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Executive Orders

EXECUTIVE ORDER MJF 97-14

Emergency Response Commission

WHEREAS: Executive Order MJF 96-48, signed on October 17, 1996 establishes the Louisiana Emergency Response Commission (hereafter "Commission"); and

WHEREAS: it is necessary to expand the membership of that Commission to include three additional at-large members;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR. Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: Section 1 (I) of Executive Order MJF 96-48 is amended to provide as follows:

I. Ten at-large members.

SECTION 2: All other Sections and Subsections of Executive Order MJF 96-48 shall remain in full force and effect.

SECTION 3: The provisions of this Order are effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana at the Capitol, in the City of Baton Rouge on this 3rd day of March, 1997.

M.J. "Mike" Foster
Governor

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9704#011

EXECUTIVE ORDER MJF 97-15

Violence-free Workplace

WHEREAS: the goal of the State of Louisiana is to have all the officers and employees in state government work in a violence-free workplace;

WHEREAS: a peaceful and secure work environment facilitates productivity and job performance;

WHEREAS: the occurrence of violence, aggressive acts, and verbal or nonverbal threatening behavior and harassment in the workplace has a negative impact on the officers and employees of state government and the public they serve; and

WHEREAS: developing and maintaining a violence-free workplace requires both the commitment of management and the involvement of the officers and employees of state government working to achieve the same goal;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority vested through the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The goal of the State of Louisiana is to achieve and maintain a violence-free workplace.

SECTION 2: The Commissioner of Administration (hereafter "commissioner") shall develop and promulgate guidelines and a model plan for a violence-free workplace by April 1, 1997. The guidelines and a model plan shall provide practical information on the prevention of workplace violence and on the mitigation of its ill effects, specifically including information on the following:

A. prohibiting acts or threats of violence, by or against state officers and employees, at all work sites and whenever official state business is being conducted;

B. minimizing the chance of exposure of state officers and employees to violent, threatening, or harassing situations by implementing effective security measures and administrative procedures and practices;

C. analyzing each state work site from the perspective of preventing the occurrence and minimizing the effects of any violent, threatening, and harassing situations; and

D. educating state officers and employees to increase their awareness about security, health, and safety concerns and training them how to properly respond in the event that a violent, threatening, or harassing situation occurs.

SECTION 3: By January 1, 1998, each state agency shall implement a plan to maintain a violence-free workplace. Each agency's plan shall incorporate the guidelines and model plan promulgated by the commissioner, tailoring them to the specific needs of the agency. Each agency shall also provide seminar(s) for its officers and employees to educate and train them regarding the prevention of workplace violence. The commissioner shall monitor the implementation of each agency's plan, and shall report his findings and conclusions to the Governor by March 15, 1998.

SECTION 4: All departments, commissions, boards, agencies, and officers of the state, or any political subdivision thereof, are authorized and directed to cooperate with the commissioner in implementing the provisions of this Order.

SECTION 5: This Order is effective upon signature of the Governor and shall continue in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 5th Day of March, 1997.

M.J. "Mike" Foster, Jr.
Governor

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9704#020

EXECUTIVE ORDER MJF 97-16

International Trade Commission

WHEREAS: Executive Order MJF 97-12, signed on February 21, 1997, established the Louisiana International Trade Commission (hereafter "commission"); and

WHEREAS: it is necessary to amend a provision in the Order;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority vested through the Constitution and the laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: Section 5 of Executive Order MJF 97-12, is amended to provide as follows:

The membership of the commission shall elect all of its officers.

SECTION 2: All other Sections and Subsections of Executive Order MJF 97-12 shall remain in full force and effect.

SECTION 3: This Order is effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 6th day of March, 1997.

M.J. "Mike" Foster, Jr.
Governor

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9704#010

EXECUTIVE ORDER MJF 97-17

Board of Parole

WHEREAS: the Board of Parole (hereafter "the board"), created within the Department of Public Safety and Corrections by R.S. 15:574.2, consists of seven members appointed by and serving at the pleasure of the Governor;

WHEREAS: R.S. 15:574.2 (A)(1) only provides for the position of chairman of the board (hereafter "chair"); and

WHEREAS: in order for the board to function more effectively, it is necessary to create a position of vice-chair;
NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The position of vice-chair of the Board of Parole is hereby created. The Governor shall select the vice-chair from its membership.

SECTION 2: The vice-chair shall not receive any compensation in addition or supplemental to the annual salary for members of the board set forth in R.S. 15:574.2 (A)(3).

SECTION 3: The vice-chair shall preside in the absence of the chair and shall, in addition to such other duties assigned by the Governor, be responsible for developing and administering the schedule of parole hearings in accordance with R.S. 15:574.4 (B)(1), and preparing for the board, for its adoption, such rules, regulations, and procedures deemed necessary and proper to facilitate the effective operation of the board.

SECTION 4: The chair and the vice-chair shall work with the Governor's executive counsel and assistant executive counsel in accomplishing the duties set forth in Section 3 of this Order.

SECTION 5: This Order is effective upon signature of the Governor and shall continue in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana at the Capitol, in the City of Baton Rouge on this 11th day of March, 1997.

M.J. "Mike" Foster, Jr.
Governor

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9704#019

EXECUTIVE ORDER MJF 97-18

Bond Allocation—Housing Finance Agency

WHEREAS: pursuant to the Tax Reform Act of 1986 (hereafter "the Act") and Act 51 of the 1986 Louisiana Legislature, Executive Order MJF 96-25 (hereafter "MJF 96-25") was issued on August 27, 1996 to establish (1) a method for allocating bonds subject to private activity bond volume limits, including the method of allocating bonds subject to the private activity bond volume limits for the calendar year of 1997 (hereafter "the 1997 Ceiling"); (2) the procedure for obtaining an allocation of bonds under the 1997 Ceiling; and (3) a system of central record keeping for such allocations; and

EXECUTIVE ORDER MJF 97-19

Federal Property Assistance Program

WHEREAS: the Louisiana Housing Finance Agency has requested an allocation from the 1997 Ceiling to be used in connection with financing mortgage loans for first time home buyers throughout the State of Louisiana, in accordance with the provisions of Section 143 of the *Internal Revenue Code* of 1986, as amended;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The bond issue, as described in this Section, shall be and is hereby granted an allocation from the 1997 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$50,000,000	Louisiana Housing Finance Agency	Single Family Mortgage Revenue Bonds

SECTION 2: The granted allocation shall be used only for the bond issue described in Section 1 and for the general purpose set forth in the "Application for Allocation of a Portion of the State of Louisiana Private Activity Bond Ceiling" submitted in connection with the bond issue described in Section 1.

SECTION 3: The granted allocation shall be valid and in full force and effect through the end of 1997, provided that such bonds are delivered to the initial purchasers thereof on or before June 10, 1997.

SECTION 4: All references in this Order to the singular shall include the plural, and all plural references shall include the singular.

SECTION 5: The undersigned certifies, under penalty of perjury, that the granted allocation was not made in consideration of any bribe, gift, or gratuity, or any direct or indirect contribution to any political campaign. The undersigned also certifies that the granted allocation meets the requirements of Section 146 of the *Internal Revenue Code* of 1986, as amended.

SECTION 6: This Order is effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 12th day of March, 1997.

M.J. "Mike" Foster, Jr.
Governor

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9704#023

WHEREAS: Public Law 94-519, enacted on October 17, 1976, amended the Federal Property and Administrative Act of 1949, 40 U.S.C. §484 et seq., to permit the donation of federal surplus personal property to the states and local organizations for public purposes and for other purposes;

WHEREAS: the General Services Agency within the Executive Branch of the United States Government is the designated federal agency which allocates the surplus property among the states in a fair and equitable manner pursuant to criteria which are based on need and utilization;

WHEREAS: after the administrator of General Services transfers the surplus property to a designated state agency, the property is distributed by the state agency 1) to public agencies for use in carrying out or promoting for the residents of a given political area public purposes, which include conservation, economic development, education, parks and recreation, public health and public safety; and 2) to nonprofit educational or public health institutions or organizations, including medical institutions, hospitals, health clinics, schools, colleges, universities, schools for the mentally retarded or physically handicapped, child care centers, and certain radio and television stations;

WHEREAS: before any property may be transferred to a state agency by the administrator of General Services, the state shall develop, according to state law, a detailed plan of operation, developed in conformity with federal law, which includes adequate assurance for the federal government that the state agency has the "necessary organizational and operational authority and capability, including staff, facilities, means and methods of financing, and procedures with respect to: accountability, internal and external audits, cooperative agreements, compliance and utilization reviews, equitable distribution and property disposal, determination of eligibility, and assistance through consultation with advisory bodies and public and private groups";

WHEREAS: a permanent, revised plan of operation must be submitted to the administrator of General Services for approval in order that the state and/or state program may continue to qualify under Public Law 94-519; and

WHEREAS: in addition to the federal surplus personal property that may be transferred to the states pursuant to the Federal Property and Administrative Act of 1949, as amended, under 10 U.S.C. §2576 a, added by Public Law 104-181, the secretary of Defense may also transfer to federal and state agencies the personal property of the Department of Defense, including small arms and ammunition, which the secretary of Defense determines is excess to the needs of the Department of Defense, but suitable for use by state and federal agencies in law enforcement activities, such as counter-drug and counter-terrorism actions;

NOW THEREFORE I, M.J. "MIKE" FOSTER, JR., Governor of the State of Louisiana, by virtue of the authority

vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The Louisiana Federal Property Assistance Agency is hereby renamed the Federal Property Assistance Program (hereafter "program").

SECTION 2: The program shall submit a revised Plan of Operation to the administrator of General Services for approval so that the state and/or the public agencies in the State of Louisiana may participate or continue to participate as donees under the Federal Property and Administrative Services Act of 1949, as amended.

SECTION 3: The program shall be the agency within the State of Louisiana that is responsible for carrying out the provisions of the Plan of Operation, as approved by the administrator of General Services, and the counter-drug program, as prescribed by the secretary of Defense.

SECTION 4: The program shall be a unit within the Louisiana Property Assistance Agency (hereafter "agency"), a section of the Division of Administration, within the Executive Branch, Office of the Governor. The program manager shall report to the commissioner of Administration, through the director of the agency.

SECTION 5: The director of the agency, acting through the program manager, shall possess all power and authority

necessary to exercise and perform all the functions, duties, and responsibilities cited in both the revised Plan of Operation and the counter-drug program, so as to comply with all applicable state and federal laws and regulations.

SECTION 6: All departments, commissions, boards, agencies, and officers of the state, and any political subdivisions thereof, are authorized and directed to cooperate in the implementation of the provisions of this Order.

SECTION 7: Upon signature of the Governor, the provisions of this Order shall be retroactive to January 1, 1997 and shall continue in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of the State of Louisiana at the Capitol, in the City of Baton Rouge on this 17th day of March, 1997.

M.J. "Mike" Foster, Jr.
Governor

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9704#021

Emergency Rules

DECLARATION OF EMERGENCY

Department of Agriculture and Forestry
Office of Agro-Consumer Services
Weights and Measures Commission

Bar Code Scanning Devices (LAC 7:XXXV.Chapter 175)

In accordance with the emergency provisions of the Administrative Procedure Act, R.S. 49:953(B) and R.S. 3:4608, the Commissioner of Agriculture and Forestry finds that this Emergency Rule setting forth amendments to the weights and measures Regulations governing the use of bar code scanning devices is necessary in order to protect the welfare of the citizens of Louisiana.

Due to recent publicity regarding the accuracy of scanning devices in commerce and the receipt of several citizen complaints regarding overcharges, the Commissioner conducted a baseline survey of businesses in Louisiana which use scanning devices in order to establish the accuracy of the scanning devices. The results of the survey were presented at a duly noticed and constituted meeting of the Weights and Measures Commission held on November 12, 1996, with the results indicating that consumers are overcharged an average of 2.73 percent per transaction. Following receipt of the survey results, the Department immediately began the process of amending the weights and measures Regulations through the normal promulgation process to put into place an inspection and enforcement program governing the use of bar code scanning devices. The normal promulgation process pursuant to the Administrative Procedure Act will not be complete for several months. The lack of an inspection and enforcement program for bar code scanning devices would cause imminent peril to public health, safety, and welfare of the citizens of this state in that citizens would continue to be overcharged in this, the busiest consumer spending period of the year.

In order to insure protection of the consumer pending final adoption of this Rule through the normal promulgation process, the Commissioner declares an emergency to exist and adopts by emergency process the following Emergency Rule setting forth an inspection and enforcement program for bar code scanning devices.

The effective date of this Emergency Rule is March 31, 1997, and it shall be in effect for 120 days or until the final Rule takes effect through the normal promulgation process, whichever occurs first.

Title 7

AGRICULTURE AND ANIMALS

Part XXXV. Agro-Consumer Services

Chapter 175. Weights and Measures

§17501. Specifications, Tolerances and Regulation for Commercial Weighing and Measuring Devices

The Commissioner of Agriculture and Forestry, under authority conferred by the Louisiana Revised Statutes of 1950, Title 3, Section 4608, and for the enforcement of requirements applicable to the equipment therein referred to, hereby adopts by reference all rules, regulations, standards, specifications and tolerances as contained in the *National Bureau of Standards and Technology Handbook H-44*, and amendments thereto, entitled *Specifications, Tolerances, and Regulations for Commercial Weighing and Measuring Devices*, and as contained in the National Conference on Weights and Measures Publication 19 entitled *Examination Procedure for Price Verification*, but only insofar as the Louisiana Revised Statutes of 1950, as amended, may provide.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:4606 and R.S. 3:4608 (formerly R.S. 55:4 and R.S. 55:6).

HISTORICAL NOTE: Adopted by the Department of Agriculture, Commission of Weights and Measures, April 1953, amended and promulgated by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Division of Weights and Measures, LR 19:1530 (December 1993), amended by the Weights and Measures Commission, LR 23:

§17502. Definitions

Wherever in these Regulations the masculine is used, it includes the feminine and vice versa; wherever the singular is used, it includes the plural and vice versa.

* * *

Hand-held Scanning Device—a portable device that scans UPC codes that allows for the comparison of the price displayed on a shelf, item, or otherwise advertised, to the price for the item in the point-of-sale database.

* * *

Point-of-Sale—an assembly of elements including a weighing element, indicating element, and receiving element (which may be equipped with a scanner) used to complete a direct sale transaction.

Price Look-Up Code or PLU—a pricing system where numbers are assigned to items or commodities and the price is stored in a data-base for recall when the numbers are manually entered. PLU codes are used with scales, cash registers, and point-of-sale items.

* * *

Scanner or Scanning Device—an electronic system that employs a laser bar code reader to retrieve product identity, price and other information stored in computer memory.

Universal Product Code or *UPC*—a unique symbol that consists of a machine-readable code and human-readable numbers.

Weights, Measures, or Weighing and Measuring Devices—all weights, scales, scanners, taxi meters, beams, measures of every kind, instruments and mechanical devices for weighing or measuring, and any appliances and accessories connected with any such instruments. However, it does not include or refer to devices used to meter or measure, other than by weight, water, natural or manufactured gas, electricity, or motor fuel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:4603 (formerly R.S. 55:3).

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Commission of Weights and Measures, LR 13:157 (March 1987), amended by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Division of Weights and Measures, LR 19:1531 (December 1993), amended by the Weights and Measures Commission, LR 23:

§17514. Bar Code Scanning Devices and Labels

A. The price of a commodity or item offered for retail sale which is labeled with a computerized bar code label shall be plainly displayed, either by a price marked in English on the package containing the individual commodity or item, or by a placard or card placed on the shelf in front of the commodity or item which is clearly visible and legible.

B. The price displayed on the shelf, commodity or item required by Subsection A of this Section shall be precisely equal to the price actually charged by the seller.

C. In calculating violations of this Section, multiple items contained in the same lot shall constitute one violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:4608.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Division of Weights and Measures, LR 19:1533 (December 1993), amended by the Weights and Measures Commission, LR 23:

§17522. Fee Schedule

A. - D. ...

E. The registration fee for each location utilizing scanning devices shall be as follows:

Category	Number of Point-of-Sale Devices	Fee
A	1 to 10	\$ 50
B	11 to 25	\$100
C	Over 25	\$150

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:4608.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Division of Weights and Measures, LR 19:1534 (December 1993), amended by the Weights and Measures Commission, LR 23:

§17523. Registration

A. Each commercial weighing and measuring device in use in Louisiana shall be registered annually with the Division insofar as is specified in this Regulation.

B. - C. ...

D. Scanning devices shall be registered according to the following criteria:

1. make;
2. model;
3. serial number; and
4. number of point-of-sale devices.

E. A late fee of \$25 will be assessed for each device, the maximum penalty of \$100 per outlet, when the application is submitted after December 31.

F. A late fee of \$25 will be assessed for each new device not registered within 30 days from the date it is put into service.

G. A compound weighing device shall be considered one or more devices for the purpose of registration in accordance with the following:

1. A compound weighing device that consists of a single load receiving element and more than one indicating element shall be considered a single device when all indicating elements may be tested during the same test for the purpose of sealing the device as correct. Said device shall be considered separate devices for each separate test necessary for sealing.
2. A compound weighing device that consists of one indicating element and more than one load receiving element shall for the purpose of registration be considered a separate device for each load receiving element.

H. Applicants for registration may request application forms, verbally or in writing, from the Division of Weights and Measures of the Department of Agriculture and Forestry.

I. Each application for annual registration shall be accompanied by payment of required fee and said registration shall be valid until December 31. To remain valid, each annual registration must be renewed before January 1. The initial annual registration and fees due for scanning devices for calendar year 1997 shall be payable on or before April 30, 1997. Registration renewals and fees due for scanning devices for calendar years after 1997 shall be due and payable as set forth in this Section.

J. Any registration obtained without complying with all of the requirements of these Regulations may be voided by the Division.

K. Before a device may be sealed to certify the accuracy and correctness of a device, that device must be registered with the Division of Weights and Measures of the Louisiana Department of Agriculture and Forestry.

L. In accordance with R.S. 3:4611, no one shall use a weight, measure or weighing or measuring device which has not been sealed by the Division, its director, or its inspectors, at its direction, within the year prior thereto, unless written notice has been given to the Division to the effect that the weight, measure or weighing or measuring device is available for examination or is due for re-examination.

M. Application for registration or renewal of registration shall fulfill the requirement of notification in Subsection L of this Section.

N. Applications for annual renewal of registration shall be mailed by the Division of Weights and Measures of the Department of Agriculture and Forestry to all registrants, at

the last address provided by the registrant, on or before November 15 and must be returned before January 1.

O. The record of all registrations shall be maintained by the Division of Weights and Measures and the director of the Division of Weights and Measures in its office in Baton Rouge.

P. Any registrant having a device registered under provisions of this Regulation, and that is taken out of commercial use at the location shown on the application for registration, shall notify the Commission's Office in writing to remove said device from its records.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:4603 (formerly R.S. 55:3).

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Commission of Weights and Measures, LR 13:158 (March 1987), amended LR 15:78 (February 1989), amended by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Division of Weights and Measures, LR 19:1534 (December 1993), amended by the Weights and Measures Commission, LR 23:

Bob Odom
Commissioner

9704#009

DECLARATION OF EMERGENCY

Office of the Governor
Division of Administration
Architects Selection Board

Interview Procedure; Voting (LAC 4:VII.128)

In accordance with R.S. 38:2310 et seq., as amended, the Rules governing the voting procedure of the Architects Selection Board are hereby amended. This Emergency Rule is to be effective upon publication in the *Louisiana Register* and will remain in effect for 120 days or until a final Rule takes effect through the normal rulemaking process.

Emergency rulemaking is necessary in order to proceed immediately with the selection of a designer for the Capitol Complex—North Building. This selection is imminent and will benefit from the revised procedure by having more qualified architects included in the interview procedure.

Title 4

ADMINISTRATION

Part VII. Governor's Office

Chapter 1. Architects Selection Board

Subchapter B. Selection Procedure

§128. Interview Procedure

A.1. - 3.c. ...

4. The selection procedure (§127) will be followed from Subsections A and B.1, 2, 3, 4, and 6. However, if an applicant is not selected unanimously on the first ballot, the following procedure will be implemented.

a. After the results of the weighted ballot are reported, the board secretary will list all applicants receiving one or more points. They will be listed in order, ranked by number of points from highest to lowest.

b. After the list is prepared, there will be a roll call vote on each applicant starting with the first applicant on the list. Voting for each applicant will take place in the order that he is listed. Each applicant on the list will receive a "yes" or "no" vote from each board member. Each applicant who receives a majority will be invited to be interviewed.

c. Voting will end when the end of the list is reached or when there are five applicants to be invited to be interviewed, whichever comes first.

d. In the event that the end of the list is reached before there are at least three applicants to be interviewed, the board may begin voting again by the method of their choice.

e. All applicants selected by the foregoing process will be invited to be interviewed at an interview meeting.

5. The interview meeting will be held in accordance with criteria that the board sets forth in a letter to the applicants that have been selected to be interviewed.

6. At the interview meeting, the board will begin in an open meeting and vote to go into executive session to conduct the interviews in accordance with the criteria set forth in Paragraph 5 above and pursuant to R.S. 42:6 and 42:6.1.

7. After all the interviews have been conducted, the board will return to a public meeting, and the selection procedure will then resume from §127.B.5, 7, 8, and 9.

AUTHORITY NOTE: Promulgated in accordance with R.S. 38:2310 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Architects Selection Board, LR 17:1206 (December 1991), amended LR 23:

Roger Magendie
Director

9704#066

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Eligibility of Aliens

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first. Adoption of this Rule on an emergency basis is necessary to avoid sanctions or penalties from the federal government arising from failure to adopt appropriate regulations related to the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) significantly changed Medicaid eligibility for individuals who are not citizens of the United States. Medicaid must be provided to eligible citizens or

nationals, but certain noncitizens may be eligible to receive only treatment for an emergency medical condition. This Emergency Rule adopts the mandatory provisions of P.L. 104-193 and states the options chosen by the state. This Emergency Rule addresses only the citizenship requirement: every applicant for Medicaid under any classification addressed in this Emergency Rule must meet all requirements for eligibility. Previous regulations for Medicaid eligibility of lawful permanent residents and aliens Permanently Residing in the United States Under Color of Law (PRUCOL) no longer apply and are replaced by this Emergency Rule. A previous Emergency Rule, effective January 1, 1997, redefined and replaced all definitions and categories of alien groups (*Louisiana Register*, Volume 23, Number 1, page 24). The following Emergency Rule will continue the provisions of the corresponding Emergency Rule in force.

All noncitizens are classified as qualified aliens or nonqualified aliens (which includes illegal aliens). Nonqualified aliens are eligible only for emergency services. Some specifically defined qualified aliens are eligible for regular Medicaid benefits. Those qualified aliens who are not eligible for regular Medicaid benefits are eligible only for emergency services.

In general, aliens who are refugees, asylees, or whose deportation is being withheld are eligible for consideration of Medicaid eligibility until five years after the date of entry into the United States, regardless of when they enter the country, and veterans and those on active duty in the armed services and their families.

Mandatory qualified alien groups eligible for regular Medicaid benefits are:

1. aliens receiving Medicaid on August 22, 1996 (until January 1, 1997);
2. aliens receiving SSI (until SSA notifies Medicaid that SSI benefits have stopped);
3. qualified aliens who were in the United States prior to August 22, 1996, who are members of these groups, whether or not receiving Medicaid on that date and meet any of these criteria:
 - a. lawful permanent residents to whom 40 qualifying quarters of Social Security can be credited;
 - b. refugees until five years after the date of the alien's entry into the United States;
 - c. asylees until five years after the grant of asylum;
 - d. aliens who have had deportation withheld under Section 243(h) of the INA until five years after the grant of withholding; and
 - e. honorably discharged veterans and aliens on active duty in the United States armed forces, and the spouse or dependent child(ren) of such individuals;
4. qualified aliens entering the United States on or after August 22, 1996, who are members of the groups below:
 - a. refugees for five years from date of entry;
 - b. asylees for five years from date of entry;
 - c. aliens whose deportation has been withheld under Section 423(h) of the INA for five years from grant of withholding;

d. veterans and aliens on active duty in the United States' armed forces, and the spouse or dependent child(ren) of such individuals;

5. American Indians born in Canada who have at least 50 percent Indian blood who enter and reside in the United States.

The state has determined that the following optional groups of qualified aliens are not eligible for regular Medicaid services under this Emergency Rule, but may be eligible for emergency services if they meet all eligibility criteria other than citizenship:

1. aliens receiving Medicaid benefits on August 22, 1996, but not receiving SSI, are not eligible January 1, 1997 and afterward.

2. aliens who were in the United States prior to August 22, 1996, who are included in the definition of qualified alien, but not included in the mandatory group of qualified aliens living in the United States before August 22, 1996 are not eligible for Medicaid.

Definitions

Illegal Aliens either were never legally admitted to the United States for any period of time, or were admitted for a limited period of time and did not leave the United States when their period of time expired. Illegal aliens are eligible only for emergency services if they meet all eligibility criteria other than citizenship.

Ineligible Aliens are aliens lawfully admitted to the United States but only for a temporary or specified period of time as legal nonimmigrants. Ineligible aliens are eligible only for emergency services if they meet all eligibility criteria other than citizenship. The following categories of individuals are ineligible aliens:

1. foreign government representatives on official business and their families and servants;
2. visitors for business or pleasure, including exchange visitors;
3. aliens in travel status while traveling directly through the U.S.;
4. crewmen on shore leave;
5. treaty traders and investors and their families;
6. foreign students;
7. international organization representation and personnel and their families and servants;
8. temporary workers including agricultural contract workers; and
9. members of foreign press, radio, film, or other information media and their families.

Qualified Aliens are eligible for regular Medicaid if they also meet additional criteria described above for mandatory Medicaid eligibility, or are eligible only for emergency services if they do not. An alien must meet all eligibility requirements for Medicaid other than citizenship to receive either regular Medicaid eligibility or emergency services. Qualified aliens are aliens who are:

1. lawful permanent residents;
2. refugees;
3. asylees;

4. aliens who have had deportation withheld under Section 243(h) of the Immigration and Nationality Act (INA);
 5. aliens granted parole for at least one year by the INS;
- or
6. aliens granted conditional entry under immigration law in effect before April 1, 1980.

Emergency Medical Services are not related to either an organ transplant procedure or routine prenatal or post-partum care. The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

It is estimated that total savings resulting from implementation of this Emergency Rule is \$2,082,702 for SFY 1996-97.

Emergency Rule

Effective for dates of service May 1, 1997 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the provisions of Section 401 of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) regarding Medicaid eligibility for noncitizens. The following optional groups of qualified aliens are not eligible for regular Medicaid services under this Emergency Rule, but may be eligible for emergency services if they meet all eligibility criteria other than citizenship:

1. aliens receiving Medicaid benefits on August 22, 1996, but not receiving SSI, are not eligible January 1, 1997 and afterward;
2. aliens who were in the United States prior to August 22, 1996, who are included in the definition of qualified alien, but not included in the mandatory group of qualified aliens living in the United States before August 22, 1996 are not eligible for Medicaid.

Bobby P. Jindal
Secretary

9704#044

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Hospital Program—Out-of-State Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and it shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first.

The Bureau of Health Services Financing adopted an Emergency Rule, with an effective date of July 1, 1995, to

reduce reimbursement for out-of-state inpatient hospital services to the lower of 50 percent of billed charges or the Medicaid per diem rate of the state where the services are provided and reduce out-of-state outpatient hospital services to 50 percent of billed charges (*Louisiana Register*, Volume 21, Number 7). Prior to the adoption of July 1, 1995 Emergency Rule, reimbursement for out-of-state inpatient hospital services was at 72 percent of billed charges. After a review of the prior authorization process for out-of-state care, the bureau has determined it is necessary to revise the reimbursement methodology for out-of-state inpatient hospital services rendered to recipients under the age of 21 by increasing the payment to 72 percent of billed charges. Outpatient services will continue to be reimbursed at 50 percent of billed charges except for ambulatory surgical procedures and outpatient laboratory procedures which are reimbursed in accordance with a fee schedule. This action is necessary to assure the health and welfare of these recipients by maintaining access to medical services when a recipient requires emergency care while out of state or when the medical services are not available in this state.

It is anticipated that implementation of this Emergency Rule will increase expenditures by approximately \$1,277,157 for the fiscal year of 1997-1998.

Emergency Rule

Effective for dates of service on or after April 4, 1997, the Department of Health and Hospitals, Bureau of Health Services Financing increases reimbursement to out-of-state hospitals to 72 percent of billed charges for inpatient services provided to recipients under the age of 21.

Interested persons may submit written comments to Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquires regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bobby P. Jindal
Secretary

9704#006

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Low Income Families Eligibility Group

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first. Adoption of this Rule on an emergency basis is necessary to avoid sanctions or

penalties from the federal government arising from failure to adopt appropriate regulations related to the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193). A previous Emergency Rule (*Louisiana Register*, Volume 23, Number 1, page 29) established a new group of eligibles replacing AFDC eligibles. The following Emergency Rule continues the previous provisions in force.

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the Aid to Families with Dependent Children (AFDC) program which provided financial assistance to families meeting certain requirements, and replaced it with a block grant program for Temporary Assistance for Needy Families (TANF) effective July 1, 1997, or such earlier date as the Secretary of DHHS receives the TANF State Plan. Receipt of TANF does not entitle the recipient to Medicaid. TANF provisions were adopted in Louisiana by Department of Social Services, effective October 1, 1996.

Also, P.L. 104-193 establishes criteria for a new category of Medicaid recipients. According to that Regulation, low income families are defined as follows:

1. the family includes a dependent child who is living with a caretaker relative;
2. the family income does not exceed the 185 percent gross income test limit; and
3. the family's countable income and resources do not exceed the applicable AFDC income and resource standards (including any special needs) established in the Medicaid State Plan. This description is now found in Section 1931 of the Social Security Act. The state has elected to maintain income and resource criteria in effect on July 16, 1996 as the basis for determining eligibility for this new classification of Medicaid recipients.

Among those who will meet the income and resource criteria for low-income families are persons who are eligible for TANF financial assistance because TANF criteria are currently more restrictive than low-income family criteria. Other families who meet the criteria for low-income family but are not TANF-eligible will be eligible for Medicaid under this definition. This Emergency Rule provides notification that the population described in Section 1931 of the Social Security Act constitutes an eligibility group covered by Medicaid and establishes the income and resource limitations applicable.

Emergency Rule

Effective May 1, 1997 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing establishes a new Medicaid eligibility group for low income families with children who meet eligibility requirements described in Section 1931 of the Social Security Act. Eligibility criteria under the AFDC State Plan in effect on July 16, 1996 will be used to determine eligibility. Additionally, recipients of TANF are deemed to meet these criteria so long as TANF requirements are more restrictive than eligibility requirements under the AFDC State Plan in effect on July 16, 1996.

