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COUNCIL OF THE DISTRICT OF COLUMBIA

NOTICE

D.C. LAW 12-274

"Health Benefits Plan Members Bill of Rights Act of 1998"

Pursuant to Section 412 of the District of Columbia Home Rule Act, P.L. 93-198 "the Act", the Council of the District of Columbia adopted Bill 12-501 on first and second readings, December 1, 1998 and December 15, 1998, respectively. Following the signature of the Mayor on December 29, 1998, pursuant to Section 404(e) of "the Act", the bill became Act 12-607 and it was published in the February 19, 1999 edition of the D.C. Register (Vol. 46, page 1294). The Act was transmitted to Congress on February 23, 1999 for a 30-day review, in accordance with Section 602(c)(1) of the Act.

The Council of the District of Columbia hereby gives notice that the 30-day Congressional review period has expired, and the Act is now D.C. Law 12-274, effective April 27, 1999.



LINDA W. CROPP
Chairman of the Council

Days Counted During the 30-day Congressional Review Period:

Feb. 23,24,25

Mar. 1,2,3,4,5,8,9,10,11,15,16,17,18,19,22,23,24,25

Apr. 12,13,14,15,19,20, 21,22,26

AN ACT
D.C. ACT 12-607

*Codification
District of
Columbia
Code
1999 Supp.*

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA
DECEMBER 29, 1998

To establish grievance procedures for members of health benefits plans in the District, to provide matter-of-right access to specialists as primary care providers in certain situations, and to require notification of physician termination and continuance of coverage for 90 days.

*New Chapter
5B,
Title 32,*

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Health Benefits Plan Members Bill of Rights Act of 1998".

Title I. Grievance and appeals procedures.
Sec. 101. Definitions.

*New
Subchapter I*

For the purposes of this act, the term:

*New Section
32-571.1*

(1) "Director" means the Director of the District of Columbia Department of Health.

(2) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(3) "Grievance" means a written request by a member or a member representative for review of a decision of an insurer to deny, reduce, limit, terminate or delay covered health care services to a member.

(4) "Grievance decision" means a determination accepting or denying the basis or requested remedy of the grievance.

(5) "Health benefits plan" means a group or individual insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by an insurer or subcontracting facility of an insurer for the purpose of providing, paying for, or reimbursing expenses for health related services. "Health benefits plan" does not include disability income or accident only insurance.

(6) "Health care services" means items or services provided under the supervision of a physician or other person trained or licensed to render health care necessary for the prevention, care, diagnosis, or treatment of human disease, pain, injury, deformity or other

physical or mental condition including the following: pre-admission, outpatient, inpatient, and post-discharge care; home care; physician's care; nursing care; medical care provided by interns or residents in training; other paramedical care; ambulance service and care; bed and board; drugs; supplies; appliances; equipment; laboratory services; any form of diagnostic imaging or therapeutic radiological services; and services mandated under the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Act of 1986, effective February 28, 1987 (D.C. Law 6-195; D.C. Code § 35-2301 *et seq.*).

(7) "Independent review organization" means an impartial, certified health entity engaged by the Director to review any adverse grievance decision by an insurer, including an insurer's decision to deny, terminate, or limit covered health care services.

(8) "Insurer" means any individual, partnership, corporation, association, fraternal benefit association, hospital and medical services corporation, health maintenance organization, or other business entity that issues, amends, or renews group or individual health insurance policies or contracts, including health maintenance organization membership contracts in the District.

(9) "Member" means an individual who is enrolled in a health benefits plan.

(10) "Member representative" means any person acting on behalf of a member with the member's consent.

(11) "Urgent medical condition" means a condition which, if not treated within 24 hours, could reasonably be expected to result in (i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Sec. 102. Medicare not applicable.

(a) The provisions of Title I of this act shall not apply in cases directly involving coverage determinations or benefit requirements under the federal Medicare program. The provisions of Title II and Title III shall not apply in cases directly involving federal Medicare benefits.

(b) Any complaint by a member involving coverage or benefits provided pursuant to the federal Medicare program shall be resolved in accordance with federal laws, regulations, and procedures established for fair hearings and appeals for the Medicare programs and with any appropriate District law.

**New Section
32-571.2**

Sec. 103. Establishment of grievance system.

