GUIDE TO D.C. HEALTH INSURANCE REQUIREMENTS IN THE DISTRICT OF COLUMBIA

Source	Reference	Description
DC Official Code	§31-2801	Access to Emergency Medical Services
DC Official Code	§31-2803	Emergency Department HIV Screening
DC Official Code	§44-302.01 (2001 ed.)	Access to Specialists as Primary Care Providers (applicable to HMOs only)
DC Official Code	§31-4712 (2011 ed.)	Accident and Sickness Policies
DC Title 26 Municipal Regulations	DCMR 26-A211.1	Advertisement: Accident and Sickness Insurance
DC Title 26 Municipal Regulations	DCMR 26-A2618	Advertisement: Long Term Care (Filing Requirements for Advertising)
DC Act 17-0236	§16-4401	Arbitration Act of 2007
DC Official Code	§31-2901	Cancer Prevention Statute for Women
DC Official Code	§31-2995.01	Chemotherapy Pill Coverage Act of 2009
DC Official Code	§31-2993.01	Clinical Trials Insurance Coverage Act of 2008
DC Official Code	§31-2931	Colorectal Cancer Screening Insurance
DC Official Code	§31-2991	Closed (obstetrician/gynecologist) Malpractice Claims
DC Official Code Administrative Order	§32-732, 09-IB-02-05/11	Continuation of Health Coverage ("Baby COBRA")
DC Official Code	§31-2996	Dependent Child Health Insurance
DC Official Code	§31-3001	Diabetes Health Insurance Coverage Expansion Act of 2000
DC Official Code	§44-302.03 (2001 ed.)	Direct access to qualified specialists for females' health services (applicable to HMOs only)
DC Official Code	§31-3011	Discontinue of Class of Health Insurance Policies
DC Law 18-0033	DC Act 18-0033	Domestic Partnership Judicial Determination of Parentage Amendment Act of 2009
DC Official Code	§ 32-701	Domestic Partnership Registration/Termination Procedures and Fees Approval Resolution of 2002 & Domestic Partnership Notice Update
DC Official Code	§31-3101	Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage/Expansion of Substance Abuse and Mental Illness Insurance Coverage Amendment Act of 2006
DC Official Code	§31-3103	Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage Amendment Act of 2000 (Mental Parity Provisions)
DC Notice	November 8, 2007	Drug Exclusion Definition used in Life and Disability Insurance Policies
DC Official Code	§46-401	Equal Access to Marriage

DC Official Code	§22-3225.09 et seq.	FRAUD WARNING Compliance With the Insurance Fraud Prevention and Detection Amendment Act of 1998
DC Official Code	§31-3151	Health Benefits Plan Withdrawal from the Market
DC Official Code	§31-3201	Health Insurance Claim Forms
DC Official Code	§31-3271	Health Insurance Coverage for Habilitative Services for Children
DC Official Code	§31-2996.01	Health Insurance for Dependents Act of 2010 (DC Law 18-203)
DC Official Code	§31-3301.1	Health Insurance Portability and Accountability • Guaranteed DC HIPAA individual health benefit plans for eligible individuals • Renewability of current health benefit plans • Availability of health benefit plans by small employers
DC Official Code	§ 31- 3401	Health Maintenance Organizations HMOs are required to "…provide or arrange for basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments of deductibles, or both…" Basic health care services include the following benefits: • Preventive care • Emergency care • Inpatient and outpatient hospital and physician care • Diagnostic laboratory and diagnostic and therapeutic radiological services, and • Services mandated under the statutes listed in items 1 through 3
DC Official Code	§31-3501	Hospital and Medical Services Corporation Regulation
DC Official Code	§31-3851.01	Health Organization Risk Based Capital
DC Bulletin	Bulletin No. 09-IB-01-10/02	Implementation of the Domestic Partnership Judicial Determination of Parentage Amendment Act of 2009 & the Jury and Marriage Amendment Act of 2009
DC Bulletin	§46-401 Bulletin No. 10--IB-04-12/17	Implementation of the Religious Freedom & Civil Marriage Equality Amendment Act of 2009
DC Law 18-0009	§46-401	Jury and Marriage Amendment Act of 2009
DC Bulletin	Bulletin No. 06-IB-001-4/14	Limited Maternity Health Benefit
DC Official Code	§31-3601	Long-Term Care Insurance

