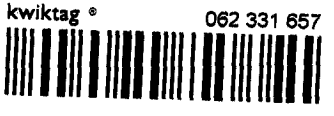
ENROLLMENT(S)



(5)

COUNCIL OF THE DISTRICT OF COLUMBIA

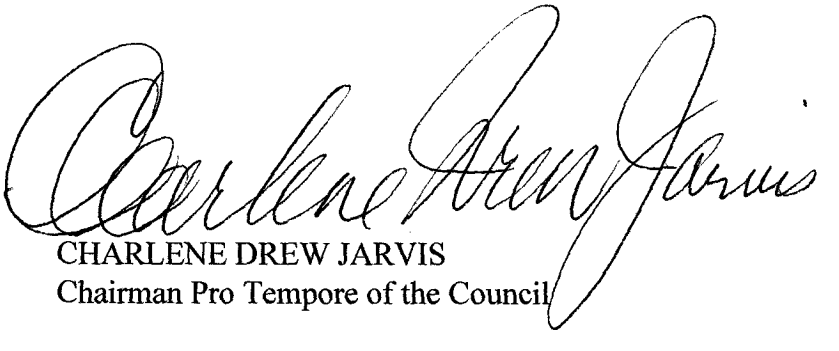
NOTICE

D.C. LAW 11-235

"Health Maintenance Organization Act of 1996".

Pursuant to Section 412 of the District of Columbia Self-Government and Governmental Reorganization Act, P.L. 93-198 "the Act", the Council of the District of Columbia adopted Bill No. 11-442, on first and second readings, November 7, 1996 and December 3, 1996, respectively. Following the signature of the Mayor on December 24, 1996, pursuant to Section 404(e) of "the Act", and was assigned Act No. 11-495, and published in the February 14, 1997, edition of the D.C. Register (Vol. 44 page 818) and transmitted to Congress on January 31, 1997 for a 30-day review, in accordance with Section 602(c)(1) of the Act.

The Council of the District of Columbia hereby gives notice that the 30-day Congressional Review Period has expired, and therefore, cites this enactment as D.C. Law 11-235, effective April 9, 1997.



CHARLENE DREW JARVIS
Chairman Pro Tempore of the Council

Dates Counted During the 30-day Congressional Review Period:

Feb. 3,4,5,6,7,10,11,12,13,24,25,26,27,28

Mar. 3,4,5,6,10,11,12,13,14,17,18,19,20,21

Apr. 7,8

ENROLLED ORIGINAL

AN ACT

D.C. ACT 11-495

Codification District of Columbia Code **1997 Supp.**

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

DECEMBER 24, 1996

To set forth standards for the formation, operation, and regulation of Health Maintenance Organizations in the District of Columbia.

New Chapter 45, Title 35

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Health Maintenance Organization Act of 1996".

Sec. 2. Definitions.

New Section 35-4501

For the purposes of this act, the term:

(1) "Administrative services provider contract" means a contract entered into between a health maintenance organization and a contracting provider in which the contracting provider accepts payments for certain covered services provided to the enrollees of the health maintenance organization by external providers, and the contracting provider pays the external providers pursuant to a contract between the contracting provider and the health maintenance organization.

(2) "Agent" means a person who solicits, negotiates, effects, procures, delivers, renews, or continues a contract for health maintenance organization membership, other than for himself, or a person who advertises or otherwise holds himself out to the public as such. Health maintenance organization agents shall not include salaried employees and officers of the HMO or its parents, subsidiaries or other corporations under common control with the HMO, whose principal duties do not include the negotiation or solicitation of enrollee contracts.

(3) "Basic health care services" means preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services, and services mandated under the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Act of 1986, effective February 28, 1987 (D.C. Law 6-195; D.C. Code § 35-2301 *et seq.*), the Newborn Health Insurance Act of 1979, effective October 20, 1979 (D.C. Law 3-33; D.C. Code § 35-1101 *et seq.*), and the District of Columbia Cancer Prevention Act of 1990, effective March 7, 1991 (D.C. Law 8-225; D.C. Code § 35-2402 *et seq.*).

(4) "Capitated basis" means fixed per member per month payment or percentage of dues payment wherein the provider or an affiliation of providers assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For the purposes of this definition, the term "capitated basis" includes the cost associated with operating staff or group model facilities.

(5) "Carrier" means a health maintenance organization, a licensed insurer, Group Hospitalization and Medical Services, Inc., or other entity responsible for payment of benefits or provision of services under a group or individual contract.

(6) "Commissioner" means the Commissioner of Insurance and Securities.

(7) "Contracting provider" means a physician or other health care provider who enters into an administrative service provider contract with a health maintenance organization.

(8) "Copayment" means either a dollar or percentage amount an enrollee must pay in order to receive a specific covered service which is not fully prepaid.

(9) "Covered services" means health care services included in the health maintenance organization's evidence of coverage in accordance with the terms of the health maintenance organization's group or individual contract.

(10) "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(11) "Director" means the Director of the Department of Health, established by Reorganization Plan No. 4 of 1996.

(12) "District" means the District of Columbia.

(13) "Enrollee" means an individual who is covered by a health maintenance organization.

(14) "Enrollment fees" means the payment charged by the health maintenance organization which shall be paid by an enrollee or by a group on behalf of enrollees for coverage in the health maintenance organization.

(15) "Evidence of coverage" means a statement of the essential features and covered services of the health maintenance organization which is given to the enrollee by the health maintenance organization or by the group contract holder.

(16) "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is hospitalized on the date of termination.

(17) "External provider" means a health care provider, including a physician or hospital, that is not a contracting provider, or an employee, shareholder, or partner of a contracting provider.

(18) "Grievance" means a written complaint which has been submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the

enrollee.

(19) "Group contract" means a contract issued and delivered in the District for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

(20) "Group contract holder" means the person to which the group contract has been issued.

(21) "Health maintenance organization or "HMO" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments and deductibles.

(22) "Health maintenance organization producers" means any person who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for HMO membership or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such.

(23) "Hold harmless" means an expressed or implied arrangement between a provider and a health maintenance organization by which the provider, or any representative of the provider, agrees not to collect or attempt to collect from any enrollee any money owed to the provider by the health maintenance organization or by a contracting provider, except for copayments and deductibles owed by the enrollee, or any payment or charges for health care services not covered under the evidence of coverage.

(24) "Individual contract" means a contract delivered in the District for health care services issued to and covering an individual enrollee. The individual contract may include dependents of the enrollee.