(a) A member or member representative shall have a right to file a grievance with an insurer for a review of a decision to deny, reduce, limit, terminate or delay covered health care services. An insurer's health benefits plan shall include a grievance system that provides for the presentation and resolution of grievances brought by members or member representatives.

**New Section
32-571.3**

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(b) A grievance system established pursuant to this section shall, at a minimum, incorporate the following components:

(1) The right of a member to file a grievance regarding any aspect of the insurer's health care services;

(2) A procedure for filing an appeal from a grievance decision;

(3) A standardized method of recording, documenting, and reporting the status of all grievances and appeals, which shall be maintained for at least 3 years;

(4) Availability of a member services representative to assist members with grievances upon request;

(5) The right of a member to designate an outside independent representative to assist the member or member representative in following the grievance procedures upon request;

(6) A specified time for responding to grievances not to exceed 45 business days from receipt of the grievance by the insurer;

(7) An oral and written procedure describing how grievances are processed and resolved;

(8) Procedures for follow-up action including the methods to be used to inform the member of resolution; and

(9) In the case of grievances regarding emergency or urgent medical conditions, procedures that will allow a member or member representative to immediately request expedited informal review in accordance with section 105 or expedited formal review in accordance with section 106.

(c) At the time a member first enrolls with an insurer, the insurer shall provide each member with written notice of the components required in subsection (b)(1) and (2) of this section, as well as the following information:

(1) The telephone numbers and business addresses of the insurer's representatives responsible for grievance resolution;

(2) A statement that describes a member's or member representative's right to contact the Director if dissatisfied with the resolution reached through the insurer's grievance system; and

(3) A statement that describes a Medicaid enrollee's right to appeal to the Office of Fair Hearings at any time, if applicable.

(d) In the case of a reduction or a termination of services that is contrary to the recommendations of the treating physician or advance practice registered nurse, an insurer shall provide a member or member representative with 24 hours prior verbal notification, followed by a written decision as soon as practical.

(e) An insurer shall include in the "evidence of coverage" and "member handbook" issued to members a description of the procedures for filing grievances and appeals.

(f) An insurer shall not take retaliatory action of any sort against a member who files a grievance pursuant to this section or an appeal pursuant to section 105.

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(g) The Director may waive exhaustion of the grievance process required by section 105 and 106 as a prerequisite for proceeding to the external grievance process in cases of emergency or urgent medical conditions.

Sec. 104. Grievance process.

(a) A member or member representative may appeal any grievance decision resulting in a denial, termination, or other limitation of covered health care services in accordance with the provisions of this section.

**New Section
32-571.4**

(b) At the time a grievance decision is determined, an insurer shall provide to the affected member or member representative a written description of the procedures for filing grievances.

(c) The grievance process shall consist of 3 separate grievance levels: informal internal review by the insurer; formal review by the insurer; and formal external review by an independent review organization.

(d) Nothing in the health benefits plan shall prohibit a member or member representative from discussing or exercising the right to appeal pursuant to this section.

Sec. 105. Informal internal review.

(a) An insurer shall establish and maintain an informal internal grievance process whereby a member or member representative who is dissatisfied with any grievance decision made by an insurer may discuss and appeal the decision with the insurer's medical director or with the physician or health care provider designee who rendered the decision.

**New Section
32-571.5**

(b) An appeal conducted pursuant to this section shall be concluded by the insurer as soon as possible in accordance with the medical exigencies of the case. If an appeal is from a determination regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours of receiving notification of appeal from the member or member representative. All other concurrent or prospective appeals conducted pursuant to this section shall be concluded by the insurer within 14 business days.

(c) If an informal internal appeal is not resolved to the satisfaction of a member or member representative, the insurer shall provide the member or member representative with a written explanation of the decision and notify the member or member representative of the right to proceed to the next stage of the grievance process.

(d) At a minimum, the written explanation of the decision provided by the insurer pursuant to subsection (c) of this section shall include the following:

(1) The reviewer's understanding of the member's or member representative's grievance;

(2) The reviewer's decision in clear terms;

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(3) The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and

(4) All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

Sec. 106. Formal internal review.