Bobby P. Jindal
Secretary

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

**Mentally Retarded/Developmentally Disabled
Waiver Program—Annual Individual Cost Cap**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing administers the waiver for Mental Retardation/Developmentally Disabled (MR/DD) individuals under the Home and Community Based Services Waiver Program. Waiver participation is limited to a specific number of participants based on the approval of the waiver application by the Health Care Financing Administration. Home and community based services waiver programs are based on federal criteria which allow services to be provided in a home or community based setting for a recipient who would otherwise require institutional care. Aggregate costs for participants in the MR/DD Waiver Program must not exceed the costs for recipients of institutional care.

The department has determined that the cost effectiveness of the waiver may be jeopardized as more institutionalized individuals requiring intensive care are considered for admission to the waiver program. Therefore, the bureau is establishing an annualized individual cost cap not to exceed \$100,000 for waiver services. For the purpose of monitoring waiver costs, waiver service expenditures for each participant will be reviewed on a quarterly basis to assure that the expenditures for the services identified on the care plan are within the cost cap. It is the responsibility of the case management services provider, with oversight from the Office for Citizens with Developmentally Disabilities (OCDD), to:

1. assure that the services identified on the care plan are adequate to meet the individual's needs;
2. document waiver service costs on the initial and updated care plans;
3. routinely monitor care plans to insure that waiver service costs do not exceed the cost cap; and
4. timely report any changes in the individual's circumstances that could impact the care plan and cost cap.

When an individual's waiver service costs exceed \$25,000 a quarter for one or more quarters, the bureau will notify OCDD that expenditures to date indicate that waiver service costs will exceed the cost cap if they continue at the current rate. If the services necessary to assure the health and safety of an individual cannot be provided at an annualized cost less

than the cost cap, then that individual shall not be determined eligible (at application) or continue to be eligible (at redetermination) for waiver participation. In the event that an individual loses waiver eligibility, the bureau will refer the individual to OCDD as member of their target population to coordinate alternate arrangements for care. In order to facilitate the management of the annualized individual cost cap in the MR/DD Waiver Program, the bureau is also transferring authority for the issuance of the waiver services authorization form (MR-14) from the case management services provider to the Health Standards Section. This action is necessary to maintain cost effectiveness in the waiver and to assure that the health and safety of waiver participants can be maintained in the community with the services available under the MR/DD Waiver Program.

Emergency Rule

Effective April 21, 1997, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following regulations governing the Mental Retardation/Developmentally Disabled Waiver Program: 1) establish an annualized individual cost cap not to exceed \$100,000 for wavier services and 2) transfer the authority for the issuance of the waiver services authorization form (MR-14) from the case management services provider to the Health Standards Section. The annualized individual cost cap shall be applicable for all admissions certified to the MR/DD waiver on or after April 21, 1997 and for subsequent updates to the care plan. For the purpose of monitoring waiver costs, waiver service expenditures for each participant will be reviewed on a quarterly basis to assure that the expenditures for the services identified on the care plan are within the cost cap. It is the responsibility of the case management services provider, with oversight from the Office for Citizens with Developmentally Disabilities (OCDD), to:

1. assure that the services identified on the care plan are adequate to meet the individual's needs;
2. document waiver service costs on the initial and updated care plans;
3. routinely monitor care plans to insure that waiver service costs do not exceed the cost cap; and
4. timely report any changes in the individual's circumstances that could impact the care plan and cost cap.

When an individual's waiver costs exceed \$25,000 a quarter for one or more quarters, the bureau will notify OCDD that expenditures to date indicate that waiver service costs will exceed the cost cap if they continue at the current rate. If the services necessary to assure the health and safety of an individual cannot be provided at an annualized cost less than the cost cap, then that individual shall not be determined eligible (at application) or continue to be eligible (at redetermination) for waiver participation. In the event that an individual loses waiver eligibility, the bureau will refer the individual to OCDD as member of their target population to coordinate alternate arrangements for care.

Interested persons may submit written comments to Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available at the parish Medicaid offices for review by interested persons.

Bobby P. Jindal
Secretary

9704#045

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

**State-Funded Medically Needy
Program—Organ Transplant Services**

The Department of Health and Hospitals, Bureau of Health Services Financing adopts the following Emergency Rule under the Administrative Procedure Act, R.S. 49:950 et seq., and it shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted an Emergency Rule with an effective date of July 1, 1996 in compliance with Executive Order 96-17 to establish a State-Funded Medically Needy Program which limited eligibility to those individuals who were either certified under the Title XIX Medically Needy Program or had a pending application under the Title XIX Medicaid Program and were subsequently determined eligible for the Title XIX Medically Needy for June 1996 (*Louisiana Register*, Volume 22, Number 7). The July 1, 1996 Emergency Rule was subsequently amended effective October 8, 1996 to establish an eligibility determination process under the State-Funded Medically Needy Program for specified applicant groups (*Louisiana Register*, Volume 22, Number 10). The department has now determined it is necessary to expand the number of applicant groups who may participate in the eligibility determination process under the State-Funded Medically Needy Program. Therefore, the following Emergency Rule is being adopted to amend the general provisions of the State-Funded Medically Needy Program to include persons who meet the medical criteria for organ transplant surgery as the fifth category for the eligibility determination process.

Adoption of this Emergency Rule is necessary to protect the health and welfare of those persons who meet the medical criteria for organ transplant surgery from the imminent peril that would result if they have no resources to access necessary medical services. It is anticipated that implementation of this Emergency Rule will increase expenditures by approximately \$1,500,000 for state fiscal year 1996-1997.

Emergency Rule

Effective March 14, 1997 the Department of Health and Hospitals, Bureau of Health Services Financing amends Section D of the general provisions for the State-Funded Medically Needy Program to incorporate persons who meet the medical criteria for the following organ transplant

surgeries as the fifth category for the eligibility determination process.

- a. Bone Marrow
- b. Heart
- c. Heart/Lung
- d. Kidney
- e. Liver
- f. Lung
- g. Pancreas
- h. Pancreas/Kidney

Interested persons may submit written comments to Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule.

Bobby P. Jindal
Secretary

9704#081

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Temporary Assistance for Needy
Families (TANF) Work Requirements

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first. Adoption of this Emergency Rule on an emergency basis is necessary to avoid sanctions or penalties from the federal government arising from failure to adopt appropriate regulations related to the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the Aid to Families with Dependent Children (AFDC) program which provided financial assistance to families meeting certain requirements, and replaced it with a block grant program for Temporary Assistance for Needy Families (TANF) effective July 1, 1997, or such earlier date as the Secretary of DHHS receives the TANF State Plan. TANF provisions were adopted in Louisiana by Department of Social Services effective October 1, 1996. A previous Emergency Rule (*Louisiana Register*, Volume 23, Number 1, page 31) and Notice of Intent (*Louisiana Register*, Volume 23, Number 2, page 233) provided notification that Medicaid coverage will not be available to persons who fail to meet the work requirement associated with TANF, with the following exceptions: a

pregnant woman; infant; or child under one of the poverty level related groups; or a minor child who is not the head of the household under TANF. The following Emergency Rule shall continue the provisions of the corresponding Rule in force.

Emergency Rule

Effective May 1, 1997 and concurrently with implementation of the Personal Responsibility and Work Opportunity Act of 1996 provisions for financial assistance by Department of Social Services, eligibility for Medicaid as a TANF recipient is terminated for failure to meet work requirements as described in Section 1931(b)(3) of the Social Security Act.

Bobby P. Jindal
Secretary

9704#043

DECLARATION OF EMERGENCY

Department of Public Safety and Corrections
Office of State Police
Division of Charitable Gaming Control

Charitable Bingo, Keno, Raffle; Compensation of Workers;
Progressive Mega Jackpot Bingo (LAC 42:I.1732 and 1791)

The Department of Public Safety and Corrections, Office of State Police, Division of Charitable Gaming Control hereby adopts LAC 42:I.1732 and amends LAC 42:I.1791 in accordance with R.S. 33:4861.26, R.S. 36:408, R.S. 40:1485.4, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. R.S. 33:4861.12 provides in part for the payment of certain employees and workers of licensed charitable organizations.

The division adopted Emergency Rules and promulgated final Rules, LAC 42:I.1791, which regulated the play of a new form of bingo known as progressive mega jackpot bingo as mandated by R.S. 33:4861.26. The final Rule was adopted effective February 20, 1996 (*Louisiana Register*, Volume 22, Number 2).

The Emergency Rule is necessary to prevent the imminent threat to the public welfare in that it has become necessary to adopt LAC 42:I.1732 in order to regulate more efficiently the payment of such employees and workers, and to amend LAC 42:I.1791 in order to regulate more efficiently the activity of the progressive mega jackpot bingo game. Since the inception of the progressive mega jackpot bingo game in October, 1995, charitable gaming revenues have declined significantly. As a result, a number of licensees have discontinued gaming. The amendment is necessary in order to enhance gaming activity and provide a means to increase charitable gaming revenues and for related matters.

This Emergency Rule shall become effective March 20, 1997, and shall remain in effect for a period of 120 days or until the final Rule is promulgated, whichever occurs first.

Title 42

LOUISIANA GAMING

Part I. Charitable Gaming

Chapter 17. Charitable Bingo, Keno and Raffle

Subchapter G. Civil Penalties

§1732. Compensation of Workers

A. Payment of Workers. In accordance with R.S. 33:4861.12(A)(2) and (B)(2), any person, association, or corporation licensed to hold, operate, or conduct any games of chance pursuant to this Part may pay eligible workers for services actually rendered in assisting in the holding, operating, or conducting of a licensed charitable game of chance. Payments to workers shall not exceed \$5 for each hour actually worked up to a total of six hours. In no event shall payments exceed \$30 per licensed session per paid worker. No more than 10 workers shall be paid for any one licensed session. All workers, paid or unpaid, shall be bona fide active members of the licensed organization conducting the game.

1. Payments to workers shall be made once a month for the preceding calendar month, or as otherwise provided by the division.

2. Payment shall only be made by check from the licensed organization's charitable gaming checking account. Payments in the form of cash or money orders are prohibited. Organizations shall document on each check the amount of gross wages and the amount deducted for any state or federal tax withholdings.

3. Each organization shall be responsible for withholding and timely submitting all applicable social security, state and federal taxes.

B. Records Required. Any licensee choosing to pay workers as provided by this Section shall maintain, for each gaming session, separate documents or written forms required by the division for each worker paid.

1. The licensee shall declare the accuracy of its information and the document shall include the following information:

- a. date of the session;
- b. printed name and signature of each worker with a declaration attesting to the fact that the worker has been paid for the number of hours indicated on this document for services actually rendered;
- c. social security number of each worker;
- d. drivers license number of each worker;
- e. number of hours actually worked during the session by the worker;
- f. printed name and signature of the designated session manager; and
- g. name of the licensed organization of which such worker is a bona fide active member.

2. All such affidavits or documentation shall be retained for a period of three years as provided by this Part. Each organization is responsible for all applicable social security, state and federal taxes.

C. Any licensed charitable organization that pays any worker as provided in this Section must maintain positive net gaming proceeds for each quarter. Net gaming proceeds shall equal total gross proceeds minus prize payouts and expenses.

Unless otherwise provided by the division, in the event that any licensed charitable organization fails to maintain positive net gaming proceeds during any quarter, such licensee shall discontinue the payment of workers as provided in this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4861.12 and R.S. 40:1485.4.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Division of Charitable Gaming Control, LR 23:

§1791. Progressive Mega Jackpot Bingo

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C. Requirements Prior to Start-Up. Each location, hall, commercial lessor or noncommercial lessor that has any licensed organization(s) participating in the progressive mega bingo jackpot game shall transmit by facsimile to the division and to the respective governing authority of the parish or municipality or the certified public accountant contracted to oversee the progressive mega jackpot bingo game, if applicable, the following information and documentation prior to the start-up of a progressive mega jackpot bingo game or before any additional organizations are allowed to enter:

1. list of names and license numbers of licensed charitable organizations participating in the progressive mega jackpot bingo game and the respective gaming location's name and physical address, and the designated organization representative as provided in Paragraph 2 of Subsection I and any subsequent changes;

2. list of all members holding, operating, or conducting or assisting in holding, operating, or conducting any game or games of chance, if different from the list submitted with the most current license application, as well as an affidavit from each such member confirming membership as a bona fide active member and other related information as otherwise provided by the division;

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5. the name of the governing authority of the parish or municipality, or the certified public accountant contracted to oversee the progressive mega jackpot bingo game, if applicable;

* * *

D. Entry and Withdrawal. Each participating organization shall provide a start up fee in the amount of \$200 at the commencement of or entry into a progressive mega jackpot bingo game for deposit into a "Charitable Gaming Progressive Mega Jackpot Bingo Account." All organizations electing to participate in a progressive mega jackpot bingo game shall contribute an additional \$100 prior to the commencement of a progressive mega jackpot bingo game which shall constitute the progressive mega jackpot bingo prize for the first 24-hour period. This contribution is nonrefundable and shall also be considered part of the total amount of prizes awarded for each organization's first scheduled session of the progressive mega jackpot bingo game.

1. Each participating organization shall submit a check made payable from the organization's charitable gaming checking account to the designated hall, commercial lessor or noncommercial lessor representative in the amount of \$100 during its licensed four-hour session and prior to the commencement of the organization's first scheduled call

bingo game made payable to the "Charitable Gaming Progressive Mega Jackpot Bingo Account." This \$100 contribution is nonrefundable and shall constitute part of the progressive mega jackpot bingo prize for the following day and shall be considered part of the total amount of prizes awarded during that session. In no instance shall participating organizations be allowed to make any contributions or submit any start-up fees in the form of cash or money order.

3. The \$200 start-up fee deposit shall remain in the account until the progressive mega jackpot bingo game is discontinued by the organizations and shall be refundable upon discontinuance of the progressive mega jackpot bingo blackout game or to any single organization withdrawing, whether voluntarily or involuntarily, from the progressive mega jackpot bingo game within three calendar days of withdrawal or as otherwise provided by the division.

E. Structure of Game. The progressive mega jackpot bingo game shall be conducted in conjunction with the organization's regular blackout bingo games and the structure of such game shall be as follows:

1. A separate additional 3 on 1 up sealed vertical disposable bingo card shall be sold at \$2 per card for the play of only the progressive mega jackpot bingo game. Also, participating organizations may offer only to those patrons who purchase a 3 on 1 up sealed vertical disposable bingo card for \$2 per card a separate additional 3 on 1 up sealed vertical disposable bingo card at no (zero) value for the purchase of each such card. Such 3 on 1 up sealed vertical disposable bingo cards shall afford patrons a chance to win the progressive mega jackpot bingo game and the regular blackout bingo prize. Participating organizations shall assign a fixed value or price structure for the 3 on 1 up sealed vertical disposable bingo cards with the division in writing on forms provided by the division and receive written approval from the division prior to purchasing any such bingo cards from a licensed distributor and prior to the start up or entry into a progressive mega jackpot bingo game.

2. Only those patrons who have purchased a minimum buy-in package for the organization's regular session games shall be allowed to purchase separate 3 on 1 up sealed vertical disposable bingo cards for the progressive mega jackpot bingo game at that session. The minimum buy-in package shall not contain disposable bingo cards that entitle a patron to win the progressive mega jackpot bingo prize, but the purchase of any such package shall afford a patron the opportunity to win only the respective organization's regular blackout bingo prize.

3. Any disposable bingo card that is altered from the original manufacturer's cut, collation, or print shall be invalid.

4. No progressive mega jackpot bingo game 3 on 1 up sealed vertical disposable bingo cards shall be sold after the announcement by the caller that the progressive mega jackpot bingo game shall commence at least five minutes before the first ball is called. Such progressive mega jackpot disposable bingo cards shall:

a. be purchased by the organization on a separate invoice from a licensed distributor;

b. have an assigned fixed value or price structure for each participating organization approved by the division in writing prior to the purchase from a licensed distributor and prior to the start up or entry into any progressive mega jackpot bingo game and shall only be good for the session date stamped;

F. Amount of Prizes Awarded. A progressive mega jackpot bingo account consists of all contributions made by participating organizations excluding the \$200 start-up fee as provided in Subsection D of this Section during the progressive mega jackpot bingo game.

2. The dollar amount of any progressive mega jackpot bingo game shall not exceed the sum of \$50,000. Participating organizations may establish a maximum progressive mega jackpot or cap which does not exceed the sum of \$50,000 only upon written application to and receipt of written approval from the division. Once approved by the division, any subsequent change to the maximum jackpot or cap shall require written approval from the division. Once the maximum jackpot or cap is reached for any progressive mega jackpot bingo game, participating organizations may continue to make contributions in the amount of \$100 to the progressive mega jackpot bingo account to accumulate a second or subsequent jackpot and shall establish with the division the amount of the next maximum jackpot or cap to be offered. However, in the event that the maximum jackpot or cap is reached, organizations shall not offer any subsequent progressive mega jackpot bingo prize until such time that the first progressive mega jackpot bingo prize is won. Only one progressive mega jackpot bingo prize of participating organizations shall be awarded during any 24-hour period as provided in Subsection G of this Section. Unless otherwise provided by the division, the request for written approval as set forth herein shall be submitted on forms prescribed by the division.

H. Winner(s). A progressive mega jackpot bingo game shall be won when any player(s) achieves a blackout in 48 balls called or less only on the 3 on 1 up sealed vertical disposable bingo card and only during the 24-hour period described in Subsection G of this Section. Each face on any 3 on 1 up sealed vertical disposable bingo card shall be considered when determining the number of winners.

1. In the event that a patron achieves a blackout in 47 balls called or less on a card from a minimum buy-in package, that patron shall win only the regular blackout bingo prize of the respective organization and that regular blackout bingo game shall end. If such a blackout is achieved in 47 balls called or less, play shall resume until the forty-eighth ball is called, and once called, the progressive mega jackpot bingo game shall end. If no blackout is achieved, the game shall continue until a consolation prize is won as provided in Paragraph 5 of this Subsection.

2. In the event a patron achieves a blackout on cards from a minimum buy-in package on the same number of balls called as a patron who achieves a blackout on a 3 on 1 up sealed vertical disposable bingo card, the regular blackout

bingo prize of the respective organization shall be divided equally between all verified winners of the progressive mega jackpot bingo game at that session. The progressive mega jackpot bingo game shall be won only by a patron(s) who achieves a blackout on the 3 on 1 up sealed vertical disposable bingo card as provided in this Subsection.

3. In the event there is more than one winner of the progressive mega jackpot bingo game during the 24-hour period as provided in Subsection G of this Section, the progressive mega jackpot bingo prize shall be divided equally between all verified winners of that progressive mega jackpot bingo game. Once the progressive mega jackpot prize is won, the number of balls called to achieve a winner for the next 24-hour period shall revert to 48 balls unless otherwise provided by the division.

4. A patron who achieves a blackout on a 3 on 1 up sealed vertical disposable bingo card in fewer balls called than a patron who achieves a blackout on a 3 on 1 up sealed vertical disposable bingo card at another licensed session of a participating organization shall share the progressive mega jackpot bingo prize equally with all verified winners during the 24-hour period as provided in Subsection G of this Section.

5. If no blackout is achieved in 48 balls called or less, the organization's progressive mega jackpot bingo game shall continue until a consolation prize is won. The consolation prize shall be the respective organization's regular blackout bingo prize and shall constitute part of the total amount of prizes awarded during that called bingo session.

* * *

7. The division may, upon written request and adequate justification, issue a written approval allowing participating organizations in a progressive mega jackpot bingo game to increase the number of balls called to achieve a progressive mega jackpot bingo prize winner. In the event such request is granted by the division to increase the number of balls called to achieve a winner, the method of determining a winner as provided in this Subsection shall be modified accordingly.

I. Noninterest Bearing Account. A separate noninterest bearing checking account shall be opened by the participating organizations for the progressive mega jackpot bingo game.

* * *

2. Each location, hall, commercial lessor, or noncommercial lessor that has any licensed organization(s) participating in the progressive mega jackpot bingo game shall designate in writing and submit to the division a representative who shall make deposits and obtain bank receipts of all monies contributed and deposited into the progressive mega jackpot bingo game account before 11:30 a.m. on the next banking day.

3. Unless as otherwise provided by the division, at least two designated representatives of each participating organization shall be authorized signatories on the progressive mega jackpot bingo bank account.

4. Monthly bank statements for the progressive mega jackpot bingo game account shall be mailed directly to the division, governing authority of the parish or municipality, or the contracted certified public accountant overseeing the progressive mega jackpot bingo game, if applicable.

* * *

K. All revenues related to the progressive mega jackpot bingo game, and all checks written to and issued from the "Charitable Gaming Progressive Mega Jackpot, Bingo Account" shall be reported by each participating organization in a manner acceptable to the division.

L. Any licensed charitable organizations playing bingo within the state who participate in a progressive mega jackpot bingo game may contract a certified public accountant selected by the participating organizations and who shall be approved by the division to oversee the progressive mega jackpot bingo game and bank account in the event that the governing authority of the parish or municipality does not have a regulatory body to oversee the game.

1. The division, governing authority of the parish or municipality, or if applicable, the contracted certified public accountant approved by the division shall be responsible for, but not limited to the following:

a. reconciling bank statements monthly;

b. ensuring that each \$100 contribution for each session played has been properly deposited in a timely manner, as provided in Subsection R of this Section;

c. ensuring that all banking fees and other related costs as provided in Subsection N of this Section are recovered from the proper parties;

d. ensuring that checks written on the account are disbursed only to verified progressive mega jackpot bingo blackout prize winners, to organizations requesting refunds of the \$200 start up fee due to voluntary or involuntary withdrawal from the progressive mega jackpot bingo game as provided in Subsection D of this Section, or for those purposes as may be necessary, if approved in writing by the division;

e. immediately notifying by facsimile all organizations participating in the progressive mega jackpot bingo game that the maximum progressive mega jackpot or cap has been reached;

f. notifying by facsimile each day all participating locations, halls, commercial lessors, or noncommercial lessors of the amount of the estimated progressive mega jackpot bingo prize; and

g. notifying the division of any discrepancies, problems, violations, or deficiencies in the reporting, conduct of the game, or compliance requirements of this Part.

2. The division shall have the right to approve any contracts or agreements, and the terms or conditions thereof entered into with a certified public accountant contracted to oversee a progressive mega jackpot bingo game. The division may, at any time, revoke any such approval granted and declare any such contract void with or without cause, upon written notice to any such certified public accountant.

M. Equipment. Each location, hall, commercial lessor or noncommercial lessor that has any licensed organization(s) participating in the progressive mega jackpot bingo game shall have at least the following equipment on site and operational at all times.

1. Facsimile machine at each such location capable of transmitting to the division, the governing authority of the parish or municipality, or the certified public accountant

contracted to oversee the progressive mega jackpot bingo game, if applicable.

2. A minimum of at least one camera and one monitor at each such location that is capable of televising the first and the next ball to be called including the letter and number on the bingo balls, and the winning card(s) of the progressive mega jackpot bingo game(s) to the patrons at that session.

3. A video cassette recorder at each such location capable of monitoring and recording any winning card and all bingo balls including the letter and number on the bingo balls, as they are extracted from the bingo machine and announced to the patrons along with any hand movement of the caller during the entire progressive mega jackpot bingo game.

* * *

N. Costs. Each location, hall, commercial lessor or noncommercial lessor that has any licensed organization(s) participating in the progressive mega jackpot bingo game shall bear all costs, related to, but not limited to, the following:

1. facsimile machine installation at each such location capable of transmitting the required data and information to the division, the governing authority of the parish or municipality, or the certified public accountant contracted to oversee the progressive mega jackpot bingo game for the parish or parishes, if applicable.

2. banking fees and other related costs, accounting fees of the certified public accountant contracted to oversee all deposits, disbursements, and reporting and tax requirements of the progressive mega jackpot bingo game bank account(s), if applicable. Unless as otherwise provided by the division, these costs shall be shared by each such location proportionate to the number of sessions held at each site.

3. attorney fees as may be required for any progressive mega jackpot bingo game. Unless as otherwise provided by the division, these costs shall be shared by each such location proportionate to the number of sessions held at each site.

4. a minimum of at least one camera and one monitor at each such location that is capable of televising the first and next ball to be called, including the letter and number on the bingo balls, and the winning card(s) of the progressive mega jackpot bingo game to patrons at that session.

5. a video cassette recorder capable of monitoring and recording any winning card and all bingo balls, including the letter and number on the bingo balls, as they are extracted from the bingo machine and announced to the patrons along with any hand movement of the caller during the entire progressive mega jackpot bingo game.

* * *

O. Organization Requirements and Verification Procedures. All licensed charitable organizations participating in a progressive mega jackpot bingo game shall use the following procedures in verifying the play and winner(s) of the progressive mega jackpot bingo game.

1. Use at each of its games the required camera, monitor, and video cassette recorder at its gaming location to televise and record the following:

a. the caller announcing the information as set forth in Paragraph 5 of this Subsection;

b. all bingo balls as they are extracted from the bingo machine and announced to the patrons along with any hand movement of the caller during the entire progressive mega jackpot bingo game. Each ball, including the letter and number on the ball should be visible to the patrons prior to being extracted from the bingo machine hopper;

c. the winning card(s) of the progressive mega jackpot bingo game and to display on the monitor such card(s) to the patrons at that session.

* * *

5. The caller shall announce:

a. the organization's name, license number, session date, session time, the name of the location of the game, and record this information on the video cassette prior to calling the first ball of the progressive mega jackpot bingo game;

b. the dollar amount of the progressive mega jackpot bingo prize and the number of balls to be called for the progressive mega jackpot bingo game prior to the start of each gaming session;

c. that the progressive mega jackpot bingo game shall commence at least five minutes before the first ball is called for the progressive mega jackpot bingo game;

d. when the forty-eighth ball is called or subsequent ball is called as provided in accordance with Paragraph 7 of Subsection H and ask if there are any winners and then state that the progressive mega jackpot bingo game has ended;

e. any progressive mega jackpot bingo game winners from another organization's licensed session for the 24-hour period as provided in Subsection H of this Section prior to the first called bingo game of a session, the start of the progressive mega jackpot bingo game, and upon receipt of the facsimile as provided in Paragraph 12 of this Subsection;

f. in order to be eligible to win the progressive mega jackpot bingo game and to collect the prize, one must possess two of the four types of personal identification as provided in Subsection P of this Section;

g. each bingo ball by letter and number as it is extracted from the bingo machine and placed on the bingo board for view by all patrons during the progressive mega jackpot bingo game.

6. A person, other than the caller, working in a managerial capacity with the licensed organization conducting the progressive mega jackpot bingo game shall reduce to writing the sequence that the bingo balls are actually called for the progressive mega jackpot bingo game. Such record shall be in ink and shall become part of the session records and shall be maintained for a period of three years as required by this Part.

7. In the event that there is a progressive mega jackpot bingo game winner as provided in Subsection H of this Section, the video cassette tape shall immediately be rendered incapable of further recording, and secured by the session manager of that organization.

a. The organization shall verify that the winning progressive mega jackpot bingo card(s) compares to the actual balls called. Such verification shall be made by at least three separate persons working in a managerial capacity on behalf of the licensed organization.

b. The organization shall use at each of its games the master verification checkbook or similar verification device at its gaming location to compare to the winning card(s) of the progressive mega jackpot bingo game to ensure that such winning card(s) is a valid winner and has not been altered. Such verification shall be made by at least three separate persons working in a managerial capacity on behalf of the licensed organization.

c. The organization shall make available such cassette to the division or to the governing authority of the parish or municipality within three business days where it shall be reviewed and retained for a period of one year.

8. In the event that a licensed bingo session is not held by any participating organization, such organization shall transmit by facsimile a license modification form immediately to the division and the governing authority of the parish or municipality or the contracted certified public accountant, if applicable, stating that a licensed session was not held and the reason why the session was not held. The modification form shall be signed by the organization's member-in-charge.

9. Ensure that the contracted certified public accountant, if applicable, receives a copy of the participating organization's licensed scheduled sessions prior to beginning the progressive mega jackpot bingo game and any subsequent changes to said license. Unless as otherwise provided by the division, all proposed modifications to licensed schedules shall be submitted to the division for approval at least 72 hours in advance of any proposed change.

10. Vouchers. All organizations participating in a progressive mega jackpot bingo game shall utilize the same type of carbon copy voucher when awarding progressive mega jackpot bingo prize winners. All required information on the voucher(s) shall be accurately completed and properly signed immediately after the winning progressive mega jackpot bingo card(s) has been verified as provided by this Subsection. The voucher(s) shall contain, but shall not be limited to, the following information:

- a. organization name, license number, session date, and session starting time;
- b. printed names and signatures of at least three separate persons working in a managerial capacity on behalf of the licensed organization;
- c. name and physical address of the hall;
- d. number of winners for the session;
- e. dollar amount of the progressive mega jackpot bingo prize and the number of balls called for the winning card; and

* * *

11. Any winner(s) of the progressive mega jackpot bingo game shall be given the original voucher, and the carbon copy voucher(s) shall be retained along with the winning 3 on 1 up sealed vertical disposable bingo cards by the organization awarding the progressive mega jackpot bingo prize. The progressive mega jackpot bingo winner(s) printed name(s), signature(s), and social security number(s) shall be affixed to the back of the winning card(s) in order to be valid.

12. Any participating organization(s) which has a progressive mega jackpot bingo winner(s) at its licensed session shall immediately transmit by facsimile the completed

voucher(s), the session record as provided in Paragraph 6 of this Subsection and the winning card(s) of the progressive mega jackpot bingo game to the following:

- a. the division;
- b. governing authority of the parish or municipality, if applicable;
- c. the contracted certified public accountant approved by the division for that progressive mega jackpot bingo game, if applicable; and
- d. all locations, halls, commercial lessors and noncommercial lessors whose organizations participate in the progressive mega jackpot bingo game.

P. Payment of the Winner(s). The original voucher(s), the carbon copy voucher(s), and the original winning 3 on 1 up sealed vertical disposable bingo card(s) shall be presented to the division or the governing authority of the parish or municipality, or the contracted certified public accountant(s), if applicable, within three working days for verification. No winner(s) of the progressive mega jackpot bingo prize shall be certified and no winner shall be paid until verified by the division or the governing authority of the parish or municipality. Any winner of the progressive mega jackpot bingo game shall be paid only by check from the charitable gaming progressive mega jackpot bingo account.

1. No winner(s) of the progressive mega jackpot bingo prize shall be paid unless two of the following types of personal identification are presented by the winner(s) to the division, governing authority of the parish or municipality or the certified public accountant overseeing the progressive mega jackpot bingo account, if applicable:

- a. Social Security card;
- b. valid driver's license or other valid state issued picture identification;
- c. voter registration card; or
- d. birth certificate.

2. Failure to provide a valid Social Security card and a valid driver's license or other state issued picture identification may result in the withholding of taxes from any prize awarded. The organization that sponsored the progressive mega jackpot bingo game at which the progressive mega jackpot bingo prize was won shall submit to each respective taxing authority the taxes withheld and the appropriate forms indicating the amount of any such withholdings.