(25) "Insolvent" or "insolvency" means that the organization has been declared bankrupt and placed under an order of liquidation by a court of competent jurisdiction.

(26) "Mayor" means the Mayor of the District of Columbia.

(27) "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

(28) "Participating provider" means a provider who, under an express or implied contract with a health maintenance organization or with its contractor or subcontractor, has agreed to provide covered services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

(29) "Person" means any natural or artificial person, including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

(30) "Point of service plan" means a delivery system that permits an enrollee of a health maintenance organization to receive services outside the provider panel of the health maintenance organization under the terms and conditions of the enrolle's contract with the health maintenance organization.

(31) "Primary care provider" means a participating provider who the enrollee has

selected or who has otherwise been assigned responsibility for the coordination of covered services to the enrollee.

(32) "Provider" means any hospital or health professional licensed or authorized by reciprocity or endorsement to practice a health occupation by the District pursuant to the Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Code § 2-3301.1 *et seq.*), or any state.

(33) "Provider panel" means a group of providers that have entered into a written provider service contract with an HMO to provide services under the HMO's health benefit plan.

(34) "Replacement coverage" means the benefits provided by a succeeding carrier after termination of a member's enrollment with the preceding carrier.

(35) "Uncovered expenditures" means the cost to the health maintenance organization for covered services that are the obligation of the health maintenance organization for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the Commissioner.

Sec. 3. Establishment of health maintenance organizations. **New Section 35-4502**

(a) Any person may apply to the Commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in the District without obtaining a certificate of authority under this act, except as provided for herein. All health maintenance organizations shall, as a condition of certification, agree to accept the risk for the provision of services rendered to enrollees on a prepaid basis except for enrollee responsibility for copayments or deductibles, or both.

(b) A foreign corporation may qualify under this act subject to its registration to do business pursuant to this section and compliance with all provisions of this act and other applicable District laws.

(c) All health maintenance organizations operating as health maintenance organizations in the District shall submit an application for a certificate of authority under subsection (d) of this section within 120 days after the effective date of this act. Each applicant may continue to operate until the Commissioner acts upon the application. In the event that an application is denied pursuant to section 4, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked. Notwithstanding a revocation under this act, any contracts issued to groups or individuals residing in the District shall remain in effect with respect to a health maintenance organization which has a valid certificate of authority issued by the Maryland Insurance Division or Virginia Bureau of Insurance until the next renewal date or anniversary date of coverage of such contracts, or 120 days from the date the application is denied, whichever date shall occur later.

(d) Each application for a certificate of authority shall be accompanied by a filing fee of $500, which shall be deposited in the Insurance Regulatory Trust Fund established by section 3 of the Insurance Regulatory Trust Fund Act of 1993, effective October 23, 1993 (D.C. Law 10-40; D.C. Code § 35-2702), and shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions and biographical information, on forms acceptable to the Commissioner, of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers in the case of a corporation, or the partners or members in the case of partnership or association;

(4) A sample of any contract form made, or to be made, between any class of providers and the health maintenance organization and a copy of any contract form made, or to be made, between third party administrators, marketing consultants, or persons listed in paragraph (3) of this subsection and the health maintenance organization;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, including both a copy of the applicant's most recent certified financial statement and an unaudited current financial statement;

(8)(A) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining dues to be charged during the first 12 months of operations certified by an actuary, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the District, and income and expense statements anticipated from the start of operations until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other sources of funding.

(B) The requirement of submitting a financial feasibility plan shall not apply to any person that holds an unencumbered certificate of authority to operate a health maintenance organization in Maryland or Virginia.

(9) A power of attorney duly executed by the applicant, if not domiciled in the District, appointing the Commissioner, or his or her successors in office, and duly authorized

deputies, as the true and lawful attorney of the applicant in and for the District upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in the District may be served;

(10) A statement or map reasonably describing the geographical area or areas to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection against insolvency requirements in section 13

(14) A list of the names, addresses, and license numbers of all providers with which the health maintenance organizations has agreements;

(15) The method of determining the situs of each group contract; and

(16) Such other information as the Commissioner may require to make the determinations required in section 4.

(e)(1) The Commissioner may issue rules and regulations necessary for the proper administration of this act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the information, modification, or amendments to the items described in subsection (d) of this section to the Commissioner, either for the Commissioner's approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to the Commissioner at the time of the next succeeding site visit or examination.

(2) Any modification or amendment for which the Commissioner's approval is required shall be deemed approved unless disapproved within 30 days, provided that the Commissioner may postpone the action for such additional time, not to exceed 30 days, as necessary for proper consideration.

Sec. 4. Issuance of certificate of authority.

New Section 35-4503

(a) Upon receipt of an application for issuance of a certificate of authority, the Commissioner, in consultation with the Director of the Department of Health, shall determine whether the applicant, with respect to the health care services to be provided, has complied with section 7.

(b) Within 45 days of receipt of the application for issuance of a certificate of authority, the Commissioner, in consultation with the Director of the Department of Health, shall certify that the proposed health maintenance organization meets the requirements of section 7 or notify the applicant that it does not meet such requirements and specify in what respects it is deficient.

(c) The Commissioner shall issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and upon the Commissioner being satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) Any deficiencies identified by the Commissioner have been corrected and the health maintenance organization's proposed plan of operation meets the requirements of section 7;

(3) The health maintenance organization will effectively provide or arrange for basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles, or both; and

(4) The health maintenance organization is in compliance with sections 13 and 15.

(d) A certificate of authority may be denied only after the Commissioner complies with the requirements of section 20.

(e) The Commissioner, in carrying out his obligations under this act, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Recommendations may be accepted in full or in part by the Commissioner.

Sec. 5. Powers of health maintenance organizations.

New Section 35-4504

(a) The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property and equipment as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, enrollee, etc.) between affiliates or between the health maintenance organization and its parent;

(3) The furnishing of health care services through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization;

(4) The contracting with any person for the performance on its behalf of certain functions, such as marketing, enrollment, and administration;

(5) The contracting with an insurance company, including Group Hospitalization and Medical Service, Inc., licensed in the District for the provision of insurance, indemnity, or reimbursement against the cost of covered services provided by the health maintenance organization or with optometry services, podiatry services, dental services, pharmaceutical service plans, and other entities authorized to do business in the District for the provision of

supplemental health services;

(6) The joint marketing of products with an insurance company authorized to do business in the District as long as the company that is offering each product is clearly identified; and

(7) Entering into administrative service provider contracts with contracting providers whereby covered services are rendered to enrollees by external providers who have entered into contracts with the contracting provider.