New Section
32-571.6

(a) An insurer shall establish and maintain a formal internal appeals process whereby a member or member representative who is dissatisfied with a decision rendered in the informal appeals process can have the opportunity to pursue an appeal before a reviewer or panel of physicians, or advanced practice registered nurses, or other health care professionals selected by the insurer.

(b)(1) The reviewer or panel selected by the insurer pursuant to subsection (a) of this section shall not have been involved in the grievance decision under review.

(2) For all reviews requiring medical expertise, the reviewer or panel shall include at least one medical reviewer who is trained or certified in the same specialty as the matter at issue.

(3) A medical reviewer shall be a physician, or an advance practice registered nurse or other appropriate health care provider possessing a nonrestricted license to practice or provide care anywhere in the United States and have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

(4) A medical reviewer shall be certified by a recognized specialty board in the areas appropriate to review.

(c) All formal internal appeals shall be acknowledged by the insurer, in writing, to the member or member representative filing the appeal within 10 business days of receipt.

(d) All formal internal appeals shall be concluded as soon as possible after receipt by the insurer of all necessary documentation in accordance with the medical exigencies of the case. If the formal internal appeal is from a decision regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours notification of appeal by the member or member representative. All other appeals conducted pursuant to this section shall be concluded by the insurer within 30 business days; except, that the time may be extended at the request of a member or the member representative.

(e) If an insurer denies a member's or member representative's formal internal appeal, the insurer shall provide the member or member representative with a written explanation of the denial and written notification of his or her right to proceed to an external appeal. This notification shall include specific instructions as to how the member or member representative may arrange for an external appeal and shall also include any forms required to initiate the external appeal.

(f) At a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (e) of this section shall include the following:

- (1) The reviewer's understanding of the member's or member representative's complaint;
- (2) The reviewer's decision in clear terms;
- (3) The contractual basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
- (4) All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

(g) In the event that the insurer fails to comply with any of the deadlines for completion of a formal internal appeal, the member or member representative shall be relieved of his or her obligation to complete the formal internal review process and may, at his or her option, proceed directly to the external appeals process required by section 107.

Sec. 107. External grievance process.

New Section
32-571.7

(a) The Director shall establish and maintain an external appeals process whereby a member or member representative who is dissatisfied with a decision rendered in a formal internal appeals process shall have the opportunity to pursue an appeal before an independent review organization.

(b) To initiate an external appeal, a member or member representative shall, within 30 business days from receipt of the written decision of the formal internal appeal panel, file a written request with the Director. The member or member representative shall submit a signed form allowing the insurer to release medical records of the member that are pertinent to the appeal.

(c) Upon receipt of the request for an external appeal, together with the executed release form, the Director shall determine whether:

- (1) The individual was or is a member of the health benefits plan;
- (2) The health care service which is the subject of the appeal reasonably appears to be a service covered by the health benefits plan;
- (3) The member or member representative has fully complied with sections 105 and 106 regarding informal and formal internal appeals; and
- (4) The member or member representative has provided all information required by the independent review organization and the Director to make the preliminary determination, including the appeal form, and a copy of any information provided by the insurer regarding its decision to deny, reduce, or terminate a covered service, and the release form required pursuant to subsection (b) of this section.

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(d) Upon completion of the preliminary review, the Director shall notify the member or member representative and insurer in writing as to whether the appeal has been accepted for processing. If the appeal is accepted by the Director, the Director shall assign the appeal to an independent review organization for full review. If the appeal is not accepted by the Director, the Director shall provide a statement of the reasons for the nonacceptance to the member or member representative and the insurer.

(e) The staff of the independent review organization that is assigned to the appeal pursuant to subsection (d) of this section, shall have meaningful prior experience in performing utilization review, peer review, quality of care assessment or assurance, or the hearing of appeals. Any independent review organization, its staff, and its professional and medical reviewers, shall not have any material, professional, familial, or financial affiliation with the insurer that is a party to the appeal.

(f) The Director may waive exhaustion of the appeals process required by section 105 and 106 as a prerequisite for proceeding to the external appeals process in cases of emergency or urgent care.

(g) The insurer shall provide timely access to all its records relating to the matter under review and to all provisions of the health benefits plan or health insurance coverage, including any evidence of coverage, "member handbook", certificate of insurance or contract and health benefits plan relating to the matter.

