



October 6, 2026

HCA Rules Coordinator
Washington State Health Care Authority
PO Box 42716
Olympia, WA 98504-2716
arc@hca.wa.gov

Re: Proposed Rule WSR 26-18-005 — Prescription Drug Affordability Board: Definitions (WAC 182-52-0010) and Upper Payment Limits (new WAC 182-52-0100)

Dear Rules Coordinator and PDAB Committee:

Dear Rules Coordinator:

The Washington State Pharmacy Association (WSPA) appreciates the opportunity to comment on the Health Care Authority's proposed rules implementing upper payment limits (UPLs) under RCW 70.405.050. The Washington State Pharmacy Association is the home and voice of pharmacy practice. We advocate on behalf of the profession to ensure pharmacy professionals are uniformly recognized as a vital member of the healthcare team. WSPA represents pharmacists, pharmacy technicians, and pharmacies across Washington.

WSPA shares the goal of making prescription drugs affordable for Washington patients. As drafted, however, the proposed rule places the financial risk of every upper payment limit on the participant in the supply chain least able to absorb it: the pharmacy that dispenses the drug to the patient. When pharmacies cannot dispense a drug without losing money on every prescription, they stop stocking it, cut hours and staff, or close. Each of those outcomes falls hardest on patients. The sections below describe the specific ways the proposed rule threatens the financial health of Washington pharmacies and, through them, patient access.

1. The UPL is a ceiling on pharmacy payment with no floor beneath it

The proposed amendment to WAC 182-52-0010 defines the upper payment limit as "the maximum amount that may be paid, by any entity" for an affected drug. Proposed WAC 182-52-0100(2)(c) then applies that maximum to the combined amount a pharmacy receives from the patient and the payer on a claim.

Nothing in the rule requires a health carrier, pharmacy benefit manager (PBM), or health plan to pay the pharmacy the UPL amount. The UPL sets the most a pharmacy can receive; it says nothing about the least. PBMs already set pharmacy reimbursement through their own maximum allowable cost lists and contract terms, and pharmacies have little ability to negotiate those terms. A state-published maximum gives PBMs a new, government-sanctioned benchmark to reimburse from — and to reimburse below.

The result is a one-way ratchet. The UPL can only lower what a pharmacy is paid. It can never protect a pharmacy from being paid less than the drug costs it to buy.

2. Dispensing fees are excluded from the cap but not guaranteed, and nothing stops clawbacks

Proposed WAC 182-52-0100(2)(b) states that the UPL does not include "reasonable dispensing fees or delivery charges separately charged by a pharmacy." Thank you for that consideration, however practically it is not helpful as many PBMs pay little to nothing as a dispensing fee specifically.

The rule does not require any payer to pay a dispensing fee, does not define "reasonable," and does not address contracts in which the dispensing fee is nominal or folded into a single payment. A pharmacy cannot separately charge a fee its PBM contract does not allow. Perhaps consider citing the Washington Medicaid State Plan Amendment minimum dispensing fees as a minimum.

The rule is also silent on what happens after a claim is paid. PBMs routinely reduce pharmacy payments through post-adjudication fees, performance adjustments, audits, and clawbacks; sometimes weeks or months after the drug was dispensed. Under the proposed rule, a pharmacy could be reimbursed at or below the UPL at the counter and then have that amount reduced further. Because the UPL is written only as a maximum, those after-the-fact reductions are not limited by it in any way.

The proposed rule's broad definition of the UPL as "inclusive of all components of the transaction price" (WAC 182-52-0100(2)) adds further uncertainty about which pharmacy fees and service charges payers will treat as falling inside the cap.

3. Pharmacies may have to buy above the UPL and be paid at or below it

Pharmacies buy drugs from wholesalers and distributors, most of which are located outside Washington, at prices set by manufacturers and wholesalers. The proposed rule imposes no obligation on any wholesaler or distributor to make an affected drug available to Washington pharmacies at or below the UPL. The only supply-side provision, WAC 182-52-0100(10), asks the manufacturer to tell the Board whether it will make the drug available in the state. It is not clear that it requires any entity sell to pharmacies at a price that makes dispensing viable.