(b) A health maintenance organization shall file notice, with adequate supporting information, with the Commissioner prior to the exercise of any power granted in subsection (a)(1), (2), or (4) which may affect the financial soundness of the health maintenance organization. The Commissioner shall disapprove such exercise of power only if the Commissioner determines it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Commissioner does not disapprove within 30 days of the filing of the notice, the exercise of power shall be deemed approved.

(c) The Commissioner may issue rules and regulations exempting those activities having a de minimis effect from the filing requirement of this subsection.

Sec. 6. Fiduciary responsibilities. **New Section 35-4505**

(a) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the organization.

(b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees and officers, directors, and partners in an amount not less than $250,000 and not more than $5,000,000.

Sec. 7. Quality assurance program. **New Section 35-4506**

(a) A health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

(b) A health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan which describes the following:

(A) The health maintenance organization's scope and purpose in quality assurance;

(B) The organizational structure responsible for quality assurance activities;

(C) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(D) Confidentiality policies and procedures;

(E) A system of ongoing evaluation activities;

(F) A system of focused evaluation activities;

(G) A system for credentialing providers and performing peer review activities; and

(H) Duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) A written statement describing the system on ongoing quality assurance activities including:

(A) Problem assessment, identification, selection, and study;

(B) Corrective action, monitoring, evaluation, and reassessment; and

(C) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) A written statement describing the system focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation, and report format; and

(5) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been provided have not been provided.

(c) The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the Commissioner.

(d) The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(e) Enrollee clinical records shall be available to the Commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the Commissioner.

(f) The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, and appropriate staff.

(g) If a quality assurance program has received approval in Maryland or Virginia, or if a quality assurance program has been approved by the D.C. Medicaid Program, it shall be deemed

approved.

(h) The following shall apply to health maintenance organizations, carriers, and providers:

(1) No contract between a health maintenance organization and a provider shall prohibit, impede, or interfere in the discussions between a patient and a provider of medical treatment option including discussions regarding financial coverage of those treatment options.

(2) A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

(3) A health maintenance organization may not terminate or refuse to contract with a provider solely because the provider discussed medical treatment options with an enrollee.

Sec. 8. Requirements for group contract, individual contract, and evidence of coverage. **New Section 35-4507**

(a) Every group and individual contract holder is entitled to a group or individual contract.

(1) The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation.

(2) The contract shall contain a clear statement of the following:

(A) Name and address of the health maintenance organization;
(B) Eligibility requirements;
(C) Covered services within the service area;
(D) Covered emergency care benefits and services;
(E) Out of area covered benefits and services, if any;
(F) Copayments, deductibles, or other out-of-pocket expenses;
(G) Limitations and exclusions;
(H) Enrollee termination;
(I) Enrollee reinstatement, if any;
(J) Claims procedures;
(K) Enrollee grievance procedures;
(L) Continuation of coverage, if any;
(M) Conversion;
(N) Extension of benefits if any;
(O) Coordination of benefits, if applicable;
(P) Subrogation, if any;
(Q) Description of the service area;
(R) Entire contract provision;
(S) Term of coverage;
(T) Cancellation of group or individual contract holder;
(U) Renewal;

(V) Reinstatement of group or individual contract holder, if any;

(W) Grace period;

(X) Conformity with District of Columbia law; and

(Y) Payment provisions.

(3) An evidence of coverage may be filed as part of the group contract to describe the provisions required in paragraph (2)(A) through (Q) of this subsection.

(b) In addition to the requirements of subsection (a)(2)(A) through (Y) of this section, an individual contract shall provide for a 10-day period to examine and return the contract and have the dues refunded. If services were received during the 10-day period and the person returns the contract to receive a refund of the dues paid, the person must pay for such services.

(c) Every enrollee shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

(1) The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, or deceptive.

(2) The evidence of coverage shall contain a clear statement of the requirements in subsection (a)(2)(A) through (Q) of this section.

(d) The Commissioner may adopt regulations establishing readability standards for individual contract, group contract, and evidence of coverage forms.

(e) No group or individual contract, evidence of coverage, or amendment thereto shall be delivered or issued for delivery in the District unless its form has been filed with and approved by the Commissioner pursuant to subsections (f) and (g) of this section.

(f) If an evidence of coverage issued pursuant to a contract issued in the District is intended for delivery in the District, the evidence of coverage must be submitted to and approved by the Commissioner in accordance with subsection (g) of this section.

(1) If an evidence of coverage issued pursuant to a contract issued in Virginia or Maryland is intended for delivery in the District, the evidence of coverage shall be deemed approved if it has been filed and approved by the appropriate regulatory authority of Virginia or Maryland, as applicable.

(2) If an evidence of coverage issued pursuant to a contract issued in another state, excepting Virginia and Maryland as described in paragraph (1) of this subsection, is intended for delivery in the District, the evidence of coverage must be submitted to and approved by the Commissioner in accordance with subsection (g) of this section.

(g) Every form required by this section shall be filed with the Commissioner not less than 30 days prior to delivery or issue for delivery in the District. At any time during the initial 30-day period, the Commissioner may extend the period for review for an additional 30 days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the Commissioner has taken no action. The filer shall notify the Commissioner in writing prior to using a form that is deemed approved.

(1) At any time, after 30-days notice and for cause shown, the Commissioner

may withdraw approval of any form effective at the end of the 30 days if the form would violate a statute or regulation of the District. For group and individual contracts and evidence of coverages which have already been issued and delivered, the effective date shall not occur until the next anniversary date of the group or individual contract unless the Commissioner requires that the effective date shall be earlier. In such case, the health maintenance organization may revise its dues and other terms contained in the contract or evidence of coverage to reflect any changes required as a result of the Commissioner's withdrawal of approval.

(2) When a filing is disapproved or approval of a form is withdrawn, the Commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within 30 days of receipt of the notice the health maintenance organization may request a hearing. A hearing will be conducted within 30 days after the Commissioner has received the request for a hearing.

(h) The Commissioner may require the submission of any relevant information the Commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

Sec. 9. Annual report.

New Section 35-4508

(a) Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least 2 principal officers with the Commissioner covering the preceding calendar year. The reports shall be on forms prescribed by the Commissioner. In addition, a health maintenance organization shall file with the Commissioner, unless otherwise stated:

(1) Audited financial statements on or before June 1;

(2) A list of the providers who have executed a contract that complies with section 13(d)(1); and

(3) A description of any changes to the grievance procedures and the total number of grievances initiated by District group and individual contract enrollees handled through such procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

(b) The Commissioner may require such additional reports as he deems necessary and appropriate to enable the Commissioner to implement this act.