(h) Upon acceptance of the appeal for processing, the independent review organization shall conduct a full review to determine whether, as a result of the insurer's decision, the member was deprived of any service covered by the health benefits plan.

(i) The full review of an appeal of a health benefits decision shall be initially conducted by at least 2 physicians licensed to practice medicine in the District of Columbia, Maryland, or Virginia. On an exceptions basis, when necessary based on the medical, surgical, or mental condition under review, the independent review organization may select medical reviewers licensed anywhere in the United States who have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

(j) In reaching a determination, the independent review organization shall take into consideration all pertinent medical records, consulting physician reports, and other documents submitted by the parties, any applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, any applicable clinical protocols or practice guidelines developed by the insurer, and may consult with such other professionals as appropriate and necessary.

(k) The member or member representative and one insurer representative may request to appear in person before the independent review organization. The independent review organization shall conduct the hearing in the District of Columbia. The independent review

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organization's procedures for conducting a review, when the member or member representative or the insurer has requested to appear in person, shall include the following:

(1) The independent review organization shall schedule and hold a hearing as soon as possible after receiving a request from a member or member representative or from an insurer representative to appear before the independent review organization. The independent review organization shall notify the member or member representative and insurer representative, either orally or in writing, of the hearing date and location. The independent review organization shall not unreasonably deny a request for postponement of the hearing made by the member or member representative or insurer representative.

(2) A member or member representative and an insurer representative shall have the right to the following:

- (A) To attend the independent review organization hearing;
- (B) To present his or her case to the independent review organization;
- (C) To submit supporting material both before and during the hearing;
- (D) To ask questions of any representative of the independent review

organization; and

- (E) To be assisted or represented by a person of his or her choice.

(l) When necessary, the independent review organization shall consult with a physician or advance practice registered nurse trained in the same specialty or area of practice as the type of treatment that is the subject of the grievance and appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

(m) The independent review organization shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. Except as provided for in this subsection, the independent review organization shall complete its review within 30 business days, or 72 hours in the case of an expedited appeal, from the time the Director assigns the appeal to the independent review organization. An insurer shall provide all documentation to the independent review organization within 5 days of receipt of the notice of approval of the appeal by the Director, or within 24 hours of receipt of the notice of approval of the grievance, for an expedited review. If an insurer does not provide the independent review organization all documentation required by this subsection within the time frames, or obtain the necessary extensions, the independent review organization may decide the appeal without receiving the information. The independent review organization shall extend its review for a reasonable period of time as may be necessary due to circumstances beyond its or the insurer's control, but only when the delay will not result in increased medical risk to the member. In such an event, the independent review organization shall, prior to the conclusion of the initial review

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period, provide written notice to the member or member representative and to the insurer setting forth the status of its review and the specific reasons for the delay.

(n) If the independent review organization determines that the member was deprived of medically necessary covered services, the independent review organization shall recommend to the Director the appropriate covered health care services the member should receive. The Director shall forward copies of the recommendation to the member or member representative and the insurer.

(o) When necessary, the independent review organization shall refer a case for review to a consultant physician or other health care provider in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

(p) The decision of the independent review organization shall be nonbinding on all parties and shall not affect any other legal causes of action.

(q)(1) This section shall not apply in cases directly involving Medicaid benefits.

(2) Any appeal brought pursuant to this section by a member involving coverage provided pursuant to the Medicaid program shall be resolved in accordance with federal and District of Columbia laws, regulations, and procedures established for fair hearings and appeals for the Medicaid program.

Sec. 108. Certification and general requirements for independent review organizations.

**New Section
32-571.8**

(a) Each independent review organization selected by the Director to review external appeals must be certified every 2 years by the Director.

(b) The Director shall be responsible for developing, applying, and enforcing certification standards for independent review organizations. These standards shall ensure that an independent review organization:

(1) Properly maintains a policy involving the review of the appeal in strict confidence pursuant to rules established by the Director;

(2) Uses only qualified professional and medical reviewers in any review; and

(3) Demonstrates an ability to render decisions in an equitable and timely manner and consistent with this act.

(c) An independent review organization may not be a subsidiary of, or in any way owned or controlled by a health benefits plan, insurer, or trade association of health care providers.

