Councilmember Anita Bonds

Councilmember Mary M. Cheh

A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To impose a limit on the amount that a person must pay in copayment or coinsurance through a health benefit plan for a prescription for a specialty drug.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Specialty Drug Copayment Limitation Act of 2015".

Sec. 2. Definitions.

For the purposes of this act, the term:

(1) "Class of drugs" means a group of medications having similar actions designed to treat a particular disease process.

(2) "Coinsurance" means a cost-sharing amount set as a percentage of the total cost of a drug.

(3) "Copayment" means a cost-sharing amount set as a dollar value.

(4)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(B) The term "health benefit plan" does not include:

32 (i) Coverage only for accident or disability income insurance, or
33 any combination thereof;
34 (ii) Liability insurance, including general liability insurance and
35 automobile liability insurance;
36 (iii) Coverage issued as a supplement to liability insurance;
37 (iv) Workers' compensation or similar insurance;
38 (v) Automobile medical payment insurance;
39 (vi) Credit-only insurance;
40 (vii) Coverage for on-site medical clinics; or
41 (viii) Other similar insurance coverage, specified in federal
42 regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996,
43 approved August 21, 1996 (110 Stat. 1976; 42 U.S.C. § 201, note) ("HIPAA"), under which
44 benefits for health care services are secondary or incidental to other insurance benefits.
45 (C) The term "health benefit plan" does not include the following benefits
46 if they are provided under a separate policy, certificate of insurance, or contract of insurance, or
47 are otherwise not an integral part of the plan:
48 (i) Limited scope dental or vision benefits;
49 (ii) Benefits for long-term care, nursing home care, home health
50 care, community-based care, or any combination thereof; or
51 (iii) Other similar, limited benefits specified in federal regulations
52 issued pursuant to HIPAA.
53 (D) The term "health benefit plan" does not include the following benefits
54 if the benefits are provided under a separate policy, certificate of insurance, or contract of

55 insurance, and there is no coordination between the provision of the benefits and any exclusion
56 of benefits under any group health plan maintained by the same plan sponsor, and the benefits
57 are paid with respect to an event without regard to whether benefits are provided with respect to
58 such an event under any group health plan maintained by the same plan sponsor:
59 (i) Coverage only for a specified disease or illness; or
60 (ii) Hospital indemnity or other fixed indemnity insurance.
61 (E) The term "health benefit plan" does not include the following if
62 offered as a separate policy, certificate of insurance, or contract of insurance:
63 (i) A Medicare supplemental policy as defined in section
64 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));
65 (ii) Coverage supplemental to the coverage provided under 10
66 U.S.C. § 1071 *et seq.*; or
67 (iii) Similar supplemental coverage provided to coverage under a
68 group health plan.
69 (5) "Health insurer" means any person that provides one or more health benefit
70 plans or insurance in the District of Columbia, including an insurer, a hospital and medical
71 services corporation, a fraternal benefit society, a health maintenance organization, a multiple
72 employer welfare arrangement, or any other person providing a plan of health insurance subject
73 to the authority of the Commissioner of the Department of Insurance, Securities, and Banking.
74 (6) "Member" means an individual who is enrolled in a health benefits plan.
75 (7) "Member representative" means a:
76 (A) Person acting on behalf of a member with the member's
77 consent;