Sec. 10. Information to enrollees.

New Section 35-4509

(a) A health maintenance organization shall provide to its enrollees a list of providers, upon enrollment and re-enrollment.

(b) Every health maintenance organization shall provide to its enrollees within 30 days notice of any material change in the operation of the organization that will affect them directly.

(c) An enrollee must be notified in writing by a health maintenance organization of the

termination of the primary care provider who provided health care services to that enrollee. A health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

(d) A health maintenance organization shall provide to enrollees information on how services may be obtained, where additional information on access to services can be obtained, and a number where the enrollee can contact the HMO at no cost to the enrollee.

Sec. 11. Grievance procedures. New Section 35-4510

(a) Every health maintenance organization shall establish and maintain a grievance procedure which has been approved by the Commissioner to provide procedures for the resolution of grievances initiated by enrollees. A health maintenance organization shall maintain records regarding grievances received since the date of its last examination of such grievances.

(b) The Commissioner may examine grievance procedures.

Sec. 12. Investments. New Section 35-4511

With the exception of investments made in accordance with section 5(a)(1), the funds of a health maintenance organization shall be invested in accordance with NAIC Health Maintenance Organization Investment Guidelines adopted by the Commissioner.

Sec. 13. Protection against insolvency. New Section 35-4512

(a) Net worth requirements.

(1) Before issuing any certificates of authority, the Commissioner shall require that the health maintenance organization have an initial net worth of $1,500,000 and shall thereafter maintain the minimum net worth required by paragraph (2) of this subsection.

(2) Except as provided in paragraphs (3) and (4) of this subsection, every health maintenance organizations must maintain a minimum net worth equal to the greater of:

(A) $1,000,000;

(B) Two percent of annual dues revenues as reported on the most recent annual financial statement filed with the Commissioner on the first $150,000,000 of dues and 1% of annual dues on the dues in excess of $150,000,000;

(C) An amount equal to the sum of 3 months uncovered health care expenditures as reported on the most recent financial statement filed with the Commissioner; or

(D) An amount equal to the sum of:

(i) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the Commissioner; and

(ii) Four percent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the

Commissioner.

(3) A health maintenance organization meeting the exemption of section 3(d)(8)(A) before the effective date of this act, and any HMO that does not meet the requirements of this section on the effective date of this act or within 12 months of the effective date of this act, must meet and maintain the following annual minimum net worth standards.

(A) Twenty-five percent of the amount otherwise required by this section by the end of the first full calendar year following the effective date of this act;

(B) Fifty percent of the amount otherwise required by this section by the end of the second full calendar year following the effective date of this act;

(C) Seventy-five percent of the amount otherwise required by this section by the end of the third full calendar year following the effective date of this act; and

(D) One hundred percent of the amount otherwise required by this section by the end of the fourth full calendar year following the effective date of this act.

(4) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

(A) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

(B) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the Commissioner, shall not be considered a liability and shall be recorded as equity.

(b) Deposit requirements.

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the Commissioner or, at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the Commissioner which at all times shall have a value of not less than $300,000.

(2)(A) A health maintenance organization that is in operation on the effective date of this section shall make a deposit equal to $150,000.

(B) In the second year, the amount of the additional deposit for a health maintenance organization that is in operation on the effective date of the section shall be equal to $150,000, for a total of $300,000.

(3) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

(4) All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the Commissioner before being deposited or substituted.

(5) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of covered services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The Commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If a health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

(6) The Commissioner may reduce or eliminate the deposit requirement if a health maintenance organization deposits with the District treasurer, Commissioner, or other official body of the District or jurisdiction of domicile for the protection of all enrollees, wherever located, of such health maintenance organization, cash, acceptable securities, or surety, and delivers to the Commissioner a certificate to such effect, duly authenticated by the regulatory authority in the state of domicile or by the appropriate District official holding the deposit.

(c) Liabilities.

Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned dues and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities may be computed in accordance with generally accepted accounting principles.

(d) Hold harmless.

(1) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event a health maintenance organization fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the enrollee sums owed by a health maintenance organization.

(3) No participating provider, agent, trustee, or assignee thereof may maintain any action at law against an enrollee to collect sums owed by a health maintenance organization.

(e) Continuation of benefits.

(1) The Commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

(2) In considering the plan, the Commissioner may require:

(A) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(B) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after a health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(C) Insolvency reserves;

(D) Acceptable letters of credit; and

(E) Any other arrangements to assure that benefits are continued as specified above.

(f) Notice of termination.

An agreement to provide covered services between a provider and a health maintenance organization must require that if the provider terminates the agreement, the provider shall give the organization at least 60 days advance notice of termination.

Sec. 14. Uncovered expenditures insolvency deposit.

New Section 35-4513

(a) If at any time uncovered expenditures exceed 10% of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the Commissioner, or with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Commissioner. The deposit shall at all times have a fair market value in an amount of 120% of the HMO's outstanding liability for uncovered expenditures for enrollees in the District, including incurred, but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under section 13 and is an admitted asset of a health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of a health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the Commissioner.

(c)(1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(A) A substitute deposit of cash or securities of equal amount and value is made;

(B) The fair market value exceeds the amount of the required deposit; or

(C) The required deposit under subsection (a) of this section is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the Commissioner.

(d) The deposit required under this section is in trust and may be used only as approved under this section. The Commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment claims of enrollees of the District for uncovered expenditures. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

(e) The Commissioner may by regulation prescribe the time, manner, and form for filing claims under subsection (d) of this section.

(f) The Commissioner may by regulation or order require health maintenance organizations to file annual, quarterly, or more frequent reports as the Commissioner deems necessary to demonstrate compliance with this section. The Commissioner may require that the reports include liability for uncovered expenditures as well as an audit option.

Sec. 15. Enrollment period; replacement coverage in the event of insolvency.

New Section 35-4514

(a) Enrollment period.

(1) In the event of the insolvency of a health maintenance organization, upon order of the Commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a 30-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier has been offered to groups enrolled in the insolvent health maintenance organization or if the Commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the Commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for such groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The Commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by this type of coverage in the insolvent health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

(b) Replacement coverage.

(1) For the purposes of this subsection, the term "discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(2) Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(3) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

Sec. 16. Filing requirements for rating information.

