

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of a new Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Home and Community-Based Waiver Services for Persons with Mental Retardation and Developmental Disabilities." These rules establish eligibility requirements and other general standards for participation in the Medicaid Home and Community-Based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver). These rules also establish standards governing reimbursement by the Medicaid program for personal care services furnished by Waiver providers. The Waiver will enable the District to provide home and community-based services to individuals aged 18 or over who would otherwise require institutional care in an intermediate care facility for persons with mental retardation.

The Centers for Medicare and Medicaid Services (CMS), formerly the federal Health Care Financing Administration has advised the District that the maintenance and expansion of all approved services to persons served by the Waiver is essential to the continuation of the Waiver. These rules establish the general terms and conditions governing the provision of all Waiver services.

On March 26, 2004, a notice of emergency and proposed rules was published in the D.C. Register (51 DCR 3317). These rules amend the previously published rules by amending the eligibility requirements to include the criteria for the level of care determination and income levels and requiring providers to submit a quality assurance plan with each provider application.

A notice of emergency and proposed rulemaking was published in the *D.C. Register* on September 3, 2004 (51 DCR 8680). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *D.C. Register*.

Amend Title 29 DCMR by adding the following new Chapter 19 to read as follows:

**CHAPTER 19 HOME AND COMMUNITY-BASED WAIVER SERVICES
FOR PERSONS WITH MENTAL RETARDATION AND
DEVELOPMENTAL DISABILITIES**

1900 GENERAL PROVISIONS

- 1900.1 The purpose of this chapter is to establish criteria governing Medicaid eligibility for Home and Community-based Waiver Services for Persons with Mental Retardation and Developmental Disabilities (Waiver) and to establish conditions of participation for providers of Waiver services.
- 1900.2 The Waiver is authorized pursuant to section 1915 (c) of the Social Security Act, approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS) and shall be effective through November 19, 2007, plus any extensions thereof.
- 1900.3 The Waiver shall be operated by the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (MRDDA) under the supervision of the Department of Health, Medical Assistance (MAA).
- 1900.4 Enrollment of persons eligible to receive Waiver services shall not exceed the ceiling established by CMS.

1901 COVERED SERVICES

- 1901.1 Services available under the Waiver shall include the following:
- (a) Adaptive equipment, as set forth in section 928 of Title 29 DCMR;
 - (b) Adult companion, as set forth in section 944 of Title 29 DCMR;
 - (c) Attendant care, as set forth in section 927 of Title 29 DCMR;
 - (d) Case management, as set forth in section 940 of Title 29 DCMR;
 - (e) Chore services, as set forth in section 929 of Title 29 DCMR;
 - (f) Day habilitation, as set forth in section 945 of Title 29 DCMR;
 - (g) Dental services, as set forth in section 936 of Title 29 DCMR;
 - (h) Environmental accessibility adaptation services, as set forth in section 926 of Title 29 DCMR;
 - (i) Family training, as set forth in section 942 of Title 29 DCMR;
 - (j) Homemaker services, as set forth in section 938 of Title 29 DCMR;
 - (k) Independent habilitation, as set forth in section 993 of Title 29 DCMR;
 - (l) Nutritional counseling, as set forth in section 930 of Title 29 DCMR;
 - (m) Occupational therapy, as set forth in section 935 of Title 29 DCMR;
 - (n) Personal care services, as set forth in sections 5004 and 1910 of Title 29 DCMR;
 - (o) Personal emergency response system (PERS), as set forth in section 907 of Title 29 DCMR;

- (p) Physical therapy services, as set forth in section 934 of title 29 DCMR;
- (q) Preventive, consultative and crisis support, as set forth in section 937 if Title 29 DCMR;
- (r) Prevocational services, as set forth in section 920 of Title 29 DCMR;
- (s) Residential habilitation, as set forth in section 946 of Title 29 DCMR;
- (t) Respite care, as set forth in section 994 of Title 29 DCMR;
- (u) Skilled nursing, as set forth in section 933 of Title 29 DCMR;
- (v) Speech, hearing and language services, as set forth in section 932 of Title 29 DCMR;
- (w) Supportive employment, as set forth in section 929 of Title 29 DCMR; and
- (x) Transportation, as set forth in section 943 of title 29 DCMR.