DC Notice	June 2003	Medical Necessity/Medically Necessary Definition Add the following to definition: The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.
DC Official Code	§44-301.01	Medical Necessity Cases (Grievance and Appeals Procedures)
DC Official Code	§31-3701 et seq.	Medicare Supplement Insurance
United States Code	H.R. 2851	Michelle's Law (Federal Law)
DC Official Code	§31-3801 & §7-875.01 et seq.	Newborn Health Insurance/Uniform Child Health Screening Requirements
DC Official Code	§44-303.01 et seq. (2001 ed.)	Notification of Health care provider termination; continuance of coverage (applicable to HMOs only)
DC Bulletin	Bulletin No. 09-IB-05-10/08	Prohibition of Consideration of Domestic Violence in Life and Health Insurance
DC Official Code	§31-1601 & DC Law 17-0177	Prohibition of Discrimination in the Provision of Insurance on Basis of HIV/AIDS Test (Prohibition of Discrimination on the Basis of Gender Identity and Expression Amendment Act of 2008)
DC Official Code	§31-3161	Prohibition on Gender-Based Discrimination in Rate Making
DC Official Code	§31-3131	Prompt Payment - Health Benefits Plans
DC Official Code	§31-2951	Prostate Cancer Screening Insurance Act of 2002
DC Official Code	§31-4724	Psychologists or Optometrists Access to psychologists or optometrists under group health insurance policy
DC Official Code	§44-302.01	Standing referrals to specialists (applicable to HMOs only)
DC Bulletin	Bulletin No. 06-IB-004 8/29	Supplemental Health Policies
DC Official Code	§31-2231.01	Unfair Insurance Trade Practices
DC Bulletin	01-IB-007-02/08	Update for Limited Benefit Alert
DC Notice	March 27, 2009	Updated Fraud Warning Language
DC Notice	June 14, 2011	Use of Discretionary Clauses/Language
United States Code	H.R. 6983	Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
DC Official Code	§31-3831	Women's Rights Regarding Certain Health Insurance
DC Bulletin	13-IB-01-03/15	Prohibition of Discrimination Based on Gender Identity

Overview:

Access to Emergency Medical Services:
This mandate requires all health insurance companies to coordinate with emergency care providers so that they are reimbursed in a medical emergency. The necessary claims and information about the patient's symptoms and services provided should be sent to the insurance company. The patient should only be responsible for co-payment, deductibles and reinsurance as required by the policy.

Emergency Department HIV Screening
Under this mandate insured patients in the District have the right to a free voluntary HIV screening test while be treated in the emergency room regardless of what they are being treated for.

Access to Primary Care Providers
This mandate permits a patient with a member with a chronic, disabling or life threatening conditions to appoint a specialist qualified to treat the condition as their primary care provider. The chosen specialist can treat the member without receiving a referral and can authorize referrals, procedures, and medical services. The appointed specialist should develop a treatment plan which encompasses medically necessary procedures, test, and medical services.

Accident and Sickness Policies
This requires most insurance plans including health insurance companies to submit a copy of the form and rates of a plan. Additionally, DISB has 30 days to review the forms and rates before the company can issue or deliver the plan.

DC is a file and approve jurisdiction. In order for an issuer to administer a plan in the District it must be first filed and approved. It can be approved if the DISB takes no action in 30 days. If the DISB does take action within the 30 day window, the issuer must work with the DISB reviewer to resolve the filing.

Advertisement Regulations
These regulations set advertisement standards for issuers, agents and brokers operating in the District. It requires the advertisements to be truthful and not to misconstrue information or facts that would mislead or deceive the consumer. This section provides 26 regulations on advertising insurance products many of which are consistent with the 1971 NAIC advertisement regulations.

Advertising Filing Requirements
This regulation requires every long-term care insurance advertisement to be filed with DISB regardless of whether it is a written, radio or television advertisement. The advertisement should be retained by the insurer for at least three years. The commissioner has the discretion to exempt a company of this requirement.

Arbitration Act of 2007
This law regulates arbitration organizations and requires parties drafting consumer arbitration agreements to disclose the costs associated with arbitration. Moreover, a consumer and insurance may resolve a dispute via arbitration if the decision to arbitrate is made by the parties at the time a dispute arises and any decision to arbitrate is not a condition of continuing coverage under the same terms that would have otherwise applied. Insurance companies should have procedures to process arbitration requests.

Cancer Prevention Statute for Women
This mandate requires any individual or group health plan administered in the District of Columbia to provide a baseline and annual screening mammogram and cervical cytological screenings. These benefits shall not be subject to a co-payment unless they are provided out of network. Patients can still be charged a co-payment for the doctor visit.

Chemotherapy Pill Coverage Act of 2009
This mandate requires any health plans that provides coverage for prescription drugs to provide coverage for prescribed, orally administered anti-cancer medication used to kill or slow the growth of cancerous cells and the person receiving the medication shall have the option of having ti dispensed at any appropriately licensed pharmacy. Additionally, the pill should be priced (cost-sharing and max deductibles) no less favorably than coverage provided for tier IV administered or injected cancer medications.

