D.C. Law 19-229, effective March 19, 2013

AN ACT

Bill 19-376
Act 19-546 effective November 20, 2012

To amend the Health Benefits Plan Members Bill of Rights Act of 1998 to strengthen the consumer protection provisions of the District's internal and external grievance processes for health benefit plans and comply with the federal Patient Protection and Affordable Care Act of 2010.

Codification District of Columbia Official Code 2001 Edition

Health Benefits Plan Members Bill of Rights Amendment Act of 2012

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 Amendment Act of 2012".

Amend § 44-301.01

Sec. 2. The Health Benefits Plan Members Bill of Rights Act of 1998, effective April 27, 1999 (D.C. Law 12-274; D.C. Official Code § 44-301.01 *et seq.*), is amended as follows:

(a) Section 101 (D.C. Official Code § 44-301.01) is amended as follows:

(1) Paragraph (1) is redesignated as paragraph (1B).

(2) New paragraphs (1) and (1A) are added to read as follows:

"(1) "Adverse benefit determination" means a denial, reduction, limitation, termination, failure to make a payment for a benefit, or a delay of a benefit to a member, regarding determinations about:

"(A) The medical necessity, appropriateness, or level of care, or health care setting;

"(B) Whether a benefit is experimental or investigational;

"(C) A decision to rescind coverage;

"(D) A member's eligibility to participate in a plan;

"(E) Whether a wellness incentive has been properly applied; or

"(F) Whether the member was given a reasonable alternative standard for satisfying a wellness plan when required.

"(1A) "Appeal" means a written request by a member or a member representative for a review of an adverse benefit determination.".

(3) Paragraphs (2) and (3) are amended to read as follows:

"(2) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

"(A) Placing the health or mental health of the individual in serious jeopardy;

"(B) Serious impairment to bodily functions or mental or emotional functions;

"(C) Serious dysfunction of any bodily organ or part or mental or emotional functions; or

"(D) With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

"(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 a benefit to a member, including regarding:

"(A) A determination about the medical necessity, appropriateness, or level of care, health-care setting, or effectiveness of a treatment;

"(B) A determination as to whether treatment is experimental;

"(C) An insurer's decision to rescind coverage;

"(D) The failure to provide or make payment that is based on a determination of a member's eligibility to participate in a plan;

"(E) Whether a wellness incentive has been properly applied; and

"(F) Whether the member was given a reasonable alternative standard for satisfying a wellness plan when required.".

(4) Paragraph (10) is amended to read as follows:

"(10) "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 covered person;

"(C) Family member of the covered person;

"(D) Covered person's treating health care professional when the covered person 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 covered person's medical condition.".

(5) A new paragraph (10A) is added to read as follows:

"(10A) "Rescission" means a cancellation or discontinuance of coverage that has a retroactive effect (which is prohibited except in cases of fraud or intentional misrepresentation of material fact).".

(6) Paragraph (11) is amended to read as follows:

"(11) "Urgent medical condition" means a condition with respect to which the application of time periods for making non-urgent claims decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain his or her maximum possible function, or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that could not be adequately managed without the health care services being requested.".

Amend § 44-301.03

(b) Section 103 (D.C. Official Code § 44-301.03) is amended as follows:

(1) Subsections (a), (b), and (c) are amended to read as follows:

"(a)(1) A member or member representative shall have a right to file an appeal with an insurer for a review of an adverse benefit determination. An insurer's health benefits plan shall

include an appeal system that provides for the presentation and resolution of appeals brought by members or member representatives.

"(2) Health insurers shall notify members when claims are denied, setting forth the reasons for the denial and procedures for appealing the determination through internal and external review. The notice shall be written in a manner calculated to be understood by the participant, in accordance with federal rules for group health plans promulgated by the U.S. Department of Labor, federal rules for individual health plans promulgated by the U.S. Department of Health and Human Services, and any rules promulgated by the Director pursuant to this act.