* * *

R. Each location, hall, commercial lessor, or noncommercial lessor that has any licensed organization participating in the progressive mega jackpot bingo game shall:

1. prepare a detailed deposit slip(s) for all participating organizations' contributions to the progressive mega jackpot bingo game to be deposited from the previous calendar day indicating each licensed organization's name, license number, and the amount to be deposited. Contributions shall only be accepted in the form of a check made payable from the participating organization's charitable gaming checking account made payable to the Charitable Gaming Progressive Mega Jackpot Bingo Account. Contributions in the form of cash and money orders are prohibited;

2. deposit all participating organizations' contributions to the progressive mega jackpot bingo game from the previous calendar day(s) into the progressive mega jackpot bingo account before 11:30 a.m. on the next banking day, and maintain a detailed log of such deposits;

3. transmit daily by facsimile the detailed deposit slip and proof of deposit as provided in Paragraphs 1 and 2 of this Subsection to the division, governing authority of the parish or municipality or the contracted certified public accountant overseeing the progressive mega jackpot bingo account for that game, if applicable;

4. immediately and conspicuously display at each participating progressive mega jackpot bingo game site for a period of one week after the awarding of the progressive mega jackpot bingo game prize at least the following information concerning the progressive mega jackpot bingo winner;

* * *

d. the dollar amount of the progressive mega jackpot bingo prize awarded;

* * *

10. immediately notify by facsimile the division, governing authority of the parish or municipality, or the contracted certified public accountant, if applicable, of any problems, suspected violations of any provision of this Part, deficiencies, breakdowns, discrepancies, or malfunctions with equipment or the conduct of the progressive mega jackpot bingo game;

11. transmit daily by facsimile on forms prescribed by the division, a list of all progressive mega jackpot bingo games scheduled indicating whether such games were conducted. Such forms shall be transmitted by facsimile to the division, the governing authority of the parish or municipality, or the contracted certified public accountant, if applicable, and must be transmitted prior to the end of the last session held within each respective 24-hour period.

S. The following persons shall be strictly prohibited from playing for the progressive mega jackpot bingo prize.

1. No charitable gaming employee or volunteer shall play for the progressive mega jackpot bingo prize while on duty at any gaming session where a progressive mega jackpot bingo game is being conducted. For purposes of this Section, a gaming employee or volunteer is any member of the licensed organization who participates in the holding, operating or conducting of any game or games of chance or any member of another licensed organization assisting in the holding, operating or conducting of any game or games of chance. A charitable gaming employee or volunteer working any part of a session or taking a temporary break shall be considered on duty for that gaming session.

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3. No licensed distributor owners, or its shareholders, directors, employees or agents shall play the progressive mega jackpot bingo game at any participating organization's licensed session.

4. No licensed manufacturer owners, or its shareholders, directors, employees or agents shall play the progressive mega jackpot bingo game at any participating organization's licensed session.

5. No licensed private casino contractor owners, or its shareholders, directors, employees or agents shall play the

progressive mega jackpot bingo game at any participating organization's licensed session.

6. No employee who regulates charitable games of chance for any state, parish, or municipal governing authority, shall play the progressive mega jackpot bingo game at any participating organization's licensed session.

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U. Any licensed charitable organization, commercial or noncommercial lessor, or the respective officers, agents, or employees thereof who violate any provision of this Section shall be subject to civil penalties, the suspension, restriction, or revocation of its gaming license, and a finding of unsuitability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4861.26 and R.S. 40:1485.4.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Charitable Gaming Division, LR 22:116 (February 1996), amended by the Division of Charitable Gaming Control, LR 23:

Colonel R. W. "Rut" Whittington
Superintendent

9704#012

DECLARATION OF EMERGENCY

Department of Social Services Office of Family Support

AFDC—Alien Eligibility (LAC 67:III.1141 and 1143)

The Department of Social Services, Office of Family Support has exercised the emergency provision of the Administrative Procedure Act, R.S. 49:953(B) to adopt the following Emergency Rule in the Aid to Families with Dependent Children (AFDC) Program, effective April 9, 1997. It is necessary to extend emergency rulemaking since the Emergency Rule of December 10, 1996 was effective for a maximum of 120 days and will expire before the final Rule takes effect.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, which was signed into law on August 22, 1996, mandated revision of AFDC Program policy regarding the eligibility of noncitizens effective October 1, 1996. This Emergency Rule supersedes the original Emergency Rule which was effective October 1, 1996. Clarification redefining the eligible categories of aliens was received from the Administration for Children and Families. Action has been taken to certify eligible individuals who were erroneously rejected due to misinterpretation of policy. The Emergency Rule limits eligibility for noncitizens by redefining the groups of noncitizens who may be eligible for benefits, assigning time-limits and deeming income and resources of a sponsor and sponsor's spouse. An Emergency Rule is necessary to effect these federal regulations and to avoid sanctions or penalties which could be imposed by delaying implementation.

Title 67

SOCIAL SERVICES

Part III. Office of Family Support

Subpart 2. Aid to Families with Dependent Children

Chapter 11. Application, Eligibility, and Furnishing Assistance

Subchapter B. Coverage and Conditions of Eligibility

§1141. Eligibility Requirements for Aliens

A. An alien who is not a qualified alien is not eligible. A qualified alien is:

1. an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act;
2. an alien who is granted asylum under Section 208 of such Act;
3. a refugee who is admitted to the United States under Section 207 of such Act;
4. an alien who is paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;
5. an alien whose deportation is being withheld under Section 243(h) of such Act; or
6. an alien who is granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980.

B. Time-limited Benefits. An alien who is a qualified alien as defined above who enters the United States after August 22, 1996 is ineligible for five years from the date of entry into the United States unless:

1. the alien is admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act;
2. the alien is granted asylum under Section 208 of such Act;
3. the alien's deportation is being withheld under Section 243(h) of such Act;
4. the alien is lawfully residing in the United States and is a veteran who is honorably discharged for reasons other than alienage and his spouse and unmarried dependent children;
5. the alien is lawfully residing in the United States and is on active duty (other than for training) in the Armed Forces and his spouse and unmarried dependent children.

C. When determining eligibility, income of an alien parent who is disqualified is considered available to the otherwise eligible child by applying the stepparent deeming formula. The needs and income of disqualified alien siblings are not considered in determining the eligibility of an otherwise eligible dependent child.

AUTHORITY NOTE: Promulgated in accordance with F.R. 52:48687 et seq., P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Eligibility Determinations, LR 14:280 (May 1988), LR 14:438 (July 1988), amended by the Department of Social Services, Office of Family Support, LR 23:448 (April 1997).

§1143. Income and Resources of Alien Sponsors

In determining eligibility and benefit amount for an alien, the income and resources of the alien shall be deemed to include the income and resources of the sponsor and the sponsor's spouse. A sponsor is defined as any person who executed an affidavit of support pursuant to Section 213A of the Immigration and Nationality Act on behalf of the alien.

The income and resources of the sponsor and the sponsor's spouse shall apply until the alien:

1. achieves United States citizenship through naturalization; or

2. has worked 40 qualifying SSA quarters of coverage or can be credited with such qualifying quarters, and in the case of any such qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any Federal means-tested public benefit during any such period. In determining the number of qualifying quarters of coverage an alien shall be credited with:

a. all of the qualifying quarters of coverage worked by a parent of such alien while the alien was under age 19; and

b. all of the qualifying quarters worked by a spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased.

AUTHORITY NOTE: Promulgated in accordance with P.L. 97-35, P.L. 100-485 (Section 402) and 45 CFR 205-206,233-234, P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 8:8 (January 1982), amended by the Department of Social Services, Office of Family Support, LR 23:448 (April 1997).

Madlyn B. Bagneris
Secretary

9704#068

DECLARATION OF EMERGENCY

**Department of Wildlife and Fisheries
Wildlife and Fisheries Commission**

Commercial Red Snapper Fishery Closure

In accordance with the emergency procedures of R.S. 49:953(B), the Administrative Procedure Act, R.S. 49:967, which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, and R.S. 56:317, which provides that the Secretary of the Department may declare a closed season when it is in the best interest of the state, the Secretary of the Department of Wildlife and Fisheries hereby finds that an imminent peril to the public welfare exists and accordingly adopts the following Emergency Rule:

Effective 12:01 a.m., April 4, 1997, the commercial fishery for Red Snapper in Louisiana waters will close until 12:01 a.m., September 15, 1997. Nothing herein shall preclude the legal harvest of Red Snapper by legally licensed recreational fishermen. Effective with this closure, no person shall commercially harvest, purchase, barter, trade, sell or attempt to purchase, barter, trade or sell Red Snapper. Effective with the closure, no person shall possess Red Snapper in excess of a daily bag limit. Nothing shall prohibit the possession or sale of fish legally taken prior to the closure providing that all commercial dealers possessing Red Snapper taken legally prior to the closure shall maintain appropriate records, in accordance with R.S. 56:306.4.

The Secretary has been notified by the Gulf of Mexico Fishery Management Council and the National Marine Fisheries Service that the gulfwide commercial Red Snapper quota has been reached, and the season closure is necessary to prevent overfishing of this species.

James H. Jenkins, Jr.
Secretary

9704#008

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Turkey Season Closure—1997

In accordance with the emergency provisions of R.S. 49:953(B) of the Administrative Procedure Act, and under the authority of R.S. 56:115, the Wildlife and Fisheries Commission hereby closes the following portions of the 1997 wild turkey season until further notice. The Secretary of the Department of Wildlife and Fisheries has been delegated the authority vested in the Commission by virtue of provisions of the 1996-97 Louisiana Hunting Regulations promulgated by the Commission.

A Declaration of Emergency is necessary to protect the turkey resources in these areas that are experiencing flooding conditions. The closure is in effect until further notice.

The following described areas will be closed until further notice for turkey hunting:

Turkey Hunting Area A

All of East Carroll Parish and all lands east of and including the Mississippi River Levee in Madison, Tensas, and Concordia Parishes;

The area in West Feliciana Parish known as Cat Island is closed west of the right-of-way of the abandoned L and A Railroad grade from St. Francisville north to Como Bayou, south of Como Bayou westward to the Mississippi River, east of the main channel of the Mississippi River southward to La. Hwy. 10, and west of La. Hwy. 10 from the Mississippi River

to St. Francisville; also, all of West Feliciana Parish west of the main channel of the Mississippi River including Turnbull Island;

Also closed are Raccourci Island in West Feliciana Parish and all those lands in Pointe Coupee and West Baton Rouge Parishes east of and including the Mississippi River Levee, from La. Hwy. 15 south to U.S. Hwy. 190;

Avoyelles Parish: that portion bounded on the east by the Atchafalaya River northward from Simmesport, on the north by Red River to the Brouillette Community, on the west by La. Hwy. 452 from Brouillette to La. Hwy. 1 eastward to Simmesport, EXCEPT that portion surrounding Pomme de Terre WMA, bounded on the north, east and south by La. Hwy. 451, on the west by the Big Bend Levee from its junction at the Bayou des Glaise structure east of Bordelonville southward to its junction with La. Hwy. 451.

Turkey Hunting Area C

The portions of Avoyelles, Tensas and Concordia parishes within Area C as described below:

Avoyelles Parish: that portion surrounding Pomme de Terre WMA, bounded on the north, east, and south by La. Hwy. 451, on the west by the Big Bend levee from its junction at the Bayou des Glaise structure east of Bordelonville southward to its junction with La. Hwy. 451.

Concordia Parish: north and east of Sugar Mill Chute (Concordia Parish) from the state line westward to Red River, east of Red River northward to Cocodrie Bayou, east of Cocodrie Bayou northward to U.S. Hwy. 84, south of U.S. Hwy. 84 eastward to La. Hwy. 15 (Ferriday), east of La. Hwy. 15 northward to U.S. Hwy. 65 (Clayton), east of U.S. Hwy. 65 northward to Tensas Parish line.

Tensas Parish: east and south of U.S. Hwy. 65 from Concordia Parish line to La. Hwy. 128, south of La. Hwy. 128 to St. Joseph, east and south of La. Hwys. 605, 604, and 3078 northward to Port Gibson Ferry.

The following Wildlife Management Areas shall also be closed: Dewey Wills, Little River, Red River, Three Rivers, Pomme de Terre and Grassy Lake.

James H. Jenkins, Jr.
Secretary

9704#007

Rules

RULE

Department of Economic Development Board of Architectural Examiners

License Renewal Procedure (LAC 46:I.1101)

Under the authority of R.S. 37:144 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Board of Architectural Examiners amends LAC 46:I.1101 pertaining to license renewal procedures. The board increases the renewal license registration fee and the delinquent fee charged to an architect domiciled outside Louisiana from \$100 to \$125.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part I. Architects

Chapter 11. Administration

§1101. Renewal Procedure

A. A license for individual architects shall expire and become invalid on December 31 of each year. Licenses for professional architectural corporations, architectural-engineering corporations, and limited liability companies shall expire and become invalid on June 30 of each year. An individual architect, professional architectural corporation, architectural-engineering corporation, and limited liability company who desires to continue his or its license in force shall be required annually to renew same.

B. It is the responsibility of the individual architect, professional architectural corporation, architectural-engineering corporation, and limited liability company to obtain, complete, and timely return a renewal form and fee to the board office, which forms are available upon request from said office.

C. Prior to December 1 of each year, the board shall mail to all individual architects currently licensed a renewal form. An individual architect who desires to continue his license in force shall complete said form and return same with the renewal fee prior to December 31. The license renewal fee for an individual architect domiciled in Louisiana shall be \$50; the license registration fee for an individual domiciled outside Louisiana shall be \$125. Upon payment of renewal fee, the executive director shall issue a renewal certificate.

D. Prior to June 1 of each year, the board shall mail to all professional architectural corporations, architectural-engineering corporations, and limited liability companies currently licensed a renewal form. A professional architectural corporation, an architectural-engineering corporation, and a limited liability company which desires to continue its license in force shall complete said form and return same with the renewal fee prior to June 30. The fee

shall be \$50. Upon payment of the renewal fee, the executive director shall issue a renewal license.

E. The failure to renew a license timely shall not deprive the architect of the right to renew thereafter. An individual architect domiciled in Louisiana who transmits his renewal form and fee to the board subsequent to December 31 in the year when such renewal fee first became due shall be required to pay a delinquent fee of \$50. An individual architect domiciled outside Louisiana who transmits his renewal form and fee to the board subsequent to December 31 in the year when such renewal fee first became due shall be required to pay a delinquent fee of \$125. The delinquent fee shall be in addition to the renewal fee set forth in the §1101.C.

F. The failure to renew its license in proper time shall not deprive a professional architectural corporation, an architectural-engineering corporation, or a limited liability company of the right to renew thereafter. A professional architectural corporation, an architectural-engineering corporation, or a limited liability company who transmits its renewal form and fee to the board subsequent to June 30 in the year when such renewal fee first became due shall be required to pay a delinquent fee of \$50. This delinquent fee shall be in addition to the renewal fee set forth in §1101.D.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:144.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Architectural Examiners, December 1965, amended May 1973, LR 4:334 (September 1978), LR 10:739 (October 1984), LR 10:737 (October 1984), amended by Department of Economic Development, Board of Architectural Examiners, LR 15:7332 (September 1989), LR 20:995 (September 1994), repromulgated LR 20:1259 (November 1994), amended LR 23:402 (April 1997).

Mary "Teeny" Simmons
Executive Director

9704#002

RULE

Department of Economic Development Board of Architectural Examiners

Placing of Seal or Stamp (LAC 46:I.1105)

Under the authority of R.S. 37:144 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Board of Architectural Examiners amends LAC 46:I.1105 pertaining to sealing or stamping construction document drawings and specifications. The board clarifies its existing Rule and replaces it with the following:

**Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part I. Architects

Chapter 11. Administration

§1105. Placing of Seal or Stamp

A. An architect shall affix his or her seal or stamp to all construction document drawings which were prepared by the architect or under the architect's responsible supervision. Construction document drawings prepared by a consulting electrical, mechanical, structural, or other engineer shall be sealed or stamped only by the consulting engineer.

B. An architect shall clearly identify the specification sections prepared by that architect or under that architect's responsible supervision and distinguish such sections from those prepared by consulting engineers. An architect shall affix his or her seal or stamp either to:

1. each specification section, page, or sheet prepared by or under the responsible supervision of the architect; or
2. the appropriate portion of any seals/stamp page in the specification document which identifies the specification sections prepared by the architect or under his or her responsible supervision and those sections prepared by consulting engineers. Consulting engineers shall affix their seal or stamp either to each specification section, page, or sheet prepared by that consultant, or to that portion of any seals/stamp page which identifies the specification sections prepared by that consultant.

C. If a public or governmental agency requires further certification by the architect (such as that the title or index page of the specifications be certified by the architect), the architect's further certification shall include a description of exactly what drawings and what portions or sections of the specifications were prepared by or under the architect's responsible supervision, and what drawings and what portions or sections of the specifications were prepared by others. In addition, the architect shall include a certification from any consulting engineers as to what drawings and what portions or sections of the specifications were prepared by or under the responsible supervision of the consulting engineers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:145-146.

HISTORICAL NOTE: Adopted by the Department of Commerce, Board of Architectural Examiners, December 1965, amended May 1973, amended and promulgated LR 4:334 (September 1978), repromulgated LR 10:739 (October 1984), amended by the Department of Economic Development, Board of Architectural Examiners, LR 20:534 (May 1994), LR 23:403 (April 1997).

Mary "Teeny" Simmons
Executive Director

RULE

Board of Elementary and Secondary Education

Bulletin 741—Class Size Waivers

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education amends Bulletin 741, Policy 1.00.40.c as stated below:

1.00.40.c Administrative Waivers of Bulletin 741 Standards

1. Waivers for Class Size/Ratios. Waivers granted by the state department in the following categories will be considered only when the citation would place the school in an approved probational category.

a. Class Size Waivers. The department may waive class size requirements up to two students over the maximum allowable on receipt of the following:

- i. a letter from the local superintendent detailing each class that exceeds the class size;
- ii. documentation from the principal and the superintendent showing how efforts have been made to comply with standards; and
- iii. a copy of the school's master schedule with class sizes included;
- iv. class sizes above the limit of two will go directly to the appropriate board committee with an executive recommendation from the department.

b. Guidance/Librarian Ratios. The department may waive the required guidance and librarian ratios on receipt of the following:

- i. a letter of justification from the local superintendent;
- ii. a list of all administrative personnel in the school (part-time and full-time); and
- iii. a detailed plan stating how the services will be provided to students.

2. Waivers for Deadlines

Electives and Alternative School Programs. A letter must be provided by the local superintendent specifying the reasons the deadline was not met.

3. Chronological Age Waivers. The Department of Education may waive chronological age requirements based on the following:

a. A request from the parish or system superintendent for deviation of the standard on the required form provided by the Office of Special Educational Services.

b. A letter from the parish or system supervisor/director of special education stating a rationale for the deviation and assuring that parents have been made aware through documented notification procedures of the deviation from standard.

c. Technical assistance will be provided by the regional coordinator and a recommendation on the request will be made to the Office of Special Educational Services.

d. The OSES will notify the city or parish systems or schools of the recommendation.

e. If denied, the city or parish systems may ask for a waiver from the Board of Elementary and Secondary Education.

Implementation to begin with the 1990-91 school year.

4. Waivers for Time Requirements

a. A letter of request must be provided by the local school superintendent or nonpublic school principal.

b. A proposal for implementation must be submitted to the department.

5. Waivers for Integrated Curricula

a. A letter of request must be provided by the local school superintendent or nonpublic school principal.

b. Documentation must be provided to assure that appropriate course content is addressed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6.

HISTORICAL NOTE: Amended by the Board of Elementary and Secondary Education, LR 23:403 (April 1997).

Weegie Peabody
Executive Director

9704#058

RULE

Board of Elementary and Secondary Education

Bulletin 741—GED Minimum Score

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education amended Bulletin 741, Standard 1.124.05, referenced in the *Louisiana Administrative Code*, Title 28, Section 953.E.5. Standard 1.124.05 in Bulletin 741 is revised as follows:

1.124.05 To successfully complete the General Educational Development (GED) test, a student must earn a minimum standard score of 40 on each of the five tests and an average standard score of 45 on the test battery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6.

HISTORICAL NOTE: Amended by the Board of Elementary and Secondary Education, LR 23:404 (April 1997).

Weegie Peabody
Executive Director

9704#059

RULE

Board of Elementary and Secondary Education

Finance and Property—Nonpublic Sector (LAC 28:I.1713)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of

Elementary and Secondary Education amended LAC 28:I.1713.B.4 as follows:

**Title 28
EDUCATION**

**Part I. Board of Elementary and Secondary Education
Chapter 17. Finance and Property
§1713. Nonpublic Sector**

* * *

B. Required Services Act: Guidelines

1. - 3. ...

4. Parameters for reporting by function and personnel type are included on the form. The parameters are an estimate of the amount of time that may be dedicated to the preparation of the forms and provisions of the services required. The number of hours actually recorded may vary from school to school. If the parameters are exceeded, additional auditing may be required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6.

HISTORICAL NOTE: Amended by the Board of Elementary and Secondary Education, LR 23:404 (April 1997).

Weegie Peabody
Executive Director

9704#061

RULE

**Department of Environmental Quality
Office of Air Quality and Radiation Protection
Air Quality Division**

**Permit Applications and Submittal of
Information (LAC 33:III.517)(AQ147)**

Under the authority of the Louisiana Environmental Quality Act, R. S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Air Quality Division Regulations, LAC 33:III.517 (AQ147).

The Rule revises LAC 33:III.517.B.3 to allow the Department of Environmental Quality's Small Business Assistance Program (SBAP) staff to prepare and certify permit applications for exemptions, small source permits, and general permits. Previous language required that only persons properly qualified to perform engineering work as provided in the Louisiana Professional Engineers and Land Surveyors Registration Act were authorized to perform this activity. The average cost to hire consultants to prepare exemptions, small source permits, or general permits is generally cost prohibitive for small businesses. This Rule allows DEQ to prepare permit applications for small businesses who do not have financial resources for outside consultants. This Section is in keeping with Section 507 of the 1990 Clean Air Act Amendments, which requires that SBAPs assist small business stationary sources in receiving permits.

This Rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 49:953(G)(3), therefore, no report regarding

environmental/health benefits and social/economic costs is required.

**Title 33
ENVIRONMENTAL QUALITY**

Part III. Air

Chapter 5. Permit Procedures

§517. Permit Applications and Submittal of Information

* * *

[See Prior Text in A-B.2.d]

3. Any permit application for a major source, including Part 70 applications, shall be prepared by or under the supervision of a person properly qualified to perform engineering work as provided in the Louisiana Professional Engineers and Land Surveyors Registration Act. The application shall be certified by a professional engineer, as defined in the above named act, or by a responsible person authorized to act on behalf of the professional engineer. All other permit applications shall be certified by a responsible facility official or his/her designee.

* * *

[See Prior Text in C-G]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 19:1420 (November 1993), amended LR 20:1375 (December 1994), amended by the Office of the Secretary, LR 22:344 (May 1996), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 23:405 (April 1997).

Gus Von Bodungen
Assistant Secretary

9704#075

RULE

**Department of Health and Hospitals
Board of Medical Examiners**

**Clinical Exercise Physiologists;
Licensing (LAC 46:XLV.3701-3767)**

In accordance with R.S. 49:950 et seq., the State Board of Medical Examiners (board), pursuant to the authority vested in the board by the Louisiana Clinical Exercise Physiologists Licensing Act, R.S. 37:3421-3433, the Louisiana Medical Practice Act, R.S. 37:1270(B)(6), and the provisions of the Administrative Procedure Act, hereby adopts LAC 46:XLV.3701-3767 to govern the licensing of clinical exercise physiologists to engage in the practice of clinical exercise physiology in the state of Louisiana. The Rules are set forth below.

**Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part XLV. Medical Profession

Subpart 2. Licensure and Certification

Chapter 37. Clinical Exercise Physiologists

Subchapter A. General Provisions

§3701. Scope of Chapter

The Rules of this Chapter govern the licensing of clinical exercise physiologists to engage in the practice of clinical exercise physiology in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:405 (April 1997).

§3703. Definitions

As used in this Chapter, the following terms shall have the meaning specified:

Act—the Louisiana Clinical Exercise Physiologists Licensing Act, R.S. 37:3421-3433, as hereafter amended or supplemented.

Applicant—a person who has applied to the board for a license to engage in the practice of clinical exercise physiology in the state of Louisiana.

Application—a written request directed to and received by the board upon forms supplied by the board, for a license to practice clinical exercise physiology in the state of Louisiana, together with all information, certificates, documents and other materials required by the board to be submitted with such forms.

Board—the Louisiana State Board of Medical Examiners.

Clinical Exercise Physiologist—a person who, under the direction, approval, and supervision of a licensed physician, engages in the practice of exercise physiology.

Exercise Physiology—the formulation, development, and implementation of exercise protocols and programs, administration of graded exercise tests, and providing education regarding such exercise programs and tests, in a cardiopulmonary rehabilitation program to individuals with deficiencies of the cardiovascular system, diabetes, lipid disorders, hypertension, cancer, chronic obstructive pulmonary disease, arthritis, renal disease, organ transplant, peripheral vascular disease, and obesity.

Exercise Protocols and Programs—the intensity, duration, frequency and mode of activity to improve the cardiovascular system.

Good Moral Character—as applied to an applicant, means that an applicant has not, prior to or during the pendency of an application to the board, been guilty of any act, omission, condition or circumstance which would provide legal cause under R.S. 37:3429 for the suspension or revocation of exercise physiology licensure; the applicant has not, prior to or in connection with his application, made any representation to the board, knowingly or unknowingly, which is in fact false or misleading as to material fact or omits to state any fact or matter that is material to the application; and the applicant has not made any representation or failed to

make a representation or engaged in any act or omission which is false, deceptive, fraudulent or misleading in achieving or obtaining any of the qualifications for a license required by this Chapter.

License—the lawful authority to engage in the practice of clinical exercise physiology in the state of Louisiana, as evidenced by a certificate duly issued by and under the official seal of the board;

Licensed Physician—a person who is licensed by the board to practice medicine in the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:405 (April 1997).

Subchapter B. Qualifications for License

§3705. Scope of Chapter

The Rules of the Subchapter govern the licensing of clinical exercise physiologists who, in order to practice clinical exercise physiology or hold themselves out as a clinical exercise physiologist, or as being able to practice clinical exercise physiology or to render clinical exercise physiology services in the state of Louisiana must meet all of the criteria set forth in this Subchapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:406 (April 1997).

§3707. Qualification for License

A. To be eligible for a license, an applicant shall:

1. be at least 21 years of age;
2. be of good moral character as defined by §3303 of this Chapter;
3. be a citizen of the United States or possess a valid and current legal authority to reside and work in the United States, duly issued by the commissioner of Immigration and Naturalization of the United States under and pursuant to the Immigration and Nationality Act (66 Stat. 163) and the Commissioner's regulations thereunder (8 CFR);
4. have successfully completed a Masters of Science degree or a Master of Education degree in an exercise studies curriculum at an accredited school, which school at the time of the applicant's graduation, was approved by the American College of Sports Medicine or the board;
5. be certified by as an exercise specialist by the American College of Sports Medicine (ACSM), having taken and successfully passed the ACSM certifying examination, as administered by ACSM or by the board pursuant to Subchapter D of these Rules; and
6. have successfully completed an internship of 300 hours in exercise physiology under the supervision of a licensed exercise physiologist.

B. The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by, and to the satisfaction of, the board.

C. In addition to the substantive qualifications specified in Subsection A to be eligible for a license, an applicant shall satisfy the procedures and requirements for application

provided in §§3711–3715 of Subchapter C of this Chapter and the procedures and requirements for examination provided by §§3717–3337 of Subchapter D of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:406 (April 1997).

§3709. Exemptions from Licensure

The following persons and their activities are exempt from the licensing requirements of this Chapter:

1. any person employed or supervised by a licensed physician whose primary duty it is to provide graded exercise testing within the confines of the physician's office. The supervisor shall not represent himself to the public as a licensed clinical exercise physiologist;

2. any student in an accredited educational institution, while carrying out activities that are part of the prescribed course of study, provided such activities are supervised by a licensed clinical exercise physiologist. Such student shall hold himself out to the public only by clearly indicating his student status and the profession in which he is being trained;

3. any person employed as a clinical exercise physiologist by any federal or state agency provided such person's activities constitute part of the duties for which they are employed or solely within the confines or under the jurisdiction of the organization by which they are employed; and

4. any natural person licensed as a health care provider under any other law while acting within the scope of such licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:406 (April 1997).

Subchapter C. Application

§3711. Purpose and Scope

The Rules of this Subchapter govern the procedures and requirements applicable to application to the board for licensing as a clinical exercise physiologist in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:406 (April 1997).

§3713. Application Procedure

A. Application for licensing shall be made upon forms supplied by the board.

B. If application is made for licensing on the basis of examination to be administered by the board an initial application must be received by the board not less than 90 days prior to the scheduled date of the examination for which the applicant desires to sit. A completed application must be received by the board not less than 60 days prior to the scheduled date of such examination.

C. Application forms and instructions pertaining thereto may be obtained upon written request directed to the office of the board. Application forms will be mailed by the board within 30 days of the board's receipt of request, therefore, to

ensure timely filing and completion of application, forms must be requested not later than 40 days prior to the deadlines for initial applications specified in the preceding Subsection.

D. An application for licensing under this Chapter shall include:

1. proof, documented in a form satisfactory to the board as specified by the secretary, that the applicant possesses the qualifications set forth in the Chapter;

2. three recent photographs of the applicant; and

3. such other information and documentation as the board may require to evidence qualification for licensing.

E. All documents required to be presented to the board or its designee must be the original thereof. For good cause shown, the board may waive or modify this requirement.

F. The board may refuse to consider any application which is not complete in every detail, including submission of every document required by the application form. The board may, in its discretion require a more detailed or complete response to any request for information set forth in the application form as a condition to consideration of application.

G. Each application submitted to the board shall be accompanied by a nonrefundable application and license fee in the amount of \$75.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:406 (April 1997).

§3715. Effect of Application

A. The submission of an application for licensing to the board shall constitute and operate as an authorization by the applicant to each educational institution at which the applicant has matriculated, each state or federal agency to which the applicant has applied for any license, permit, certificate or registration, each person, firm, corporation, clinic, office or institution by whom or with whom the applicant has been employed in the practice of clinical exercise physiology or exercise physiology, each physician or other health care practitioner whom the applicant has consulted or seen for diagnosis or treatment and each professional organization to which the applicant has applied for membership, to disclose and release to the board any and all information and documentation concerning the applicant which the board deems material to consideration of the application. With respect to any such information or documentation, the submission of an application for licensing to the board shall equally constitute and operate as a consent by the applicant to disclosure and release of such information and documentation and as a waiver by the applicant of any privilege or right of confidentiality which the applicant would otherwise possess with respect thereto.