1902 ELIGIBILITY REQUIREMENTS

- 1902.1 An individual eligible to receive Waiver services shall meet all of the following requirements:
- (a) Have a special income level equal to 300% of the SSI federal benefit or be aged and disabled with income at 100% of the federal poverty level or be medically needy as set forth in 42 CFR 435.320, 435.322, 435.324 and 435.330;
 - (b) Be mentally retarded and developmentally disabled;
 - (c) Be eighteen (18) years of age or older;
 - (d) Be a resident of the District of Columbia as defined in D.C. Official Code § 7-1301.03(22);
 - (e) Have a level of care determination that the individual requires services furnished in an intermediate care facility for persons with mental retardation (ICF/MR) or persons with related conditions pursuant to the criteria set forth in section 1902.4; and
 - (f) Meet all other eligibility criteria applicable to Medicaid recipients including citizenship and alienage requirements.
- 1902.2 Waiver services shall not be furnished to a person who is an inpatient of a hospital, ICF/MR or nursing facility.
- 1902.3 Each individual enrolled in the Waiver shall be re-certified annually as having met all of the eligibility requirements as set forth in subsection 1902.1 for continued participation in the Waiver.
- 1902.4 An individual shall meet the level of care determination set forth in section 1902.1(e) if one of the following criteria has been met:

- (a) The individual's primary disability is mental retardation with an intelligence quotient (IQ) of 59 or less;
- (b) The individual's primary disability is mental retardation with an intelligence quotient of 60-69 and the individual has at least one of the following handicapping conditions:
 - (1) Mobility deficits;
 - (2) Sensory deficits;
 - (3) Chronic health problems;
 - (4) Behavior problems;
 - (5) Autism;
 - (6) Cerebral Palsy;
 - (7) Epilepsy; or
 - (8) Spina Bifida.
- (c) The individual's primary disability is mental retardation with an intelligence quotient of 60-69 and the individual has severe functional limitations in at least three of the following major life activities:
 - (1) Self care;
 - (2) Understanding and use of language;
 - (3) Functional academics;
 - (4) Social skills;
 - (5) Mobility;
 - (6) Self-direction;
 - (7) Capacity for independent living; or
 - (8) Health and safety.
- (d) The individual has autism, cerebral palsy, prader willi or spina bifida, and has severe functional limitations in at least three of the major life activities set forth in sections 1902.4 (c)(1) through 1902.4 (c)(8).

1903**PROVIDER QUALIFICATIONS**

1903.1

Each prospective provider shall complete an application to participate in the Medicaid program and submit to MAA the following information:

- (a) A description of ownership and a list of major owners or stockholders owning or controlling five percent (5%) or more outstanding shares;
- (b) A list of Board members and their affiliations;
- (c) A roster of key personnel, their qualifications and a copy of their position descriptions;

- (d) Copies of job descriptions, resumes, licenses and certifications of all staff providing services;
- (e) Addresses of all sites where services will be provided to clients;
- (f) A copy of the most recent audited financial statement of the organization;
- (g) A completed provider application;
- (h) A copy of the basic organizational documents of the provider, including an organizational chart and current Articles of Incorporation;
- (i) A copy of the Bylaws or similar documents regarding conduct of the provider's internal affairs;
- (j) A copy of the business license or certificate of good standing;
- (k) A copy of the Joint Commission on Accreditation of Health Care Organization's certification, if required;
- (l) A copy of the Certificate of Need approval, if required;
- (m) A copy of the Certificate of Occupancy;
- (n) Program policies and procedures;
- (o) Staffing ratios, if required;
- (p) A quality assurance plan; and
- (q) Any other documentation deemed necessary to support the approval as a provider.

- 1903.2 MAA shall notify each prospective provider, in writing, of the approval or disapproval to become a provider of Waiver services, no later than 45 days of receipt of all required documentation. If additional information is requested by MAA, the provider shall have 30 days from the date of the request to submit the additional information. If an application is disapproved, the notice shall set forth the reason for disapproval. Failure to submit all required documentation may result in disapproval.
- 1903.3 Each provider shall enter into a provider agreement with MAA for the provision of Waiver services.
- 1903.4 The provider agreement shall specify the services to be provided, methods of operation, financial and legal requirements, and identification of the population to be served.
- 1903.5 Each provider shall be subject to the administrative procedures set forth in Chapter 13 of Title 29 DCMR during the provider's participation in the program.
- 1903.6 Each provider shall comply with all applicable provisions of District and federal law and rules applicable to the Title XIX of the Social Security Act, and all District and federal law and rules applicable to the service or activity provided pursuant to these rules.