New Section 35-4515

(a) No fees may be used until either a schedule of enrollment fees or methodology for determining enrollment fees dues has been filed with and approved by the Commissioner.

(b) Either a specific schedule of fees, or a methodology for determining fees, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the enrollment fees applicable to an enrollee shall not be individually determined based on the status of an enrollee's health. However, the fees shall not be excessive, inadequate, or

unfairly discriminatory. A statement by a qualified actuary or other qualified person acceptable to the Commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(c) The Commissioner shall approve the schedule of enrollment fees dues or methodology for determining enrollment fees if the requirements of subsection (b) of this section are met. If the Commissioner disapproves the filing, the Commissioner shall notify the health maintenance organization. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing shall be held within 30 days after a request in writing by the person filing. If the Commissioner does not take action on the schedule or methodology within 30 days of the filing, it shall be deemed approved.

Sec. 17. Regulation of health maintenance organization producers. **New Section 35-4516**

(a) The Commissioner shall issue rules and regulations to provide for the licensing of health maintenance organization producers. The rules shall establish:

(1) The requirements for licensure of resident health maintenance organization producers;

(2) The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers;

(3) Any examination, prelicensing, or continuing education requirements;

(4) The requirements for registering and terminating the appointment of health maintenance organization producers;

(5) Any requirements for registering any assumed names or office locations in which a health maintenance organization producer does business;

(6) The conditions for health maintenance organization producer license renewal;

(7) The grounds for denial, refusal, suspension, or revocation of a health maintenance organization producer's license;

(8) Any required fees for the licensing activities of health maintenance organization producers; and

(9) Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

(b) The provisions of subsection (a) of this section shall not apply to the following:

(1) Any regular salaried officer or employee of a health maintenance organization who devotes substantially all of his time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

(2) Employers or their officers or employees or the trustees of any employee benefit plan to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits involving the use of health maintenance organization memberships; provided, that such employers, officers, employees, or trustees are not in any manner compensated directly or indirectly by the health maintenance organization memberships;

(3) Banks or their officers and employees to the extent that such banks, officers, and employees collect and remit charges, charging the same against accounts of depositors on the orders of such depositors; or,

(4) Any person or the employee of any person who has contracted to provide administrative, management, or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income or profits of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this act.

(c) The Commissioner may, by rule, exempt certain classes of persons from the requirements of subsection (a) of this section if:

(1) The functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or,

(2) Other existing safeguards make regulation unnecessary.

Sec. 18. Powers of insurance corporations.

New Section 35-4517

(a) An insurance company authorized to do business in the District may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this act. Notwithstanding any other provisions of law, any two or more such insurance companies, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or subsidiary thereof.

(b) Notwithstanding any other provision of insurance laws, an insurer may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of a health maintenance organization to meet its obligations.

(1) The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts the insurer may make benefit payments to health maintenance organizations for health care services rendered by providers.

New Section 35-4518

Sec. 19. Examinations.

(a) The Commissioner may make an examination of the affairs of any health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of the District, but not less frequently than once every 3 years.

(b) The Commissioner may make an examination concerning the quality assurance program of a health maintenance organization and of any providers with whom a health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of the District, but not less frequently than once every 3 years.

(c) Every health maintenance organization and provider shall make its books and records available for such examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the Commissioner may administer oaths to and examine the officers and agents of a health maintenance organization and the principals of such providers concerning their business.

(d) The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the Commissioner for whom the examination is being conducted.

(e) Such examination made by the Commissioner shall be performed in a manner to provide efficient effective review. In this regard the Commissioner shall work to avoid duplication of effort by using information prepared by the health maintenance organization, and, to the extent possible, coordinating such examinations with other jurisdictions which may be performing similar examinations of the health maintenance organization.

(f) In lieu of such examination, the Commissioner may accept the report of an examination made by the appropriate officials of another state.

New Section 35-4519

Sec. 20. Suspension or revocation of certificate of authority.

(a) Any certificate of authority issued under this act may be suspended or revoked, and any application for a certificate of authority may be denied, if the Commissioner finds that any of the conditions listed below exist:

(1) A health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner inconsistent with this act.

(2) A health maintenance organization issued an evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of sections 8 and 16.

(3) A health maintenance organization does not provide or arrange for basic health care services.

(4) The Commissioner certifies that:

(A) A health maintenance organization does not meet the requirements

of section 4(b); or

(B) A health maintenance organization is unable to fulfil its obligations to furnish health care services.

(5) A health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(6) A health maintenance organization has failed to correct, within the time prescribed by subsection (c) of this section, any deficiency occurring due to such health maintenance organization's prescribed minimum net worth being impaired.

(7) A health maintenance organization has failed to implement the grievance procedure required by section 11 in a reasonable manner to resolve valid complaints.

(8) A health maintenance organization, or any person authorized to act on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(9) The continued operation of a health maintenance organization would be dangerous to its enrollees.

(10) The health maintenance organization has otherwise failed substantially to comply with this act.

(b) In addition to, or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subject to an administrative penalty of up to $1000 a day for each cause for suspension or revocation.

(c) The following shall pertain when insufficient net worth is maintained:

(1) Whenever the Commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this act is less than the minimum net worth required to be maintained by section 13, the Commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require:

(A) Filing with the Commissioner a plan for correction of the deficiency acceptable to the Commissioner; and

(B) Correction of the deficiency within a reasonable time, not to exceed 60 days, unless an extension of time is granted by the Commissioner.

(2) Such a deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation, or liquidation.

(3) Except for newborn children, other newly acquired dependents of existing enrollees, or other newly eligible individuals, or as otherwise allowed by the Commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue, or deliver any certificate, agreement, or contract of coverage in the District, for which a premium dues is charged or collected, when a health maintenance organization writing

such coverage is impaired, and the fact of the impairment is known to the health maintenance organization or to the person.

(4) The existence of an impairment, however, shall not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

(d) A certificate of authority shall be suspended or revoked, or an application or a certificate of authority denied, or an administrative penalty imposed only after compliance with the requirements of this section.

(1) Suspension or revocation of a certificate of authority, the denial of an application, or the imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, or denial or administrative penalty is based. A health maintenance organization or applicant may in writing request a hearing within 30 days from the date of mailing of the order. If no written request is made, such order shall be final upon the expiration of the 30 days.

(2) If a health maintenance organization or applicant requests a hearing pursuant to this section, the Commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail. The notice shall include the following:

(A) A specific time for the hearing, which may not be less than 20 days nor more than 30 days after mailing of the notice of hearing; and

(B) A specific place for the hearing.