It is easy to foresee a situation where a pharmacy has only the option to purchase a medicine at a nationally negotiated rate above the UPL, and then the UPL only allows reimbursement far below what they paid for the medicine. In such a situation, a pharmacy could not afford to carry that medicine and patient access would be impacted.

The rule contains no rebate, chargeback, or reconciliation mechanism to make a pharmacy whole when its acquisition cost exceeds the UPL. Without one, the gap between what a pharmacy pays and what it is allowed to receive is the pharmacy's loss, on every fill.

Under the CMS UPL plan and in some other states, the timing makes this worse. Under WAC 182-52-0100(14), a UPL applies only to purchases, contracts, and plans issued or renewed after its effective date. Pharmacies hold inventory purchased weeks earlier, and plan renewal dates do not line up with

pharmacy purchasing. A pharmacy may dispense stock it bought at the pre-UPL price and be reimbursed at the UPL. Annual reassessment of UPLs under WAC 182-52-0100(12) means this inventory risk can recur every year.

4. Pharmacies face pressure to dispense at a loss

The proposed rule does not address whether a pharmacy may decline to dispense a UPL drug when its acquisition cost exceeds what it will be paid. Pharmacies operate under network contracts, Medicaid participation requirements, and professional and ethical obligations to the patients in front of them. In practice, many will dispense anyway rather than send a patient away without needed medication.

Every such fill is a direct loss. For high-cost drugs — exactly the drugs most likely to be selected for affordability review — a single high cost prescription dispensed at a significant loss or high carrying cost can equal a pharmacy's margin on dozens of other prescriptions. Independent pharmacies operate on thin margins and cannot sustain repeated below-cost dispensing.

Further, pharmacies have carrying costs for stocking and selling these medications. For example, pharmacies must pay a 0.5% Business and Occupation (B&O) tax on these medications. This is because the B&O tax is on gross profit, and does not allow pharmacies to write off the cost of goods. Further many pharmacies receive payments from PBMs quite a bit after their wholesaler bills are due, and may incur interest fees for bridging the payment gap for these medications. While 0.5% may not seem like much, realize the high cost of these medications multiplied month after month and patient after payment. I have a serious fear that pharmacies will have to choose between keeping these medications in stock or shutting their doors.

5. The rule creates a patchwork that pharmacies must sort out at the counter

Under the proposed rule, whether a UPL applies to a given prescription depends on facts the pharmacy often cannot see:

- **Plan renewal date.** The UPL applies only to plans issued or renewed after its effective date (WAC 182-52-0100(14)), so the same drug may be subject to a UPL for one patient and not the next.
- **Self-funded plan elections.** Employer self-funded plans may opt in (WAC 182-52-0100(13)), and pharmacies have no reliable way to know which have done so.
- **Medical necessity overrides.** A carrier may disregard the UPL for medical necessity (WAC 182-52-0100(17)), changing the applicable price claim by claim.
- **Product-level specifics.** The UPL applies by unit of measure, package size, and dosage form (WAC 182-52-0100(2)(c)).
- **Shortage suspensions.** The Board may suspend a UPL during a shortage (WAC 182-52-0100(11)) and reinstate it later.

Pharmacies will need to track all of this, verify it, reconcile payments against it, and explain it to patients. The rule assigns no responsibility for eligibility determinations and offers pharmacies no relief from the resulting compliance, audit, and staffing burden. That cost is real, recurring, and unfunded.

6. No one is required to measure the impact on pharmacies or patient access

The factors the Board must consider under WAC 182-52-0100(6) — the cost of administering and delivering the drug, shortage status, and administrative costs of production and delivery — do not include pharmacy acquisition cost, pharmacy reimbursement, or whether pharmacies can afford to dispense the drug at the proposed limit. Even the listed factors apply only "depending on the board's ability to obtain the necessary data."