"(3) All notices regarding adverse benefit determinations shall meet the requirements of the Patient Protection and Affordable Care Act of 2010, approved March 23, 2010 (Pub. L. No. 111-148; 124 Stat. 119), regarding cultural and linguistic appropriateness, and, if the insurer is a subcontractor or grantee of a covered entity, as that term is defined in the Language Access Act of 2003, effective June 19, 2004 (D.C. Law 15-167; D.C. Official Code § 2-1931 *et seq.*) ("Language Access Act"), shall also meet the language access standards under the Language Access Act. At a minimum, insurers shall include information in languages identified by the Director about how to obtain free oral interpretation and translation of notices and vital documents.

"(b) An appeal system established pursuant to this section shall, at a minimum, incorporate the following components:

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

"(2) The right of a member to file an appeal regarding an insurer's decision to rescind coverage;

"(3) A procedure for filing an appeal from an adverse benefit determination;

"(4) A standardized method of recording, documenting, and reporting the status of all adverse benefit determinations and appeals, which includes the requirements that a health insurer maintain for 6 years records of all claims, and notices associated with the claims, grievances, appeals, and the review process, and limit access to patient-identifying information in those records in accordance with the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub. L. No. 104-191; 110 Stat. 1936), and any other applicable patient confidentiality rules;

"(5) Availability of a member services representative to assist members with grievances and appeals upon request;

"(6) 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;

"(7) A specified time for responding to appeals not to exceed the time frames set forth in section 106(f), from receipt of the grievance by the insurer;

"(8) An oral and written procedure describing how grievances and appeals are processed and resolved;

"(9) Procedures for insurers to follow concerning the methods to be used to inform the member of the resolution; and

"(10) In the case of appeals regarding emergency or urgent medical conditions, procedures that will allow a member or member representative to immediately request an expedited review in accordance with section 106 and section 107.

"(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) through (3) of this section, as well as:

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

"(2) The telephone number, business address, and description of the Health Care Ombudsman's services;

"(3) A statement that describes the member's or member representative's right to contact the Director, or the Director's designee, to seek external review if dissatisfied with the resolution reached through the insurer's grievance system; and

"(4) A statement that describes a Medicaid or D.C. Health Care Alliance enrollee's right to appeal to the Office of Administrative Hearings at any time, if applicable.".

(2) Subsection (d) is amended by striking the phrase "treating physician or" and inserting the phrase "treating physician, mental health professional, or" in its place.

(3) Subsection (f) is amended by striking the phrase "section 105" and inserting the phrase "sections 106 and 107" in its place.

(4) Subsection (g) is amended to read as follows:

"(g) The Director or the Director's designee shall waive exhaustion of the appeal process required by section 106 as a prerequisite for proceeding to the external appeal process:

"(1) In cases of emergency or urgent medical conditions;

"(2) If the insurer has not complied with the requirements of the internal review process; or

"(3) If further participation in the internal appeal process would require the provision of mental health information that the patient or treating mental health professional considered confidential.".

(c) Section 104 (D.C. Official Code § 44-301.04) is amended as follows: **Amend § 44-301.04**

(1) Subsections (a), (b), and (c) are amended to read as follows:

"(a) A member or member representative may appeal any adverse benefit determination decision resulting in a rescission, denial, termination, or other limitation of a benefit in accordance with the provisions of this act.

"(b) At the time an insurer denies, reduces, terminates, or limits a benefit, an insurer shall provide to the affected member or member representative a written description of the procedures for filing appeals, including procedures to request expedited internal or external review if the matter concerns an emergency or urgent medical condition. The notice shall adhere to requirements of Title XXVII of the Public Health Service Act, approved July 1, 1944 (42 U.S.C. § 300gg *et seq.*), and the Employee Retirement Income Security Act of 1974, approved

September 2, 1974 (Pub. L. No. 93-406; 88 Stat. 829), and shall include information sufficient to identify the claim, the reason for the denial, any standards relied on to deny the claim, contact information for the Health Care Ombudsman, and notice of the right of the claimant to receive free of charge all documents relevant to the claim.

