[D.C. Code § 48-855.01.]

§ 48-855.01. Definitions: Specialty Drug Copayment Limitation

For the purposes of this chapter, 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:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Liability insurance, including general liability insurance and automobile liability insurance;

(iii) Coverage issued as a supplement to liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (110 Stat. 1936; scattered sections of the United States Code) ("HIPAA"), under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) The term "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate of insurance, or contract of insurance, or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

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(ii) Benefits for long-term care, nursing-home care, home-health care, community-based care, or any combination thereof; or

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

(D) The term "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate of insurance, or contract of insurance, and there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same health insurer, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same health insurer:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) The term "health benefit plan" does not include the following if offered as a separate policy, certificate of insurance, or contract of insurance:

(i) A Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act, approved June 9, 1980 (94 Stat. 476; 42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under An Act To amend titles 10, 14, and 32, United States Code, to codify recent military law, and to improve the Code, approved September 2, 1958 (72 Stat. 1437; 10 U.S.C. § 1071 et seq.); or

(iii) Similar supplemental coverage provided under a group health plan.

(5) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner of the Department of Insurance, Securities and Banking.

(6) "Member" means an individual who is enrolled in a health benefit plan.

(7) "Member representative" means a:

(A) Person acting on behalf of a member with the member's consent;

(B) Person authorized by law to provide substituted consent for a member;

(C) Family member of the member;

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(D) Member's treating health care professional when the member is unable to provide consent; or

(E) In the case of a request regarding an emergency or urgent medical condition, a health-care professional with knowledge of the member's medical condition.

(8) "Non-preferred drug" means a specialty drug formulary classification for certain specialty drugs that are subject to limits on eligibility for coverage or to higher cost-sharing amounts than preferred specialty drugs.

(9) "Preferred drug" means a specialty drug formulary classification for certain specialty drugs that are not subject to limits on eligibility for coverage or to higher cost-sharing amounts than a non-preferred drug.

(10) "Specialty drug" means a prescription drug that:

(A) Is prescribed for a person with:

(i) A physical, behavioral, or developmental condition that may have no known cure, is progressive, or can be debilitating or fatal if left untreated or undertreated, such as multiple sclerosis, hepatitis C, or rheumatoid arthritis; or

(ii) A disease or condition that affects fewer than 200,000 persons in the United States or approximately one in 1,500 persons worldwide, such as cystic fibrosis, hemophilia, or multiple myeloma;

(B) Has a total monthly prescription cost of $600 or more; and

(C) Has one or more of the following characteristics:

(i) Is an oral, injectable, or infusible drug product or a drug product that is delivered topically, through inhalation, implantation, or transmucosally;

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

(iii) Requires patient education and support beyond traditional dispensing activities.

(11) "Specialty tier" means a tier of cost sharing designed for select specialty drugs that imposes a cost-sharing obligation that is based on a coinsurance or copayment and exceeds that amount for non-specialty drugs.

(12) "Step therapy" means a protocol established by a health insurer that requires a prescription drug or sequence of prescription drugs to be used by an insured or an enrollee before a prescription drug ordered by a prescriber for the insured or the enrollee is covered.

(13) "Tiered formulary" means a formulary that provides coverage for prescription drugs as part of a health benefit plan for which cost-sharing, deductibles, or coinsurance is determined by category or tier of prescription drugs, and that includes at least 2 different tiers.

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