1904 INDIVIDUAL HABILITATION PLAN (IHP) OR INDIVIDUAL SERVICE PLAN (ISP)

- 1904.1 The IHP or ISP shall be developed by the Interdisciplinary Team (IDT) for each client.
- 1904.2 At a minimum, the composition of the IDT team shall include the client, the client's parent, guardian or other individual directly involved in the client's life and the case manager.
- 1904.3 The IHP or ISP shall be reviewed and updated annually by the IDT team. The IHP or ISP may be updated more frequently if there is a significant change in the client's status or any other significant event in the client's life which affects the type or amount of services and supports needed by the client or if requested by the client.
- 1904.4 A written plan of care shall be developed for each client by staff within the MRDDA Waiver Unit. The plan of care shall describe medical and other services to be furnished to the client, the frequency of the services and the type of provider to furnish the services. The plan of care shall be consistent with the IHP or ISP.
- 1904.5 MAA shall not reimburse a provider for services that are not authorized in the IHP or ISP, not included in the written plan of care, furnished prior to the development of the IHP or ISP, not prior-authorized by MRDDA or furnished pursuant to an expired IHP or ISP.
- 1904.6 After notification by MRDDA that a service has been authorized, each provider shall develop a written plan which shall address how the service will be delivered to each client.
- 1904.7 Each provider shall submit to the client's case manager a quarterly review which summarizes the client's condition, progress made toward achieving the desired goals and outcomes and identification and response to any issue relative to the provision of the service.

1905 LEVEL OF CARE

- 1905.1 When an individual is determined to be likely to require a level of care as set forth in section 1902.1(e) of these rules and meets all other eligibility requirements, the individual or his or her authorized representative shall be informed by the case manager, as evidenced by the signed Waiver Beneficiary Freedom of Choice Form of:

(a) any feasible alternatives under the Waiver; and

(b) the choice of either institutional or home and community- based services.

- 1905.2 Each individual who is not given the choice of home or community-based services as an alternative to institutional care in an ICF/MR as set forth in subsection 1909.1, shall be entitled to a fair hearing in accordance with 42 CFR Part 431, Subpart E.
- 1905.3 A registered nurse or qualified mental retardation professional, employed by MRDDA, shall perform the initial evaluation of the level of care and make a level of care determination.
- 1905.4 Re-evaluations of the level of care shall be conducted every twelve (12) months or earlier when indicated.
- 1905.5 Each re-evaluation shall be performed by persons with the same educational and professional qualifications as those for persons conducting the initial evaluations.
- 1905.6 Written documentation of each evaluation and re-evaluation shall be maintained for a minimum period of three (3) years, except when there is an audit or investigation, the records shall be maintained until the review has been completed.

1906 CLIENT RIGHTS

- 1906.1 Each provider shall develop and adhere to policies which ensure that each client receiving services has the following rights:
- (a) To be treated with courtesy, dignity and respect;
 - (b) To participate in the planning of his or her care and treatment;
 - (c) To receive treatment, care and services consistent with the IHP and ISP;
 - (d) To receive services by competent personnel who can communicate with the client;
 - (e) To refuse all or part of any treatment, care or service and be informed of the consequences;
 - (f) To be free from mental and physical abuse, neglect and exploitation from persons providing services;
 - (g) To be assured that for purposes of record confidentiality, the disclosure of the contents of the client's records is subject to all the provisions of applicable District and federal laws and rules;
 - (h) To voice a complaint regarding treatment or care, lack of respect for personal property by persons providing services without fear of reprisal;
 - (i) To have access to his or her records; and

- (j) To be informed orally and in writing of the following:
- (1) Services to be provided, including any limitations;
 - (2) The amount charged for each service, the amount of payment required by the client and the billing procedures, if applicable;
 - (3) Whether services are covered by health insurance, Medicare, Medicaid or any other third party source;
 - (4) Acceptance, denial, reduction, or termination of services;
 - (5) Complaint and referral procedures;
 - (6) The name, address and telephone number of the provider; and
 - (7) The telephone number of the hotline maintained by MRDDA.

