[D.C. Code § 48-855.02.]

§ 48-855.02. Specialty drug copayment or coinsurance limitation: Specialty Drug Copayment Limitation

(a)(1) A health benefit plan that provides coverage for prescription drugs shall ensure that a required copayment or coinsurance applicable to a drug on a specialty tier does not exceed $150 per month for up to a 30-day supply of the specialty drug or $300 for a 90-day supply.

(2) On July 1 of each year, the limit on a required copayment or coinsurance applicable to a drug on a specialty tier provided in paragraph (1) of this subsection shall increase by a percentage equal to the percentage change from the preceding year in the medical care component of the March Consumer Price Index for All Urban Consumers, Washington-Baltimore metropolitan area, as published by the Bureau of Labor Statistics of the United States Department of Labor.

(b)(1) For a health benefit plan that provides coverage for prescription drugs and utilizes a tiered formulary, a member or member representative shall have the right to request that a non-preferred drug be covered under the cost sharing applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual, or both.

(2) The denial of a request made pursuant to paragraph (1) of this subsection shall be considered an adverse event and shall be subject to the health benefit plan's internal review process.

(c) A health benefit plan that provides coverage for prescription drugs shall not place all drugs in a given class of drugs on a specialty tier.

(d) Nothing in this section shall be construed to require a health benefit plan to:

(1) Provide coverage for any additional drugs not otherwise required by law;

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) Cease the use of tiered cost-sharing structures, including strategies used to incentivize use of preventive services, disease management, and low-cost treatment options.

(e) Nothing in this section shall be construed to require a pharmacist to substitute a drug without the consent of the prescribing physician.

(f) A health insurer shall not be precluded from requiring specialty drugs to be obtained through a designated pharmacy or other source of specialty drugs.