"(c) The appeal process shall consist of 2 separate appeal levels:

"(1) Review by the insurer; and

"(2) External review by an independent review organization.".

(2) New subsections (e) and (f) are added to read as follows:

"(e)(1) The insurer shall notify a member seeking a resolution of an adverse benefit determination about the:

"(A) Availability of the Health Care Ombudsman;

"(B) Right to review; and

"(C) Procedures for obtaining continued coverage pending the outcome of the grievance.

"(2) For grievances and appeals concerning urgent or emergency medical conditions, the member has the right to continued coverage at the level of benefits provided before the reduction, termination, or limitation, pending the outcome of the appeal.

"(f)(1) Any request that a physician, with knowledge of the covered person's medical condition, determines involves an emergency or urgent medical condition shall be treated as an urgent care request.

"(2) An individual acting on behalf of the health insurer shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine to determine if other requests involve an emergency or urgent medical condition.

"(3) For the purposes of expedited external review, the Director, or the Director's designee, shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine to determine if other requests involve an emergency or urgent medical condition.".

Repeal § 44-301.05

(d) Section 105 (D.C. Official Code § 44-301.05) is repealed.

Amend § 44-301.06

(e) Section 106 (D.C. Official Code § 44-301.06) is amended to read as follows:

"Sec. 106. Internal appeals process.

"(a)(1) An insurer shall establish and maintain an internal appeals process whereby a member or member representative who has received an adverse benefit determination can have the opportunity to pursue an appeal before a reviewer or panel of physicians, a mental health professional, advanced practice registered nurses, or other health care professionals selected by the insurer.

"(2) Group health plans and individual health insurers shall follow claims procedures established pursuant to the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (Pub. L. No. 93-406; 88 Stat. 829), Title XXVII of the Public Health Service Act, approved July 1, 1944 (42 U.S.C. § 300gg *et seq.*), and the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. § 18001, note), as amended by the Health Care and Education Reconciliation Act of 2010, approved March 30,

2010 (124 Stat. 1029; 42 U.S.C. § 1305, note), if applicable. At a minimum, the member or member's representative shall be allowed to request an internal review within 180 days of receipt of a notice of an adverse benefit determination.

"(b) Reviews shall be in accordance with the following:

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

"(2) For all reviews requiring medical expertise or mental health expertise, the review 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, a mental health professional, an advanced practice registered nurse, or other appropriate health care provider possessing a non-restricted license to practice or provide care anywhere in the United States and the District of Columbia and have no history of disciplinary action or sanctions taken or pending against him or her by any governmental or professional regulatory body.

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

"(5) The health insurer shall ensure the independence and impartiality of the individuals making review decisions. The health insurer shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

"(6)(A) For claims involving mental health care, the confidentiality of mental health information shall be preserved pursuant to the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1201.01 *et seq.*) ("1978 act"). Pursuant to a valid authorization, the provider may share limited information as described in section 303 of the 1978 act to determine payment.

"(B) The patient may authorize (or for participating providers, the provider and insurer may jointly authorize) review of the patient's record of mental health information by an independent mental health professional. Mental health information disclosed to an independent mental health professional under these procedures shall not be disclosed to the health insurer.

"(c) All 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) The member and the member's representative shall have the right to:

"(1) Review the member's file;

"(2) Request and receive free of charge copies of all documents and records relevant to the claim;

"(3) Present evidence and testimony as part of the appeals process;

"(4) Review any new or additional evidence considered or generated by the health insurer;

"(5) Review any new or additional rationale used by the insurer in connection with the claim; and

"(6) Sufficient opportunity to respond.

"(e) The member has the right to continued coverage, upon request, at the level of benefits provided before the reduction, termination, or limitation, pending the outcome of the appeal.