1906.2 Each provider shall notify MRDDA and MAA, Office of Disabilities and Aging of any client incidents as set forth in MRDDA's Policy and Procedure entitled "Incident Management System".

1906.3 MRDDA shall notify MAA in writing of any complaints regarding treatment, care and services rendered by Waiver providers.

1907 RECORDS AND CONFIDENTIALITY OF INFORMATION

1907.1 Each provider shall allow appropriate personnel of MAA, MRDDA and other authorized agents of the District of Columbia government and the federal government full access to all records during announced and unannounced audits and reviews.

1907.2 Each provider shall maintain all records, including but not limited to progress reports, financial records, medical records, treatment records, and any other documentation relating to costs, payments received and made, and services provided, for six years or until all audits, investigations or reviews are completed, whichever is longer.

1907.3 Each client's record shall include, but not be limited to, the following information:

- (a) General information including each client's name, Medicaid identification number, address, telephone number, age, sex, name, and telephone number of emergency contact person, physician's name, address and telephone number and case manager's name and telephone number;
- (b) A copy of the beneficiary freedom of choice form;
- (c) A copy of the current IHP or ISP;
- (d) A record of all services(s) provided, including description and dates of service;

- (e) A record of all prior authorizations for services;
- (f) A record of all requests for change in services;
- (g) A record of the client's initial and annual health history;
- (h) A discharge summary, if applicable; and
- (i) Any other records necessary to demonstrate compliance with all rules and requirements, guidelines and standards for the implementation and administration of this Waiver.

1907.4 Each provider shall secure client treatment records in a locked room or file cabinet and limit access only to authorized employees.

1907.5 The disclosure of treatment information by a provider shall be subject to all provisions of applicable federal and District laws and rules, for the purpose of confidentiality of information.

1908 INITIATING, CHANGING OR TERMINATING ANY APPROVED SERVICE

1908.1 The case manager shall be responsible for initiating, changing, or terminating Waiver services for each client in accordance with the IHP or ISP and identifying those clients for whom home and community-based services are no longer an appropriate alternative.

1908.2 The case manager shall notify MAA in writing whenever any of the following circumstances occur:

- (a) Death of a client;
- (b) Hospitalization of a client or any other circumstance in which Waiver services are interrupted for more than seven days;
- (c) The client is discharged or terminated from services; or
- (d) Any other delay in the implementation of Waiver services.

1908.3 Each provider shall notify the client or the client's representative and the case manager, in writing of the intent to terminate services at least fifteen (15) days prior to termination. The written notice shall state the reason for the termination.

1908.4 When the health and safety of the client or provider agency personnel is endangered, the fifteen (15) day advance notice shall not be required. The provider shall notify the client or client's representative and case manager as soon as possible and a written notice sent on the date of termination.

1909 FAIR HEARINGS

1909.1 Each client shall be entitled to a fair hearing in accordance with 42 CFR 431 and D.C. Official Code § 4-210.01 if the government:

- (a) Fails to offer the client a choice of either institutional care in an ICF/MR or home and community-based waiver services;
- (b) Denies a waiver service requested by the client;
- (c) Terminates, suspends or reduces a waiver service;
- (d) Fails to give a client the provider of his or her choice; or
- (e) Terminates, suspends or reduces Medicaid eligibility.

1909.2 The Department of Human Services shall be responsible for issuing each legally required notice to the client or client's representative regarding the right to request a hearing as required in subsection 1909.1.

1909.3 The content of the notice issued pursuant to subsections 1909.1 and 1909.2 shall comply with the requirements set forth in 42 CFR 431.210 and D.C. Official Code § 4-205.55.

1910 PERSONAL CARE SERVICES

1910.1 Each provider shall comply with standards governing personal care services set forth in §§ 5000 through 5004 and 5006 of Title 29 DCMR.

1910.2 Each provider shall be reimbursed \$13.50 per hour for services rendered by personal care aides.

1910.3 Reimbursement for personal care services shall not exceed sixteen (16) hours per day per client regardless of the Medicaid funding source.

1999 DEFINITIONS

When used in this Chapter, the following terms and phrases shall have the meanings ascribed:

Client-An individual who has been determined eligible to receive services under the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities.