B. By submission of an application for licensing to the board, an applicant shall be deemed to have given his consent to submit to physical or mental examinations if, when, and in the manner so directed by the board and to waive all objections as to admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privilege provided by law. The expense of any such examination shall be borne by the applicant.

C. The submission of an application for licensing to the board shall constitute and operate as an authorization and consent by the applicant to the board to disclose and release any information or documentation set forth in or submitted with the applicant's application or obtained by the board from other persons, firms, corporations, associations or governmental entities pursuant to Subsections A or B of this Section to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:407 (April 1997).

Subchapter D. Examination

§3717. Purpose and Scope

For purposes of licensure, the board shall use the examination administered by and under contract with the American College of Sports Medicine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:407 (April 1997).

§3719. Eligibility for Examination

To be eligible for examination an applicant for licensure must make application to the American College of Sports Medicine or its designated contract testing agency in accordance with procedures and requirements of the American College of Sports Medicine. Information on the examination process, including fee schedules and application deadlines, must be obtained by each applicant from the American College of Sports Medicine. Application for licensure under §3713 does not constitute application for examination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:407 (April 1997).

§3721. Dates, Places of Examination

The American College of Sports Medicine certification examination for clinical exercise physiologists is given annually (examination dates are subject to change by the American College of Sports Medicine). In Louisiana, examination centers are located in New Orleans and Monroe.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:407 (April 1997).

§3723. Observance of Examination

A. The American College of Sports Medicine Examination may be observed by a representative appointed by the board. The representative is authorized and directed by the board to obtain positive photographic identification from all applicants for licensure appearing and properly registered for the examination and to observe that all applicants for licensure abide by the Rules of Conduct established by the American College of Sports Medicine.

B. An applicant for licensure who appears for examination shall:

1. present to the board's representative proof of registration for the examination and positive personal photographic and other identification in the form prescribed by the board; and

2. fully and promptly comply with any and all rules, procedures, instructions, directions or requests made or prescribed by the American College of Sports Medicine or its contract testing agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:407 (April 1997).

§3725. Subversion of Examination Process

A. An applicant-examinee who engages or attempts to engage in conduct which subverts or undermines the integrity of the examination process shall be subject to the sanctions specified in §3729 of this Subchapter.

B. Conduct which subverts or undermines the integrity of the examination shall be deemed to include:

1. refusing or failing to fully and promptly comply with any rules, procedures, instructions, directions or requests made by the American College of Sports Medicine or its contract testing agency, or the board's representative;

2. removing from the examination room or rooms any of the examination materials;

3. reproducing or reconstruction by copying, duplication, written notes or electronic recording, any portion of the licensing examination;

4. selling, distributing, buying, receiving, obtaining or having unauthorized possession of a future, current, or previously administered licensing examination;

5. communicating in any manner with any other examinee or any person during the administration of the examination;

6. copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the examination;

7. having in one's possession during administration of the examination any materials or objects other than the examination materials distributed, including, without limitation, any books, notes, recording devices, or other written, printed or recorded materials or data of any kind;

8. impersonating an examinee by appearing for and as an applicant and taking the examination for and in the name of the applicant other than himself;

9. permitting another person to appear for and take the examination on one's behalf and one's name; or

10. engaging in any conduct which disrupts the examination or the taking thereof by other examinees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:408 (April 1997).

§3727. Finding of Subversion

A. When, during the administration of the examination the board's representative has reasonable cause to believe that an applicant-examinee is engaging or attempting to engage, or has engaged, or attempted to engage, in conduct which

subverts or undermines the integrity of the examination process, the board's representative shall take such action as he deems necessary or appropriate to terminate such conduct and shall report such conduct in writing to the board and the American College of Sports Medicine.

B. In the event of suspected conduct as described in above §3725.B.5 or 6, the subject applicant-examinee shall be permitted to complete the examination, but shall be removed at the earliest practical opportunity to a location precluding such conduct.

C. When the board, upon information provided by the board's representative, the American College of Sports Medicine or its contract testing agency, an applicant-examinee or any person has probable cause to believe that an applicant has engaged or attempted to engage in conduct which subverts or undermines the integrity of the examination process, the board shall so advise the applicant in writing, setting forth the grounds for its findings of probable cause specifying the sanctions which are mandated or permitted by such conduct by §3729 of this Subchapter and provide the applicant with an opportunity for hearing pursuant to R.S. 49:955-58 and applicable Rules of the board governing administrative hearings. Unless waived by the applicant, the board's findings of fact, conclusions of law under these Rules and its decisions as to sanctions, if any, to be imposed shall be made in writing and served upon the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:408 (April 1997).

§3729. Sanctions for Subversion of Examination

A. An applicant who is found by the board, prior to the administration of the examination, to have engaged in conduct or to have attempted to engage in conduct which subverts or undermines the integrity of the examination process may be permanently disqualified from taking the examination and from licensure in the state of Louisiana.

B. An applicant-examinee who is found by the board to have engaged or to have attempted to engage in conduct which subverts or undermines the integrity of the examination process shall be deemed to have failed the examination. Such failure shall be recorded in the official records of the board.

C. In addition to the sanctions permitted or mandated by Subsections A and B of this Section, as to an applicant-examinee found by the board to have engaged or to have attempted to engage in conduct which subverts or undermines the integrity of the examining process, the board may:

1. revoke, suspend or impose probationary conditions on any license issued to such applicant;

2. disqualify the applicant, permanently or for a specified period of time, from eligibility for licensure in the state of Louisiana; or

3. disqualify the applicant, permanently or for a specified number of subsequent administrations of the examination, from eligibility for examination for purposes of licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:408 (April 1997).

§3731. Passing Score

The board shall use the criteria for satisfactory performance of the examination adopted by the American College of Sports Medicine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

§3733. Reporting of Examination Score

Applicants for licensure shall request the American College of Sports Medicine to notify the board of the applicant's scores upon each taking of the examination according to the procedures for such notification established by the American College of Sports Medicine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

§3735. Restriction, Limitation on Examinations

With respect to any written examination the successful passage of which is a condition to any license or permit issued under the Chapter, an applicant having failed to obtain a passing score upon taking any such examination four or more times shall not thereafter be considered eligible for licensing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

§3737. Lost, Stolen, or Destroyed Examination

The submission of an application for examination by the board shall constitute and operate as an acknowledgment and agreement by the applicant that the liability of the board, its members, committees, employees and agents, and the state of Louisiana to the applicant for the loss, theft or destruction of all or any portion of an examination taken by the applicant, prior to the reporting of scores, thereon by the board shall be limited exclusively to the refund of the fees paid for examination by the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

Subchapter E. Licensure Issuance, Expiration, Renewal, Termination

§3739. Issuance of License

A. If the qualifications, requirements and procedures prescribed or incorporated by §§3705-3715 are met to the satisfaction of the board, the board shall issue to the applicant a license to engage in the practice of exercise physiology in the state of Louisiana.

B. A license issued by the board on the basis of examination by the board shall be issued by the board within 30 days following the reporting of the applicant's licensing examination scores to the board. A license issued under any

other Section of this Chapter to an applicant not required to be examined by the board shall be issued by the board within 15 days following the meeting of the board next following the date on which the applicant's application, evidencing all requisite qualifications, is completed in every respect.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

§3741. Expiration of License

A. Every license issued by the board under this Chapter, the expiration date of which is not stated thereon or provided by these Rules, shall expire, and thereby become null, void and to no effect, on the last day of the year in which such license was issued.

B. The timely submission of an application for renewal of license shall operate to continue the expiring license in full force and effect pending the board's issuance or denial of issuance, of the renewal license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

§3743. Renewal of License

A. Every license issued by the board under this Chapter shall be renewed annually on or before its date of expiration by submitting to the board an application for renewal, upon forms supplied by the board, together with a renewal fee in the amount of \$25 and documentation of satisfaction of the continuing professional education requirements prescribed by Subchapter G of these Rules.

B. An application for renewal of license shall be mailed by the board to each person holding a license on or before the first day of December of each year. Such form shall be mailed to the most recent address of each licensee as reflected in the official records of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

§3745. Reinstatement of License

A. A license which is expired without renewal may be reinstated by the board subject to the conditions and procedures hereinafter provided.

B. An application for reinstatement shall be made upon forms supplied by the board and accompanied by two letters of recommendation, one from a reputable physician and one from a reputable clinical exercise physiologist of the former licensee's last professional location, together with applicable renewal fee, plus a penalty equal to the renewal fee.

C. With respect to an application for reinstatement made more than one year after the date on which the license expired, as a condition of reinstatement, the board may require that the applicant complete a statistical affidavit upon a form provided by the board, provide the board with a recent photograph, and evidence satisfaction of the requirements of Subchapter G with respect to continuing professional education.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:409 (April 1997).

Subchapter F. Advisory Committee on Clinical Exercise Physiology

§3747. Organization; Authority and Responsibilities

A. The Advisory Committee on Clinical Exercise Physiology (the "committee"), as established, appointed and organized pursuant to R.S. 37:3427 of the Act is hereby recognized by the board.

B. The committee shall:

1. have such authority as is accorded it by the Act;
2. function as prescribed by the Act;
3. advise the board on issues affecting the licensing of clinical exercise physiologists and on the regulation of clinical exercise physiology in the state of Louisiana; and
4. perform such other functions and provide such additional advice and recommendations as may be requested by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:410 (April 1997).

§3749. Delegated Duties and Responsibilities

A. The Advisory Committee is authorized by the board to:

1. advise and assist the board in the ongoing evaluation of the clinical exercise physiology licensing examination required by the board;
2. provide advice and recommendations to the board respecting the modification, amendment and supplementation of rules and regulations, standards, policies and procedures respecting clinical exercise physiology licensure and practice;
3. serve as a liaison between and among the board, licensed clinical exercise physiologists and exercise physiology professional associations;
4. receive reimbursement for attendance at board meetings and for other expenses when specifically authorized by the board;
5. evaluate organizations and entities providing or offering to provide continuing professional education programs for clinical exercise physiologists and provide recommendations to the board with respect to the board's recognition and approval of such organizations and entities as sponsors of qualifying continuing professional education programs and activities pursuant to §3759 of these Rules;
6. review documentation of continuing professional education by clinical exercise physiologists, verify the accuracy of such documentation, and evaluation of and make recommendations to the board with respect to whether programs and activities evidenced by applicants for renewal of licensure comply with and satisfy the standards for such programs and activities prescribed by these Rules; and
7. request and obtain from applicants for renewal of licensure such additional information as the Advisory Committee may deem necessary or appropriate to enable it to make the evaluations and provide the recommendations for which the committee is responsible.

B. In discharging the functions authorized under this Section, the committee and the individual members thereof shall, when acting within the scope of such authority, be deemed agents of the board. Advisory Committee members are prohibited from communicating, disclosing or in any way releasing to anyone other than the board, any information or documents obtained when acting as the agents of the board without first obtaining written authorization of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:410 (April 1997).

Subchapter G. Continuing Professional Education

§3751. Scope of Subchapter

The Rules of this Subchapter provide standards for the continuing professional education requisite to the annual renewal of licensure as a clinical exercise physiologist, and prescribe the procedures applicable to satisfaction and documentation of continuing professional education in connection with application for renewal of licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:410 (April 1997).

§3753. Requirements

A. To be eligible for renewal of licensure for 1998 and thereafter, a clinical exercise physiologist shall, within each year during which he holds licensure, evidence and document, upon forms supplied by the board, successful completion of not less than 10 contact hours, 1.0 Continuing Education Units (CEUs).

B. One Continuing Education Unit (CEU) constitutes and is equivalent to 10 hours of participation in an organized continuing professional education program approved by the board and meeting the standards prescribed in this Subchapter. One continuing professional education hour is equal to 0.1 of a CEU. Ten hours, or 1.0 CEUs, are required to meet the standards prescribed by this Subchapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:410 (April 1997).

§3755. Qualifying Continuing Professional Education Programs

A. To be acceptable as qualified continuing professional education under these Rules a program shall:

1. have significant and substantial intellectual or practical content dealing principally with matters germane and relevant to the practice of clinical exercise physiology;
2. have pre-established written goals and objectives, with its primary objective being to maintain the participant's competence in the practice of clinical exercise physiology;
3. be presented by persons whose knowledge and/or professional experience is appropriate and sufficient to the subject matter of the presentation;
4. provide a system or method for verification of attendance or course completion; and
5. be a minimum of one continuous hour in length.

B. None of the following programs, seminars, or activities shall be deemed to qualify as acceptable Continuing Professional Education Programs under these Rules:

1. any program not meeting the standards prescribed above;
2. independent study not approved or sponsored by the Louisiana Association of Exercise Physiologists;
3. any program, presentation, seminar or course of instruction not providing the participant an opportunity to ask questions or seek clarification of specific matters presented;
4. teaching, training or supervisory activities;
5. holding office in professional or governmental organizations, agencies or committees;
6. participation in case conferences, informal presentations, or in-service activities;
7. giving or authorizing verbal or written presentations, seminars, articles, or grant applications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:410 (April 1997).

§3757. Approval of Program Sponsors

A. Any program, course, seminar, workshop or other activity meeting the standards prescribed by §3755 sponsored, offered or approved by the American College of Sports Medicine or by the Louisiana Association of Exercise Physiologists shall be presumptively approved by the board for purposes of qualifying as an approved continuing education program under these Rules.

B. Upon the recommendation of the Advisory Committee, the board may designate additional organizations and entities whose programs, courses, seminars, workshops or other activities shall be deemed approved by the board for purposes of qualifying as an approved continuing professional education program under this proposal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:411 (April 1997).

§3759. Approval of Programs

A. A continuing professional education program sponsored by an organization or entity not deemed approved by the board pursuant to the information above may be pre-approved by the board as a program qualifying and acceptable for satisfying continuing professional education requirements under this Subchapter upon written request to the board therefor, upon a form supplied by the board, providing a complete description of the nature, location, date, content and purpose of such program and such other information as the board or the Advisory Committee may request to establish the compliance of such program with the standards prescribed by §3755. Any such request for pre-approval respecting a program which makes and collects a charge for attendance shall be accompanied by a nonrefundable processing fee of \$30.

B. Any such written request shall be referred by the board to the Advisory Committee for its recommendation. If the Advisory Committee's recommendation is against approval,

the board shall give notice of such recommendation to the person or organization requesting approval and such person or organization may appeal the Advisory Committee's recommendation to the board by written request delivered to the board within 10 days of such notice. The board's decision with respect to approval of any such activity shall be final. Persons and organizations requesting pre-approval of continuing professional education programs should allow not less than 60 days for such requests to be processed

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:411 (April 1997).

§3761. Documentation Procedure

A. A form for annual documentation and certification of satisfaction of the continuing professional education requirements prescribed by these Rules shall be mailed by the board to each clinical exercise physiologist subject to such requirements with the application for renewal of licensure form mailed by the board. Such form shall be completed and delivered to the board with the licensee's renewal application.

B. Any certification of continuing professional education not presumptively approved by the board pursuant to these Rules, or pre-approved by the board in writing, shall be referred to the Advisory Committee for its evaluation and recommendations. If the Advisory Committee determines that a program or activity certified by an applicant for renewal in satisfaction of continuing professional education requirements does not qualify for recognition by the board or does not qualify for the number of CEUs claimed by the applicant, the board shall give notice of such determination to the applicant for renewal and the applicant may appeal the Advisory Committee's recommendation to the board by written request delivered to the board within 10 days of such notice. The board's decision with respect to approval and recognition of any such program or activity shall be final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3421-3433 and R.S. 37:1270(A)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:411 (April 1997).

§3763. Failure to Satisfy Continuing Professional Education Requirements

A. An applicant for renewal of licensure who fails to evidence satisfaction of the continuing professional education requirements prescribed by these Rules shall be given written notice of such failure by the board. The license of the applicant shall remain in full force and effect for a period of 60 days following the mailing of such notice, following which it shall be deemed expired, unrenewed and subject to revocation without further notice, unless the applicant shall have, within such 60 days furnished the board satisfactory evidence, by affidavit, that:

1. the applicant has satisfied the applicable continuing professional education requirements;
2. the applicant is exempt from such requirements pursuant to these Rules; or
3. the applicant's failure to satisfy the continuing professional education requirements was occasioned by

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in Section 8B of this Regulation.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible as defined in Section 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (3) and (8), respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Sections 8C(1), (2), (8) and (10), respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Sections 8C(1), (2), (8) and (9), respectively.

(6) Standardized Medical supplement benefit plan "F" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, the Part B Deductible, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (3), (5) and (8), respectively.

(7) Standardized Medicare supplement benefit plan "G" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefits as defined in Sections 8C(1), (2), (4), (8) and (10), respectively.

(8) Standardized Medicare supplement benefit plan "H" shall consist of only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (6) and (8), respectively.

(9) Standardized Medicare supplement benefit plan "I" shall consist of only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10), respectively.

(10) Standardized Medicare supplement benefit plan "J" shall consist of only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10), respectively.

Section 10. Medicare Select Policies and Certificates

A.(1) This Section shall apply to Medicare Select policies and certificates, as defined in this Section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.

B. For the purposes of this Section:

(1) *Complaint*—any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) *Grievance*—dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) *Medicare Select Issuer*—an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) *Medicare Select Policy* or *Select Certificate*—mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) *Network Provider*—a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) *Restricted Network Provision*—any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) *Service Area*—the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this Regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall

reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(b) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals;

(c) there are written agreements with network providers describing specific responsibilities;

(d) emergency care is available 24 hours per day and seven days per week;

(e) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This Paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) a statement or map providing a clear description of the service area.

(3) a description of the grievance procedure to be utilized.

(4) a description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) a list and description, by specialty, of the network providers.

(6) copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) any other information requested by the Commissioner.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing such changes. Such changes shall be considered approved by the Commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the Commissioner at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) it is not reasonable to obtain such services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates.

(2) a description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer;

(7) a description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include mediation procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare

RULE

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Medicaid Application Centers

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing renames the Medicaid Enrollment Center Program as the Medicaid Application Center Program. Reimbursement for applications taken by Medicaid Application Centers is available only under the following conditions:

1. the application is complete;
2. the application is sent to the appropriate Regional/ Parish Medicaid office; and
3. the application is forwarded within established time frames as set forth in the *Application Center Handbook*.

Bobby P. Jindal
Secretary

9704#049

RULE

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Outpatient Hospital Program Laboratory Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reimburses hospitals for outpatient laboratory services as described below:

A uniform reimbursement methodology for all laboratory services subject to the Medicare fee schedule is established regardless of the setting in which the services are performed. The reimbursement rate for outpatient hospital laboratory services subject to the Medicare fee schedule are reimbursed at the same reimbursement rate for laboratory services provided in a nonhospital setting.

Bobby P. Jindal
Secretary

9704#047

RULE

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Medically Needy Program

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing terminates coverage for all individuals certified for the Medically Needy Program including those individuals with an approved period of coverage which extends beyond June 30, 1996.

Bobby P. Jindal
Secretary

9704#052

RULE

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Professional Services Program—Physicians Services

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Bureau of Health Services Financing adopts the following Regulations governing the provision of physician services under the Professional Services Program.

1. Anesthesia Services

A. Anesthesia services are reimbursed for the day of surgery or delivery.

B. CPT procedure code 00098 must be used when a period of several hours lapses between a delivery and the performance of a tubal ligation and the re-injection of the epidural catheter is required.

2. Surgery Services

A. Each CPT surgical procedure code shall be assigned to one of the global surgery periods.

B. Three different global surgery periods will be utilized. One period shall consist of 0 days defined as the day before and the day of surgery only; the second period shall consist of 10 days defined as the day before and the day of surgery and 10 post-operative days; and the third period shall consist of 90 days defined as the day before and the day of surgery and 90 post-operative days.

C. No outpatient or inpatient visits during the global surgery period will be reimbursed unless the diagnosis code for the visit is different from that of the diagnosis code necessitating the surgery.

3. Bilateral Medical and Surgical Procedure Reductions. Reimbursement shall be made at 150 percent of the fee on the Physician's Formulary File for the following CPT procedure codes.

30903	31276	49505	69420	31254
49495	49507	69421	31255	49496
49520	69424	31256	49500	49521
69433	31267	49501	49525	69436

4. Other Reimbursement Reductions

CPT Code	Description	New Fee
36415	Routine finger stick to collect specimen	\$ 2.65
99211	Outpatient visit, established patient (may not require physician's presence)	\$ 9.24
99212	Outpatient visit, established patient straightforward medical decision making	\$18.91
99233	Subsequent hospital care, medical decision making of high complexity	\$42.60

Bobby P. Jindal
Secretary

9704#051

RULE

**Department of Insurance
Office of the Commissioner**

Regulation 32—Group Coordination of Benefits

Under the authority of R.S. 22:3.2014 and the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Insurance gives notice that the following regulation is adopted and becomes effective January 1, 1998. This action complies with the statutory law administered by the Department of Insurance.

Existing Regulation 32 of the Department of Insurance is repealed as of the effective date of this regulation.

Regulation 32

Group Coordination of Benefits

Section 1. Authority

This regulation is adopted and promulgated by the Department of Insurance pursuant to the authority granted by R.S. 22:3.2014 and the Administrative Procedure Act, R.S. 49:950 et seq. This regulation replaces and repeals the regulation of similar purpose which took effect on January 20, 1994.

Section 2. Purpose and Applicability

The purpose of this regulation is to:

- A. permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law;
- B. establish a uniform order of benefit determination under which plans pay claims;
- C. provide authority for the orderly transfer of necessary information and funds between plans;
- D. reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first;
- E. reduce claims payment delays; and
- F. require that COB provisions be consistent with this regulation.

Section 3. Definitions

As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise:

A. *Allowable Expense*—a health care service or expense including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

(1) The following are examples of expenses or services that are not an allowable expense:

(a) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private hospital rooms) is not an allowable expense.

(b) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense.

(c) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

(c) the addition of either guaranteed issue or underwritten coverage;

(d) the offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this Section, a *Type* means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

D.(1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Regulation that has been approved by the Commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this Subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Commissioner may approve a change to the differential which is in the public interest.

E.(1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 13 of this Regulation.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Section 15. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the

first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this Section, *Compensation* includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Section 16. Required Disclosure Provisions

A. General Rules

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery

and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to such applicants a *Medicare Supplement Buyer's Guide* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Buyer's Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Regulation. Except in the case of direct response issuers, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Buyer's Guide shall be obtained by the issuer. Direct response issuers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

B. Notice Requirements

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. Such notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this Section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage--Cover Page:
Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]
Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (Generally, 20 percent) of Medicare-approved expenses).

Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care

F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible				Part B Deductible

However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) secondary to the plan covering the person as a dependent; and

(b) primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) the parents are married;

(ii) the parents are not separated (whether or not they ever have been married); or

(iii) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This Subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(d) If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(i) the plan of the custodial parent;

(ii) the plan of the spouse of the custodial parent;

(iii) the plan of the noncustodial parent; and then

(iv) the plan of the spouse of the noncustodial

parent.

(3) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection D(1).

(4) Continuation Coverage

(a) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within 24 hours after the first ended.

(b) The start of a new plan does not include:

(i) a change in the amount of scope of a plan's benefits;

(ii) a change in the entity that pays, provides or administers the plan's benefits; or

(iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Section 6. Procedure to be Followed by Secondary Plan

A. (1) When a plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings shall be recorded as a benefit reserve for the covered person and shall be used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the secondary plan must:

(a) determine its obligation, pursuant to its contract;

(b) determine whether a benefit reserve has been recorded for the covered person; and

(c) determine whether there are any unpaid allowable expenses during that claims determination period.

(2) If there is a benefit reserve, the secondary plan shall use the covered person's recorded benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claim determination period the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so

that they and the benefits payable under the other plans do not total more than the allowable expenses.

(1) When the benefits of a plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

(2) The requirements of Paragraph B(1) do not apply if the plan provides only one benefit, or may be altered to suit the coverage provided.

Section 7. Notice to Covered Persons

A plan shall, in its explanation of benefits provided to covered persons, include the following language:

"If you are covered by more than one health benefit plan, you should file all your claims with each plan."

Section 8. Miscellaneous Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

B. (1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (noncomplying plan) on the following basis:

(a) if the complying plan is the primary plan, it shall pay or provide its benefits first;

(b) if the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

(c) if the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

(2) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

(3) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it

may have against a noncomplying plan in the absence of subrogation.

C. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

D. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

Section 9. Effective Date; Existing Contracts

A. This regulation is applicable to every group contract that provides health care benefits and that is issued on or after the effective date of this regulation, which is January 1, 1997.

B. A group contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

(1) the next anniversary date or renewal date of the group contract; or

(2) the expiration of any applicable collectively bargained contract pursuant to which it was written.

APPENDIX A

Model COB Contract Provisions Coordination of this Group Contract's Benefits with Other Benefits

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense.

Definitions

A. *Plan*—any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) *Plan* includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$300 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

(2) *Plan* does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of \$300 or less per day; school accident type coverage, benefits for nonmedical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN C

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN D

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN E

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan which does not contain your state's coordination of benefits rules will always be primary.

When this Plan Is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when;

Your Own Expenses

The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

A. The claim is for the health care expenses of a child covered by this plan; and

B. your birthday is earlier in the year than your spouse's. This is known as the "birthday rule"; or

C. you are not married and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

D. there is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

1. If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.

2. We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

3. If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we will pay

for those items as long as there is a balance in your benefit reserve, as explained below.

4. We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Benefit Reserve

When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve.

1. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings.

2. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans.

3. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

James H. "Jim" Brown
Commissioner

9704#022

RULE

Department of Insurance Office of the Commissioner

Regulation 33—Medicare Supplement Insurance Minimum Standards

Pursuant to the provisions of R.S. 49:950 et seq., R.S. 22:224, and 42 U.S.C. 1395 et seq., the Commissioner of Insurance has amended Regulation 33 relative to Medicare Supplement Insurance policies. The revised Regulation 33 implements a new provision governing the marketing of Medicare Select policies in this state as authorized by recent revisions to federal legislation (OBRA, 1990) governing the marketing of Medicare Supplement insurance policies. The new provision is found in Section 10 of the Regulation. The provisions formerly included in Section 10 have been moved to Section 19D.

Regulation 33 as revised establishes the minimum standards which must be complied with by insurers seeking to market Medicare Select policies in Louisiana. A Medicare Select policy is a Medicare Supplement policy which utilizes a restricted provider network.

The revision to Regulation 33 consists of the relocation of the current provisions of Section 10 relative to premium payment to Section 19. Revised Section 10 adopts new provisions regulating the marketing of Medicare Select policies in accordance with federally prescribed standards.

Regulation 33 as revised establishes the minimum standards which must be complied with by insurers seeking to market Medicare Select policies in Louisiana. A Medicare Select policy is a Medicare Supplement policy which utilizes a restricted provider network. Use of a restricted provider network reduces costs thus making such policies more affordable for the elderly many of whom are facing a financial crisis due to the escalating costs of medical care. Medicare does not cover the cost of prescriptions which is one of the largest health care expenses for the elderly. An affordable supplemental policy is a life saving necessity for many senior citizens. The authority for implementation of this Regulation is found in R.S. 22:224 and in 42 U.S.C. 1395 et seq. (OBRA'90).

The revised Regulation sets forth the minimum standards for policy conditions and benefits that must be followed by insurers providing Medicare select insurance plans. It also sets forth the requirements for coverage and standards for payment for services and fees. The Regulation includes charts which detail the types of coverage and costs covered under the various plans. It also sets standards for the payment of claims, the payment of premiums, the filing and approval of policies including mandatory policy provisions and the approval of premium rates. And it also requires insurers to submit the plan of operation with evidence that it has an adequate number of providers in the network and that they are accessible.

Rule

Section 1. Purpose

The purpose of this Regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

This Regulation is issued pursuant to the authority vested in the Commissioner under R.S. 49:950 et seq., the Administrative Procedure Act, and R.S. 22:224 of the Insurance Code.

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 12, 13 and 21, this Regulation shall apply to:

(1) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof, and

(2) all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This Regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 4. Definitions

For purpose of this Regulation:

A. *Applicant*—

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy, the proposed certificate holder.

B. *Certificate*—any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

C. *Certificate Form*—the form on which the certificate is delivered or issued for delivery by the issuer.

D. *Issuer*—includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

E. *Medicare*—the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

F. *Medicare Supplement Policy*—a group or individual policy of health insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 or Section 1833 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

G. *Policy Form*—the form on which the policy is delivered or issued for delivery by the issuer.

Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this Section.

A. *Accident, Accidental Injury, or Accidental Means*—shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words or description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. *Benefit Period or Medicare Benefit Period*—shall not be defined more restrictively than as defined in the Medicare program.

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN H

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN H

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%--\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN I

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

PLAN I

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	All Costs	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%--\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN J

total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(b) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(c) Reinstatement of such coverages:

(i) shall not provide for any waiting period with respect to treatment of pre-existing conditions;

(ii) shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. Standards for Basic ("Core") Benefits Common to All Benefit Plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent

quantities of packed red blood cells, as defined under Federal Regulations) unless replaced in accordance with Federal Regulations;

(5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this Regulation:

(1) Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One-hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit. Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar-year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(7) Extended Outpatient Prescription Drug Benefit. Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(8) Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, *Emergency Care* shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit. Coverage for the following preventive health services:

(a) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures.

(b) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

- (1) fecal occult blood test and/or digital rectal examination;
- (2) mammogram;
- (3) dipstick urinalysis for hematuria, bacteriuria and proteinuria;
- (4) pure tone (air only) hearing screening test, administered or ordered by a physician;
- (5) serum cholesterol screening (every five years);
- (6) thyroid function test;
- (7) diabetes screening.

(c) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every 10 years).

(d) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) **At-Home Recovery Benefit.** Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) *Activities of Daily Living*—include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) *Care Provider*—a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) *Home*—any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) *At-home Recovery Visit*—the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(b) **Coverage Requirements and Limitations**

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(i) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(ii) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(iii) \$1,600 per calendar year;

(iv) seven visits in any one week;

(v) care furnished on a visiting basis in the insured's home;

(vi) services provided by a care provider as defined in this Section;

(vii) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(viii) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

(11) **New or Innovated Benefits.** An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

Section 9. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 8B of this Regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 8C(11) and in Section 10 of this Regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this Subsection and conform to the definitions in Section 4 of this Regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C and list the benefits in the order shown in this Subsection. For purposes of this Section, *Structure, Language, and Format* means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. **Make-up of Benefit Plans**

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in Section 8B of this Regulation.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible as defined in Section 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (3) and (8), respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Sections 8C(1), (2), (8) and (10), respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Sections 8C(1), (2), (8) and (9), respectively.

(6) Standardized Medical supplement benefit plan "F" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, the Part B Deductible, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (3), (5) and (8), respectively.