(d) The Director shall develop an application form for certifying an independent review organization that contains a description of the organization, including names, biographical sketches of all directors, officers, and executives of the organization.

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(e) The independent review organization shall submit to the Director the following information, for purposes of creating a file of public records, upon initial application for certification, and thereafter upon any change to any of this information:

(1) The names of all stockholders and owners of more than 5% of any stock or options, if it is a publicly held organization;

(2) The names of all holders of bonds or notes in excess of \$100,000 if any;

(3) The names of all corporations and organizations that the independent review organization controls or is affiliated with and the nature and extent of any ownership or control, including the affiliated organization's type of business; and

(4) The names of all directors, officers, and executives of the independent organization, as well as a statement regarding any relationships the directors, officers, and executives may have with any health care plan, disability insurer, managed care organization, provider group or board or committee.

(f)(1) The independent review organization shall not have any material professional, familial, or financial conflict of interest with any of the following:

(A) The insurer;

(B) Any officer, director, or management employee of the insurer;

(C) The physician, the physician's medical group, or the independent practice association or the treating provider proposing the service or treatment;

(D) The institution at which the service or treatment would be provided;

or

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the member whose treatment is under review.

(2) For the purposes of this subsection, the term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical research center, provides health services to the insurer's member, except as subject to the requirement of paragraph (1)(D) of this subsection, affiliations which are limited to staff privileges at a health facility; or an independent review organization's participation as a contracting insurer's provider where the independent review organization is affiliated with an academic medical center, or other similar medical research center, that is acting as an independent review organization under this section.

(g) The independent review organization shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(h) Neither an independent review organization nor an individual working for an external review panel pursuant to this act shall be held liable for any recommendation presented by the

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independent review organization, except in cases of gross negligence, recklessness, or intentional misconduct.

(i) An insurer, bound by the decision of the independent review entity, shall not be liable for following such decision. A determination by the independent review entity in favor of the insurer shall create a rebuttal presumption in any subsequent action at law that the insurer's coverage determination was appropriate.

(j) The Director shall, from time to time, enter into contracts with as many independent review organizations as the Director deems necessary to conduct the external appeals. The contracts shall set forth all terms which the Director deems necessary to ensure a member's right of appeal, including an assessment of separate costs to the insurer for the independent review organization review.

(k) As part of the contract process set forth in subsection (j) of this section, all independent review organizations shall submit to the Director and shall maintain a current list identifying all insurers, health care facilities, and other health care providers with whom the independent review organization maintains any health related business arrangements. The list shall include a brief description of the nature of any such arrangement.

(l) Upon receipt of any request for an external appeal, the Director shall assign that appeal to one of the approved independent review organizations on a random basis. The Director may reserve the right to deny any assignment to any independent review organization if the Director determines that making an assignment would result in a conflict of interest or would otherwise create an appearance of impropriety.

(m) The terms and conditions of a contract entered into pursuant to subsection (j) of this section shall provide that the reasonable direct costs of the external review process, not including costs of representation of a member, shall be paid by the insurer.

Sec. 109. Assessment of insurers.

The Mayor shall assess all insurers to cover all the costs of administering this act. The Mayor shall promulgate regulations to determine the assessment formula.

**New Section
32-571.9**

Sec. 110. Reporting requirements.

(a) Every insurer shall submit to the Director, an annual grievance report, that chronicles all grievance activity during the preceding year. The Director shall develop a system for classifying and categorizing grievances and appeals that all insurers and independent review organizations will use when collecting, recording, and reporting grievance and appeals information. The Director shall also develop a reporting form for inclusion in the annual

**New Section
32-571.10**

grievance report that shall include the following information:

- (1) The name and location of the reporting insurer;
- (2) The reporting period in question;
- (3) The names of the individuals responsible for the operation of the insurer's grievance system;
- (4) The total number of grievances received by the insurer, categorized by cause, insurance status, and disposition;
- (5) The total number of requests for expedited review, categorized by cause, length of time for resolution, and disposition; and
- (6) The total number of requests for external review, categorized by cause, length of time for resolution, and disposition.

(b) The Director shall provide current and aggregate information about each health benefits plan's grievance and appeals activity to the public.

(c) The Director shall develop appropriate annual reporting requirements for independent review organizations.