Individual Habilitation Plan (IHP)- That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (DC Law 2-137; D.C. Official Code §7-1304.03).

Individual Support Plan (ISP)- The successor to the Individual Habilitation Plan as defined in the court-approved *Joy Evans* Exit Plan.

Interdisciplinary Team (IDT)- A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons which has the responsibility of performing a comprehensive evaluation of each client and participating in the

development, implementation and monitoring of the client's ISP. The IDT team shall also include the client or client's representative.

Intermediate Care Facility for Persons with Mental Retardation- Shall have the same meaning as set forth in section 1905(d) of the Social Security Act.

Mentally retarded- Shall have the same meaning as set forth in D.C. Official Code § 7-1301.03 (19).

Quality assurance plan- A written plan which describes the process by which the provider will evaluate the quality and appropriateness of services delivered to each client. The plan should describe the process for identifying, evaluating and resolving any problem related to the services rendered.

Qualified mental retardation professional- Shall have the same meaning as set forth in 42 CFR § 483.430(a).

Provider- Any entity that meets the Waiver service requirements, has signed an agreement with MAA to provide those services, and is enrolled by MAA to provide Waiver services.

Registered Nurse- A person who is licensed or authorized to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq*) or licensed as a registered nurse in the jurisdiction where services are provided.

**DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING**

NOTICE OF FINAL RULEMAKING

The Commissioner of the Department of Insurance, Securities and Banking, pursuant to the authority set forth in section 3(h) of the "Life Insurance Amendments Reform Act of 1984", effective March 14, 1985 (D.C. Law 5-160; D.C. Official Code § 31-4728 (2001)), gives notice of the adoption of the following amendments to Title 26 (Insurance and Securities) of the District of Columbia Municipal Regulations ("DCMR"). These final rules will become effective upon the publication of this notice in the D.C. Register. The purpose of the amendments is to adopt the 2001 Commissioner's Standard Ordinary ("CSO") Mortality Table and replace the 1980 CSO Mortality Table, which is used in determining minimum reserve liabilities under the standard valuation laws, and in determining minimum cash surrender values and paid-up non-forfeiture benefits.

CHAPTER 30 (VALUATION OF LIFE INSURANCE POLICIES) OF TITLE 26, DCMR, IS AMENDED AS FOLLOWS:

The title to Section 26-3001 is amended to read as follows:

3001 **General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves Prior to January 1, 2005**

Section 3004.1 is amended by adding the following definitions:

"2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the National Association of Insurance Commissioners ("NAIC") in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the National Association of Insurance Commissioners* (2nd Quarter 2002). Unless the context indicates otherwise, the 2001 CSO Mortality Table includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

"2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

"2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

“Composite mortality tables” means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

“Smoker and nonsmoker mortality tables” means mortality tables with separate rates of mortality for smokers and nonsmokers.

A new section 3005 is added to read as follows:

3005 2001 CSO Mortality Table for Determining Minimum Reserve Liabilities and Nonforfeiture Benefits After January 1, 2005

3005.1 The regulations in this section shall have the following applicability:

- (a) At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in § 3005.2, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2005 and before the date specified in paragraph (b) and pursuant to D.C. Official Code §§ 31-4701(c)(2)(A) and 31-4705.02(e)(16)(A)(i). If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.
- (b) Subject to the conditions stated in § 3005.2, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009 and pursuant to D.C. Official Code §§ 31-4701(c)(2)(A) and 31-4705.02(e)(16)(A)(i).
- (c) The 2001 CSO Mortality Table may be applied to Chapter 30 of Title 26, DCMR, in the following manner and subject to the transition dates in this section:
 - (1) For § 3001.1, the 2001 CSO Mortality Table shall be the minimum standard for basic reserves;
 - (2) For § 3001.2, the 2001 CSO Mortality Table shall be the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in §§ 3001.2(c)(1) to 3001.2(c)(9). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by regulation or

necessary to be in compliance with relevant Actuarial Standards of Practice;