(7) Standardized Medicare supplement benefit plan "G" shall include only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefits as defined in Sections 8C(1), (2), (4), (8) and (10), respectively.

(8) Standardized Medicare supplement benefit plan "H" shall consist of only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (6) and (8), respectively.

(9) Standardized Medicare supplement benefit plan "I" shall consist of only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10), respectively.

(10) Standardized Medicare supplement benefit plan "J" shall consist of only the following: the Core Benefit as defined in Section 8B of this Regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10), respectively.

Section 10. Medicare Select Policies and Certificates

A.(1) This Section shall apply to Medicare Select policies and certificates, as defined in this Section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.

B. For the purposes of this Section:

(1) *Complaint*—any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) *Grievance*—dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) *Medicare Select Issuer*—an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) *Medicare Select Policy* or *Select Certificate*—mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) *Network Provider*—a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) *Restricted Network Provision*—any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) *Service Area*—the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this Regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall

reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(b) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals;

(c) there are written agreements with network providers describing specific responsibilities;

(d) emergency care is available 24 hours per day and seven days per week;

(e) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This Paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) a statement or map providing a clear description of the service area.

(3) a description of the grievance procedure to be utilized.

(4) a description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) a list and description, by specialty, of the network providers.

(6) copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) any other information requested by the Commissioner.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing such changes. Such changes shall be considered approved by the Commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the Commissioner at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) it is not reasonable to obtain such services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates.

(2) a description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer;

(7) a description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include mediation procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare

supplement policy or certificate otherwise offered by the issuer.

M.(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(2) For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be re-authorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 11. Open Enrollment

A. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six-month period beginning with the first month in which an individual (who is 65 years of age or older) first enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate

currently available from an insurer shall be made available to all applicants who qualify under this Subsection without regard to age.

B. Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a pre-existing condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before it became effective.

Section 12. Standards for Claims Payment

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. Number 100-203) by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

Section 13. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards

(1) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(a) at least 75 percent of the aggregate amount of premiums earned in the case of group policies; or

(b) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall

also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this Section and Subsection C(3) of Section 14 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

B. Refund or Credit Calculation

(1) An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-Week Treasury Notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued before or after the effective date of Regulation 33 (Revised, 1992) in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Commissioner, in accordance with the applicable filing procedures of this state:

(1)(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The Commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of Regulation 33 as revised July 20, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the Commissioner.

Section 14. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.

C.(1) Except as provided in Paragraph (2) of this Subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan:

(2) An issuer may offer, with the approval of the Commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

- (a) the inclusion of new or innovative benefits;
- (b) the addition of either direct response or agent marketing methods;

(c) the addition of either guaranteed issue or underwritten coverage;

(d) the offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this Section, a *Type* means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

D.(1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Regulation that has been approved by the Commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this Subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Commissioner may approve a change to the differential which is in the public interest.

E.(1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 13 of this Regulation.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Section 15. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the

first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this Section, *Compensation* includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Section 16. Required Disclosure Provisions

A. General Rules

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery

and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to such applicants a *Medicare Supplement Buyer's Guide* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Buyer's Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Regulation. Except in the case of direct response issuers, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Buyer's Guide shall be obtained by the issuer. Direct response issuers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

B. Notice Requirements

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. Such notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this Section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage--Cover Page:

Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (Generally, 20 percent) of Medicare-approved expenses).

Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care

F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible				Part B Deductible

Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
	At-Home Recovery		At-Home Recovery	At-Home Recovery
		Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (3,000 Limit)
				Preventive Care

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this Paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this Regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.]

PLAN A

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$0	\$760(Part A Deductible)
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	\$0	Up to \$95/day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN A

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs

BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100 %	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80 %	20 %	\$0

PLAN B

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	\$0	Up to \$95/day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN B

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			

First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN C

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN D
MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR**

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN E

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN E

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare approved Amounts	80%	20%	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

PLAN F

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760 (Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN F

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	All Costs	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All Approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN G

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN H

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN H

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%--\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN I

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

PLAN I

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	All Costs	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%--\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN J

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN J

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	All Costs	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE(cont'd) AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by our doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50%--\$3,000 calendar year maximum benefit	50%
Over \$6,000 each calendar year	\$0	\$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in Section 3.B of this Regulation, issued for delivery in this state to persons eligible for Medicare by reason of age shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. Such notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

Section 17. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(3) The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

(4) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[Questions]

To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

(a) If so, with which company?

(2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

(a) If so, with which company?

(b) What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?

(4) Are you covered by Medicaid?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than 10-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE
[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits.
- No change in benefit, but lower premiums.
- Fewer benefits and lower premiums.
- Other. (please specify)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this Paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to pre-existing conditions) may be deleted by an issuer if the replacement does not involve application of a new pre-existing condition limitation.

Section 18. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the Commissioner to the extent it may be required under state law.

Section 19. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Louisiana Revised Statutes 22:1211 et seq. the following acts and practices are prohibited:

(1) **Twisting.** Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) **High Pressure Tactics.** Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether

explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) **Cold Lead Advertising.** Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this Regulation.

D. No insurer providing Medicare supplement insurance in this state shall allow its agent to accept premiums except by check, money order, or bank draft made payable to the insurer. If payment in cash is made, the agent must leave the insurer's official receipt with the insured or the person paying the premium on behalf of the insured. This receipt shall bind the insurer for the monies received by the agent.

Under this Section, the agent is prohibited from accepting checks, money orders and/or bank drafts payable to the agent or his agency. The agent is not to leave any receipt other than the insurer's for premium paid in cash.

Section 20. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

Section 21. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

- (1) policy and certificate number, and
- (2) date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Section 22. Prohibition Against Pre-existing Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods.

Section 23. Separability

If any provision of this Regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 24. Effective Date

The revisions to this Regulation shall become effective on January 1, 1997.

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

Type _____ SMSBP(W) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

	(a) Earned Premium (x)	(b) Incurred Claims (y)
line _____	_____	_____

- 1 Current Year's Experience
 - a. Total (all policy years)
 - b. Current year's issues (z)
 - c. Net (for reporting purposes = 1a - 1b)
- 2 Past Years' Experience (All Policy Years)
- 3 Total Experience (Net Current Year + Past Years' Experience)
- 4 Refunds last year (Excluding Interest)
- 5 Previous Since Inception (Excluding Interest)
- 6 Refunds Since Inception (Excluding Interest)
- 7 Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO I)
- 8 Experienced Ratio Since Inception

Total Actual Incurred Claims (line 3, col b) = Ratio 2

Tot. Earned Prem.(line 3, col a) - Refunds Since Inception(line 6)
- 9 Life Years Exposed Since Inception _____

If the Experience Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) _____

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

Type _____ SMSBP(W) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

11 Adjustment to Incurred Claims for Credibility

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the benchmark ratio, then proceed.

12 Adjusted Incurred Claims =
[Tot. Earned Premiums(line 3, col a)-Refunds Since Inception(line 6)] X Ratio 3(line 11)

13 Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6)

Adjusted Incurred Claims (line 12)

Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table	
Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

Type _____ SMSBP(W) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

- (w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
- (x) Includes modal loadings and fees charged.
- (y) Excludes Active Life Reserves.
- (z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____
Name - Please Type _____
Title _____
Date _____

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR _____

Type _____ SMSBP(p) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)
1		2.770				0.000		0.000	
2		4.175		0.507		0.000		0.000	
3		4.175		0.567		1.194		0.000	
4		4.175		0.567		2.245		0.759	
5		4.175		0.567		3.170		0.771	
6		4.175		0.567		3.998		0.782	
7		4.175		0.567		4.754		0.792	
8		4.175		0.567		5.445		0.802	
9		4.175		0.567		6.075		0.811	
10		4.175		0.567		6.650		0.818	
11		4.175		0.567		7.176		0.824	
12		4.175		0.567		7.655		0.828	
13		4.175		0.567		8.093		0.831	
14		4.175		0.567		8.493		0.834	
15		4.175		0.567		8.684		0.837	
				0.567				0.838	
Total		(k):	-----	(l):	-----	(m):	-----	(n):	-----

Benchmark Ratio Since Inception: $(1 + n) / (k + m)$:

- (a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

Type _____ SMSBP(p) _____
 For the State of _____
 Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____
 Person Completing This Exhibit _____
 Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)
1		2.770		0.442		0.000		0.000	
2		4.175		0.493		0.000		0.000	
3		4.175		0.493		1.194		0.000	
4		4.175		0.493		2.245		0.659	
5		4.175		0.493		3.170		0.669	
6		4.175		0.493		3.998		0.678	
7		4.175		0.493		4.754		0.686	
8		4.175		0.493		5.445		0.695	
9		4.175		0.493		6.075		0.702	
10		4.175		0.493		6.650		0.708	
11		4.175		0.493		7.176		0.713	
12		4.175		0.493		7.655		0.717	
13		4.175		0.493		8.093		0.720	
14		4.175		0.493		8.493		0.723	
15		4.175		0.493		8.684		0.725	
				0.493				0.725	
Total		(k):	-----	(l):	-----	(m):	-----	(n):	-----

Benchmark Ratio Since Inception: $(1 + n) / (k + m)$:

(a): Year 1 is the current calendar year - 1
 Year 2 is the current calendar year - 2
 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990;
 Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(c): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p) "SMSBP" = Standardized Medicare Supplement Benefit Plan

Appendix B
FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

James H. "Jim" Brown
Commissioner

9704#028

RULE

**Department of Revenue and Taxation
Office of the Secretary**

Electronic Funds Transfer (LAC 61:I.4910)

Under the authority of R.S. 47:1519 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue and Taxation amends LAC 61:I.4910 concerning the electronic funds transfer of tax payments.

This amendment defines the term *Business Tax* for the purposes of electronic funds transfer and provides that effective January 1, 1998, taxpayers whose tax payments average \$20,000 or more will be required to electronically transfer the funds. In addition, this amendment also makes an exception to the tax return filing requirement for withholding tax return Form L-1, which may be included with the electronic funds transfer transmission.

Title 61

REVENUE AND TAXATION

**Part I. Taxes Collected and Administered
by the Secretary of Revenue and Taxation**

Chapter 49. Tax Collection

§4910. Electronic Funds Transfer

A. Electronic Funds Transfer Effective Dates

1. Taxpayers whose payments in connection with the filing of any business tax return or report, including declaration payments, during the prior 12-month period average \$50,000 or more will be required to remit the respective tax or taxes electronically or by other immediately investible funds, as required by R.S. 47:1519, effective January 1, 1995.

2. Effective January 1, 1998, electronic payments or payment by other immediately investible funds will be required of filers of all business taxes whose payments during the previous 12-month period averaged \$20,000 or more.

3. Any taxpayer whose tax payments for a particular tax averages less than \$20,000 per payment may voluntarily remit amounts due by electronic funds transfer with the approval of the secretary. Once a taxpayer requests to electronically transfer tax payments he must continue to do so for a period of at least 12 months.

B. Definitions. For the purposes of this Section, the following terms are defined:

Business Tax—any tax, except for individual income tax, collected by the Department of Revenue and Taxation.

E. Failure to Timely Transfer Funds Electronically

4. Except for the withholding tax return Form L-1, which may be included with the electronic funds transfer transmission, the filing of a tax return or report is to be made separately from the electronic transmission of the remittance. Failure to timely file a tax return or report shall subject the affected taxpayer or obligee to penalty, interest, and loss of applicable discount, as provided by state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:1519.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Office of the Secretary, LR 19:1032 (August 1993), repromulgated LR 19:1340 (October 1993), amended LR 20:672 (June 1994), LR 23:448 (April 1997).

John Neely Kennedy
Secretary

9704#004

RULE

**Department of Social Services
Office of Family Support**

**AFDC—Alien Eligibility
(LAC 67:III.1141 and 1143)**

The Department of Social Services, Office of Family Support has amended LAC 67:III.Subpart 2, the Aid to Families with Dependent Children (AFDC) Program.

The text of this Rule may be viewed in its entirety in the Emergency Rule Section of this issue of the *Louisiana Register*.

Madelyn B. Bagneris
Secretary

9704#070

RULE

**Department of Social Services
Office of Family Support**

**AFDC—Eligibility and Special Conditions; Job
Opportunities and Basic Skills Training Program
(LAC 67:III.Chapters 9, 11, 13, 15, 29)**

The Department of Social Services, Office of Family Support has amended the *Louisiana Administrative Code*, LAC 67:III.Subpart 2, the Aid to Families with Dependent Children (AFDC) Program and Subpart 5, Job Opportunities and Basic Skills Training Program.

Title 67

SOCIAL SERVICES

**Part III. Office of Family Support
Subpart 2. Aid to Families with Dependent
Children (AFDC)**

Chapter 9. Administration

§902. State Plan

The Title IV-A State Plan as it existed on October 1, 1996 is hereby adopted to the extent that its provisions are not in conflict with any Emergency or normal Rules adopted or implemented on or after October 1, 1996.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:474, R.S. 46:233 and P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:448 (April 1997).

Chapter 11. Application, Eligibility and Furnishing Assistance

Subchapter B. Coverage and Conditions of Eligibility

§1113. Eligibility Requirements

A. - B. ...

C. Cooperation. Each applicant for, or recipient of AFDC is required to cooperate in identifying and locating the parent of a child with respect to whom aid is claimed, establishing the paternity of a child born out of wedlock with respect to whom aid is claimed, obtaining support payments for such applicant or recipient and for a child with respect to whom aid is claimed, and obtaining any other payment or property due such applicant or recipient. Effective January 1, 1997, failure to cooperate in establishing paternity or obtaining child support will result in denial or termination of cash assistance benefits.

D. - F. ...

G. Living in the Home. A child must reside with a qualified relative who is responsible for the day-to-day care of the child. Benefits will not be denied when the qualified relative or the child is temporarily out of the home. Good cause must be established for a temporary absence of more than 45 days.

AUTHORITY NOTE: Promulgated in accordance with 45 CFR 232, P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Health and Human Resources Administration, Division of Family Services, LR 1:494 (November 1975), amended by the Department of Social Services, Office of Family Support, LR 23:449 (April 1997).

§1116. Fleeing Felons and Probation/Parole Violators

A. No cash assistance shall be provided to a person fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the state from which the individual flees. This does not apply with respect to the conduct of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct.

B. No cash assistance shall be provided to a person violating a condition of probation or parole imposed under federal or state law. This does not apply with respect to the conduct of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:449 (April 1997).

§1118. Individuals Convicted of a Felony Involving a Controlled Substance

An individual convicted under federal or state law of any offense which is classified as a felony by the law of the jurisdiction involved and which has as an element the possession, use, or distribution of a controlled substance (as defined in Section 102(6) of the Controlled Substances Act [21 U.S.C. 802(6)]) shall be permanently disqualified from receiving cash assistance. This shall not apply to convictions occurring on or before August 22, 1996.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:449 (April 1997).

Chapter 13. Special Conditions of Eligibility

Subchapter A. Family Independence Project (FIP)

§1301. Terms and Conditions

A. - E. ...

F. Life-Time Limit

1. Eligibility for cash assistance is limited to a life-time limit of 60 months.

2. No cash assistance will be provided to a family that includes an adult who has received assistance for 60 months (whether or not consecutive).

3. Any month for which such assistance was provided will be disregarded with respect to the individual, if the individual was:

a. a minor child; and

b. not the head of a household or married to the head of a household.

G. All individuals determined ineligible under any of these provisions shall retain the same Medicaid eligibility that they would have had in the absence of the project.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:447.3, 46:460, 46:474, 46:477, 46:239, 46:459, P. L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 22:1232 (December 1996), amended LR 23:449 (April 1997).

Chapter 15. General Program Administration

Subchapter A. Fraud

§1501. Fraud Control Program

A. - B.2. ...

3. Cash assistance shall be denied to an individual for 10 years from the date that individual is convicted in federal or state court of having made a fraudulent statement or representation with respect to his place of residence in order to receive assistance simultaneously from two or more states. This does not apply with respect to a conviction of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct which was the subject of the conviction.

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with P.L. 100-203 and CFR 235, P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, LR 14:439 (July 1988), amended by the Department of Social Services, Office of Family Support, LR 20:1019 (September 1994), LR 23:449 (April 1997).

Subchapter B. Recovery

§1506. Special Considerations in Determining Recovery Amounts

If the payee fails to report a child's absence of more than a 45-day duration by the end of the five-day period that begins with the date that it became clear to the payee that the child would be absent for a 45-day period, and good cause for the absence is not established, the needs of the payee as well as the needs of the child will be excluded when determining the recovery amount.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:449 (April 1997).

**Subpart 5. Job Opportunities and Basic Skills
Training Program**

Chapter 29. Organization

**Subchapter A. Designation and Authority of State
Agency**

§2902. State Plan

The Title IV-F and IV-A/F State Plan as it existed on October 1, 1996 is hereby adopted to the extent that its provisions are not in conflict with any Emergency or normal Rules adopted or implemented on or after October 1, 1996.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:474, R.S. 46:233 and P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:450 (April 1997).

Madelyn B. Bagneris
Secretary

9704#069

RULE

**Department of Social Services
Office of Family Support**

**Project Independence—Participation
and Services (LAC 67:III.Chapter 29)**

The Department of Social Services, Office of Family Support has amended LAC 67:III, Subpart 5, Job Opportunities and Basic Skills Training Program, known in Louisiana as the Project Independence Program.

Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 mandated changes regarding mandatory recipients and the number of participation hours required in a JOBS Program. This law places increased emphasis on work activities rather than educational activities.

Title 67

SOCIAL SERVICES

Part III. Office of Family Support

**Subpart 5. Job Opportunities
and Basic Skills Training Program**

Chapter 29. Organization

**Subchapter A. Designation and Authority of State
Agency**

§2903. Implementation

Repealed.

AUTHORITY NOTE: Promulgated in accordance with F.R. 54:42146 et seq., 45 CFR 250.0 and R.S. 46:451 et seq., P. L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR 16:626 (July 1990), amended by the Department of Social Services, Office of Family Support, LR 17:1227 (December 1991), LR 18:967 (September 1992), LR 19:504 (April 1993), LR 19:1297 (October 1993), LR 20:24 (January 1994), LR 20:199 (February 1994), repealed LR 23:450 (April 1997).

§2905. Program Administration

A. - A.1. ...

2. A case management system is maintained by case managers in each OFS parish office to assist participants in

their efforts to become economically independent. Case managers shall assess the participant's family circumstances, education and training status, and level of job readiness; negotiate with the participant an individual responsibility plan that is realistic and achievable; provide positive intervention and act as a participant advocate to maximize the effectiveness of the program; select and arrange for appropriate work activity participation; and monitor program activities.

B. ...

C. A grievance procedure is available for resolving displacement complaints by regular employees or their representatives relating to JOBS participants. A grievance procedure is also available for resolving complaints by, or on behalf of JOBS participants in a work-related activity. This grievance procedure hears complaints relating to on-the-job working conditions and workers' compensation coverage.

AUTHORITY NOTE: Promulgated in accordance with F.R. 54:42146 et seq., 45 CFR 250.30, 45 CFR 250.33, R.S. 460.3(A) (3), R.S. 46:453(B), 45 CFR 251.4 and 45 CFR 251.5., P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR 16:626 (July 1990), amended by the Department of Social Services, Office of Family Support, LR 17:646 (July 1991), LR 17:973 (October 1991), LR 19:504 (April 1993), LR 23:450 (April 1997).

Subchapter B. Participation

§2907. Individual Participation Requirements

A. All recipients of cash assistance are mandatory participants unless determined exempt.

1. A single parent/caretaker who is personally providing care for a child under age 1 is exempt. This exemption is limited to a total of 12 months per single parent/caretaker.

2. A parent/caretaker not included in the cash assistance certification, for any reason other than sanction, is exempt.

B. All nonexempt applicants and recipients are required to participate a minimum average number of hours per week in an allowable work activity as an eligibility condition for receipt of cash assistance.

1. A single parent/caretaker eligible for cash assistance is required to participate a minimum of 20 hours per week, in an activity described in §2911.A.1, 2, 3, 4, 5, 9, or 10.

2. In any two-parent family eligible for cash assistance, one parent must participate a minimum of 35 hours per week, not fewer than 30 hours per week of which are attributable to an activity described in §2911.A.1, 2, 3, 4, 5, 9, or 10. If child care is provided, the second parent, unless disabled, must also participate a minimum of 20 hours per week in an activity described in §2911.A.1, 2, 3, or 9.

3. Participation in activities described in §2911.A.6 and 7 may only be counted for single heads of household who have not attained 20 years of age. All other participants may participate in the activities in §2911.A.6 and 7 if they simultaneously meet the requirements described in B.1 or B.2 of this Section.

4. Participation in activities described in Subsection B.3 of this Section and in §2911.A.5 cannot comprise more than 20 percent of individuals in all families and in two-parent families.

AUTHORITY NOTE: Promulgated in accordance with P. L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR 16:626 (July 1990), amended by the Department of Social Services, Office of Family Support, LR 16:1064 (December 1990), LR 19:504 (April 1993), LR 19:1177 (September 1993), LR 23:450 (April 1997).

§2909. Failure to Participate

A. Failure to participate in the JOBS program, without good cause, will result in the following progressive levels of sanctioning:

1. first occurrence: until the failure or refusal to comply ceases;
2. second occurrence: until failure or refusal to comply ceases, or three months, whichever is longer.
3. any subsequent occurrence: until failure or refusal to comply ceases, or six months, whichever is longer.

B. Sanctions will result in the removal of needs of the sanctioned individual from the cash assistance budget.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR 16:626 (July 1990), amended by the Department of Social Services, Office of Family Support, LR 18:870 (August, 1992), LR 19:504 (April 1993), LR 23:451 (April 1997).

Subchapter C. Activities and Services

§2911. Work Activities

The following are allowable work activities, with certain limitations or restrictions, that may be provided to a participant:

1. any paid employment, unsubsidized or subsidized;
2. unpaid work experience (including Community Work Experience and Independence through Work);
3. on-the-job training;
4. job search/job readiness, limited to six weeks per individual, of which no more than four may be consecutive;
5. vocational education, limited to a total of 12 months per individual;
6. secondary school attendance and preparation for a graduate equivalency diploma, in the case of a recipient who has not completed secondary school or received such a certificate;
7. education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;
8. job skills training directly related to employment;
9. community service;
10. provision of child care services to an individual who is participating in community service.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR 16:626 (July 1990), amended by the Department of Social Service, Office of Family Support, LR 17:1227 (December 1991), LR 19:504 (April 1993), LR 20:1130 (October 1994), LR 22:1142 (November 1996), LR 23:451 (April 1997).

§2913. Support Services

Support services include child care, transportation and other employment-related expenses designed to eliminate or moderate the most common barriers to employment.

1. Child Care Payments

a. The following is the Standard Rate Schedule for payment for child care services provided to the children of Project Independence participants. The statewide limit is established as the maximum amount allowable based upon the provider type, age of child, and the type of care provided.

STANDARD RATE SCHEDULE			
Regular Care			
Child Under Age 2 - Class A Centers			
Full Time		Part Time	
Monthly	\$238.50	Monthly	\$119.15
Weekly	\$ 55.00	Weekly	\$ 27.50
Daily	\$ 11.00	Daily	\$ 5.50
Hourly	\$ 1.38	Hourly	\$ 1.38
Child Age 2 or Older - Class A Centers			
Full Time		Part Time	
Monthly	\$216.50	Monthly	\$108.25
Weekly	\$ 50.00	Weekly	\$ 25.00
Daily	\$ 10.00	Daily	\$ 5.00
Hourly	\$ 1.25	Hourly	\$ 1.25
Child Under Age 2 and Child Age 2 or Older - All Other Service Providers			
Full Time		Part Time	
Monthly	\$216.50	Monthly	\$108.25
Weekly	\$ 50.00	Weekly	\$ 25.00
Daily	\$ 10.00	Daily	\$ 5.00
Hourly	\$ 1.25	Hourly	\$ 1.25

b. All rates herein are established as maximum allowable amounts; payments will be the provider's actual charges or the maximum rate, whichever is less. Daily rates are based on eight hours per day; weekly rates are based on five days per week; monthly rates are based on 4.333 weeks per month. Part-time care is considered to be 20 hours per week or less. Part-week care is considered to be fewer than five days per week, paid at the daily rate.

2. Transportation Payment

a. Payments may not exceed \$500 per participant per month.

b. Participants who become ineligible for cash assistance due to earned income are eligible for a transportation payment of \$33.33 1/3 per month, this paid as a one-time allotment of \$100 for the 90-day period following ineligibility.

3. Other Supportive Services

- a. Payment of union dues not to exceed \$100.
- b. Payments not to exceed a combined total of \$100 per fiscal year may be made for certain costs deemed

necessary such as eyeglasses; hearing aids and other small medical appliances; uniforms, tools and training materials; medical exam not provided by Medicaid or other resource; placement test fees and other course pre-requisite costs; safety equipment; and transportation related expenses.

c. The purchase of refreshments at a maximum cost of \$1 per day per participant is allowed for in-house activities. Supplies will be purchased in bulk from vendors following state procurement Rules and Regulations, and utilized in accordance with the projected numbers of participants and days of activities the supplies are to cover.

AUTHORITY NOTE: Promulgated in accordance with F.R. 54:42146 et seq., 45 CFR Parts 250, 255, 257, and R.S. 46:456 and 457, P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 17:309 (March 1991), amended LR 17:388 (April 1991), LR 18:244 (March 1992), LR 18:687 (July 1992), LR 18:748 (July 1992), LR 18:1268 (November 1992), LR 19:504 (April 1993), LR 20:793 (July 1994), LR 23:451 (April 1997).

Madlyn B. Bagneris
Secretary

9704#071

Notices of Intent

NOTICE OF INTENT

Department of Agriculture and Forestry
Office of Animal Health Services
Livestock Sanitary Board

Equine Infectious Anemia and Livestock Auction
Market Requirements (LAC 7:XXI.Chapter 118)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49.950 et seq., the Department of Agriculture and Forestry, Livestock Sanitary Board hereby gives notice of its intent to adopt LAC 7:XXI.Chapter 118.

These proposed Rules will govern the Equine Infectious Anemia control program whereby the Livestock Sanitary Board identifies and controls equine that are infected with Equine Infectious Anemia and removes infected equine from the population in order to prevent the spread of Equine Infectious Anemia.

These proposed Rules comply with the statutory law administered by the Livestock Sanitary Board, R.S. 3:2091-2222, including R.S. 3:2093(1), the enabling legislation.

A preamble to the proposed Rules is contained in §11803 ("Statement of Purpose") of the proposed Rules.

Title 7

AGRICULTURE AND ANIMALS

Part XXI. Diseases of Animals

Chapter 118. Equine Infectious Anemia

Wherever in these EIA Rules and Regulations the masculine is used, it includes the feminine and vice versa; wherever the singular is used, it includes the plural and vice versa.

§11801. Definitions

Approved EIA Testing Laboratory—a laboratory which is authorized by the board to conduct the EIA test analysis on equine blood samples.

Board—the Louisiana State Livestock Sanitary Board.

Buyer—any person who purchases EIA positive or S branded equine for slaughter.

Direct to Slaughter—for shipment or movement from the premises of origin directly to an approved slaughter establishment for the purpose of slaughter without any stopping or diversion except as is necessary or incidental to such shipment.

EIA Negative Equine—equine that is currently tested for EIA with a negative test result in accordance with these EIA Rules and Regulations.

EIA Positive Equine—an equine that has completed an EIA test with a positive test result.

EIA Quarantine—the secure and physical isolation of EIA positive equine, S branded equine or both in a specific confined area the perimeter of which is at all times at least 200 yards away from all other equine.

EIA Test—has the same meaning as test for EIA defined hereinafter.

Equine—any member of the family of *Equidae* including horses, mules, burros, donkeys, asses, and zebra.

Equine Infectious Anemia—a contagious and infectious disease of equine caused by a lentivirus the symptoms of which can include intermittent fever, depression, weakness, edema, anemia and sometimes death. The disease is also known as Swamp Fever and is sometimes referred to herein as "EIA."

Equine Quarantined Holding Area—an area where the secure and physical isolation of only EIA positive equine, S branded equine, or both are confined, the perimeter of which provides for separating by at least 440 yards from all other equine that are not EIA positive equine, S branded equine, or both.

Exposure to EIA—in the presence of an EIA positive equine.

Foal—an equine less than 1 year old.

In the Presence of—coming within 200 yards of the animal or object referred to.

Owner—any person who, in any form, possesses, has custody of, or has an ownership interest in an equine. A person is an owner during the period of time of the described relationship. A parent or tutor of an owner who is a minor is also an owner during the period of time that the owner-parent or tutor's minor resides with the parent or tutor. A curator of an owner who has been interdicted is an owner during the period of time that the interdict is an owner.

Permanent Individual Equine Identification—one of the following methods of identifying equine:

- operational implanted electronic identification transponder with individual number;
- legible individual lip tattoo; or
- legible individual hot brand or freeze brand other than the brand S or 72A on the left shoulder.

Person—any natural person, partnership, limited partnership, limited liability company, corporation, association or any legal entity whatsoever.

Premises—any immovable or movable property in which or upon which an equine is, was or could be located.

Public Livestock Market—any place, establishment or facility commonly known as a "livestock market," "livestock auction market," "sales ring," "stockyard," or the like, operated for compensation or profit as a public market for livestock, consisting of pens, or other enclosures, and their appurtenances, in which livestock are received, held, sold, or kept for sale or shipment.

Quarantine—the secure and physical isolation of equine in a specific confined area the perimeter of which is at all times at least 200 yards away from other equine.

S Branded Equine—an equine which has been branded with the letter S at least 3 inches in height on the left shoulder.

Stall Barn—a building in which equine are customarily housed.

Test for EIA—a test, approved by the United States Department of Agriculture, Animal and Plant Health Inspection Service, Veterinary Services, for scientifically testing equine for the presence of EIA. The test for EIA is also sometimes herein referred to as the "EIA test."

Testing Veterinarian—a veterinarian accredited by the United States Department of Agriculture who draws an equine's blood for an EIA test and who submits the blood sample to an approved EIA testing laboratory.

Verification—a written statement signed by each owner which includes the name, address, telephone number of each owner, the name of the equine, if any, the permanent individual identification of the equine, and an affirmative attestation of the date, place and the manner of ending the life of the equine.

VS Form 10-11—the form provided by the board or the United States Department of Agriculture utilized in EIA testing which provides for information including the name of the laboratory, the case number, the date of completion of the EIA test, the equine owner's name, address, telephone number and the permanent individual identification of the equine and the test results.

VS Form 1-27 Permit—a form provided, completed and issued by the board or the United States Department of Agriculture which is required before certain livestock may be moved from the premises of origin.