Clinical Trials Insurance Coverage Act of 2008
This mandate prohibits health insurance companies from limiting or denying coverage or imposing additional conditions on the payment of drugs and services to a qualified individual participating in an approved clinical trial. However, a health insurer is not required to pay for items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial.

Colorectal Cancer Screening Insurance
This provision requires every individual and group health insurance policy to provide colorectal cancer screening for policyholders in the District of Columbia. The screenings shall be incompliance with the American Cancer Society colorectal cancer screening guidelines.

Closed (obstetrician/gynecologist) Malpractice Claims
This provision calls for a database of closed OBGYN malpractice claims report to be submitted by providers of medical malpractice insurance. The database is intended to identify trends in order to develop recommendations and best practices for OBGYN practitioners and facilities.

Continuation of Health Coverage ("Baby COBRA")
This act continues the COBRA premium assistance program for District employees covered in the small group market who are involuntarily terminated from coverage on or prior to May 31, 2010. Employees

can enjoy premium assistance for up to 15 months after termination. The Act extends the 15 month premium assistance for individuals who were not originally covered under law due to maximum income limits of $145,000 for an individual and $290,000 for a joint file. Individuals eligible for other group coverage such as Medicare or Medicaid are not eligible for COBRA.

Dependent Child Health Insurance
This mandate requires a group or individual health plan that provides coverage for a dependent child must make coverage be available to all dependents. Benefits and premium rates should be the same for all dependents.

Diabetes Health Insurance Coverage Expansion Act of 2000
This law requires a health benefit plan to provide coverage for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of various diabetes diagnosis. It also prohibits insurers from charging persons with diabetes a higher deductible, copayment, or coinsurance, longer waiting periods and refusing or canceling a plan solely because the applicant or insured is diabetic. Insurance companies are prohibited from offering to pay for any type of financial or material incentive to an insured or health care provider in an effort to decrease the utilization of diabetes services.

Direct access to qualified specialists for females' health services (applicable to HMOs only)
This requirement allows for insured female to list a female provider to designate as their primary care provider (PCP) including a participating physician, advance practice registered nurse who specializes in obstetrics and gynecology (OBGYN). If the insured female does not appoint a female as their PCP, the plan is prohibited from requiring a referral or prior authorization for that female to receive medically necessary OBGYN services. The HMO has the discretion to require the provider administering OBGYN services to provide a written notification to the PCP what health care services they are providing to the PCP's patient.

Discontinue of Class of Health Insurance Policies
In order for an insurer to discontinue a health policy in the District the insurance company must receive approval by the commissioner. The commissioner has within 60 days of receiving the discontinuance notice to determine that the insurer is not discontinuing the policy due to claims experience or health status-related factor relating to any policy holder; the commissioner must also examine the histories and premium rates for each policy in the class, historical profits and losses, and comments from the policyholders. If approved the insurer must provide written notice to each policyholder 90 days prior to the date of discontinuance while also providing the option to purchase all other plans being offered to the group in the market.

Domestic Partnership Judicial Determination Parentage Amendment Act of 2009
This law allows for domestic partners to be parents in the event a child born to a couple in a domestic partnership. For legal purposes domestic partners are treated as parents the same way a married couple is, and are entitled to the same rights, privileges, duties, and obligations under D.C. law.

Domestic Partnership Registration/Termination Procedures and Fees Approval Resolution of 2002 & Domestic Partnership Notice Update

These guidelines provide qualifying steps necessary to establish an existence of a domestic partnership in order to qualify for benefits offered in a domestic partnership. Additionally, the guidelines specify ways the domestic partnership terminates for example death or legal marriage. A district government employee who is separated from service, or an employee's dependent child who ceases to be a dependent, may be eligible for extended health benefits coverage in accordance with 1-621.14.

Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage/Expansion of Substance Abuse and Mental Illness Insurance Coverage Amendment Act of 2006

This rule requires both employer sponsored and individual health insurance to provide medical and psychological treatment of drug abuse, alcohol abuse, and mental illness. Covered benefits for services are limited to coverage of treatment of clinically significant mental illness substance use disorders defined in the International Classification of Diseases or of the Diagnostic and Statistical Manual of the American Psychiatric Association. The treatment limits are 60 days/year for inpatient care and cover 75% of the first 40 visits and 60% of any outpatient visits thereafter for that year.

Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage Amendment Act of 2000 (Mental Parity Provisions)

This provision determines level of payment for mental illness and drug and alcohol abuse. It states that it should be consistent with the reasonable and customary standards for physical illnesses. Cost sharing, out-of-pocket maximums are set forth in this rule, however plans are exempt from the provision if the cost of this mandate results in a 1% increase in the cost of the plan.

Drug Exclusion Definition used in Life and Disability Insurance Policies

This notice requires exclusion language for drugs to state "(1) The voluntary use of illegal drugs; (2) the intentional taking of over the counter medication not in accordance with recommended dosage and warning instructions; and (3) intentional misuse of prescription drugs"

Equal access to marriage

This regulation defines marriage to be "any person in DC regardless of gender," except for certain circumstances referenced in the code.

FRAUD WARNING Compliance with the Insurance Fraud Prevention and Detection Amendment Act of 1998

This rule requires every insurer licensed in the District to submits an insurance fraud prevention and detection plan to DISB. The rule specifies the requirements of the plan and the penalty for non-compliance.

Health Benefits Plan Withdrawal from the Market

This rule states the required procedures for a health insurance company to discontinue an offering of all health benefit plans in the District of Columbia. The carrier must submit an application to the commissioner.

Health Insurance Claim Forms
This section of the code designates HCFA 1500 and UB 92 claims for as the official health insurance claim forms for the District of Columbia. The forms can be modified to accommodate electronic transmission process.

Habilitative Services for Children
This section requires health insurers to provide coverage of habilitative services for children under the age of 21. The coverage cannot be more restrictive than the treatment for any other illness, condition, or disorder for purposes of cost sharing and treatment limits. Habilitative services is defined as occupational therapy, physical therapy, and speech therapy, for the treatment of a child with congenital or genetic birth defect to enhance the child's ability to function.

Health Insurance for Dependents Act of 2010 (Bill 18-0499)
This notice enforces the PPACA requirement for health plans to allow young adults to stay on their parents plan until they are 26 years of age.

Health Insurance Portability and Accountability
This sections guarantees DC HIPAA protections for individual health benefits plans, including renewability of current health benefit plans, and availability of health benefits plans by small employers.

Health Maintenance Organizations
This sections requires Health Maintenance Organizations to provide healthcare services including preventive care, emergency care, inpatient and outpatient, diagnostic laboratory and therapeutic radiological services, and other mandated services.

Hospital and Medical Services Corporation Regulation
This sections requires for-profit hospitals such as community reinvestment and surplus requirement, it requires hospital to assist in open –enrollment activity.

Implementation of the Domestic Partnership Judicial Determination of Parentage Amendment Act of 2009 & the Jury and Marriage Amendment Act of 2009
This law further marriage for same-sex couples and domestic partnerships to be recognized as eligible for health insurance benefits operating in the District.

Implementation of the Religious Freedom & Civil Marriage Equality Amendment Act of 2009
The bulletin states that health issuers shall cover same-sex spouse of the insured and allow equal rights and privileges in the policy as given to a spouse of the opposite sex.

Jury and Marriage Amendment Act of 2009
Marital relationships or familial relationships, gender specified terms shall be construed to be gender neutral for all purposes of throughout the law in DC.

Limited Maternity Health Benefit
This bulletin states that health plans that provide limited maternity benefits tare required to include

language that states “Maternity Benefits may contain a limited maximum benefit under the policy. Please reference the schedule of benefits in the group or individual plan contract.”

Long-Term Care Insurance
This section defines long-term care insurance as “any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis; for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital.” Long-term care insurance" includes group and individual annuities and life insurance policies or riders which provide directly, or which supplement, long-term care insurance.” Long-term care insurance also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity as well as qualified long-term care insurance contracts.” It also provides regulations on the scope, eligible issuers, and group policies issued in other state.

Medical Necessity/Medically Necessary Definition
This notice adds “The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Group Policy” to the medical necessity definition.

Medical Necessity Cases (Grievance and Appeals Procedures)
This rule establishes a formal review process for an adverse benefit determination. The member should first file an appeal with their insurance company. Health insurers shall notify members when the claims are denied, setting forth reasons for the denial and provide the procedures for appealing the determination through internal and external review. External review requires an independent review organization to make the determination on a grievance decision by an insurer, including an insurer’s decision to deny, terminate, or limit covered health care services. The health insurer shall maintain records of all communications documents.

Medicare Supplement Insurance
This rule sets standards for Medicare supplemental policies. It states that benefits should not duplicate with benefits provided by traditional Medicare, it also allows the Mayor to set standards for these policies including but not limited to terms of renewability, initial and subsequent conditions of eligibility and much more. It authorizes the Mayor to issue reasonable regulations that will bring these policies in compliance with Federal law and regulations.