(3) If a hearing is requested, the Commissioner or his designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the Commissioner in respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority shall be conclusive and binding upon the Mayor.

(4) After such a hearing, or upon failure of the health maintenance organization to appear at the hearing, the Commissioner shall take whatever action he or she deems necessary based on written findings and shall mail his or her decision to the health maintenance organization or applicant. The action of the Commissioner shall be subject to review under the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Code § 1-1501 *et seq.*) ("DCAPA").

(5) The provisions of the DCAPA shall apply to proceedings under this section.

(6) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children, other newly acquired dependents of existing enrollees, or other newly eligible individuals, and shall not engage in any advertising or

solicitation whatsoever.

(7) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order or revocation, to wind up its affairs within the District, and shall conduct no further business within the District except as may be essential to the orderly conclusion of the affairs of such organization within the District. It shall engage in no further advertising or solicitation whatsoever within the District. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

New Section 35-4520

Sec. 21. Rehabilitation, liquidation, or conservation of health maintenance organizations.

(a) Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The Commissioner may apply for an order directing the Commissioner to rehabilitate, liquidate, or conserve a health maintenance organizations upon any one or more grounds set forth in sections 11 and 16 of the Insurers Rehabilitation and Liquidation Act of 1993, effective October 15, 1993 (D.C. Law 10-35; D.C. Code §§ 35-2810 and 35-2815), or when in the Commissioner's opinion the continued operation of a health maintenance organization would be hazardous either to the enrollees or to the people of the District. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(b) For the purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by section 16 of the Insurers Rehabilitation and Liquidation Act of 1993, effective October 15, 1993 (D.C. Law 10-35; D.C. Code § 35-2815), for policyholders and beneficiaries of insured of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets.

(c) Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollee's beneficiaries as described herein, and immediately preceding the priority of distribution.

New Section 35-4521

Sec. 22. Summary orders and supervision.

(a) Whenever the Commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this act, the Commissioner may, after notice and hearing, order the health maintenance organization to take such action reasonably necessary to rectify the condition or violation, including, but not limited to, one or more of the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the Commissioner;

(2) Reduce the volume of new business being accepted;

(3) Reduce expenses by specified methods;

(4) Suspend or limit the writing of new business for a period of time;

(5) Increase the health maintenance organization's capital and surplus by contribution; or

(6) Take such other steps as the Commissioner may deem appropriate under the circumstances.

(b) For the purposes of this section, a violation by a health maintenance organization of any law of the District to which the health maintenance organization is subject shall be deemed a violation of this act.

(c) The Commissioner is authorized, by rules and regulations, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purpose expressed in subsection (a) of this section.

(d) The remedies and measures available to the Commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the Commissioner under the provisions of sections 9 and 10 of the Insurers Rehabilitation and Liquidation Act of 1993, effective October 15, 1996 (D.C. Law 10-35; D.C. Code section 35-2801 *et seq.*).

New Section 35-4522

Sec. 23. Regulations.

The Commissioner, within 120 days of the effective date of this act, shall issue rules and regulations necessary to implement the provisions of this act. To facilitate the timely issuance of rules and regulations, the Commissioner may contract out for the drafting of rules and regulations pursuant to emergency procurement provisions set forth in section 312 of the District of Columbia Procurement Practices Act of 1985, effective February 21, 1986 (D.C. Law 6-85; D.C. Code § 1-1183.12).

Sec. 24. Regulatory fees.

The Insurance Regulatory Trust Fund Act of 1993, effective October 21, 1993 (D.C. Law 10-40; D.C. Code section 35-2701 *et seq.*), is amended as follows:

(a) Section 2(3) (D.C. Code section 35-2701(3)) is amended to read as follows: Section 35-2701

"(3) "Department of Insurance and Securities" means the District of Columbia's regulatory body which is responsible for administering the insurance laws and health maintenance organization laws of the District of Columbia.".

(b) Section 3(a) (D.C. Code section 35-2702(a)) is amended to read as follows: Section 35-2702

"(a) There is established within the General Fund of the District of Columbia a trust fund designated as the Insurance Regulatory Trust Fund, to which shall be credited all funds obtained pursuant to this act without regard to fiscal year limitation. All monies and interest earned on monies deposited in the Insurance Regulatory Trust Fund shall be credited to the Fund and used solely for the purpose of this act. Insurers and health maintenance organizations will be assessed separately. The funds obtained from assessments on insurance companies and health maintenance organizations will not be commingled within the Trust Fund, and separate accounts will be maintained within the Trust Fund in order to properly allocate assessment revenue and expenditures to insurers and health maintenance organizations.".

(c) Section 3(b) (D.C. Code section 35-2702(b)) is amended to read as follows: Section 35-2702

"(b) Subject to the applicable laws relating to the appropriation of District funds, monies received and deposited in the Insurance Regulatory Trust Fund or a division thereof, shall be used to defray the expenses of the Department of Insurance and Securities in the discharge of its administrative and regulatory duties as prescribed by law. These monies shall be deemed to include all administrative costs for regulating insurers and health maintenance organizations doing business in the District of Columbia, and no other assessments shall be charged for such purpose after the effective date of this act. The Mayor shall be respponsible for the deposit and expenditure of these monies as provided by law.".

(d) Section 3(d) (D.C. Code section 35-2702(d)) is amended by striking the last sentence which reads as follows: "This review shall be conducted as part of the review of the budget of the Department of Consumer and Regulatory Affairs.". Section 35-2702

(e) Section 4 (D.C. Code section 35-2703) is amended to read as follows: Section 35-2703

"(a) The Mayor shall assess annually each insurer and health maintenance organization doing business in the District an amount based on a percentage of its direct gross receipts for the preceeding year, provided that each insurer and health maintenance organization shall be subject to a minimum annual assessment of no less than $1000. The Mayor shall establish in each assessable year the assessment rate, not to exceed 3/10 of 1% of the direct gross receipts. In no event shall the amount assessed exceed the amount budgeted by the Council.

"(b) The Mayor shall compute the assessment for each insurer and health maintenance organization and send the insurer and health maintenance organization this information in a

"Notice of Assessment". Each insurer and health maintenance organization shall pay to the Mayor the amount stated in the Notice of Assessment within 30 days of the mailing date of the Notice of Assessment.

"(c) The annual billing cycle for the assessment established by this section shall be the fiscal year of the District of Columbia.".

