State PBM Reform Inventory

Updated October 2026

Washington

Issue	Summary	Citation
Licensing/Registration	PBMs are considered health care benefit managers (HCBMs) and must register with the Commissioner of Insurance and annually renew their registration. PBMs must submit an application on forms designated by the commissioner as well as either an initial registration fee of $500 or a renewal fee of $750.	Wash. Rev. Code § 48.200.030
Reporting Requirements	An HCBM must file with the commissioner in the form and manner prescribed by the commissioner, every benefit management contract and contract amendment between the HCBM 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 programs, within 30 days following the effective date of the contract or contract amendment. By March 1st of each year, a PBM must submit to the Health Care Authority the following data from the previous calendar year: • All discounts, including the total dollar amount and percentage discount, and all rebates received from a manufacturer for each drug on the PBM's formularies; • The total dollar amount of all discounts and rebates that are retained by the PBM for each drug on the PBM's formularies; • Actual total reimbursement amounts for each drug the PBM pays retail pharmacies after all direct and indirect administrative and other fees that have been retrospectively charged to the pharmacies are applied; • The negotiated price health plans pay the PBM for each drug on the PBM's formularies; • The amount, terms, and conditions relating to copayments, reimbursement options, and other payments or fees associated with a prescription drug benefit plan;	Wash. Rev. Code § 48.200.040; Wash. Rev. Code § 43.71C.030

	• Disclosure of any ownership interest the PBM has in a pharmacy or health plan with which it conducts business; and • The results of any MAC pricing appeal pursuant to s. 48.200.280. The authority may examine or audit the financial records of a PBM for purposes of ensuring the information submitted under this section is accurate.	
PBM Income	**Spread Pricing:** Effective January 1, 2026, a PBM may not reimburse a network pharmacy for an amount less than the contract price between the PBM and the insurer, third-party payor, or the prescription drug purchasing consortium with which the PBM has contracted.	Wash. Rev. Code § 48.200.310
Pharmacy Contracting	**MAC Pricing:** A PBM: • May not place a drug on a list unless there are at least two therapeutically equivalent multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers; • Shall ensure that all drugs on a list are readily available for purchase by pharmacies in this state from national or regional wholesalers that serve pharmacies in Washington; • Shall ensure that all drugs on a list are not obsolete; • Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the reimbursement costs for multiple source drugs of the PBM; • Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy; • Shall update each list maintained by the PBM every 7 business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format; • Shall ensure that dispensing fees are not included in the calculation of the reimbursement costs for multiple source drugs; or	Wash. Rev. Code § 48.200.280; Wash. Rev. Code § 48.200.310

	• Reimburse a pharmacy an amount less than the amount the PBM reimburses an affiliate for providing the same pharmacy services.
	
	A PBM must establish a process by which a network pharmacy, or its representative, may appeal its reimbursement for a drug. A network pharmacy may appeal a reimbursement amount paid by a PBM for a drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug.
	• Before a pharmacy or pharmacist files an appeal, upon request by a pharmacy or pharmacist, a PBM must provide a current and accurate list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans and self- funded group health plans that have opted in to this section and RCW 48.200.310 and 48.200.320 pursuant to RCW 48.200.330 with which the PBM either has a current contract or had a contract that has been terminated within the past 12 months to provide pharmacy benefit management services.
	• An appeal requested under this section must be completed within 30 calendar days of the pharmacy submitting the appeal.
	• If, after 30 days, the network pharmacy has not received the decision on the appeal from the PBM, then the appeal is considered denied.
	• The PBM shall uphold the appeal of a pharmacy with fewer than 15 retail outlets within the state of Washington if the pharmacy or pharmacist can demonstrate that it is unable to purchase a therapeutically equivalent interchangeable product from a supplier doing business in Washington at the PBM's list price.
	• A PBM must provide as part of the appeals process:
	  ○ A telephone number at which a network pharmacy may contact the PBM and speak with an individual who is responsible for processing appeals;
	  ○ If the appeal is denied, the reason for the denial and the NDC of a drug that has been purchased by other network pharmacies located in Washington at a price that is equal to or less than the reimbursement amount paid by the PBM for the drug. A pharmacy with 15 or	