"(f) An internal appeal shall be conducted as soon as possible after receipt by the insurer of all necessary documentation in accordance with the medical exigencies of the case. If the internal appeal is from a decision regarding urgent or emergency medical conditions, the insurer shall conclude the appeal within 24 hours of the notification of appeal by the member or member representative. The health insurer shall conclude all other appeals conducted pursuant to this section within 30 calendar days for prospective reviews and 60 calendar days for retrospective reviews.

"(g) If an insurer denies a member's or member representative's 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 receive copies of all documents relevant to the claim and to proceed to an external appeal. The notification shall include specific instructions as to how the member or member representative may arrange for an external appeal and any forms required to initiate an external appeal.

"(h) At a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include:

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

"(2) Information sufficient to identify the claim involved, including, if applicable:

"(A) The date of service;

"(B) The health care provider;

"(C) The claim amount; and

"(D) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

"(3) The reviewer's decision in clear terms;

"(4) The title and qualifying credentials of the person or persons participating in the review, including how those credentials apply to the specific form of treatment being reviewed;

"(5) The contractual basis, including reference to specific plan provisions, or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position;

"(6) A reference to the evidence or documentation used as the basis for the decision, including internal rules, guidelines, and protocols; and

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

"(i) If the insurer fails to comply with any of the deadlines or procedures for completion of an internal appeal or if that further participation in the internal process would require the provision of mental health information that the patient or treating mental health professional considered confidential, the member or member representative shall be relieved of his or her obligation to complete the internal review process and may, at his or her option, proceed directly to the external appeals process required by section 107.".

(f) A new section 106a is added to read as follows: **New § 44-301.06a**

"Sec. 106a. Appeals of rescissions to the Department of Insurance, Securities, and Banking.

"If an insurer denies a member or member representative's appeal of a rescission, the insurer shall provide the member or member representative and the Department of Insurance, Securities, and Banking with a written explanation of why the insurer found that there was fraud or misrepresentation of a material fact. The notice shall explain the member's right to appeal to the Department of Insurance, Securities, and Banking.".

(g) Section 107 (D.C. Official Code § 44-301.07) is amended as follows: **New § 44-301.07**

(1) The heading is amended to read as follows:

"Sec. 107. External appeals process for matters other than rescissions.".

(2) Subsection (a) is amended to read as follows:

"(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 an internal appeals process shall have the opportunity to pursue an external appeal before an independent review organization. The member or member's representative has a right to pursue an external appeal if:

"(1) Dissatisfied with a decision rendered in the internal appeals process;

"(2) The health benefit plan or the Director, or Director's designee, waives the requirement that the internal appeals process shall be completed before pursuing an external appeal;

"(3) The health plan does not comply with the deadlines and requirements of the internal appeals process; or

"(4) The matter concerns an emergency or urgent medical condition and the member or the member representative has applied for expedited external review at the same time as applying for an expedited internal review.".

(3) Subsection (b) is amended by striking the phrase "30 business days" and inserting the phrase"4 months" in its place.

(4) Subsection (c) is amended to read as follows:

"(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 or benefit which is the subject of the appeal reasonably appears to be a benefit or service covered by the health benefits plan, or is not explicitly listed as an excluded benefit and would be a covered benefit except for the insurer's

determination that the service or treatment is experimental or investigational for a particular medical condition;

"(3) The member or member representative has fully complied with section 106 regarding internal appeals, or exhaustion of the internal appeals process has been waived in accordance with section 103(g) or 106(i); and

"(4) The member or member representative has provided all the information required by the independent review organization and the Director to make the preliminary determination, including the appeal form, a copy of any information provided by the insurer regarding its decision to deny, reduce, or terminate a covered service or benefit, and the release form required pursuant to subsection (b) of this section.".

(5) Subsection (f) is amended to read as follows:

"(f) The member or member's representative may initiate an external appeal without exhaustion of the internal appeals process described in section 106 in a case of an emergency or urgent medical condition, when the insurer has failed to comply with the procedures set forth in section 106, or when further participation in the internal process would require the provision of mental health information that the patient or treating mental health professional considers confidential.".