Written Proof of EIA Test—the VS Form 10-11 completed by an approved EIA testing laboratory which, when completed, provides the name of the laboratory, the case number, the date of completion of the EIA test, the equine owner's name, address, telephone number and permanent individual identification of the equine and the test results.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11803. Statement of Purpose

A. The purpose of these EIA Rules and Regulations is to better identify and control EIA infected equine and to remove EIA infected equine from the population in order to prevent the spread of EIA. Due to the persistent incidence of EIA in the equine population, a more stringent eradication program for removal of infected equine, which includes ending the life of EIA infected equine, is necessary. These EIA Rules and Regulations should be liberally construed in favor of ending the life of EIA infected equine. The authority granted therein is to be exercised only in carrying out this necessary EIA eradication program.

B. It is understood that title to an equine can be difficult to discern, that custodians and possessors are frequently the only persons exercising authority over nontitled equine and, therefore, effective enforcement of these EIA Rules and Regulations requires that possessors, custodians, and owners of equine share responsibility for eradication of a disease that has proven destructive to the industry and to equine. It is further understood that if in the board's view effective enforcement would not be jeopardized, the board should direct enforcement against titled owners over custodians and custodians over possessors. Notwithstanding the foregoing,

the board may direct enforcement against any or all owners as defined in these EIA Rules and Regulations in any given case as it shall deem fit in its sole and exclusive judgment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11805. Obligations of Owners

Any owner of equine that are physically located in Louisiana shall timely accomplish the following mandatory requirements, except as provided in §11807 herein:

1. Every owner shall have a permanent individual equine identification for each of their equine completed not later than the time of the initial test for EIA called for herein and as otherwise provided for in these EIA Rules and Regulations.

2. Every owner shall, at the following times, have their equine tested by an approved EIA testing laboratory with blood samples drawn by a testing veterinarian and shall maintain written proof of and the results of such tests for not less than 24 months.

a. Every owner shall have all of the owner's equine tested for EIA at least every 12 months.

b. Every owner shall have all of the owner's foals first tested for EIA no later than one year after the foals are born.

c. Every owner shall have all of the owner's equine coming into the state accompanied with written proof of said equine having been tested negatively for EIA not more than 12 months prior to the date of the equine's entry into the state.

d. Every owner shall have all equine, for which written proof of a negative EIA test cannot be provided, immediately quarantined, tested for EIA, and permanently and individually identified within 20 days of the date upon which an unfulfilled request for written proof of a negative EIA test is made by an authorized agent of the board.

e.i. Owners must test for EIA any equine, except EIA positive equine and S branded equine, that is for any length of time:

(a). in the presence of any equine quarantined holding area; or

(b). in the presence of an EIA positive equine; or

(c). on the same premises as an EIA positive equine; or

(d). on a premises with a perimeter less than 200 yards from the perimeter of the premises of an EIA positive equine.

ii. Said test shall be conducted no earlier than 30 days after the date of the EIA test of the EIA positive equine.

iii. The owners shall ensure that said test for EIA is conducted no sooner than 30 days and, to the extent possible, no later than 60 days from the last date upon which the owners' equine was in the presence of the EIA positive equine or in any of the aforementioned places, but, in any event, the said EIA test shall be conducted.

f. Every owner shall have all equine that are to have their ownership changed tested for EIA within six months prior to the change.

g.i. Every owner offering equine for sale at public livestock markets without written proof of a negative EIA test

conducted within six months of sale or without permanent individual equine identification shall have the equine quarantined, fitted with permanent individual equine identification if not already so fitted, tested for EIA and the results of a negative EIA test before the equine may be removed from quarantine.

ii. All such owners shall have the blood sample drawn for the EIA test before the equine leaves the public livestock market.

iii. If no veterinarian is available for official EIA testing of equine at a public livestock market, EIA testing shall be conducted by an authorized agent of the board.

iv. Prior to the drawing of blood for the EIA test required by §11805.A.1, the owner shall authorize payment of the testing fee for the EIA test to the testing veterinarian.

v. The purchaser of the equine shall pay the identification fee before the equine leaves the public livestock market.

h. Every owner offering equine for sale at public livestock markets without permanent individual equine identification shall have said equine fitted with permanent individual equine identification before said equine leaves the public livestock market.

3. Every owner shall have all of the owner's equine stabled at a racetrack governed by the Louisiana State Racing Commission which are EIA positive immediately and individually quarantined and removed from the racetrack. Owners of other equine which were in the same or directly adjacent stall barns as an EIA positive equine shall be tested for EIA. The EIA testing shall, to the extent possible, as determined by the board, be conducted no sooner than 30 days and no later than 60 days after the date upon which the EIA positive equine was removed from the presence of the equine being tested but, in any event, the said EIA test shall be conducted.

4. Every owner shall immediately, upon receipt of knowledge of a positive EIA test, quarantine and thereafter maintain quarantine of all EIA positive equine until the end of the equine's life as provided herein.

5.a. Every owner shall have all equine which test positive for EIA branded by an authorized agent of the board with a 72A brand at least 3 inches in height on the left shoulder immediately upon receipt of the positive EIA test report.

b. Upon request by the owner to the board, an owner shall be permitted to retest the EIA positive equine by a veterinarian employed by the board prior to a 72A brand being placed on the EIA positive equine.

6. In no event shall any EIA positive equine be moved from one immovable premises to another without a VS Form 1-27 Permit issued by an authorized agent of the board accompanying the EIA positive equine.

7. Every owner who receives notice of a positive EIA test shall inform all other owners of the relevant equine of the test results within 24 hours of having received notice of the EIA test results.

8.a. Every owner shall cause the ending of the life of or end the life of all equine testing positive for EIA, immediately upon notice of the positive result of the EIA test and shall provide verification of the death of such equine by written and

signed statement of the owner which shall be furnished to the office of the State Veterinarian.

b. In the event any EIA positive equine is to be sold for slaughter, the owner shall secure a VS Form 1-27 Permit issued by an authorized agent of the board before the equine may be moved from the premises where the EIA positive equine was quarantined and the owner shall cause the EIA positive equine to be accompanied with the VS Form 1-27 Permit issued by an authorized agent of the board when the EIA positive equine is en route to or at the public livestock market.

c. When the equine is sold for slaughter a properly completed VS-Form 1-27 Permit may serve as the verification called for herein.

9.a. Upon written or oral request by an authorized agent of the board, all owners shall immediately make available written proof of an EIA test demonstrating compliance with the EIA testing requirements of these EIA Rules and Regulations. If the requested written proof is not provided to an authorized agent of the board, the equine shall be presumed to be untested.

b. When a change of possession, custody or ownership of an equine occurs, the owner transferring possession, custody or ownership shall physically transfer to the transferee written proof of the most recent EIA test of the equine transferred.

10. Every owner of equine shall provide the names, addresses and telephone numbers of all other owners, if any, to the board upon the request of an authorized agent of the board.

11. Every owner shall, without prior notice, permit and assist authorized agents of the board in the inspection of equine and inspections to determine compliance with these EIA Rules and Regulations, including inspection of the equine's permanent individual equine identification, inspection of the manner in which any EIA quarantine is being maintained, inspection of the collection of blood samples for EIA tests and inspections relating to the establishment of EIA quarantines.

12. All owners of an equine are responsible and liable in solido to the board for any violation of these EIA Rules and Regulations involving that equine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11807. Exceptions

A. Notwithstanding any other provision hereof, the written proof of EIA test and the requirements of these EIA Rules and Regulations need not include permanent individual equine identification of equine for those equine that temporarily enter Louisiana from another state and that depart Louisiana before the passage of 12 months since such equine's last EIA test. This exception does not apply to equine offered for sale at a public livestock market. All equine, including those temporarily in Louisiana from another state that are offered for sale at a public livestock market, and their owners are subject to all requirements of LAC 7:XXI.11805.A.2.g

including those pertaining to permanent individual equine identification.

B. Upon request by any owner, any mare or dam testing positive for EIA that is at least 270 days into term or has a nursing foal no more than 120 days of age may be quarantined to the owner's premises prior to ending the mare's or dam's life until not later than 20 days after either her foal dies or reaches an age of 120 days by which time the mare's or dam's life shall be ended. Notwithstanding the foregoing exception, all owners shall have the EIA positive mare or dam branded with a 72A brand at least 3 inches in height on the left shoulder immediately upon receipt of the EIA positive test report.

C. Notwithstanding any other provision hereof, all owners of equine which tested positive for EIA prior to February 1, 1994 shall be permitted to confine such equine to a quarantine approved by the board in lieu of ending the EIA positive equine's life. However, in the event such a quarantine is elected by the owner and such a quarantine is thereafter shown to have been violated and the board can demonstrate, after notice and hearing, that the quarantine was not, in every respect, maintained in accordance with these EIA Rules and Regulations and any special conditions, then, in that event, the owner shall, within 20 days of such finding, cause the ending of the life of, end the life of, or sell for slaughter any EIA positive equine so found in violation of the quarantine.

D. The seller of any equine which is sold at any public livestock market with gross proceeds from the sale being less than \$50 shall not be required to pay the testing fee required herein for the EIA test.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11809. Collection and Submission of Blood Samples

A. All blood samples for EIA testing must be drawn by a testing veterinarian and submitted to an approved EIA testing laboratory. The seller of any equine sold at a public livestock market in which the gross proceeds from the sale are less than \$50 may request that the blood sample be drawn by authorized agents of the board, which, if granted, shall satisfy the requirements of these EIA Rules and Regulations in that respect.

B. Blood samples submitted to the approved EIA testing laboratory for official EIA testing shall be accompanied by and submitted with a VS Form 10-11, Equine Infectious Anemia Laboratory Test Report, signed by the testing veterinarian, with completed information as to the equine owner's name, address, telephone number, date blood sample drawn and permanent individual identification of the equine.

C. Blood samples in nonsterile tubes shall not be accepted for testing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11811. Penalties

A. The penalty for a violation of these EIA Rules and Regulations shall be a fine of up to \$1,000 for each violation.

B. With regard to continuing violations, whether acts or omissions, each day a violation occurs or continues shall be a separate violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11813. Enforcement

In addition to those relevant provisions of law, the board may do the following, as is necessary, to carry out the board's powers and duties and to accomplish the purpose of the EIA eradication program.

1. The board may brand and permanently, individually identify equine.

2. The board may quarantine equine, EIA positive equine and equine in their presence, cause the ending of the life of EIA positive equine, end the life of EIA positive equine or cause the sale of EIA positive equine for slaughter.

3. An authorized agent of the board may enter any premises or place where equine are present during reasonable hours with or without prior notice for the purpose of determining whether these EIA Rules and Regulations have been violated and to inspect the equine for the presence of EIA and exposure related to EIA. A testing veterinarian employed by the board may draw blood samples from the equine present for the EIA test.

4.a. Any authorized agent of the board shall have access to, and may enter at all reasonable hours, all places of business dealing in or with equine and all places of business where books, papers, accounts, records, or other documents related to equine are maintained.

b. The board may subpoena, and any authorized agent of the board may inspect, copy, audit or investigate any of the books, papers, accounts, records, or other documents pertaining to equine, all for the purpose of determining whether there is compliance with the provisions of R.S. 3:2091-2100, and with these EIA Rules and Regulations.

c. The authority granted in §11813.A.4.b shall also extend to books, papers, accounts, records, or other documents of persons doing business with the above referenced places of business.

5. The board may apply to a court of competent jurisdiction for a warrant to conduct any reasonable searches and seizures as is necessary to carry out the board's powers and duties not already provided for in these EIA Rules and Regulations.

6. The board may declare abandoned any equine with no apparent owner. The board is authorized to seize, test for EIA and fit with permanent individual identification any equine that has been declared abandoned. The board may also cause the ending of the life of, end the life of, or sell for slaughter any EIA positive equine that has been declared abandoned. Prior to any declaration of abandonment on the grounds of having no apparent owner, the board shall make reasonable inquiry in the geographic area where the relevant equine was initially located, and such reasonable inquiry shall include placing an advertisement in no less than two publications in the print media of greatest circulation near the geographic area where the equine was found. Further, no

declaration that an equine is abandoned shall be made until 15 days have passed since the last publication seeking the owner was made.

7. The board may issue written orders in preventing, controlling or eradicating EIA, and a violation of any such order shall constitute a violation of these EIA Rules and Regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11815. Fees

A. There shall be a testing fee of not more than \$18 per EIA test at all public livestock markets. All public livestock markets shall collect the testing fee of not more than \$18 per EIA test from sellers of equine which arrive at public livestock markets untested for EIA within six months prior to the equine's sale or offering for sale. The public livestock market shall forward the testing fee to the testing veterinarian.

B. There shall be an identification fee of \$5 at all public livestock markets. All public livestock markets shall collect an identification fee of \$5 per equine from purchasers of equine for all equine which arrive at public livestock markets untested for EIA within six months prior to the equine's sale or offering for sale. The public livestock market shall forward the fee to the Louisiana Department of Agriculture and Forestry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11817. Approved Equine Infectious Anemia Testing Laboratories

A. No person shall operate an approved EIA testing laboratory without first obtaining approval from the United States Department of Agriculture, Animal and Plant Health Inspection Service, Veterinary Services, and from the board.

B. The conditions for approving an EIA testing laboratory are as follows:

1. Any person applying for an EIA testing laboratory approval must submit a written application for approval by the board to the office of the State Veterinarian.

2. An inspection of the facility must be made by a representative of the office of the State Veterinarian who shall submit a report to the board indicating whether or not the person applying for an EIA testing laboratory approval has the facilities and equipment which are called for by the United States Department of Agriculture, currently contained in the Animal and Plant Health Inspection Service, Veterinary Services Memorandum 555.8.

3. Any person applying for an EIA testing laboratory approval must agree in writing to operate the approved EIA testing laboratory in conformity with the requirements of the United States Department of Agriculture, currently contained in Animal and Plant Health Inspection Service, Veterinary Services Memorandum 555.8.

4. If the application is given preliminary approval by the board, the person applying will proceed with successful completion of training, examination, and inspection by the United States Department of Agriculture.

5. Laboratory check test results of the United States Department of Agriculture shall be provided to the State Veterinarian for final approval by the board.

6. All EIA testing laboratories which have been approved by the United States Department of Agriculture, prior to the effective date of this Regulation, shall be deemed approved at the time this Regulation goes into effect.

C.1. Approved EIA testing laboratories must maintain a work log clearly identifying each individual blood sample, EIA test result and VS Form 10-11, all of which must be preserved and available for inspection, for a period of time of not less than 24 months from the date of the EIA test.

2. Approved EIA testing laboratories must maintain on file and make available for inspection a copy of all VS 10-11 forms for a period of 24 months.

3. Approved EIA testing laboratories must at all times meet all the requirements of the United States Department of Agriculture, including those requirements currently contained in Animal and Plant Health Inspection Service, Veterinary Services Memorandum 555.8.

4. Blood samples shall be periodically collected and approved EIA testing laboratories periodically inspected by a representative of the office of the State Veterinarian with or without prior notification.

5. Approved EIA testing laboratories shall immediately report by postage prepaid U.S. first class mail, telephone and telephonic facsimile all positive EIA test results to the State Veterinarian's office.

6. The State Veterinarian shall renew the approval of approved EIA testing laboratories in January of each year, provided the approved EIA testing laboratories maintain the standards required by this Regulation and by the United States Department of Agriculture, currently contained in Animal and Plant Health Inspection Service, Veterinary Services Memorandum 555.8.

7. Approved EIA testing laboratories must submit the white original of each VS Form 10-11 not less than monthly to the board.

8. Approved EIA testing laboratories may charge a fee to the testing veterinarian for conducting an EIA test.

D. All records of EIA tests conducted by an approved EIA testing laboratory shall contain the name of the approved EIA testing laboratory.

E. An approved EIA testing laboratory may have its approval canceled if the board finds that the approved laboratory has failed to meet the requirements of the EIA Rules and Regulations, has falsified its records or reports, or has failed to maintain the standards required by this Regulation and by the United States Department of Agriculture, currently contained in Animal and Plant Health Inspection Service, Veterinary Services Memorandum 555.8.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11819. Equine Quarantined Holding Area

A. Any person desiring to operate an equine quarantined holding area must file a written application for approval of the facility to the board and shall have:

1. the equine quarantined holding facility and area inspected and approved by the board; and

2. agree, in writing, to comply with these EIA Rules and Regulations.

B. No other equine except equine consigned for slaughter shall be kept in an equine quarantined holding area and all equine held therein shall be S branded.

C. No equine shall be kept in the equine quarantined holding area longer than 60 days by which time the life of any such equine shall be ended.

D. No equine shall be released from an equine quarantined holding area except to be delivered direct to slaughter.

E. The equine quarantined holding area shall be an area where EIA positive equine, S branded equine or both are kept at least 440 yards from all other equine at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11821. Other

A. The permit for operating an equine quarantined holding area upon approval shall be issued by the board and shall be subject to renewal annually upon such terms, conditions and requirements as the initial issuance or upon terms, conditions and requirements as are necessary to carry out the purposes of these EIA Rules and Regulations.

B. All equine that arrive at a public livestock market, that have had a blood sample drawn for an EIA test, been fitted with a permanent individual equine identification, and that have had their fee paid, may be moved by the purchaser to the purchaser's premises and, if so moved, shall be held by the purchaser under quarantine until the EIA test results are received.

C. For purposes of these EIA Rules and Regulations the date of the drawing of the blood sample used for an EIA test shall be deemed the date of the conduct of the EIA test sometimes referred to as the date of the EIA test.

D. No person may import into Louisiana any equine that is EIA positive.

E. Authorized buyers for approved slaughter establishments may request that any equine purchased by the approved slaughter establishment at a public livestock market be restricted to slaughter. Upon such request, an authorized agent of the board shall place an S brand on said equine and shall issue a VS Form 1-27 Permit before the said equine may leave the public livestock market.

F. No person shall conspire with another person or aid and abet another person in the violation of these EIA Rules and Regulations.

G. No person shall give false information, in any form, to the board or any representative thereof.

H. No equine under EIA quarantine or quarantine may be moved except with a VS form 1-27 permit.

I. No equine under EIA quarantine or quarantine may be sold other than directly to slaughter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

§11823. Severability

If any part of these EIA Rules and Regulations is declared to be invalid for any reason by any court of competent jurisdiction, said declaration shall not affect the validity of any other part not so declared.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2091-2097.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Animal Health Services, Livestock Sanitary Board, LR 23:

Interested persons may submit written comments to Dr. Maxwell Lea, 5825 Florida Boulevard, Baton Rouge, LA 70806, prior to June 1, 1997.

Dr. Maxwell Lea, Jr.
Executive Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Equine Infectious Anemia and Livestock Auction Market Requirements

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no cost to state or local governmental units to implement this proposed Rule. This Rule is being amended to correct alleged legal defects which, if proved to exist, might interrupt the Equine Infectious Anemia (EIA) eradication program. The content of the Rule will remain the same and procedures currently being enforced in the eradication program will continue to be the same.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There would be no effect on revenue collections of state or local governmental units by this proposed action.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There would be no economic benefits or costs associated with this Rule to directly affected persons or nongovernmental groups. Any fees previously imposed will remain the same.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is estimated that the proposed action will have no impact on competition or employment in the public or private sectors.

Richard Allen
Assistant Commissioner
9704#063

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

Department of Civil Service Board of Ethics

Organization; Powers; Hearings;
Penalties; Reports; Records; and Registration

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Department of Civil Service, Board of Ethics, has initiated rulemaking procedures to promulgate Rules as required by the Code of Governmental Ethics (R.S. 42:1102 et seq.); the

Campaign Finance Disclosure Act (R.S. 18:1463 et seq.); the Lobbyist Disclosure Act (R.S. 24:50 et seq.); the Elections Integrity Act (R.S. 18:41 et seq.); and certain provisions of the Gaming Control Act (R.S. 27:1 et seq.). No preamble to the proposed Rules has been prepared.

Proposed Rule

Chapter 1. Definitions

§101. Definitions

Affected Person—any person or governmental agency, or the authorized representative of such person or agency with a demonstrable and objective interest in the board's interpretation, construction, and application of any law within the board's jurisdiction.

Campaign Finance Disclosure Act—refers to LSA-R.S. 18:1481 et seq.

Code—refers to the Code of Governmental Ethics, LSA-R.S. 42:1101 et seq.

Consent Opinion—a written decision and order of the board issued with the agreement of the respondent in order to publicly settle any matter which appears to be a violation of any law within the board's jurisdiction in lieu of filing charges, holding a public hearing, or filing a civil action.

Elections Integrity—refers to LSA-R.S. 18:41 et seq.

Emergency—an unforeseen combination of circumstances that calls for immediate action.

Ethics Administration Program—the unit of the Department of State Civil Service and those employees who provide staff support for the board.

Fact-finding—the process, initiated by the board, whereby the staff under the supervision of the ethics administrator gathers information so that proper disposition can be made by the board on requests for advisory opinions, anonymous information, media reports and verbal reports. With respect to anonymous information, media reports, and verbal reports, *fact-finding* means only the solicitation of a written response by the ethics administrator or his designee from the subject of the fact-finding.

He or His—when used as a pronoun includes either gender or a legal entity, whether singular or plural, except as otherwise clearly indicated by the context.

Lobbyist Disclosure Act—refers to LSA-R.S. 24:50 et seq.

Person Aggrieved—any person who was the subject of a complaint or an investigation or any person to whom notice of charges was issued.

Publication or *Publish*—the process whereby the staff places the board's decision in written form for the board's approval and signature and thereafter sends a copy to any interested party.

Respondent—any person who is the subject of charges filed by the board.

Staff—the ethics administrator, the executive secretary and the employees of the Ethics Administration Program.

Supervisory Committee—the Board of Ethics or any panel thereof with jurisdiction over matters involving campaign finance disclosure.

Chapter 2. Organization, Rules, Procedures, and Powers of the Board

§201. Election of the Chairman and Vice-Chairman

A. The chairman and vice-chairman shall be elected for a two-year term at the first meeting held following January 1 of each odd numbered year commencing with January 1, 1997.

B. In case of a vacancy in the office of chairman or vice-chairman, the board shall elect a new chairman or vice-chairman who shall serve until the expiration of the vacated term.

C. The chairman shall:

1. preside at all meetings of the board when present;
2. assign matters to the appropriate panel for investigation;
3. act or direct the staff to act between meetings of the board on routine matters involving scheduling, docketing, appearances, continuances, and postponements;
4. provide direction on behalf of the board between meetings to the board's counsel during litigation; and
5. perform all other duties pertaining to the office of chairman or as may be assigned to him by the board.

D. In the absence of the chairman, the vice-chairman shall perform all the duties of the chairman.

E. During the course of an adjudication, the board may, by a majority vote of its participating members and with the concurrence of the chairman, designate a member who is an attorney to act as the presiding officer during the adjudication.

§202. Powers of the Board

The board is empowered to:

1. administer and enforce any law within its jurisdiction;
2. represent the public interest in the administration of any law within its jurisdiction;
3. offer and enter into consent opinions regarding violations of the provisions of any law within its jurisdiction;
4. refer to fact-finding anonymous information, media reports, verbal reports or requests for advisory opinions;
5. prescribe rules of order, evidence and procedure to govern its meetings, hearings and investigations;
6. take such steps as may be necessary to maintain proper order and decorum during the course of its hearings and other proceedings, consistent with the resolution of matters coming before it for consideration;
7. issue news releases to the news media with respect to all activities of the board other than executive meetings, private investigations and private hearings; and
8. include on the agenda for board consideration any matter of interest to any board member which is within the board's jurisdiction.

§203. Panels of the Board

A. The board may by a majority vote of its membership implement the provisions of R.S. 42:1141(A) through the selection of panels at any time it deems appropriate. The subject matter jurisdiction of each such panel shall be determined by the board.

B. Each panel shall consist of three or more members of the board. The chairman of the board may participate in all meetings of any panel. The presence of at least three members of a panel shall be required to conduct the business of the panel.

C. The panels may be implemented by a majority vote of participating members of the board. Members shall draw lots to determine on which panel(s) they will serve.

D. Each panel shall elect a chairman and may select a vice-chairman who shall serve at the pleasure of the panel. It shall be the duty of the chairman of the panel to preside at all meetings of the panel and to perform all other duties pertaining to this office.

E. Each panel shall meet at such time and place as may be fixed by the panel.

F. Except as otherwise provided by law and this Subsection, the concurrence of a majority of the participating members of the panel shall constitute a ruling upon an item of business before the panel. When a panel consists of three members, a unanimous vote shall be required to constitute a ruling upon an item of business before the panel.

G. The board, by majority vote of its membership, may review any opinion, decision, finding, or ruling of any panel.

H. Any person aggrieved by any action taken by a panel may file with the board a written request for review of the panel's action. The request shall set forth the facts and law which justify review by the board and shall be filed within 14 days of the date the decision of the panel is published. The board shall determine whether or not to review the panel's decision within 14 days of the filing of the request for review.

§204. Meetings

A. The board shall meet at such time and place as may be fixed by the board.

B. Notice of each meeting shall be given to all members of the board.

C. Notice of each meeting shall be given to the general public in accordance with LSA-R.S. 42:7.

D. All meetings shall be open to the public except as otherwise provided by law.

§205. Quorum and Voting

A. Six members of the board shall constitute a quorum for the transaction of the business of the board.

B. The presence of nine members shall be required to conduct the business of the board sitting en banc.

C. Two-thirds of the membership of the board shall be eight members of the board.

D. The concurrence of a majority of the members participating shall constitute a ruling upon an item of business before the board, except as otherwise provided by law.

E. In the event of a tie vote the board or a panel thereof may, in its discretion:

1. refer a transcript of the record of the matter under consideration to one or more absent members, who shall then vote; or

2. continue the matter for consideration at a later meeting.

F. Brief absences during the consideration of an item of business shall not disqualify a member from voting on said item.

§206. Executive Secretary to the Board

The board shall appoint an executive secretary.

§207. Minutes of Proceedings

The minutes of the proceedings of the board and any panel thereof shall be prepared and maintained by the executive

secretary or his designee on behalf of and subject to the approval of the board.

Chapter 3. Duties of the Executive Secretary

§301. Duties of the Executive Secretary

The executive secretary or his designee shall:

1. act as the board's secretary; to attend all of its meetings; and to keep minutes of its proceedings;

2. carry out the directives, orders and assignments of the board;

3. prepare such reports as the board may request regarding its work;

4. issue subpoenas and subpoenas duces tecum;

5. act between meetings of the board on routine matters not requiring board approval;

6. provide normal staff services in support of the board's activities;

7. notify in writing the appropriate appointing authority of the pending expiration of the term of each board member;

8. receive all reports filed by political committees and candidates pursuant to the provisions of the Campaign Finance Disclosure Act;

9. receive all complaints filed pursuant to the provisions of any law within the board's jurisdiction;

10. receive all reports filed pursuant to the provisions of the Lobbyist Disclosure Act;

11. receive all requests for advisory opinions and forward copies of same to each board member; and

12. schedule appearances at convened meetings of the board or any panel thereof.

§302. Oaths and Affirmations

The executive secretary, if a notary, shall have power to administer oaths in matters related to the business of the board.

Chapter 4. Designated Duties of the Ethics Administrator

§401. Duties of the Ethics Administrator

The ethics administrator or his designee shall:

1. serve as general counsel to the board and direct, control and evaluate the legal section in all of its investigatory, adjudicating and judicial activities and responsibilities for the Ethics Administration Program;

2. assume, carry out and generally discharge those responsibilities incumbent upon the ethics administrator as determined by class specifications published by the Department of State Civil Service;

3. conduct educational activities and seminars regarding any law within the board's jurisdiction open to all public servants in all state and local agencies and persons who do business with such agencies;

4. provide information and material, in booklet form, by seminar, or by other means to any individual appointed to a public board or commission, other than a state board or commission, regarding the provisions of the Code of Governmental Ethics applicable to such appointed positions;

5. publish newsletters and information bulletins regarding any law within the board's jurisdiction;

6. provide oral information and training regarding campaign finance disclosure, lobbying and ethics; and

7. manage the computerized data management system for the collection and dissemination of any material or reports

required to be filed with the board pursuant to any law within its jurisdiction.

§402. Oaths and Affirmations

The ethics administrator, if a notary, shall have power to administer oaths in matters related to the business of the board.

Chapter 5. Designated Duties of the Trial Attorney

§501. Appointment

The chairman with the concurrence of a majority of the board shall, with respect to each case in which charges have been filed and noticed for public hearing, designate a member of the staff to serve as trial attorney.

§502. Duties

It shall be the responsibility of the trial attorney to marshal the evidence with respect to the proposed public hearing, cause all subpoenas and subpoenas duces tecum to be issued and to present evidence and argument during the course of the public hearing in support of the stated charges.

§503. Ex Parte Communications

The designated trial attorney shall refrain from *ex parte* communications with the board as is otherwise specifically provided for in the Administrative Procedure Act, §956.

Chapter 6. Advisory Opinions

§601. General Requirements

A. The board shall receive requests for advisory opinions filed with it by affected persons. Requests for advisory opinions shall be in writing, state the name and address of the person requesting the advisory opinion, disclose his interest in the question presented, state the governmental agency and/or individual involved, specifically describe the transaction involved, be signed by the person making the request, and state sufficient facts to enable the board to respond. The board may decline to render an opinion with regard to any such request.

B. The board may on its own motion render an advisory opinion regarding any law within its jurisdiction.

§602. Dating and Docketing

The ethics administrator shall cause the date of receipt to be noted on each request for an advisory opinion. A docket shall be maintained upon which each request shall be given an appropriate caption and number.

§603. Placement on Agenda

All requests for advisory opinions shall be placed for consideration on the general or consent agenda as soon as practicable.

§604. Consent Agenda

A. The staff shall research and prepare a consent agenda of proposed advisory opinions consisting only of those advisory opinions which are based on and consistent with prior opinions and decisions of the board or its predecessors.

B. The board may review and revise any opinion prepared by the staff contained on the consent agenda.

C. If a member of the board objects to considering a proposed advisory opinion on the consent agenda, the item shall not be considered on the consent agenda but shall be placed on the general agenda.

§605. Emergency Opinions

Where the ethics administrator, upon receipt of a request for an advisory opinion, determines that an emergency exists and that said opinion must be rendered prior to the next regularly scheduled meeting of the board, the ethics administrator may, after consultation with the chairman of the board, issue an advisory opinion in writing. Such opinion issued by the ethics administrator may be relied upon with impunity until such time as the board adopts a contrary or qualifying opinion. Such opinion issued by the ethics administrator shall be placed on the general agenda at the next meeting of the board at which time the board shall either confirm, modify or reject the opinion.

§606. Presentation of Requests

All requests for advisory opinions shall be presented to the board by the staff at a public meeting. Following the presentation, the board shall decline the request, defer action thereon pending further fact-finding, declare its opinion, or take the request under advisement.

§607. Withdrawal

The board may allow a request for an advisory opinion to be withdrawn if the person who submitted the request provides written reasons for withdrawal which the board deems sufficient.

§608. Notification

The staff of the board shall provide the person requesting an advisory opinion written notification of the board's action within 30 days after such action.

