ENGROSSED ORIGINAL

A BILL

25-141

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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To amend the Specialty Drug Copayment Limitation Act to require health insurers to apply discounts, financial assistance payments, product vouchers, or other reductions in out-of-pocket expenses made by or on behalf of a member when calculating the member's coinsurance, copayment, cost-sharing responsibility, deductible, or out-of-pocket maximum for prescription drugs.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Copay Accumulator Amendment Act of 2023."

Sec. 2. The Specialty Drug Copayment Limitation Act of 2016, effective April 7, 2017 (D.C. Law 21-248; D.C. Official Code § 48-855.01 *et seq.*), is amended as follows:

(a) Section 2 (D.C. Official Code § 48-855.01) is amended as follows:

(1) A new paragraph (3C) is added to read as follows:

"(3C) "Generic drug" means a chemically equivalent copy of a brand-name drug with an expired patent.".

(2) A new paragraph (5A) is added to read as follows:

"(5A) "Interchangeable biological product" means a biological product that is licensed and determined by the Food and Drug Administration to meet the standards for interchangeability under 42 U.S.C. § 262(k)(4) or determined to be biosimilar to and

interchangeable with a reference biological product as stated in the Lists of Licensed Biological Products with Reference Product Exclusivity and Biosimilarity or Interchangeability Evaluations, also known as the Purple Books.".

(b) A new section 3b is added to read as follows:

"Sec. 3b. Calculation of member's contributions for a prescription drug covered under the health benefit plan.

"(a) Except as otherwise provided in subsection (b) of this section, when calculating a member's contribution to their coinsurance, copayment, cost-sharing responsibility, deductible, or out-of-pocket maximum under the member's health benefit plan, the health insurer shall include any discount, financial assistance payment, product voucher, or any other out-of-pocket expense made by or on behalf of the member for a prescription drug covered under the member's health benefit plan that:

"(1) Is without a generic drug equivalent or an interchangeable biological product preferred under the health benefit plan's formulary; or

"(2) Has a generic equivalent drug or an interchangeable biological product preferred under the health benefit plan's formulary where the member has obtained access to the drug through prior authorization, a step therapy protocol, or the exception or appeal process of the health insurer or pharmacy benefits manager.

"(b) Subsection (a) of this section shall not apply to a member covered by a high deductible health plan, as that term is defined under 26 U.S.C. § 223, until the member satisfies

their minimum deductible; provided, subsection (a) of this section shall apply to contribution amounts made for preventative care, as that term is defined under 26 U.S.C. § 223(c)(2)(C).

"(c) This section shall apply to health benefit plans entered into, amended, extended, or renewed on or after January 1, 2025.".

Sec. 3. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 4. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.