(6) Subsections (h), (i), and (j) are amended to read as follows:

"(h)(1) 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. The independent review organization shall notify the member, or member representative, that:

"(A) The member may receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's request for benefits; and

"(B) The member may submit additional information in writing to be considered in conducting the review.

"(2) The member and member's representative shall be provided at least 10 business days to submit the information pursuant to paragraph (1)(B) of this subsection. To the extent permitted by law, the independent review organization shall forward any information it receives from the member or member's representative to the health insurer within one business day; except, in a case involving mental health information, disclosure of mental health information shall be limited in accordance with section 207 of the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1202.07) ("1978 act"). Pursuant to section 207(b) of the 1978 act the member's record of mental health information disclosed for the purpose of independent review shall not be disclosed to the insurer.

"(i) The full review of an appeal of a health benefits decision shall be initially conducted by 2 physicians licensed to practice medicine in the District of Columbia, Maryland, or Virginia, or in the case of mental health services, 2 health professional peers with an equal or greater degree of training and experience in the particular kind of mental health treatment under review

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 taken or sanctions pending against them by any governmental or professional regulatory body.

"(j)(1) In reaching a determination, the independent review organization shall take into consideration all pertinent medical records, the attending health care professional's opinion, consulting physician or mental health professional reports, and other documents submitted by the parties, without regard to whether the information was submitted or considered in making the initial adverse decision, any applicable generally accepted practice guidelines developed by the federal government, national, or professional medical societies, boards and associations, and any applicable clinical protocols or practice guidelines developed by the insurer, and may consult with such other professionals as appropriate and necessary.

"(2) In a case where a denial was based on the insurer's determination that services or treatments are experimental or investigational, the review organization shall additionally consider medical or scientific evidence or evidence-based standards as to whether the expected benefits of recommended or requested health care service or treatment is more likely to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.".

(7) A new subsection (j-1) is added to read as follows:

"(j-1) Before issuing a decision in accordance with the time frames provided in subsection (m) of this section, the independent review organization shall provide free of charge to the member, or member's representative, any new or additional evidence and any new or additional rationale, relied upon or generated by the independent review organization, or at the direction of the health insurer, in connection with the grievance or appeal decision sufficiently in advance of the date the decision is required to be provided to permit the member, or the member's representative, a reasonable opportunity to respond before that date.".

(8) Subsection (k)(2) is amended as follows:

(A) Subparagraph (D) is amended by striking the word "and".

(B) Subparagraph (E) is amended by striking the period and inserting the phrase "; and" in its place.

(C) A new subparagraph (F) is added to read as follows:

"(F) To know the names and qualifications of the reviewers, including their training and experience in the specific form of treatment that is being reviewed, and that they are free from conflicts of interest.".

(9) Subsection (l) is amended to read as follows:

"(l)(A) The independent review organization shall consult with a physician, mental health professional, advance practice registered nurse, or other health professional who is

an expert in the treatment of the medical or mental health condition that is the subject of the appeal. The expert shall:

"(i) Be knowledgeable about the recommended treatment or service through recent or current actual experience treating patients with the same or similar medical or mental health condition as the covered person;

"(ii) Be licensed and hold the appropriate accreditation or certification for the specialty area under review; and

"(iii) Have no history of disciplinary actions that raise a substantial question about the reviewer's competence or moral character.

"(B) All final recommendations of the independent review organizations shall be approved by the medical director of the independent review organization.".

(10) Subsection (m) is amended as follows:

(A) Strike the phrase "30 business" and insert the phrase "45 calendar" in its place.

(B) Strike the phrase "medical risk" and insert the phrase "medical risk, including increased mental health risk," in its place.