Pharmacies are for-profit healthcare providers: they must pay for all of their expenses: insurance, legal, compliance, rent, salaries, facilities, and technology, out of the difference they make between what they purchase medicine for and what they are paid. In the most ideal UPL scenario, pharmacies are paid exactly what the drug costs, with no profit. A hardware store cannot survive if it sells hammers for what it buys them for. A hospital cannot survive if it bills insurance companies exactly what it pays for a cotton ball used in a procedure. Pharmacies are no different.

The rule requires no assessment, before a UPL is set, of how it will affect pharmacy participation in urban and rural areas, statewide drug distribution, or access in communities already served by few pharmacies. A UPL could therefore take effect without anyone having asked whether the pharmacies patients rely on can still dispense the drug.

The rulemaking itself follows the same pattern. The proposed rulemaking declares the entire proposal exempt from the Regulatory Fairness Act as "dictated by statute" and prepares no small business economic impact statement. It also forgoes a cost-benefit analysis under RCW 34.05.328. Yet the methodology choices in this rule — including defining the UPL as a maximum payment "by any entity" — are the agency's, and they will fall directly on hundreds of Washington pharmacies that are small businesses. The public record contains no analysis of what this rule will cost them.

7. Shortages and withdrawals land on the pharmacy counter

The proposed rule itself anticipates that a UPL may make a drug unavailable. WAC 182-52-0100(10) asks manufacturers whether they will continue selling in Washington; WAC 182-52-0100(11) addresses shortages; and WAC 182-52-0100(16) gives patients a review process when coverage is denied "because the drug was unavailable due to an upper payment limit."

When those scenarios occur, the pharmacy is where the patient learns of them. The Board's shortage response under subsection (11) is discretionary at every step: it "may" review, "may" vote that a shortage exists, and "may" suspend the limit, with no deadline for any of it. During that time, pharmacies must manage empty shelves, contact prescribers about alternatives, and field patient distress, all without compensation for that work.

Patients whose pharmacy cannot obtain a drug, or has stopped carrying it, face delayed therapy, switches to less appropriate alternatives, or gaps in care. Patients with fewer options — in rural areas, without reliable transportation, or dependent on a single local pharmacy — are the most exposed.

8. Other unresolved risks of this rule to pharmacies and the patients they serve

340B Impacts: The rule applies the UPL to "all purchases of the prescription drug product by an entity" and to all carrier reimbursements (WAC 182-52-0100(2)(a)). Covered entities and their contract pharmacies that serve the most vulnerable in Washington State rely on the difference between 340B acquisition prices and reimbursement to fund care for low-income and uninsured patients. A UPL that reduces reimbursement on 340B drugs could erode that support without anyone having evaluated the effect.

An appeal process that is hard for pharmacies to use: WAC 182-52-0100(15) allows an affected entity to appeal within 30 calendar days of a Board decision. Small pharmacies have had many limitation and challenges with the current appeals language under RCW 48.200.280. The system is administratively complex, and has to be completed for every fill for every payment. Based on our experiences the PDAB will need to plan significant resources to manage the process well and in a timely way.

The rule must expressly address pharmacy benefit managers (PBMs): For most Washington patients, the health carrier does not reimburse the pharmacy directly. Its PBM does. PBMs design and administer the prescription drug benefit. They set patient copays and coinsurance, control which drugs are covered and dispensed, and set reimbursement for every pharmacy in their networks. Many PBMs are also owned by or affiliated with the carriers they serve. Yet the proposed rule refers only to reimbursement "by a health carrier or a health plan." Unless it clearly states that the UPL applies to payments made by a carrier's PBM (as defined in RCW 48.200.020), and how compliance will be monitored, the entities that actually pay pharmacies could treat the UPL as a cap on pharmacy payments without passing any of the savings or protections through the supply chain. That would leave the rule hard to enforce.

Conclusion

As proposed, WAC 182-52-0100 limits what Washington pharmacies may be paid for affected drugs while leaving them exposed on every other side of the transaction: what they pay to acquire the drug, what payers actually reimburse, what is taken back after the fact, and what it costs to administer the program. Affordability achieved this way is paid for by pharmacies, and ultimately by patients who lose access to them.

We would welcome the opportunity to discuss them further.

Sincerely,



Jenny Arnold, PharmD, BCPS
Chief Executive Officer