78 (B) Person authorized by law to provide substituted consent for a
79 covered person;
80 (C) Family member of the covered person;
81 (D) Covered person's treating health care professional when the
82 covered person is unable to provide consent; or
83 (E) In the case of a request regarding an emergency or urgent
84 medical condition, a health-care professional with knowledge of the covered person's medical
85 condition.
86 (8) "Non-preferred drug" means a specialty drug formulary classification for
87 certain specialty drugs that are subject to limits on eligibility for coverage or to higher cost-
88 sharing amounts than preferred specialty drugs.
89 (9) "Preferred drug" means a specialty drug formulary classification for certain
90 specialty drugs that are not subject to limits on eligibility for coverage or not subject to higher
91 cost-sharing amounts than non-preferred specialty drugs.
92 (10) "Specialty drug" means a prescription drug that:
93 (A) Is prescribed for a person with:
94 (i) A physical, behavioral, or developmental condition that may
95 have no known cure, is progressive, or can be debilitating or fatal if left untreated or
96 undertreated, such as multiple sclerosis, hepatitis C, or rheumatoid arthritis; or
97 (ii) A disease or condition that affects fewer than 200,000 persons
98 in the United States or approximately one in 1,500 persons worldwide, such as cystic fibrosis,
99 hemophilia, or multiple myeloma;
100 (B) Has a total monthly prescription cost of $600 or more;

101 (C) Is not stocked at a majority of retail pharmacies in the United States;

102 and

103 (D) Has one or more of the following characteristics:

104 (i) Is an oral, injectable, or infusible drug product;

105 (ii) Requires unique storage or shipment, such as refrigeration; or

106 (iii) Requires patient education and support beyond traditional

107 dispensing activities.

108 (11) "Specialty tier" means a tier of cost sharing designed for select specialty

109 drugs that imposes a cost-sharing obligation that is based on a coinsurance or copayment and

110 exceeds that amount for non-preferred drugs.

111 (12) "Tiered formulary" means a formulary that provides coverage for

112 prescription drugs as part of a health benefit plan for which cost-sharing, deductibles, or

113 coinsurance is determined by category or tier of prescription drugs, and that includes at least 2

114 different tiers.

115 Sec. 3. Specialty drug copayment or coinsurance limitation.

116 (a)(1) A health benefit plan that provides coverage for prescription drugs shall ensure that

117 a required copayment or coinsurance applicable to a drug on a specialty tier does not exceed

118 $150 per month for up to a 30-day supply of the specialty drug.

119 (2) On July 1 of each year, the limit on a required copayment or coinsurance

120 applicable to a drug on a specialty tier provided in paragraph (1) of this subsection shall increase

121 by a percentage equal to the percentage change from the preceding year in the medical care

122 component of the March Consumer Price Index for All Urban Consumers, Washington-

123 Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics.

124 (b)(1) For a health benefit plan that provides coverage for prescription drugs and utilizes
125 a tiered formulary, a member or member representative shall have the right to request that a non-
126 preferred drug be covered under the cost sharing applicable for preferred drugs if the prescribing
127 physician determines that the preferred drug for treatment of the same condition either would not
128 be as effective for the individual or would have adverse effects for the individual, or both.
129 (2) The denial of a request made pursuant to paragraph (1) of this subsection shall
130 be considered an adverse event and shall be subject to the health plan's internal review process.
131 (c) A health benefit plan that provides coverage for prescription drugs shall not place all
132 drugs in a given class of drugs on a specialty tier.
133 (d) Nothing in this section shall be construed to require a health benefit plan to:
134 (1) Provide coverage for any additional drugs not otherwise required by law;
135 (2) Implement specific utilization management techniques, such as prior
136 authorization or step therapy; or
137 (3) Cease the use of tiered cost-sharing structures, including strategies used to
138 incent use of preventive services, disease management, and low-cost treatment options.
139 (e) Nothing in this section shall be construed to require a pharmacist to substitute a drug
140 without the consent of the prescribing physician.
141 (f) A health insurer shall not be precluded from requiring specialty drugs to be obtained
142 through a designated pharmacy or other source of such drugs.
143 Sec. 4. Fiscal impact statement.
144 The Council adopts the fiscal impact statement in the committee report as the fiscal
145 impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act,
146 approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

147 Sec. 5. Effective date.

148 This act shall take effect following approval by the Mayor (or in the event of veto by the
149 Mayor, action by the Council to override the veto), a 30-day period of congressional review as
150 provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December
151 24, 1973 (87 Stat. 788; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of
152 Columbia Register.