(d) The Director shall submit an annual report to the Council and the public concerning the status of the grievance and appeal procedures of all health benefits plans in the District, including external appeals. The report shall summarize grievances by category and by health benefits plan and shall include the number of decisions upholding and reversing each grievance and the length of time for complete resolution of the grievance. The Director shall, based upon individual cases and the patterns of grievance and appeals activity, include in the annual report recommendations concerning additional health consumer protections.

Title II. Access to specialists as primary care providers.

Sec. 201. Specialists as primary care providers.

(a) A health benefits plan shall permit a member with chronic disabling or life threatening conditions to choose a health care specialist as the member's primary care provider. The specialist must be a participant in the health benefits plan and be available to attend to the member.

(b) A specialist chosen by a member pursuant to subsection (a) of this section, shall be permitted to treat the member without the member first receiving a referral from another health care provider. The specialist may authorize referrals, procedures, tests, and medical services subject to the terms of a treatment plan developed by the specialist and approved by the insurer.

New
Subchapter II

New Section
32-572.1

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(c) A health benefits plan shall permit a member with a chronic disabling or life threatening condition to have direct access to a specialist qualified to treat the condition, subject to initial referral by the member's primary care provider and a treatment plan approved by the member's primary care provider. Such treatment plan shall ensure that the member will receive covered medically necessary procedures, tests, and medical services.

Sec. 202. Standing referrals to specialists.

**New Section
32-572.2**

(a) In general, subject to subsection (b) of this section, a health benefits plan shall permit a member to receive medically necessary or appropriate specialty care for more than one visit without having to obtain the insurer's approval for subsequent visits authorized by a primary care provider.

(b) Subsection (a) of this section shall not apply to specialty care if the insurer informs the member, orally and in writing, of any limitation on the choice of participating providers with respect to such care.

Sec. 203. Direct access to qualified specialists for females' health services.

**New Section
32-572.3**

(a) Every health benefits plan that requires or provides a member with the opportunity to designate a participating primary care provider, shall permit a member who is a female to designate as her primary care provider a participating physician or advance practice registered nurse who specializes in obstetric and gynecology.

(b) If a member who is a female does not designate a participating physician or advance practice registered nurse as described in subsection (a) of this section as her primary care provider, the health benefits plan may not require authorization or a referral by the member's primary care provider, or otherwise, in order for the member to receive routine obstetrical or gynecological services from a participating obstetrician or gynecologist or advance practice registered nurse described in subsection (a) of this section.

(c) For the purposes of this section, "routine obstetrical and gynecological services" means the full scope of medically necessary services provided by the obstetrician or gynecologist or advance practice registered nurse described in subsection (a) of this section in the care of, or related to, the female reproductive system and breasts and in performing annual screening and immunizations for disorders and diseases in accordance with nationally recognized medical practice.

(d) Nothing in this section shall prohibit an insurer or Health Maintenance Organization from requiring a participating obstetrician or gynecologist or advance practice registered nurse described in subsection (a) of this section to provide written notification to the covered female's primary care physician of any visit to such obstetrician or gynecologist or advance practice

registered nurse. The notification may include a description of the health care services rendered at the time of the visit.

Title III. Notification of health care provider termination; continuance of coverage.

Sec. 301. When a health care provider leaves a plan.

If a contract between an insurer and a health care provider is terminated by either party for any reason other than termination for failure to meet applicable quality standards of care or fraud, and a member is undergoing a course of treatment from the physician at the time of the termination, the insurer shall notify the member on a timely basis of the termination. When medically necessary, persons with serious illness undergoing a course of treatment or who are in the second trimester of a pregnancy shall be permitted to continue to receive medically necessary covered services, with respect to the cause of treatment, by the physician or nurse midwife during a transitional period of at least 90 days from the date of the notice under the same terms and conditions as specified under the provider contract.

New Subchapter III

New Section 32-573.1

Title IV. Regulations and standards.

Sec. 401. (a) Within 120 days of the effective date of the act, the Director shall promulgate any regulations and standards as may be necessary to carry out the purposes of this act.

New Subchapter IV

New Section 32-574.1

(b) Health benefits plans and insurers subject to this act shall comply with the regulations promulgated pursuant to subsection (a) of this section for contracts issued or renewed on or after 120 days from the promulgation of final regulations pursuant to subsection (a) of this section.