§609. Reconsideration

Any affected person may file a request for reconsideration of an advisory opinion rendered by the board. No such request shall be considered by the board unless it is received by the staff within 30 days from the date of mailing of the advisory opinion which is the subject of the request for reconsideration.

Chapter 7. Complaints

§701. General Requirements

The board shall consider any signed sworn complaint from any elector concerning a violation of any law within its jurisdiction or the regulations or orders issued by the board. The complaint may be based on firsthand knowledge or on information and belief. Upon consideration of a sworn complaint, the board may close the file, refer the complaint to investigation, or take such other action as it deems appropriate.

§702. Dating and Docketing

The executive secretary shall cause the date of receipt to be noted on each complaint. The complaint shall be deemed filed only upon the board's initial consideration of same at a convened meeting. A docket shall be maintained upon which each complaint shall be given an appropriate caption and number.

§703. Consideration of Information Concerning Possible Violations

A. Except as otherwise provided by law, the board may by two-thirds majority vote (eight votes) of its membership consider any matter which it has reason to believe may be a violation of any law within its jurisdiction, including but not limited to a notice or report sent to the board by the legislative

auditor or the inspector general, and on such consideration may close the file, refer the matter to investigation or take such other action as it deems appropriate.

B. If less than eight members of the board are participating at a convened meeting, then any matters described in §703(A) above shall be returned by the executive secretary to the board's agenda for the next scheduled meeting.

C. If at least eight members of the board are participating at a convened meeting, then a vote shall be taken on any matters described in §703(A) and such vote shall be conclusive as to each such matter.

§704. Notification

A. The executive secretary shall mail by certified mail a certified copy of the vote and explanation of the matter to the subject of the complaint and the complainant within 10 days after the vote occurs.

B. The executive secretary shall mail by certified mail a copy of the sworn complaint if one has been submitted to the board to the subject of the complaint and the complainant within 10 days after the complaint is received and considered.

§705. Fact-finding

The board may by majority vote of its participating members refer anonymous information, media reports, or verbal reports to fact-finding. The ethics administrator or his designee shall only engage in the requesting of a written response from the person who is the subject of the fact-finding and shall return the matter in not more than 60 days to the board's agenda at which time the board shall take such action as it deems necessary including, but not limited to, voting to consider a matter as provided in §703 of these Rules.

§706. Withdrawal

A. If the complainant wishes to withdraw the complaint prior to the board's commencement of its investigation, withdrawal shall be allowed, except in cases where the board, by two-thirds majority vote of its membership, determines the issues to be of such importance as to warrant ordering the investigation in its own right and in the interest of the public welfare.

B. The executive secretary shall notify the complainant by mail of the board's decision with respect to the complainant's request for withdrawal within 10 days after the vote occurs. If the board votes to continue its investigation, then the notice provisions of §704 of these Rules shall apply.

§707. Elections Integrity

A. Except as otherwise provided in this Section, the general provisions relating to complaints shall apply to complaints filed regarding violations of Elections Integrity.

B. The board may investigate violations of Elections Integrity only upon receipt of a sworn statement by any voter of this state alleging error, fraud, irregularity, or other unlawful activity in the conduct of an election for the office of governor, lieutenant governor, secretary of state, state treasurer, attorney general, commissioner of elections, commissioner of agriculture, commissioner of insurance, United States senator, United States congressman, public service commissioner, member of the state Board of Elementary and Secondary Education, and justice of the Supreme Court.

§708. Complaints; Action by the Board

The board shall have two years from the date upon which a complaint is received to either dismiss the complaint or file formal charges.

Chapter 8. Investigations

§801. General

Upon receiving a sworn complaint or voting to consider a matter as provided in §703 of these Rules, the board may instruct the executive secretary to conduct a private investigation. In the event the board divides itself into panels, the board may instruct the chairman to assign each such matter to the appropriate panel for private investigation. The executive secretary or his designee shall provide written notification of the commencement of the investigation to the subject of the investigation and complainant not less than 10 days prior to the date set for the investigation.

§802. Board Investigation

When the board conducts an investigation, once the investigation is completed and the report reviewed by the board, the board shall decide whether:

1. further investigation is necessary;
2. charges should be filed and the case noticed for public hearing;
3. a consent opinion should be offered; or
4. the file should be closed in order to serve the public interest or because no violation occurred.

§803. Panel Recommendation; Procedure

A. If an investigation is conducted by a panel, once the investigation is completed and the report reviewed by the panel, the panel shall make a recommendation to the board that:

1. further investigation is necessary;
2. charges should be filed and the case noticed for public hearing;
3. a consent opinion should be offered; or
4. the file should be closed in order to serve the public interest or because no violation occurred.

B.1. After receiving the panel's recommendation, the board shall determine whether to accept the panel's recommendation or to take such other action as it deems appropriate.

2. If the board decides to close its file, the ethics administrator shall provide written notification to the subject of the investigation and the complainant within 10 days of the ruling.

3. If the board decides to hold a public hearing, the board must decide, on a case-by-case basis, whether the public hearing shall be held before the board, the board sitting en banc or referred back to the appropriate panel for public hearing. All public hearings shall be subject to the provisions of Chapters 10, 11, and 12 of these Rules.

Chapter 9. Consent Opinions

§901. General

The board may in its sole discretion offer consent opinions to those persons alleged to have violated any law within its jurisdiction.

§902. Procedures

If the board decides to offer a consent opinion, it shall direct its staff to prepare a draft to be sent to the subject of the

allegation for acceptance, modification, or rejection. If the subject of the allegation accepts the terms of the proposed consent opinion, then the opinion shall be placed on the board's executive agenda for review. The board shall have the option to reject a proposed consent opinion and take further appropriate action. If the opinion is accepted by the board, the opinion shall be placed on the board's next general business agenda for adoption and publication. If the subject of the allegation refuses the offer, then the item shall be placed upon the board's agenda for further action.

Chapter 10. Hearings

§1001. Private Hearings

The procedure governing private hearings shall be, to the extent practicable, identical to the procedure set forth below governing public hearings, except that private hearings shall be closed to the public.

§1002. Initiating Public Hearings

A. Public hearings shall be initiated by order of the board through the issuance of charges.

B. The charges shall contain:

1. the name of the person charged;
2. the date of the meeting at which the board voted to file charges;
3. the allegations which will be explored at the public hearing and the pertinent provisions of law alleged to have been violated; and
4. the date, time, and location, if fixed, of the public hearing. Otherwise, the board shall in supplemental correspondence inform the person charged of the date, time and location of the public hearing.

§1003. Assigning Public Hearings

A. The board or a panel thereof shall fix the time and place for the public hearings.

B. For cause considered justifiable, the board or a panel thereof, the chairman, or its ethics administrator, may upset any fixing and give the hearing a special assignment both as to time and place with appropriate notification to all interested parties.

§1004. Place of Public Hearing

A. Subject to the provisions of Subsection B of this Section, all public hearings before the board or a panel thereof shall be conducted at a convenient place, accessible to the public, in the Parish of East Baton Rouge, Louisiana.

B. The board or a panel thereof may direct that a public hearing be conducted in the parish wherein the public servant or person alleged to have violated any provision of law within the jurisdiction of the board resides or in the parish of the official domicile of any office or employment held by the person charged.

§1005. Notice of Public Hearings

A. The executive secretary shall cause notice of public hearings to be posted and mailed to requesting parties at least five days prior thereto, except as otherwise specifically provided in Section 1141(E) of the Code of Governmental Ethics or in the case of emergencies.

B. Notice to the public shall be posted in the lobby of Suite 200, 8401 United Plaza Boulevard, Baton Rouge, Louisiana, 70809 and at such other place where the public hearing is to be held.

§1006. Continuance of Public Hearings

A. A public hearing fixed and not reached shall be refixed by the board.

B. The board, its chairman, or its executive secretary may, for cause deemed sufficient, grant or order, with respect to any one or more respondents involved, a continuance of any public hearing; and, in the board's discretion, the public hearing may proceed as to those respondents to whom no continuance was granted.

C. With the board's approval, a hearing may be continued by consent of all interested parties.

§1007. Procedure in Hearings

A. Except in the case of private hearings, all hearings conducted under the provisions of this Chapter shall be open to the public.

B. Respondents and witnesses shall be subject to cross-examination as in trials before the district courts of the state, and the board, each member of the board, or its designated agent or attorney may examine and cross-examine any witnesses.

C. The board may require that the respondent and trial attorney stipulate to all undisputed facts.

D. When a pending case involves substantially the same question of law or fact as presented in a prior public hearing, the board, at the request of the trial attorney, a respondent, a respondent's attorney or on its or his own motion, may admit as evidence any part of the record of such previous public hearing as it or he may deem relevant; provided, that in the application of this Rule no respondent or the trial attorney shall be deprived of the right to cross-examine any adverse witness.

E. Except with special leave of the board, only one attorney shall be permitted to present oral argument for a respondent.

F. The board may in any case on its own motion invite or allow any member or members of the Louisiana State Bar Association to present oral or written argument on any question of law, provided such oral argument is presented at a hearing when all parties are present, or represented, or that a copy of all written arguments be served on all parties, or their counsel, if any. Service of such written argument shall be made by mail by the executive secretary within two working days of the receipt thereof by him.

G. The charges filed against a respondent shall create no inference that the respondent violated any provision within the board's jurisdiction.

H. When, during the course of a hearing, a ruling by the board is to be made, the presiding member may rule and his ruling shall constitute that of the board; provided, that should an objection be made to such ruling by a member of the board, said ruling shall be immediately resolved by a majority vote of those members of the board present.

§1008. Evidence

A. Except as otherwise provided in the Administrative Procedure Act, the board may admit and give probative effect to evidence which possesses probative value commonly accepted by reasonably prudent men in the conduct of their affairs. The board may exclude incompetent, irrelevant, immaterial, and unduly repetitious evidence. Objections to

evidentiary offers may be made and shall be noted in the record.

B. The board may limit corroborative evidence.

C. When a ruling is made excluding evidence, counsel may dictate into the record as a proffer available to be considered in the case of appellate review, the facts to be proven if the excluded evidence had been admitted.

D. The charges may be enlarged to conform with the evidence admitted.

E. The board shall give effect to the rules of privilege recognized by law.

F. All evidence, including records and documents in the possession of the board of which it desires to avail itself, shall be offered and made a part of the record, and all such documentary evidence may be received in the form of copies or excerpts, or by incorporation by reference. In case of incorporation by reference, the materials so incorporated shall be available for examination by the parties before being received in evidence. The authenticity of any such copies shall be presumed.

G. The board may take notice of judicially cognizable facts and federal census data.

H. The board may take notice of the provisions of any law within its jurisdiction without the necessity of an offer in evidence.

§1009. Subpoena of Witnesses and Production of Documents

A. The board, the ethics administrator, the executive secretary, and any specially designated agent of the board, shall have power to order the appearance of witnesses and to compel the production of books and papers pertinent to the issues involved in any public hearing.

B. Any respondent desiring the issuance of a subpoena for any witness at a public hearing must apply for it in writing at least 10 days before the date fixed for the hearing and must give the name and physical address of the witness to whom the subpoena is to be directed.

C. In lieu of the issuance and service of formal subpoenas to state employees, the board or any person authorized by Subsection A of this Section may request any agency to order any designated employee under its supervision to attend and testify at any public hearing; and upon being so ordered the employee shall appear and furnish testimony.

D. Any respondent desiring the production of books, papers, photographs, or other items at any public hearing must apply for an appropriate order in writing at least 10 days before the date fixed for the hearing. Such application must describe the books or papers to be produced in sufficient detail for identification, must give the full name and physical address of the person required to make such production, and the materiality of their production to the issues must be certified to by the respondent or his counsel.

E. A subpoena duces tecum issued pursuant to this Section shall be returnable at the public hearing or at such earlier date, time and place as specified therein.

F. Authenticated copies of books, papers, photographs, or other items in the custody of any agency of the state or any subdivision thereof which have been subpoenaed may be admitted in evidence with the same effect as the originals, but

if original books, papers, photographs, or other items are subpoenaed they must be produced and made available for inspection even though authenticated copies may be subsequently introduced.

G. The board or its chairman, may, for cause deemed sufficient, issue an appropriate order at any time recalling any subpoena, subpoena duces tecum, or request issued by it or him under the provisions of this Rule. The respondent may likewise obtain an order from the board recalling any subpoena, subpoena duces tecum, or request issued or caused to be issued by him.

§1010. Exclusion of Witnesses

The board, on request of any respondent, an attorney for a respondent, the trial attorney, or on its own motion, may order that the witnesses in any hearing be excluded so as to preclude any witnesses, other than the respondents, their attorneys and the trial attorney, from hearing the testimony of any other witnesses. If so ordered, all witnesses shall be administered an oath and admonished not to discuss their testimony until the conclusion of the proceeding except with counsel.

§1011. Burden of Proof

At the public hearing, the trial attorney for the board shall have the burden of proving a violation of any law within the board's jurisdiction by a preponderance of the evidence.

§1012. Summary Disposition of Charges

A. At anytime after the filing of charges, any respondent may file with the board a written request for summary disposition thereof, in the form of a motion or exception and in accordance with the provisions of §1102 of these Rules, on any of the following grounds:

1. that the board lacks jurisdiction of the subject matter, or of the respondent;
2. that the charges have not been initiated in the manner prescribed by the Rules;
3. that the charges, if true, would not constitute a violation of the Code;
4. that the time in which to commence action as provided by any law within the board's jurisdiction has passed; and
5. that the affidavits and other documents filed in connection with the charges show that there is no genuine issue of material fact, and that the respondent is entitled to summary dismissal as a matter of law.

B. Any request for summary disposition, when made prior to the date fixed for the hearing, may be supported by sworn affidavits and shall be accompanied by written argument or brief. The board may require that copies of the motion and affidavits be furnished to the trial attorney and any other respondents, and may invite opposing motions and affidavits within a specified time.

C. When a request for summary disposition has been filed with the board in any proceeding, the trial attorney for the board shall submit oral or written argument or brief in connection therewith.

D. If the board denies the request for summary disposition or refers it to the merits, it may reconsider same at any time.

E. The board may at any time, on its own motion, summarily dispose of charges on any of the grounds listed in Subsection A of this Section.

F. When the board disposes summarily of a charge or charges, its decision shall be final on the date of publication of the board's opinion, disposing of the case. The executive secretary thereafter shall give the interested parties notice of the decision within 10 days thereof.

§1013. Consolidation of Public Hearings

When public hearings of two or more respondents involve similar or related circumstances, the board may, on its own motion, on motion of the trial attorney or on motion of a respondent, order a joint hearing of all respondents or may order separate hearings for specified respondents.

§1014. Transcripts of Public Hearings

The proceedings of all public hearings shall be recorded, but shall be transcribed only upon order of the board or upon request made by a respondent therein, accompanied by proffer of such cost as may be determined by the executive secretary.

§1015. Witness Fees in Public Hearings

A. The travel expenses of an officer or employee of a state agency who is required to appear before the board shall be paid by the agency which employs him.

B. The board may order that any person who is not an officer or employee of a state department and who is subpoenaed to testify at a public hearing shall be entitled to the same mileage and fees as are allowed witnesses in civil cases by the Nineteenth Judicial Court for the Parish of East Baton Rouge.

C. If a witness is subpoenaed by a respondent, the board may order the same cost of witness fees and mileage to be paid by such respondent.

D. The board or the executive secretary may, before issuing a subpoena, require the party requesting the subpoena to deposit with the executive secretary a sum sufficient to cover the mileage costs and witness fees pending a determination of costs by the board.

§1016. Costs of Public Hearings

The board may, in its discretion, order the costs of any public hearing, or any portion of such costs, including the costs of recording and transcribing testimony, to be paid by or charged to either the board's funds or the respondent.

§1017. Interlocutory Rulings

A. Formal exceptions to the interlocutory rulings or orders of the board, are unnecessary. At the time the ruling is made or the order is communicated, a party shall make known his objection thereto and the grounds therefore, and same shall be noted in the record.

B. The board, may at any time prior to a final decision, recall, reverse, or revise any interlocutory ruling or order.

§1018. Board Action Following Public Hearings

A.1. Following a public hearing, the board shall:

- a. dismiss the charges;
- b. render its decision; or
- c. take the matter under advisement.

2. Thereafter, the board shall announce its decision orally by dictating its findings of fact and conclusions of law into the record or by making an oral determination of whether or not a violation occurred and causing a written opinion to be confected. If the matter is taken under advisement, the board shall have 90 days within which to render a decision at a public meeting.

B. In the event the board publishes a written opinion, the board may only obtain assistance from staff attorneys who were not involved in the investigation or prosecution of the case.

C. Except as otherwise specifically ordered by the board, the decision of the board shall be final:

1. on the date of mailing of notice to the respondent of the board's decision along with a certified copy of the approved minutes of the board, if the board renders its decision orally; or

2. on the tenth day following the publication of its opinion, if the board chooses to have a written opinion confected, if there has been no timely application for rehearing in accordance with §1019 of these Rules.

D. The executive secretary shall notify the person charged and the complainant of the board's decision in writing within 10 days of the board's final decision.

§1019. Rehearings

A. Any person aggrieved may apply to the board for a rehearing in writing within 10 days from the date the board's decision becomes final. The grounds for an application for a rehearing shall be that:

1. the decision or order is clearly contrary to the law and the evidence;
2. the party has discovered, since the hearing, evidence important to the issues which he could not have with due diligence obtained before or during the hearing;
3. there is a showing that issues not previously considered ought to be examined in order to properly dispose of the matter; or
4. there is other good ground for further consideration of issues and the evidence in the public interest.

B. The petition of an aggrieved party for a rehearing shall set forth the grounds which justify such action and shall be accompanied by a written brief or argument in support thereof.

C. In the event the board grants a rehearing, a time and place for the rehearing shall be fixed and the rehearing shall be confined to those grounds upon which the rehearing was ordered.

D. If an application for rehearing is timely filed, the period within which judicial review, under the applicable statute, must be sought, shall run from the final disposition of such application.

Chapter 11. Pre-hearing Procedure

§1101. Discovery

A. Any public servant or other person who has been notified that he is to be the subject of a public hearing pursuant to the provisions of LSA-R.S. 42:1141(E), shall be entitled to the following if written request to the executive secretary is made at least 15 days prior to the date of the scheduled hearing:

1. a certified copy of the transcript of the private hearing, in the event there was a private hearing;
2. the name and address of each individual that the staff of the board has interviewed or intends to call at the proposed hearing, together with any written statements obtained by the staff from such persons; and

3. a copy of each physical document that the board's staff intends to introduce before the board at the proposed hearing.

B. The trial attorney and any respondent may obtain discovery regarding any matter, not privileged, which is relevant to the pending public hearing. It is not ground for objection that the information sought will be inadmissible at the hearing if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

C. The trial attorney and any respondent may take depositions on oral examination and pursuant to the provisions of applicable Code of Civil Procedure Articles, to the extent practicable, of those persons whose name and address has been furnished to the respondent pursuant to the provisions of §1101.A.2 and provided further that the taking of said depositions does not unreasonably impede the scheduled hearing. Such depositions shall be admissible in the public hearing as ordered by the board or any panel thereof or as otherwise provided by law.

D. The trial attorney and any respondent may serve upon each other written interrogatories, pursuant to the provisions of applicable Code of Civil Procedure Articles, to be answered by the party served within 15 days of receipt. During an entire public hearing, written interrogatories served in accordance with this provision shall not exceed 35 in number, including subparts.

§1102. Motions and Exceptions

A. Motions and exceptions may be made before, during or after a public hearing. All motions and exceptions shall be filed at least five days prior to the day when the motion or exception is sought to be heard, except for good cause as determined by the board.

B. Motions and exceptions made before or after the public hearing shall be in writing and shall be accompanied by a memorandum which shall set forth a concise statement of the grounds upon which the relief sought is based and the legal authority therefore.

C. Motions and exceptions made during the course of the public hearing may be made orally since they become part of the transcript of the proceedings.

§1103. Pre-hearing Notices

By order of the board or any panel thereof and not less than 10 days prior to a public hearing, the trial attorney and any respondent shall mutually exchange pre-hearing notices which shall set forth:

1. a brief but comprehensive statement of the party's contentions, including a list of the legal authorities to be relied upon at the hearing in support of the party's legal position;
2. a detailed itemization of all pertinent facts established by stipulations and admissions;
3. a detailed itemization of the contested issues of fact;
4. a detailed itemization of the contested issues of law;
5. a list and brief description of all exhibits to be offered in evidence by a party, identified by the exhibit number to be used at the hearing. Exhibits to be used for impeachment or rebuttal need not be included on the list. Stipulations as to exhibit authenticity and/or admissibility shall be noted on the

exhibit list. In addition, copies of all documents to be offered in evidence shall be attached to the notice;

6. a list of witnesses a party may call and a short statement as to the nature (but not to the content) of their testimony. Except for the witnesses listed, no other witnesses may be called to testify except for good cause shown. This requirement shall not apply to impeachment and rebuttal witnesses; and

7. a statement as to any other matter not included in any of the previous headings which may be relevant to a prompt and expeditious disposition of the case.

§1104. Pre-hearing Conference

A. The board or panel of the board may in its discretion, or upon request of any party, require the holding of a pre-hearing conference. All parties to the hearing shall appear at the specified time and place to consider:

1. simplification of issues;
2. possibility of stipulations, admissions of facts or documents;
3. limitations on witnesses; and
4. such other matters as may be pertinent.

B. If a pre-hearing conference is held, the staff of the board shall issue an order setting forth the actions which took place at the conference. This order shall control the subsequent course of the proceedings unless modified by further order for good cause, and shall be binding on all parties whether present at the conference or not.

Chapter 12. Penalties

§1201. Penalties for Violations; Criteria

A. Except as otherwise provided by law or these Rules, after a public hearing and upon finding a violation of the any law within its jurisdiction, the board may impose penalties or other sanctions consistent with the provisions of any law within its jurisdiction.

B. In determining the amount of the penalty or the type of sanction to impose, the board may consider:

1. the nature, circumstances, extent, and gravity of the violation;
2. the degree of culpability of the person charged;
3. the person's history of previous offenses;
4. the existence of prior notice that the described conduct was prohibited;
5. the person's ability to pay;
6. the financial or other loss to the governmental entity;
7. the damage suffered by the governmental entity; and
8. any other matters that justice requires.

C. Upon finding a violation of the Code of Governmental Ethics or any other law within its jurisdiction, the board shall have 90 days in which to determine the proper penalty and/or sanction to impose for such a violation.

D. The executive secretary shall notify the respondent, by mail, of the board's decision with respect to the assessment of penalties and/or other sanctions within 10 days of the board's final decision.

§1202. Late Filing; Notice

A. The staff shall mail by certified mail a notice of delinquency within two business days after the due date for any report or statement due under any law within the board's jurisdiction which has not been timely filed.

B. If the date on which a report is required to be filed occurs on a weekend or holiday, the report shall be filed no later than the first working day after the date it would otherwise be due.

§1203. Late Filing; Automatic Penalties

The staff shall automatically assess and order the payment of late filing fees for any failure to timely file any report or statement due under any law within the board's jurisdiction in accordance with the appropriate fee schedule provided in §1204 of these Rules.

§1204. Late Filing; Fee Schedule

A. The late filing fees for election campaign finance reports shall be as provided in LSA-R.S. 18:1505.4.

B. The late filing fees for any lobbyist required to register and file reports shall be as provided in LSA-R.S. 24:58(D).

C. The late filing fees for any violation of LSA-R.S. 42:1114 or 1124 shall be as provided in LSA-R.S. 42:1124(C).

§1205. Late Filing; Appeal and "Good Cause"

A. Any person assessed with automatic late filing fees may appeal, in writing, to the board within 20 days after mailing of the order requiring the payment of late filing fees. The ethics administrator shall place all such appeals on the next board agenda for the board's consideration.

B. The board may waive late filing fees for "good cause" shown. "Good cause" means any actions or circumstances which, in the considered judgment of the board, were not within the control of the late filer and which were the direct cause of the late filing or any provision specified in LSA-R.S.18:1511.5(B). Any late filer wishing to have a "good cause" determination shall file a written statement, within 20 days of mailing of the order for payment of late filing fees, requesting a "good cause" waiver by the board and setting forth the facts which tend to prove that the late filer had "good cause" for filing late.

C. The ethics administrator shall place all such requests on the next board agenda for the board's consideration.

D. The late filer may request an appearance before the board in connection with the "good cause" waiver. Such a request shall be made, in writing, to the executive secretary who shall schedule a time for such an appearance.

§1206. Late Filing; Failure to Pay Penalties Assessed

The board may authorize the staff to file a civil action against any person who fails to pay the automatic penalties assessed pursuant to §§1203-1204 of these Rules.

Chapter 13. Records and Reports

§1301. Custodian

The executive secretary shall be the custodian of all records, reports, and files of the board.

§1302. Copies

A. The public may request and obtain copies of any public documents or reports filed with the board. The fees for such copies shall be determined in accordance with the fees set by the Division of Administration.

B. Cash will not be accepted as payment for copying fees which exceed \$50. Any payment for copying fees which exceeds \$50 shall be by check or money order.

§1303. Statements Filed Pursuant to the Provisions of Section 1111(E) of the Code of Governmental Ethics

A. Statements Filed Pursuant to the Provisions of Section 1111(E) of the Code of Governmental Ethics shall:

1. be made under oath; and
2. contain:
 - a. the name and address of the elected official;
 - b. the name and address of the person employing or retaining the official to perform the services;
 - c. a description of the nature of the work and the amount of the compensation for services rendered or to be rendered; and
 - d. a brief description of the transaction in reference to which services are rendered or to be rendered.

B. The executive secretary shall maintain these statements suitably indexed.

§1304. Statements Filed Pursuant to the Provisions of Section 1114 of the Code of Governmental Ethics

A. Statements Filed Pursuant to the Provisions of Section 1114(A) of the Code of Governmental Ethics shall:

1. be made under oath; and
2. contain:
 - a. the amount of income or value of any thing of economic value derived;
 - b. the nature of the business activity;
 - c. the name and address, and relationship to the public servant, if applicable; and
 - d. the name and business address of the legal entity, if applicable.

B. Statements Filed Pursuant to the Provisions of Section 1114(B) of the Code of Governmental Ethics shall:

1. be made under oath; and
2. contain:
 - a. the amount of income or value of any thing of economic value derived;
 - b. the nature of the business activity;
 - c. the name and address, and relationship to the legislator, if applicable; and
 - d. the name and business address of the legal entity, if applicable.

C. Statements Filed Pursuant to the Provisions of Section 1114(C) of the Code of Governmental Ethics shall:

1. be made under oath; and
2. contain:
 - a. the amount of income or value of any thing of economic value derived;
 - b. the nature of the business activity;
 - c. the name and address, and relationship to the elected official, if applicable; and
 - d. the name and business address of the political subdivision, if applicable.

D. The executive secretary shall maintain these statements and files appropriately indexed.

§1305. Statements Filed Pursuant to the Provisions of Section 1120 of the Code of Governmental Ethics

A. Statements Filed Pursuant to the Provisions of Section 1120 of the Code of Governmental Ethics shall:

1. be made under oath; and
2. contain:
 - a. the name and address of the elected official; and
 - b. a detailed description of the matter in question, including the description of the transaction to be voted upon as well as a description of the nature of the conflict, or

potential conflict, and the reasons why despite the conflict the elected official is able to cast a vote that is fair, objective and in the public interest.

B. The executive secretary shall maintain these statements suitably indexed.

§1306. Affidavits Filed Pursuant to the Provisions of Section 1123(16) of the Code of Governmental Ethics

A. Affidavits filed pursuant to the Provisions of Section 1123(16) of the Code of Governmental Ethics shall:

1. be filed within 60 days of making the public speech;
2. be under oath; and
3. contain:
 - a. the name of the sponsoring group or organization; and
 - b. the amount expended on behalf of the legislator by the sponsoring group or organization on food, refreshments, lodging, and transportation.

B. The executive secretary shall maintain these statements suitably indexed.

§1307. Notices Filed Pursuant to Section 56(A) of the Lobbying Laws

A. Notices filed pursuant to Section 56(A) of the Lobbying Laws shall:

1. be filed not less than 30 days prior to the fund raising function;
2. be in writing; and
3. contain:
 - a. the name of the legislator by or for whom the fund raising function is being given;
 - b. the date of the fund raising function; and
 - c. the location of the fund raiser.

B. When filed by anyone other than a legislator, the notice shall also provide the name of the individual, group or organization giving or sponsoring the fund raising function.

C. The executive secretary shall maintain these statements suitably indexed.

§1308. Disclosure Forms Filed Pursuant to the Provisions of LSA-R.S. 39:1223.1

A. Disclosure forms filed pursuant to LSA-R.S. 39:1223.1 shall:

1. be in writing and on the proper form approved by the Board of Ethics; and
2. contain:
 - a. the name and address of the public servant;
 - b. the public position held by the public servant;
 - c. the name and address of the bank;
 - d. the position held with the bank by the public servant and whether that position is compensated or noncompensated; and
 - e. a description of the transaction from which the public servant recused himself from participating; and
3. be signed by the public servant.

B. The executive secretary shall maintain these forms suitably indexed.

§1309. Records and Reports; Accepting and Filing

Any record or report submitted pursuant to this Chapter shall be accepted and filed upon receipt by the staff unless the

record or report is not in compliance with the requirements established by this Chapter or by law. The names of the persons submitting records and reports which are accepted and filed shall be listed on the board's agenda. The records and reports which are not in compliance with the requirements established by this Chapter or by law shall be placed upon the board's agenda for further action by the board.

Chapter 14. Disqualification Pursuant to the Provisions of Section 1112(C) of the Code of Governmental Ethics

§1401. Application

Every public employee, excluding an appointed member of any board or commission, shall disqualify himself from participating in a transaction involving the governmental entity when a violation of Section 1112 of the Code of Governmental Ethics would result.

§1402. Reporting Requirements; In General

A. Every public employee, except an agency head, upon determining that he may be compelled to participate in a transaction involving the governmental entity in violation of Section 1112 of the Code of Governmental Ethics, shall immediately and prior to such participation report the details of the transaction, in writing, to:

1. his immediate supervisor;
2. his agency head; and
3. the Board of Ethics.

B. Every agency head, upon determining that he may be compelled to participate in a transaction involving the governmental entity in violation of Section 1112 of the Code of Governmental Ethics, shall immediately and prior to such participation report the details of the transaction, in writing, to his appointing authority and to the Board of Ethics.

§1403. Reporting Requirements; Impact on Governmental Entity and Alternative Measures

Upon receipt of such written communication from the public employee, the immediate supervisor of the public employee as well as the agency head (or appointing authority, if applicable) shall immediately and prior to such participation by the public employee provide the Board of Ethics, in writing, with a report concerning the impact on the efficient operation of the governmental entity of the potential participation by the public employee and shall provide the Board of Ethics with reports as to alternative measures available to the public employee to prevent participation in the prohibited transaction.