(11) A new subsection (m-1) is added to read as follows:

"(m-1) Expedited appeals shall be furnished:

"(1) For appeals concerning admission, availability of care, continued stay, or health care service for which the member received emergency services but has not been discharged from a facility;

"(2) When the member is seeking care for an emergency or urgent medical condition; or

"(3) When the insurer's denial of coverage is based on its determination that treatment is experimental or investigational; which expedited review shall be conducted upon the treating physician's certification that treatment will be significantly less effective if not promptly initiated.".

(12) Subsection (n) is amended as follows:

(A) Strike the phrase "necessary covered services." and insert the phrase "necessary covered services or benefits." in its place.

(B) Strike the phrase "appropriate covered health care services" and insert the phrase "appropriate covered health services or benefits" in its place.

(13) Subsection (o) is amended by striking the phrase "When necessary, the" and inserting the word "The" in its place.

(14) Subsection (p) is amended to read as follows:

"(p) The decision of the independent review organization shall be binding on the plan or issuer and the member, except to the extent that there are other remedies under District or federal law.".

(15) Subsection (q) is amended as follows:

(A) Paragraph (1) is amended by striking the word "Medicaid" and inserting the phrase "Medicaid or the District of Columbia Health Care Alliance" in its place.

(B) Paragraph (2) is amended as follows:

(i) Strike the phrase "pursuant to the Medicaid program" and insert the phrase "pursuant to the Medicaid program or District of Columbia Health Care Alliance program" in its place.

(ii) Strike the phrase "appeals for the Medicaid program" and insert the phrase "appeals for those programs" in its place.

Amend § 44-301.08

(h) Section 108 (D.C. Official Code § 44-301.08) is amended as follows:

(1) Subsection (b) is amended as follows:

(A) Paragraphs (1), (2), and (3) are amended to read as follows:

"(1) Properly maintains a policy involving the review of the appeal in strict confidence pursuant to rules established by the Director and performs reviews at a level of confidentiality equal to or stricter than the standards of confidentiality that are required of the treating health professionals for the treatment being reviewed;

"(2) Uses only qualified professional and medical reviewers in any review who do not have conflicts of interest with the patient, the treating health care professional, or the health insurer;

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

(B) A new paragraph (4) is added to read as follows:

"(4) Is accredited by a nationally recognized private accrediting organization.".

(2) Subsection (e)(4) is amended by striking the word "provider" and inserting the phrase "health or mental health professional" in its place.

(3) Subsection (f) is amended as follows:

(A) Paragraph (1) is amended as follows:

(i) Subparagraph (D) is amended by striking the word "institution" and inserting the phrase "facility or institution" in its place.

(ii) Subparagraph (E) is amended by striking the period and inserting a semicolon in its place.

(iii) New subparagraphs (F) and (G) are added to read as follows:

"(F) The claimant and any related parties to the claimant whose treatment is the subject of the external review; and

"(G) The plan administration, plan fiduciaries, or plan employees.".

(B) Paragraph (2) is repealed.

(4) A new subsection (n) is added to read as follows:

"(n)(1) An independent review organization assigned pursuant to this act to conduct an external review shall maintain written records on all requests for which it conducted an external review during a calendar year.

"(2) Each independent review organization shall submit to the Director, upon request, a report on all requests for external reviews.

"(3) The report shall include, at minimum:

"(A) The total number of requests for external review;

"(B) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

"(C) The average length of time for resolution;

"(D) A summary of the types of coverages or cases for which an external review was sought, provided in the format required by the Director; and

"(E) The number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative.

"(4) The independent review organization shall retain the written records required pursuant to this subsection for at least 3 years.".

(i) A new section 111 is added to read as follows: **New § 44-301.11**

"Sec. 111. Availability of District external review procedures for self-insured plans.

"A group health plan that is located in the District but that is not subject to District regulation may voluntarily use the District's external review system; provided, that it pays the full costs of external review and adheres to the procedures set forth in section 107.".

Sec. 3. Fiscal impact statement.

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. Official Code § 1-206.02(c)(3)).

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.