- (3) For § 3000.2(b)(2), the net level reserve premium shall be based on the ultimate mortality rates in the 2001 CSO Mortality Table;
- (4) For § 3002.6, the valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table;
- (5) For § 3002.10(d), the calculations specified in § 3002.10 shall use the ultimate mortality rates in the 2001 CSO Mortality Table;
- (6) For § 3002.11(d), the calculations specified in § 3002.11 shall use the ultimate mortality rates in the 2001 CSO Mortality Table;
- (7) For § 3002.12(b), the calculations specified in § 3002.12 shall use the ultimate mortality rates in the 2001 CSO Mortality Table;
- (8) For § 3003.1(b), the one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table; and
- (9) For § 3004.1, all calculations shall be made using the 2001 CSO Mortality Rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in § 3005.1(c)(4). The value of " $q_{x+k+t-1}$ " is the valuation mortality rate for deficiency reserves in policy year $k+t$, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

- (d) Nothing in this section shall be construed to expand the applicability of Chapter 30 of Title 26, DCMR, to include life insurance policies exempted under § 3000.2.

3005.2 The following conditions shall apply with respect to the use of the 2001 CSO mortality table:

- (a) For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use:

- (1) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;
 - (2) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by D.C. Official Code § 31-4720 and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or
 - (3) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.
- (b) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables shall be used.
- (c) For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions in § 3001.
- (d) When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the Commissioner shall be based on an asset adequacy analysis as specified in 26 DCMR § 2900 *et seq.* The Commissioner may exempt a company from this requirement if its business is conducted exclusively in the District.

3005.3 Gender-Blended Tables shall apply in the following circumstances:

- (a) For any ordinary life insurance policy delivered or issued for delivery in the District on and after January 1, 2005, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this paragraph.

- (b) When a company is choosing among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the National Association of Insurance Commissioners in December 2002.
- (c) It shall not be a violation of D.C. Official Code § 31-2231.01 *et seq.* for an insurer to issue the same kind of life insurance policy on both a gender-specific and gender-neutral basis.

3005.4 If any provision of these regulations or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLESNOTICE OF FINAL RULEMAKING

The Director of the Department of Motor Vehicles, pursuant to the authority set forth in Section 1825 of the Department of Motor Vehicles Establishment Act of 1998, effective March 26, 1999 (D.C. Law 12-175; D.C. Official Code § 50-904), sections 5 and 7 of An Act To provide for annual inspection of all motor vehicles in the District of Columbia, approved February 18, 1938 (52 Stat. 78; D.C. Official Code §§ 50-1105 & 50-1107); and Mayor's Order 03-58, effective April 21, 2003, hereby gives notice of the adoption the following rulemaking that amended Chapters 4, 6, 7 and Section 9901 of Title 18 of the District of Columbia Municipal Regulations (DCMR) (Vehicles and Traffic). The rulemaking clarified allowable content on an organization tag, established an inspection requirement that vehicles comply with federal safety standards for on-road use, eliminated an inconsistent insurance exemption for motorized bicycles, and established a new definition for moped to clarify the application of existing law. No comments were received and no changes were made to the text of the proposed rulemaking as published with a Notice of Proposed Rulemaking in the *D.C. Register* on September 24, 2004 at 51 DCR 9189. These final rules will be effective upon publication of this notice in the *D.C. Register*.

Title 18, DCMR, is amended as follows:

A. Chapter 4, MOTOR VEHICLE TITLE AND REGISTRATION, is amended as follows:

- 1) Section 432, EXCEPTIONS TO INSURANCE REQUIREMENTS, is repealed.
- 2) Section 433, ORGANIZATION TAGS, subsection 433.4 is amended to read as follows:

433.4 The organization tag shall only display either the name or the adopted insignia of the organization, or both.

B. Chapter 6, INSPECTION OF MOTOR VEHICLES, section 603, subsection 603.1 is amended by adding after the word "Manual" the phrase ", and Chapter 7 of this Title,".

C. Chapter 7, GENERAL PROVISIONS, section 700, MOTOR VEHICLE EQUIPMENT, is amended by adding a new subsection 700.9 to read as follows:

700.9 All motor vehicles must display a manufacturer's certification of compliance, attesting that the vehicle complies with federal safety standards for use on public roads, streets, and highways, as required by the National Traffic and Motor safety Act of 1966 (49 USC 30115); except that mopeds need not display such a certification of compliance.

D. Section 9901, DEFINITIONS, is amended as follows:

(a) The definition "motor scooter" is repealed.

(b) A new definition for "moped" is added to read as follows:

"moped – a motorcycle or motorized bicycle equipped with functional pedals."