Title V. Conforming Amendments.

Sec. 501. The Health Maintenance Organization Act of 1996, effective April 9, 1997 (D.C. Law 11-235; D.C. Code § 35-4501 *et seq.*), is amended as follows:

(a)(1) Section 2(18) (D.C. Code § 35-4501(18)) is repealed.

(2) Section 8(a)(2)(K) (D.C. Code § 35-4507(a)(2)(K)) is repealed.

(3) Section 9(a)(3) (D.C. Code § 35-4508 (a)(3)) is repealed.

(4) Section 11 (D.C. Code § 35-4510) is repealed.

(b) This section shall apply upon the promulgation of regulations pursuant to section 401.

Section 35-4501
Section 35-4507
Section 35-4508
Section 35-4510
Note, Sections 35-4501, 35-4507, 35-4508, 35-4510

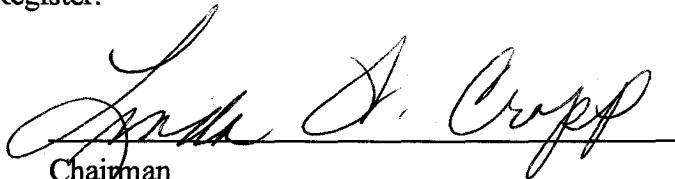
Title VI. Fiscal impact statement.

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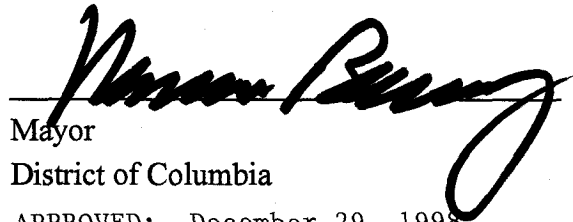
Sec. 601. The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Code §

Title VII. Effective date.

Sec. 701. 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), approval by the Financial Responsibility and Management Assistance Authority as provided in section 203(a) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, approved April 17, 1995 (109 Stat. 116; D.C. Code § 47-392.3(a)), 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. Code § 1-233(c)(1)), and publication in the District of Columbia Register.



Chairman
Council of the District of Columbia



Mayor
District of Columbia

APPROVED: December 29, 1998



COUNCIL OF THE DISTRICT OF COLUMBIA
 COUNCIL PERIOD TWELVE
 RECORD OF OFFICIAL COUNCIL VOTE

Docket No. B12-501

ITEM ON CONSENT CALENDAR

ACTION & DATE ADOPTED FIRST READING, 12-01-98

VOICE VOTE APPROVED
 RECORDED VOTE ON REQUEST

ABSENT ALL PRESENT

ROLL CALL VOTE - Result

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Cropp					Chavous					Schwartz				
Allen					Evans					Smith, Jr.				
Ambrose					Jarvis					Thomas, Sr.				
Brazil					Mason									
Catania					Patterson									

X - Indicates Vote

AB - Absent

NV - Present not Voting

CERTIFICATION RECORD

[Signature]
 Secretary to the Council

[Signature] December 21, 1998
 Date

ITEM ON CONSENT CALENDAR

ACTION & DATE ADOPTED FINAL READING, 12-15-98

VOICE VOTE APPROVED
 RECORDED VOTE ON REQUEST

ABSENT ALL PRESENT

ROLL CALL VOTE - Result

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Cropp					Chavous					Schwartz				
Allen					Evans					Smith, Jr.				
Ambrose					Jarvis					Thomas, Sr.				
Brazil					Mason									
Catania					Patterson									

X - Indicates Vote

AB - Absent

NV - Present not voting

CERTIFICATION RECORD

[Signature]
 Secretary to the Council

[Signature] December 21, 1998
 Date

ITEM ON CONSENT CALENDAR

ACTION & DATE

VOICE VOTE
 RECORDED VOTE ON REQUEST

ABSENT

ROLL CALL VOTE - Result

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Cropp					Chavous					Schwartz				
Allen					Evans					Smith, Jr.				
Ambrose					Jarvis					Thomas, Sr.				
Brazil					Mason									
Catania					Patterson									

X - Indicates Vote

AB - Absent

NV - Present not Voting

CERTIFICATION RECORD

Secretary to the Council

Date