(f) Section 5(a) (D.C. code section 35-2704(a)) is amended by adding the phrase "any health maintenance organization" after the phrase "any insurer". Section 35-2704

(g) Section 5(b)(D.C. Code section 35-2704(b)) is amended to read as follows: Section 35-2704

"(b) If an insurer or health maintenance organization fails to pay the amount of the assessment in a timely manner, the Mayor shall send the insurer or health maintenance organization a notice of deficiency, and 10 days after serving the deficiency notice may take whatever action, in the Mayor's discretion, the Mayor deems appropriate, including suspending or revoking the insurer's or health maintenance organization's certificate of authority or license to transact business, or any other appropriate action or sanction authorized under the insurance laws for failure to comply with District laws, including referring the matter to the Corporation Counsel for legal action to collect the assessment.".

(h) Section 5(c)(D.C. Code section 35-2704(c)) is amended to read as follows: Section 35-2704

"(c) In the event that any insurer or health maintenance organization fails, by reason of insolvency, impairment of capital and surplus, or other reason approved by the Mayor, to pay its assessment in full, the unpaid amounts shall be assessed against the remaining insurers or health maintenance orgainizations respectively, on a proportionate basis in comparison to their direct gross receipts. Any insurer or health maintenance organization paying this additional assessment shall have a claim against the defaulting insurer or health maintenance orgainization for the amount paid.".

(i) Section 6 (D.C. Code section 35-2705) is amended by inserting the phrase "or health maintenance organization", after the phrase "Any insurer". Section 35-2705

(j) Section 7 (D.C. Code section 35-2706) is amended to read as follows: Section 35-2706

"Insurers and health maintenance orgainizations continuing obligations.

"Any insurere or health maintenance orgainization whose license has been revoked, concelled, terminated, or surrendered shall continue to be bound by the obligations of this act including payment of all assessments, regardless of whether the insurer or health maintenance organization continues to do business in the District of Columbia.".

(k) Section 9 (D.C. Code section 35-2708) is amended by adding the phrase "and health maintenance organizations" after the word "insurers" wherever it appears. Section 35-2708

(l) Section 10 (D.C. Code section 35-2709) is amended by striking the phrase ",the Department of Consumer and Regulatory Affairs,". Section 35-2709

(m) Section 11(a) (D.C. Code section 35-2710(a)) is amended by addding the phrase " health maintenance organizations" after the word "All" in the first sentence of the subsection. Section 35-2710

New Section 35-4523

Sec. 25. Penalties and enforcement.

(a) The Commissioner may, in lieu of suspension or revocation of a certificate of authority under section 20, levy an administrative penalty in an amount not less than $10,000 nor more than $50,000, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The Commissioner may augment this penalty by an amount equal to the sum that the Commissioner calculates to be the damages suffered by enrollees or other members of the public.

(b)(1) If the Commissioner shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the Commissioner may give notice to a health maintenance organization and to its representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation; and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section are satisfied.

(c)(1) The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(2) Within 30 days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. Such hearings shall be conducted pursuant to the DCAPA, and judicial review shall be available as provided by the DCAPA.

(d) In the case of any violation of the provisions of this act, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (c) of this section, the Commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the Superior Court of the District of Columbia.

(e) Notwithstanding any other provisions of this act, if a health maintenance organization fails to comply with the net worth requirement of this act, the Commissioner may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

New Section 35-4524

Sec. 26. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this act, provisions of insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws of the District except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provisions set forth by the Board of Medicine relating to the practice of medicine.

New Section 35-4525

Sec. 27. Filings and reports as public documents.

All applications, filings, and reports required under this act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial, and financial information, other than any annual financial statement that may be required under section 9.

New Section 35-4526

Sec. 28. Confidentiality of medical information and limitation of liability.

(a) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this act:

(1) When needed for the conduct of the health maintenance organization's business;

(2) Upon the express consent of the enrollee or applicant;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent.

(b) A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

(c) A person who, in good faith and without malice or negligence, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee, or who furnishes any records, information, or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action,

nor shall the health maintenance organization which established such committee or the officers, directors, employees, or agents of such health maintenance organization be liable for the activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

(d) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate District of Columbia licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director or other member of the health maintenance organization or its staff engaged in assisting such committee, or any person assisting or furnishing information to such committee, may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

(1) Information considered by a health care review committee and the records of its action and proceedings which are used pursuant to this subsection by a state licensing or certifying agency or in appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

(e) To fulfill its obligations under section 7, a health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any enrollee.

Sec. 29. Acquisition of control of or merger of a health maintenance organization. **New Section 35-4527**

(a) No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization, or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly (or by conversion or by exercise of any right to acquire), be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the Commissioner and has sent to the health maintenance organization the following information:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to herein is to be effected (hereinafter called "acquiring party"); and

(A) If such person is an individual, his or her principal occupation and all

offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations during the past 10 years; or

(B) If such person is not an individual, a report of the nature of its business operations during the past 5 years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subparagraph (A) of this paragraph;

(2) The source, nature, and amount of the consideration used, or to be used, in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, and the identity of persons furnishing such considerations; provided, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding 5 fiscal years of each such acquiring party (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement;

(4) Any plans or proposals which each acquiring party may have to liquidate such health maintenance organizations, to sell its assets, or merge or consolidate it with any person; or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to herein which each acquiring party proposes to acquire and the terms of the offer, request, invitation, agreement, or acquisition referred to herein, and a statement as to the method by which the fairness of the proposal was arrived at:

(6) The amount of each class of any security referred to herein which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements, or understandings with respect to any security referred to herein in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such descriptions shall identify the persons with whom such contracts, arrangements, or understandings have been entered into;

(8) A description of the purchase of any security referred to herein during the 12 calendar months preceding the filing of the statement, by any acquiring party, including the

dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefore;

(9) A description of any recommendations to purchase any security referred to herein made during the 12 calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party;

(10) Copies of all tender offers for, requests or invitations for tenders of exchange offers for, and agreements to acquire or exchange any securities referred to herein, and (if distributed) of additional soliciting material relating thereto;

(11) The terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of securities referred to herein for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto; and

(12) Such additional information as the Commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of members and security holders of the health maintenance organization or in the public interest.

