provided in WAC 284-180-520.

(3) **Record review.**

(a) Review of an initial order is limited to:

(i) The evidence that the presiding officer considered;

(ii) The initial order;

(iii) The recording of the initial proceeding; and

(iv) Any records and written evidence that the parties submitted to the reviewing officer.

(b) However, the record that the presiding officer made does not need to constitute the exclusive basis for the reviewing officer's decision.

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

(d) If the reviewing officer determines that oral testimony is needed, the officer may schedule a time for both parties to present oral testimony. Oral statements before the reviewing officer shall be by telephone, unless specifically scheduled by the reviewing officer to be in person.

(e) Each party will have an opportunity to respond to the other party's request for review and may also submit any other relevant evidence and written material to the reviewing officer.

(i) The other party must:

(A) Submit material within seven days of service of the material submitted by the party requesting review of the initial order; and

(B) Serve a copy of all evidence and written material provided to the reviewing officer to the party requesting review according to WAC 284-180-540(2).

(ii) Proof of service is required under WAC 284-180-540 (2)(g) when a party submits material to the other party under this subsection.

(4) **Failure to participate.** If a party requesting review of an initial order under subsection (1) of this section fails to participate in the proceeding or fails to provide documentation to the reviewing officer upon request, the reviewing officer may uphold the initial order based upon the record.

(5) **Final orders.**

(a) The reviewing officer's final order must include the decision of the reviewing officer and a brief statement of the basis and legal authority for the decision.

(b) Unless there are continuances, the reviewing officer will issue the final order within 20 days of the petition for review.

(6) **Reconsideration.** Unless otherwise provided in the reviewing officer's order, the reviewing officer's order represents the final position of the commissioner. A petitioner may only seek a reconsideration of the reviewing officer's order if the final order contains a right to a reconsideration.

(7) **Judicial review.** Judicial review of the final order of the commissioner is available under Part V, chapter 34.05 RCW. However, as required by RCW 34.05.534, judicial review may be available only if

the petitioner has requested a review of the initial order under this subsection and has exhausted all other administrative remedies.

[Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 22-23-069 (Matter R 2022-07), § 284-180-530, filed 11/10/22, effective 12/11/22. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, amended and recodified as § 284-180-530, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-430, filed 12/20/16, effective 1/1/17.]

WAC 284-180-540 General procedures governing brief adjudicative proceedings before the commissioner. (1) **Rules of evidence - Record of the proceeding.**

(a) Evidence is admissible if in the judgment of the presiding or reviewing officer it is the kind of evidence on which reasonably prudent persons are accustomed to relying on in conducting their affairs. The presiding and reviewing officer should apply RCW 34.05.452 when ruling on evidentiary issues in the proceeding.

(b) All oral testimony must be recorded manually, electronically, or by another type of recording device. The agency record must consist of the documents regarding the matters that were considered or prepared by the presiding officer, or by the reviewing officer in any review, and the recording of the hearing. These records must be maintained by the commissioner as its official record.

(2) **Service.** All notices and other pleadings or papers filed with the presiding or reviewing officer must be served on the network pharmacy and the pharmacy benefit manager.

By electronic delivery as allowed by the presiding officer.

Service by electronic delivery is regarded as completed on the date that any party electronically sends the information to other parties or electronically notifies other parties that the information is available for them to access.

(3) **Conversion of a brief adjudicative proceeding to a formal proceeding.** The presiding or reviewing officer may at any time, on motion of either party or on the officer's own motion, convert the brief adjudicative proceeding to a formal proceeding. The presiding or reviewing officer may convert the proceeding if the officer finds that:

(a) Use of the brief adjudicative proceeding violates any provision of law;

(b) The protection of the public interest requires the agency to give notice to and an opportunity to participate to persons other than the parties; or

(c) The issues and interests involved warrant the use of procedures governed by RCW 34.05.413 through 34.05.476 or 34.05.479.

[Statutory Authority: RCW 48.02.060, 48.200.280(6), 34.05.485 (1)(c), and 48.02.100. WSR 22-23-069 (Matter R 2022-07), § 284-180-540, filed 11/10/22, effective 12/11/22. Statutory Authority: RCW 48.02.060 and 48.200.900. WSR 21-02-034, recodified as § 284-180-540, filed 12/29/20, effective 1/1/22; WSR 21-02-034, § 284-180-440, filed 12/29/20, effective 1/1/22. Statutory Authority: RCW 48.02.060, 19.340.010, 19.340.030, 19.340.100, 19.340.110, and 2016 c 210 §§ 1 and 2 through 7. WSR 17-01-139 (Matter No. R 2016-07), § 284-180-440, filed 12/20/16, effective 1/1/17.]

SUBCHAPTER F
ENROLLEES' ACCESS TO NETWORK PHARMACIES

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.

[Statutory Authority: RCW 48.200.900 and 48.02.060. WSR 26-01-215 (Matter R 2025-11), s 284-180-550, filed 12/24/25, effective 1/24/26.]