Michelle’s Law (Federal Law)
This law allows full time college students to take up to 12 months medical leave. Students can be on their parents plan and can be absent or reduce course load to part-time.

Newborn Health Insurance
Health insurance policies should provide benefits to a newly born child of an insured from the moment of birth. All plans must provide coverage for inpatient postpartum treatment in accordance with the medical criteria outlined in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics.

Uniform Child Health Screening Requirements
This rule requires the Mayor to establish a uniform, age-appropriate health screening requirement consistent with the American Academy of pediatrics for all children, from birth to 21 years of age, in the

District of Columbia, regardless of insurance status. There should be a uniform health assessment form for enrollment; parents have the legal authority to opt-out their child from health screenings.

Notification of Health care provider termination; continuance of coverage (applicable to HMOs only)
When a healthcare provider leaves a plan, the insurer shall notify the insured members on a timely basis of the termination. When medically necessary, persons may be covered for at least 90 days following the date of the termination notice under the same terms and conditions that were specified under the provider contract.

Prohibition of Consideration of Domestic Violence in Life and Health Insurance
This bulletin provides protections for victims of domestic violence by prohibiting insurance companies from cancelling, refusing to underwrite or renew a policy, refusing to pay a claim, or increase rates based on the fact that an individual is a victim of domestic violence or subject to abuse.

Prohibition of Discrimination in the Provision of Insurance on Basis of HIV/AIDS Test (Prohibition of Discrimination on the Basis of Gender Identity and Expression Amendment Act of 2008)
This rule prevents insurers from discriminating against patients with HIV/AIDS. Health insurance companies may not use an individual's HIV/AIDS status to determine whether to issue, cancel or renew coverage or while determining rates, premiums, benefits covered and much more.

Prohibition on Gender-Based Discrimination in Rate Making
This rule prohibits a premium rate or any other underwriting decision to be determined in any way based on the gender or sex of a person covered under the health benefit plan. Additionally, this rule requires health plans to provide coverage a variety of benefits that cover the birth of a child.

Prompt Payment - Health Benefits Plans
This rule requires health insurers to reimburse any person entitled to reimbursement under the health benefits plan within 30 days after receipt of a clean claim. If an insurer fails to pay within the 30 day period they will be required to pay interest on the claim.

Prostate Cancer Screening Insurance Act of 2002
This rule requires prostate cancer screening to be covered under all health benefits plans. The coverage cannot have more restrictive treatment limits or cost sharing than other illness.

Psychologists or Optometrists Access to psychologists or optometrists under group health insurance policy
This rule states that group health policies cannot require a referral for psychologists and optometrists. Additionally, the rule also states that a group health policy must provide the primary care for a minor, grandchild, niece, or nephew if the legal guardian is not covered under insurance. In order for them to be considered a dependent, the insured must provide food, clothing, and shelter on a regular and continuous basis for the minor throughout the school year.

Standing referrals to specialists (applicable to HMOs only)
This rule permits patients who have a life threatening condition to designate a specialists as their primary care provider. The patient will not need a referral to see the designated specialist.

Supplemental Health Policies
This bulletin prevents limited benefit health plans, hospital indemnity, or other supplemental health policies from marketing themselves as substitutes for health benefit plans. All supplemental health plans identified in the bulletin must include an attestation notice to consumers in the application which states that the product is not a substitute for major medical coverage.

Unfair Insurance Trade Practices
This section identifies all the unfair insurance trade practices that are prohibited including defamation, falsifying information, discrimination and much more.

Update for Limited Benefit Alert
This notice clarifies that limited benefit health plans do not provide the same level of coverage as a comprehensive medical plan. The notice has instructions for how these plans should be advertised.

Updated Fraud Warning Language
This notice requires insurer to use verbatim Fraud Warning language which is listed on the bulletin. The language is intended to prevent consumers from giving fraudulent information to an insurer.

Use of Discretionary Clauses/Languages
This notice reminds issuers that discretionary clauses such as, "We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provision of the policy." This language cannot restrict a consumer's right including the right to appeal or proceed to litigation against and insurer.

Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
This act requires group health plans that provide mental health and substance abuse disorder services to provide those services at the same level to medical/surgical benefits.

Women's Rights Regarding Certain Health Insurance
This provision allows for certain mastectomy (breast removal) services if deemed necessary to be covered by a health benefits plan.

Prohibition of Discrimination in Health Insurance Based on Gender Identity or Expression
This bulletin requires insurances to cover gender dysphoria as a medical condition when medically necessary for gender transformation surgeries or related services. Insurance companies should refer to the World Professional Association for Transgender Health Standards of Care for determining medical necessity.