	more retail outlets within the state of Washington may submit information to the commissioner about an appeal for purposes of information collection and analysis; ○ If an appeal is upheld under this section, the PBM shall make a reasonable adjustment on a date no later than 1 day after the date of determination. If the request for an adjustment has come from a critical access pharmacy, the adjustment shall apply only to critical access pharmacies. • If a network pharmacy's appeal to the PBM is denied, or if the network pharmacy is unsatisfied with the outcome of the appeal, the pharmacy or pharmacist may dispute the decision and request review by the commissioner within 30 calendar days of receiving the decision. **Patient Steering:** A PBM may not require or coerce a patient to use their owned or affiliated pharmacies. A PBM shall: • Apply the same utilization review, fees, days allowance, and other conditions upon a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the PBM's pharmacy network, including mail order pharmacies; • Permit the covered person to receive delivery or mail order of a prescription drug through any network pharmacy that is not primarily engaged in dispensing prescription drugs to patients through the mail or common carrier; and • For new prescriptions issued after January 1, 2026, receive affirmative authorization from a covered person before filling prescriptions through a mail-order pharmacy. If a covered person is using a mail-order pharmacy, the PBM shall: • Allow for dispensing at local network pharmacies under the following circumstances to ensure patient access to prescription drugs if the prescription is delayed more than one day after the expected delivery date provided by the	

	mail order pharmacy, or arrives in an unusable condition; and • Ensure patients have easy and timely access to prescription counseling by a pharmacist.	

Patient Cost-Sharing	**Maximum Cost-Sharing Levels:**
	The maximum amount a health carrier or PBM may require a person to pay at the point of sale for a covered prescription medication is the lesser of:
	• The applicable cost sharing for the prescription medication; or
	• The amount the person would pay for the prescription medication if the person purchased the prescription medication without using a health plan.
	
	Copay Adjustment Programs:
	When calculating an enrollee's contribution to any applicable cost- sharing or out-of-pocket maximum, a health carrier offering a non- grandfathered health plan with a pharmacy benefit, or an HCBM administering benefits for the health carrier, shall include any cost- sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person for a covered prescription drug that is:
	• Without a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary;
	• With a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary where the enrollee has obtained access to the drug through:
	  ○ Prior authorization;
	  ○ Step therapy; or
	  ○ The plan's prescription drug exception request process; or
	• With a generic equivalent or therapeutic equivalent preferred under the health plan's formulary, throughout an exception request process under RCW 48.43.420, including any appeal of a denial of an exception request. If the health carrier utilizes an HCBM to approve or deny exception requests, the exception request process also includes any time between the completion of the exception request process, including any appeal of a denial, and when the HCBM communicates the status of the request to the health carrier.
		Wash. Rev. Code § 48.43.430;
		
		Wash. Rev. Code § 48.43.435;
		
		Wash. Rev. Code § 48.43.780

	This section does not apply to a qualifying health plan for a health savings account to the extent necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws, regulations, and guidance. **Copay Cap:** A health plan issued or renewed on or after January 1, 2023, that provides coverage for prescription insulin drugs for the treatment of diabetes must cap the total amount that an enrollee is required to pay for a covered insulin drug at an amount not to exceed $35 per 30-day supply of the drug. Prescription insulin drugs must be covered without being subject to a deductible, and any cost-sharing paid by an enrollee must be applied toward the enrollee's deductible obligation. A health plan issued or renewed on or after January 1, 2025, that provides coverage for prescription asthma inhalers for the treatment of asthma shall cap the total amount that an enrollee is required to pay for at least 1 covered inhaled corticosteroid and at least 1 covered inhaled corticosteroid combination that is FDA-approved for the treatment of asthma at an amount not to exceed $35 per 30-day supply of the drug. A health plan must ensure that a covered inhaled corticosteroid and a covered inhaled corticosteroid combination is always available to a patient at the amount required. Prescription asthma inhalers must be covered without being subject to a deductible, and any cost-sharing paid by an enrollee must be applied toward the enrollee's deductible obligation, except in the case of HSA-eligible high-deductible plans. A health plan issued or renewed on or after January 1, 2025, that provides coverage for prescription epinephrine autoinjectors for the treatment of allergic reaction, shall cap the total amount that an enrollee is required to pay for at least 1 covered epinephrine autoinjector product containing at least 2 autoinjectors at an amount not to exceed $35. A health plan must ensure that a covered epinephrine autoinjector is always available to a patient at the amount required. Prescription epinephrine autoinjectors must be covered without being	

	subject to a deductible, and any cost-sharing paid by an enrollee must be applied toward the enrollee's deductible obligation, except in the case of HSA-eligible high-deductible plans.	