(b) If the person required to file the statement referred to in this section is a partnership, limited partnership, syndicate, or other group, the Commissioner may require that the information called for by subsection (a)(1) through (8) of this section shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation or the person required to file the statement referred to herein is a corporation, the Commissioner may require that the information called for by subsection (a)(1) through (8) of this section shall be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of such corporation. If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to such health maintenance organization pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the Commissioner and sent to such insurer within 2 business days after the person learns of such change. Such insurer shall send such amendment to its shareholders.

Sec. 30. Coordination of benefits.

New Section 35-4528

(a) Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by 2 or more carriers or health care plans.

(b) If health maintenance organizations adopt coordination of benefits, the provisions must be consistent with the coordination of benefits provisions that are in general use the District for coordinating coverage between two or more group health insurance or health care plans.

(c) To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are received from nonparticipating providers, provided outside their service areas, or not covered under the terms of their group contracts or evidence of coverage.

Sec. 31. Point of service plan. New Section 35-4529

(a) If an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through a health maintenance organization, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another carrier to offer, a point-of-service option to the employer, association, or other private group arrangement in conjunction with the health maintenance organization as an additional benefit for an employee or individual, at the employee's or individual's option to accept or reject.

(b) An employer, association, or other private group arrangement may require an employee or individual that accepts the additional coverage under a point-of-service option under subsection (a) of this section to pay a premium over the amount of the premium for the coverage offered by the health maintenance organization.

(c) A health maintenance organization may impose different cost sharing provisions for the point-of-service option based on whether the service is provided through the provider panel of the health maintenance organization or outside the providers panel of the health maintenance organization.

(d) The requirements of this section shall not apply to any subscriber contract current and in force on the effective date of this act for the duration of that contract, but these requirements shall apply to any renewal or new subscriber contract issued subsequent to the effective date of this act.

(e) The requirements of this section shall not apply to any subscriber contract issued in the individual market to a person who is not part of a contracted group of subscribers.

Sec. 32. Insolvency protection; assessment. New Section 35-4530

(a) When a health maintenance organization in the District is declared insolvent by a court of competent jurisdiction, the Commissioner may levy an assessment on health maintenance organizations doing business in the District to pay claims for uncovered expenditures for enrollees who are residents of the District and to provide continuation of coverage for enrollees not covered under section 15. The Commissioner may not assess in any one calendar year more than 2% of the aggregate premium written by each health maintenance organization in the District the prior calendar year.

(b) The Commissioner may use funds obtained under subsection (a) of this section to pay claims for uncovered expenditures for enrollees of an insolvent health maintenance

organization who are residents of the District, provide for continuation of coverage for enrollees who are residents of the District and are not covered under section 15, and administrative costs. The Commissioner may by regulation prescribe the time, manner, and form for filing claims under this section, or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

(c) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(1) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the Commissioner to the extent of the benefits received. The Commissioner may require an assignment to it of such rights by an payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon such person. The Commissioner is subrogated to these rights against the assets of any insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(2) The assignment or subrogation rights of the Commissioner and allowed claim under this subsection have the same priority against the assets of any insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(d) When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the Commissioner will distribute on a pro rata basis any amounts received under subsection (a) of this section which are not de minimus to the health maintenance organizations which have been assessed under this section.

(e) The aggregate coverage of uncovered expenditures under this section shall not exceed $300,000 with respect to any one individual. Continuation of coverage shall not continue for more than the lesser of one year after the health maintenance organization coverage is terminated by insolvency or the remaining term of the contract. The Commissioner may provide continuation of coverage on any reasonable basis, including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the Commissioner.

(f) The Commissioner may waive an assessment of any health maintenance organization if it would be or is impaired or placed in financially hazardous condition. A health maintenance organization which fails to pay an assessment within 30 days after notice is subject to a civil forfeiture of not more than $1,000 per day or suspension or revocation of its certificate of authority, or both. Any action taken by the Commissioner in enforcing the provisions of this section may be appealed by the health maintenance organization in accordance with the DCAPA.

Sec. 33. 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 Self-Government and Governmental Reorganization Act, approved December 24, 1973 (Stat. 813; D.C. Code § 1-233(c)(3)).

Sec. 34. 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), approval by the Financial Responsibility and Management Assistance Authority as provided in section 203(a) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, approved April 17, 1995 (109 Stat. 116; D.C. Code § 47-392.3(a)), a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Self-Government and Governmental Reorganization Act, approved December 24, 1973 (87 Stat. 813; D.C. Code § 1-233(c)(1)), and publication in the District of Columbia Register.

Chairman
Council of the District of Columbia

Mayor
District of Columbia

APPROVED: December 24, 1996

COUNCIL OF THE DISTRICT OF COLUMBIA

COUNCIL PERIOD ELEVEN

RECORD OF OFFICIAL COUNCIL VOTE

Docket No. B11-442

[ ] ITEM ON CONSENT CALENDAR

[X] ACTION & DATE ADOPTED FIRST READING, 11-7-96

[X] VOICE VOTE APPROVED
RECORDED VOTE ON REQUEST

ABSENT THOMAS

[ ] ROLL CALL VOTE - Result (__ __ __)

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Clarke					Jarvis					Smith, Jr.				
Brazil					Lightfoot					Thomas, Sr.				
Chavous					Mason					Whittington				
Cropp					Patterson									
Evans					Ray									

X - Indicates Vote AB - Absent NV - Present not Voting

CERTIFICATION RECORD

Secretary to the Council

Date 11, 1996

[ ] ITEM ON CONSENT CALENDAR

[X] ACTION & DATE ADOPTED FINAL READING, 12-3-96

[X] VOICE VOTE APPROVED
RECORDED VOTE ON REQUEST

ABSENT ALL PRESENT

[ ] ROLL CALL VOTE - Result (__ __ __)

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Clarke					Jarvis					Smith, Jr.				
Brazil					Lightfoot					Thomas, Sr.				
Chavous					Mason					Whittington				
Cropp					Patterson									
Evans					Ray									

X-indicates no AB-Absent NV-Present not voting

CERTIFICATION RECORD

Secretary to the Council

Date 11, 1996

[ ] ITEM ON CONSENT CALENDAR

[ ] ACTION & DATE _____

[ ] VOICE VOTE _____
RECORDED VOTE ON REQUEST

ABSENT _____

[ ] ROLL CALL VOTE - Result (__ __ __)

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Clarke					Jarvis					Smith, Jr.				
Brazil					Lightfoot					Thomas, Sr.				
Chavous					Mason					Whittington				
Cropp					Patterson									
Evans					Ray									

X - Indicates Vote AB - Absent NV - Present not Voting

CERTIFICATION RECORD

Secretary to the Council

Date