§1404. Action by the Board of Ethics

The proposed disqualification procedure shall be implemented by the public employee and his immediate supervisor and the public employee shall otherwise refrain from participating in the potential transaction until such time as the Board of Ethics has, in writing, provided the public employee, his immediate supervisor, and his agency head with instructions as to the procedure to avoid participation in the prohibited transaction.

Chapter 15. Exemption Pursuant to the Provisions of Section 1123(22) of the Code of Governmental Ethics

§1501. Application

A mayor or a member of a governing authority (the "elected official") of a municipality with a population of 1,500 or less (according to the most recently published decennial census), or a legal entity in which the elected official has a controlling interest, may enter into transactions under the supervision or jurisdiction of the municipality only if a plan is developed by the municipality in accordance with the rules set out below. The plan must be approved by the Board of Ethics prior to its implementation.

§1502. Requirements

A. The elected official involved must immediately recuse himself or herself from acting in his or her governmental capacity in matters affecting the transaction and file quarterly affidavits concerning that recusal with the clerk of the municipality and the board. The affidavits must set out the name and address of the elected official, the name and population of the municipality, and a description of the transactions that occurred during the preceding quarter. The plan of the municipality should set out the due dates of the quarterly affidavits.

B. The plan developed by the municipality must address how the transaction must be supervised after an elected official is recused.

C. Individual transactions of \$250 or less are not required to be subject to the following Rules. However, if such transactions involving a single elected official exceed \$2,500 in the aggregate within the calendar year, the guidelines contained in Subsection D of this Section do apply.

D. For transactions in excess of \$250 but less than \$2,500, telephone quotations with written confirmation or facsimile quotations must be solicited from at least three vendors within the municipality, the parish, or within a 50-mile radius of the municipality. However, in the case of an "emergency" no quotations shall be required so long as the elected official recuses himself or herself from the transaction and files an affidavit as required in Subsection A of this Section within three days of the occurrence of the transaction. "Emergency" shall be defined in the plan adopted by the municipality and subject to board approval.

E. In the case of a transaction in excess of \$250 but less than \$2,500, if the quotation submitted by the elected official or legal entity in which the elected official has a controlling interest is the lowest received by the municipality the transaction is allowed. The plan adopted by the municipality and subject to board approval may specify situations in which a quotation submitted by the elected official or his or her legal entity may be accepted even if it was not the lowest received by the municipality.

F. An elected official or legal entity in which the elected official has a controlling interest may enter into transactions with the municipality in excess of \$2,500 only after written invitations are sent to at least three bona fide qualified bidders, other than the elected official or his legal entity, and upon specific advance approval by the board. Any such

request for approval must include the details of the proposed transaction, a copy of the written invitation, copies of the bids received in response to the invitation, and the method of recusal developed by the municipality. The plan developed by the municipality shall set out the details of the bid process.

Chapter 16. The Board as Supervisory Committee of the Louisiana Campaign Finance Disclosure Act

§1601. General

The Campaign Finance Disclosure Act provides that the Board of Ethics shall function as the Supervisory Committee on Campaign Finance Disclosure.

§1602. Political Committees; Names

A. The name of a political committee shall not be the same as, nor deceptively similar to, the name of any other political committee.

B. The name of a political committee organized to support one candidate shall contain the name of that candidate.

C. The name of a political committee supporting or opposing more than one candidate shall not contain the name of an individual, unless the name of the committee in some way clearly reflects that it is not a committee supporting or opposing only that individual.

D. When a political committee uses an acronym in addition to its complete name, each document filed with the supervisory committee shall contain the complete name of the political committee with the acronym in parenthesis.

E. When the name of a political committee contains a number, the number shall be spelled out in the name and the numerical symbol(s) placed in parenthesis.

§1603. Political Committees; Filing Fees

A. A fee of \$100 shall be remitted to the supervisory committee with each statement of organization required to be filed by a political committee.

B. The \$100 fee shall be due only once per calendar year per committee. In the event that an amended statement of organization is filed by a political committee, no additional fee is required to be paid.

C. All fees paid in compliance with this Section shall be by check drawn upon the designated depository of the political committee.

D. Certificates of registration will be issued to political committees only after a sufficient time has elapsed to insure that the check used to pay the required fee has been paid by the bank upon which it is drawn.

§1604. Registration and Reporting; Forms

A. The staff shall prepare and provide upon request, forms for the registration and reporting by political committees and reporting by candidates.

B. No registration or report submitted by a political committee or report submitted by a candidate will be filed with the board unless:

1. the registration or report is on the proper form as approved by the board or a form which is substantially the same as the form approved by the board; and

2. as to political committees, the registration or report is signed by the appropriate representative of the political committee filing the document; or

3. as to candidates, the report is signed by the candidate.

§1605. Provisional Registration and Reporting

Any political committee or candidate who submits a registration or report that is not on the required form shall have 10 days, from the date of receipt by the staff of the information submitted to file the required form. If the provisions of this Section are met, then the registration or report form shall be retroactively considered as filed on the same date the original registration or report was submitted. Any submission that was not on the proper form and which is not submitted on the correct form within the 10-day period shall not be filed.

§1606. Registration and Reporting; Incomplete and Incorrect Forms

The staff may, without the board's order, request additions and corrections to any registration or report filed by a political committee or report filed by a candidate or other person which would constitute a minor violation of the Campaign Finance Disclosure Act. However, the staff shall report any material or uncorrected violations of the Campaign Finance Disclosure Act to the board.

§1607. Registration and Reporting; Dating, Numbering and Filing

The staff shall establish a procedure for the dating, indexing, and filing of all registrations and Campaign Finance Disclosure reports received by the board as supervisory committee.

Chapter 17. Lobbyist Disclosure Act

§1701. General

The Lobbyist Disclosure Act provides that the Board of Ethics shall administer and enforce the provisions of the Act.

§1702. Applicability

No person shall be considered a "lobbyist" for purposes of the Lobbyist Disclosure Act unless he makes expenditures of \$200 or more in a calendar year for the purpose of lobbying.

§1703. Filing Fees

A. A fee of \$10 shall be remitted to the Board of Ethics with each registration or supplemental registration required to be filed by a lobbyist.

B. All fees paid in compliance with this Section shall be by check or money order.

§1704. Registration and Reporting; Forms

A. The staff of the Board of Ethics shall prepare and provide upon request, forms for the registration and reporting of lobbyists.

B. No registration or report filed by a lobbyist will be dated and filed with the board unless the registration or report is on the proper form as provided by the board's staff.

§1705. Registration and Reporting; Incomplete Forms

The staff may, without the board's order, request additions and corrections to any registration or report filed by a lobbyist

which would constitute a minor violation of the Lobbyist Disclosure Act. Any lobbyist who submits a registration or report containing minor violations of the Lobbyist Disclosure Act shall have 10 days from the date of receipt by the staff of the information submitted to correct such violations. If the provisions of this Section are met, then the registration or report form shall be retroactively considered as filed on the same date the original registration or report was submitted. Any lobbyist registration or report which is not corrected within the 10-day period shall not be filed. The staff shall report any material or uncorrected violations of the Lobbyist Disclosure Act to the board.

§1706. Registration and Reporting; Dating, Numbering and Filing

The staff shall establish a procedure for the dating, indexing, and filing of all lobbyist registration and lobbyist disclosure reports received by the board.

§1707. Employer Verification Forms; Provisional Registration

A. Any lobbyist who timely files the required registration form shall have 10 days, from the date of receipt by the staff of the board of the timely filed registration form, to file the required employer verification form. If the provisions of this Section are met, then the employer verification form shall be retroactively considered as filed on the same date as the timely filed registration form.

B. A lobbyist is only required to file an employer verification form from each person whom he represents before the legislature or a legislator.

Chapter 18. Gaming

§1801. General

Section 1132(D) of the Code of Governmental Ethics provides that the Board of Ethics shall administer and enforce the provisions of LSA-R.S. 27:63, 96, 226, 261, and 316 which represent the conflict of interests standards contained in the Gaming Control Law (LSA-R.S. 27:1 et seq.).

§1802. Rebuttable Presumption; Legal Entity of Elected Public Official or Public Officer

For purposes of LSA-R.S. 27:96 and 261, there shall be a rebuttable presumption that any legal entity in which an elected public official or public officer owns more than 25 percent is controlled by the elected public official and therefore subject to the same restrictions as the elected public official.

§1803. Licensees

For purposes of LSA-R.S. 27:96, "licensee" is limited to the gaming establishment or gaming operator and therefore does not include vendors of the gaming establishment or gaming operator.

LSA-R.S. 39:1233.1 DISCLOSURE STATEMENT

The Louisiana Code of Governmental Ethics generally prohibits any member or chief executive officer of a local depositing authority from serving as an officer, director, or employee of a bank in which agency funds are deposited. LSA-R.S. 39:1233.1 creates a narrow exception allowing a local governing authority member or chief executive officer to serve in such a capacity, despite the agency's deposit of funds in the bank, if he (1) recuses himself from voting in favor of any such bank and does not otherwise participate in the depositing authority's consideration of any matter affecting actual or potential business with the bank, (2) discloses the reason for recusal and files these reasons, in writing, in the minutes or record of the agency, and (3) files this disclosure form with the Board of Ethics within 15 days of any such recusal. Any such disclosure statement shall be deemed filed when it is received in the office of the Board of Ethics or at the time it is postmarked by the United States Postal Service, if it is subsequently received in the office of the Board of Ethics, whichever is earlier. This exception may be used only by members of "local depositing authorities." Local depositing authorities are defined by law to include all parishes, municipalities, boards, commissions, sheriffs and tax collectors, judges, clerks of court, and any other public bodies or officers of any parish, municipality or township, but do not include the state, state commissions, state boards and other state agencies. Unless a written advisory opinion has been obtained from the Board of Ethics, members and chief executive officers of special agencies created by, representing OR comprised of more than one political subdivision are NOT included in this exception. Sole decision makers may NOT take advantage of this exception.

NOTE: This exception is narrow -- completion of this form will not cure any violation of the Ethics Code except those situations specifically addressed in LSA-R.S. 39:1233.1.

1. Name and address of official	2. Office held (include the office title and the political subdivision.)
3. Name and address of bank	4. Position(s) held at bank (If officer, state office held. If employee, give job title.)
5. Position with bank is _____ compensated _____ noncompensated. (Check one)	
6. Description of transaction from which you recused yourself from participating (for example, consideration of method of selecting bank(s) to be used, selection of a bank or banks, decision affecting deposits, decision to discontinue use of a bank, etc.). Include the date of each instance on which you recused yourself from voting or otherwise participating in any such transaction.	
7.	
Signature of official _____	Date _____
Mail or hand deliver to: Board of Ethics, 8401 United Plaza Boulevard, Suite 200, Baton Rouge, Louisiana, 70809. If you have any questions, call (504) 922-1400.	

Interested persons may direct their comments to R. Gray Sexton, Board of Ethics, 8401 United Plaza Boulevard, Suite 200, Baton Rouge, LA 70809-7017, (504) 922-1400, until May 16, 1997.

If necessary, a public hearing will be held by the Board of Ethics at 8401 United Plaza Boulevard, Baton Rouge, LA 70809-7017 on June 19, 1997.

R. Gray Sexton
Administrator

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Ethics Board Rules**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
Copying and mailing costs for 1996-97 will be \$1,000.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
The estimated effect on revenue collections will be none.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
The estimated costs and/or economic benefits will be none.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
The estimated effect on competition and employment will be none.

R. Gray Sexton
Administrator
9704#065

Richard W. England
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Civil Service
Civil Service Commission**

Performance Planning and Review System

The Civil Service Commission will hold a public hearing on May 7, 1997 to consider the following Notice of Intent proposals. The hearing will begin at 9 a.m. and will be held in the Department of Civil Service Second Floor Hearing Room, DOTD Annex Building, 1201 Capitol Access Road, Baton Rouge, LA.

Amend Rule 1.14.2

1.14.2 *Efficiency Rating*—the official overall rating assigned to an employee in accordance with Chapter 10 of these Rules.

Add New Rule 1.20.1.1

1.20.1.1 *New Employee*—only for purposes of the performance planning and review system, any employee who receives a new anniversary date upon entering or reentering the classified service.

Explanation: The proposed amendment to Civil Service Rule 1.14.2 and addition of Civil Service Rule 1.20.1.1 result from the changes to Chapter 10 described in the following Paragraph. The amendment causes the wording in the definition of *Efficiency Rating* to be consistent with the wording in proposed Chapter 10. The addition of 1.20.1.1 creates a definition for the term *New Employee* for the purposes of the performance planning and review system described in proposed Chapter 10.

Chapter 10

Chapter 10 in its entirety is re-enacted to read as follows:

**10.1 Performance Planning and Review System;
Required Components**

Each department shall use a performance planning and review system that complies with this Chapter and consists of at least the following components:

- (a) a performance planning and review form approved by the director;
- (b) a five-level rating system; and

(c) a performance planning and review training manual that is reasonably accessible to rating supervisors.

10.2 Rating Supervisor; Reviewer

The appointing authority shall designate a rating supervisor and a reviewer for each employee. Generally, the rating supervisor should be the person who, in the appointing authority's judgment, is in the best position to observe and document the employee's performance. The reviewer should be someone in the rating supervisor's supervisory chain of command.

10.3 Performance Factors to be Rated

(a) Each employee shall be rated on the following performance factors (or their equivalents): work product; dependability; cooperativeness; adaptability; communication; and daily decision making/problem solving.

(b) Additionally, each supervisory employee shall be rated on the following performance factors (or their equivalents): work group management and leadership; and performance planning and review.

(c) An employee may be rated on any additional performance factor(s) that the appointing authority considers applicable to the employee's job.

10.4 Ratings

(a) The rating supervisor shall rate the employee on each applicable performance factor, using the following ratings (or their equivalents) and points:

1. Outstanding = 5 points
2. Very Good = 4 points
3. Satisfactory = 3 points
4. Needs Improvement = 2 points
5. Poor = 1 point

(b) The performance factor ratings shall then be averaged and the employee's overall rating shall be assigned based upon the following scale:

1. Outstanding = 4.50 - 5.00
2. Very Good = 3.50 - 4.49
3. Satisfactory = 2.50 - 3.49
4. Needs Improvement = 1.50 - 2.49
5. Poor = 1.00 - 1.49

10.5 Performance Planning Session

(a) The rating supervisor shall conduct a performance planning session, during which the rating supervisor shall discuss with the employee the factors upon which the employee will be rated and the performance that will be expected during the coming rating period. Thereafter, the rating supervisor and the employee shall sign and date the performance planning and review form to document the session.

(b) A performance planning session shall be conducted no later than 30 calendar days after: the appointment of a new employee; or the anniversary date of a current employee; or the movement of an employee into a position having a different position number and significantly different duties.

(c) A performance planning session may be conducted when an employee gets a new rating supervisor or when performance expectations change due to changes in work.

10.6 Rating Process

(a) The rating supervisor shall complete the performance planning and review form and shall include written notes to

support the rating for each factor; shall discuss the rating with the employee; shall sign the form; shall present the form to the employee for his or her signature; and shall give the employee a copy of the form. The reviewer shall sign the form either after the rating supervisor has completed it or after the employee has signed it.

(b) For a new employee, the steps prescribed in Subsection (a) shall take place within the 45 calendar days before the employee first becomes eligible for a merit increase.

(c) For a current employee, the steps prescribed in Subsection (a) shall take place within the 45 calendar days before the employee's anniversary date.

10.7 Re-Ratings

An employee whose official overall rating is "Needs Improvement" or "Poor" shall be re-rated. Unless the employee has already been separated, the steps prescribed in Rule 10.6(a) shall take place between three and six months after the employee's anniversary date.

10.8 When a Rating or Re-Rating Becomes Official

A rating or re-rating that complies with Rules 10.6 and 10.7 becomes official when a copy of the performance planning and review form is given to the employee. A copy is considered given under the circumstances listed in Rule 12.8(d).

10.9 Employee's Refusal to Sign Form

An employee cannot prevent a rating or re-rating from becoming official by refusing to sign the performance planning and review form. If an employee refuses to sign any part of the form, the rating supervisor shall note on the form that the employee refused to sign and the date.

10.10 Effects of "Needs Improvement" or "Poor" Rating or Re-Rating

(a) A rating or re-rating of "Needs Improvement" or "Poor" is not a disciplinary action.

(b) Until he or she achieves an official overall rating or re-rating of "Satisfactory" or better, an employee whose official overall rating or re-rating is "Needs Improvement" or "Poor" is ineligible for merit increases, promotion, and in the case of a probational employee, permanent status.

(c) Apart from the ineligibilities provided for in Subsection (b), an employee whose official overall rating or re-rating is "Needs Improvement" or "Poor" may be separated or disciplined under the rules applicable to the employee's status.

10.11 Effects of Absence of Official Rating or Re-Rating

An employee who is not rated in accordance with the provisions of this Chapter shall be considered as having a "Satisfactory" rating on the employee's anniversary date, or in the case of a re-rating, on the date that falls six months after the employee's anniversary date.

10.12 Recordkeeping and Reporting Requirements

(a) Each completed performance planning and review form shall be kept in the department's personnel office, but it shall not be accessible to the public.

(b) Each official overall rating of "Needs Improvement" and "Poor" and each official re-rating shall be reported to the director promptly after a copy of the performance planning and review form has been given to the employee.

(c) By July 31 of each year, each appointing authority shall report to the director, in such form as the director prescribes, information about ratings given during the previous year ending June 30.

10.13 Review of Ratings and Re-Ratings

The grievance process shall not be used to review ratings. Instead, ratings and re-ratings are subject to review only as follows:

(a) A permanent employee who disagrees with an official overall rating or re-rating of "Satisfactory" or better and a nonpermanent employee who disagrees with any rating or re-rating may present a written response to the rating supervisor. A copy of the response shall be attached to each copy of the performance planning and review form that is maintained by the department. The rating supervisor and the reviewer shall consider the response and may raise a rating, if they deem it appropriate.

(b) A permanent employee who disagrees with an official overall rating or re-rating of "Needs Improvement" or "Poor" may present a written request to the appointing authority for a review of the rating or re-rating, as follows:

1. The request for review must be postmarked or received by the appointing authority within 30 calendar days following the day the employee received a copy of the performance planning and review form. In the request, the employee must list the performance factor ratings that are in dispute and, for each factor listed, must explain why he or she contends a higher rating was earned. The employee may attach written documentation to support his or her contentions.

2. Upon receipt of a timely request for review, the appointing authority shall review the employee's request (including any attachments) and the official performance planning and review form (including the documentation that was attached to it). The appointing authority may reach a decision based on this review or may schedule an informal meeting at which the employee and the rating supervisor and any other people the appointing authority deems appropriate may be heard.

3. No later than 60 calendar days after receiving a request for review, the appointing authority shall give the employee written notice of the outcome of the review. Notice is considered given under the circumstances listed in Rule 12.8(d).

4. The appointing authority may designate another person or persons to conduct the review, so long as the person has not participated in the rating or re-rating in dispute.

(c) If an appointing authority fails to comply with Subsection (b) of this Rule, upon timely appeal, and absent compelling reasons, the employee shall be considered as having no rating and Rule 10.11 shall apply.

10.14 Appeal of Ratings and Re-Ratings

Notwithstanding Rule 13.10(c), ratings and re-ratings shall only be appealable to the commission as follows:

(a) A permanent employee whose official overall rating or re-rating remains "Needs Improvement" or "Poor" after the appointing authority's review may appeal the rating or re-rating to the commission. To be timely, the appeal must be filed within 30 calendar days after the date on which the

employee was given written notice of the outcome of the review.

(b) Any other rating or re-rating is only appealable to the commission on the basis of discrimination. To be timely, the appeal must be filed within 30 calendar days after the date on which the employee was given a copy of the performance planning and review form.

10.15 Effective Date

This Chapter shall become effective on July 1, 1997.

10.16 Transition

The director shall establish and publish procedures to effect an orderly transition to the performance planning and review system established in this Chapter.

Explanation: If approved, the proposed new Rules will replace the current Chapter 10 of the Civil Service Rules. The main purpose of the proposed Rules will be to establish a system to ensure communication to classified employees of what will be required and expected of them for the coming rating period and then informing them at the end of the rating period how well they met those requirements and expectations.

The proposed Chapter 10 will establish and mandate use of a performance planning and review system under which each classified state employee shall participate in at least an annual planning session and an annual performance review session tied to his anniversary date. The proposed Rules will require that the performance of each classified employee must be rated on at least six required factors and that the performance of each classified supervisor must be evaluated on at least two specific additional factors. Under the proposed Rules, the rating supervisor must choose from one of five specified levels on which to rate the employee's performance on each factor and on which to calculate the employee's overall performance rating.

Amend Rule 13.10(C) and (J)

13.10 Appeals to the Commission

An appeal may be made to this commission by

(a) - (b) ...

(c) Except as is provided in Rule 10.14, any person in the classified service who alleges that he has been adversely affected by the violation of the Article or any Rule of this commission.

* * *

(j) Any permanent employee whose official overall rating remains "Needs Improvement" or "Poor" after the appointing authority's review of the rating under Rule 10.13.

* * *

Repeal Rule 13.10(K)

Amend Rule 13.20(A)

13.20 Referees

(a) The commission may appoint a referee to hear and decide any appeal pending before the commission.

* * *

Explanation: The proposed amendments to Civil Service Rules 13.10(c) and (j) also result from the changes to Chapter 10 described in the preceding Paragraph. The amendments cause the wording in these Subsections of Rule 13.10 to be consistent with the wording in the proposed Chapter 10. The proposed repeal of Rule 13.10(k) results from clarified information in the proposed Chapter 10 eliminating the need for the Subsection in Chapter 13. The proposed amendment to Civil Service Rule 13.20(a) brings the wording of the Subsection in compliance with current practice of the Civil Service Commission.

Persons interested in making comments relative to these proposals may do so at the public hearing on May 7, 1997 at

the Department of Civil Service, Second Floor Hearing Room, 1201 Capitol Access Road, Baton Rouge, LA or by writing to the director of Civil Service, Box 94111, Baton Rouge, LA 70804-9111.

If any accommodations are needed, notify the Civil Service Commission prior to this meeting.

Allen H. Reynolds
Director

9704#038

NOTICE OF INTENT

Department of Economic Development Racing Commission

Bleeder Medication (LAC 35:I.1507)

The Racing Commission hereby gives notice that it intends to amend LAC 35:I.1507, "Bleeder Medication," to make more horses accessible/eligible to race (change from 14th to 13th day under Subsection E.1 - entry cycle is 14 days).

Title 35

HORSE RACING

Part I. General Provisions

Chapter 15. Permitted Medication

§1507. Bleeder Medication

A. - E. ...

1. First time, after the expiration of the 13th day he is placed on the bleeder list.

2. - 6. ...

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:141 and R.S. 4:142.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Racing Commission, LR 6:174 (May 1980), amended LR 9:547 (August 1983), amended by the Department of Economic Development, Racing Commission LR 15:7 (January 1989), LR 23:

The domicile office of the Racing Commission is open from 8 a.m. to 4 p.m. and interested parties may contact Paul D. Burgess, Executive Director; C. A. Rieger, Assistant Director; or Tom Trenchard, Administrative Manager at (504) 483-4000 (FAX 483-4898), holidays and weekends excluded, for more information. All interested persons may submit written comments relative to this proposed Rule through Friday, May 9, 1997, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Paul D. Burgess
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Bleeder Medication

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There are no costs to implement this action.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no effect on revenue collections.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This action directly benefits owners and trainers since this Rule change will allow their horses to become eligible to race during a subsequent entry cycle, instead of having to wait two entry cycles (an entry cycle is 14 days), thereby giving more horses the opportunity to participate in racing.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This action has no effect on competition nor employment.

Paul D. Burgess
Executive Director
9704#014

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

Department of Economic Development Racing Commission

Maximum Number of Jockeys (LAC 46:XLI.901)

The Racing Commission hereby gives notice that it intends to amend LAC 46:XLI.901, "Maximum Number of Jockeys," to be in line with provisions in other racing jurisdictions (change from three to two riders per agent).

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLI. Horseracing Occupations

Chapter 9. Jockey Agent

§901. Maximum Number of Jockeys

A jockey agent may not, after June 30, 1997, contract the riding engagements of more than two riders. No jockey agent shall contract for more than two riders to start in any one race, except stakes races, who are under contract to the same jockey agent. As used herein, *Jockey Agent* shall mean any person who contracts engagements for a rider or riders.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:148.

HISTORICAL NOTE: Adopted by the Racing Commission in 1971, amended by the Department of Commerce, Racing Commission, LR 2:433 (December 1976), LR 3:29 (January 1977), repromulgated LR 4:277 (August 1978), amended LR 10:593 (August 1984), amended by the Department of Economic Development, Racing Commission, LR 23:

The domicile office of the Racing Commission is open from 8 a.m. to 4 p.m. and interested parties may contact Paul D. Burgess, Executive Director; C. A. Rieger, Assistant Director; or Tom Trenchard, Administrative Manager at (504) 483-4000 (FAX 483-4898), holidays and weekends excluded, for more information. All interested persons may submit written comments relative to this proposed Rule through Friday, May 9, 1997, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Paul D. Burgess
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Maximum Number of Jockeys

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no costs to implement this action.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no effect on revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
This action does not specifically benefit any particular groups, however, this is in line with similar provisions in many other racing jurisdictions.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This action has no effect on competition nor employment.

Paul D. Burgess
Executive Director
9704#018

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Department of Economic Development
Racing Commission**

Order of Preference
(LAC 35:V.6505)

The Racing Commission hereby gives notice that it intends to amend LAC 35:V.6505, "Order of Preference," to allow for more flexibility for the better grade horses to enter races (exception clause added at end).

Title 35

HORSE RACING

Part V. Racing Procedures

Chapter 65. Preferred List

§6505. Order of Preference

If a horse has been excluded twice consecutively, it shall have preference over a horse excluded only once, and so on. No horse shall be placed on the preferred list if the owner thereof did not accept, when presented, the opportunity of starting. Horses whose names appear in the entries and have an opportunity to start will be given no preference whatsoever should they be entered for the following day and the race overfills, except horses entered in handicap stakes and allowance stakes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:148.

HISTORICAL NOTE: Adopted by the Racing Commission in 1971, promulgated by the Department of Commerce, Racing Commission, LR 2:438 (December 1976), amended LR 3:34 (January 1977), repromulgated LR 4:280 (August 1978), amended by the Department of Economic Development, Racing Commission, LR 23:

The domicile office of the Racing Commission is open from 8 a.m. to 4 p.m. and interested parties may contact Paul D. Burgess, Executive Director; C. A. Rieger, Assistant

Director; or Tom Trenchard, Administrative Manager at (504) 483-4000 (FAX 483-4898), holidays and weekends excluded, for more information. All interested persons may submit written comments relative to this proposed Rule through Friday, May 9, 1997, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Paul D. Burgess
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Order of Preference

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no costs to implement this action.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no effect on revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
This action benefits owners and trainers by allowing more flexibility for better grade horses to enter races.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This action has no effect on competition nor employment.

Paul D. Burgess
Executive Director
9704#016

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Department of Economic Development
Racing Commission**

Qualifications for Jockey/Apprentice Jockey;
Applicant for a License (LAC 46:XLI.701 and 703)

The Racing Commission hereby gives notice that it intends to amend LAC 46:XLI.701-703, "Qualifications for Jockeys/Apprentice Jockeys" and "Applicant for a License" to eliminate probationary rides/mounts and to prevent anyone from riding while not licensed as a jockey or apprentice jockey.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part XLI. Horseracing Occupations

Chapter 7. Jockeys and Apprentice Jockeys

§701. Qualifications for Jockey/Apprentice Jockey

Any person desiring to participate in this state as a jockey and has never ridden in a race may be issued a jockey or apprentice jockey license upon the recommendation of the stewards granting permission to such person for the purpose of riding in two races to establish the qualifications and ability of such person for the license, provided, however:

- 1. such person has the qualifications of a permittee and has at least one year of experience with racing stables;

2. a licensed trainer certifies in writing to the stewards that such person has demonstrated sufficient horsemanship to be granted a jockey or apprentice jockey license;
3. the starter has schooled such person breaking from the starting gate with other horses and approves such person as capable of starting a horse properly from the starting gate in a race;
4. the stewards in their sole discretion are satisfied such person intends to become a licensed jockey, possesses the physical ability and has demonstrated sufficient horsemanship to ride in a race without jeopardizing the safety of horses or other riders in the race.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:148, R.S. 4:150 and R.S. 4:169.

HISTORICAL NOTE: Adopted by the Racing Commission in 1971, amended by the Department of Commerce, Racing Commission, LR 2:430 (December 1976), LR 3:26 (January 1977), repromulgated LR 4:275 (August 1978), amended by the Department of Economic Development, Racing Commission, LR 23:

§703. Applicant for a License

A. In addition to rules applicable to permittees, an applicant for a license as a jockey or apprentice jockey:

1. must have served at least one year with racing stables;
2. must provide an annual medical affidavit certifying such person is physically and mentally capable of performing the activities and duties of a licensed jockey or exercise person.

B. The stewards may require that any jockey or exercise person provide blood or urine samples for analysis after consultation with the track physician. Should a jockey or exercise person fail to comply with this requirement this person shall be suspended and referred to the commission to show cause for refusing to do so.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:148, R.S. 4:150, R.S. 4:151 and R.S. 4:169.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Racing Commission, LR 2:430 (December 1976), LR 3:27 (January 1977), repromulgated LR 4:275 (August 1978), amended LR 10:593 (August 1984), amended by the Department of Economic Development, Racing Commission, LR 23:

The domicile office of the Racing Commission is open from 8 a.m. to 4 p.m. and interested parties may contact Paul D. Burgess, Executive Director; C. A. Rieger, Assistant Director; or Tom Trenchard, Administrative Manager at (504) 483-4000 (FAX 483-4898), holidays and weekends excluded, for more information. All interested persons may submit written comments relative to this proposed Rule through Friday, May 9, 1997, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Paul D. Burgess
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Qualifications for Jockey/Apprentice Jockey;
Applicant for a License**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no costs to implement this action.

- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no effect on revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
This action benefits jockeys and apprentice jockeys by preventing unqualified individuals from acting in such a capacity without being properly licensed as a jockey/apprentice jockey.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This action has no effect on competition nor employment.

Paul D. Burgess
Executive Director
9704#017

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Department of Economic Development
Racing Commission**

Racing a Horse Under
Investigation (LAC 35:I.1733)

The Racing Commission hereby gives notice that it intends to amend LAC 35:I.1733, "Racing a Horse Under Investigation," to prevent a horse under investigation from running until after the stewards hearing is held.

**Title 35
HORSE RACING**

Part I. General Provisions

**Chapter 17. Corrupt and Prohibited Practices
§1733. Racing a Horse Under Investigation**

A. When a report as described in §1729 is received from the state chemist, the state steward shall immediately advise the trainer of his rights to have the "split" portion of the sample tested at his expense. The stable shall remain in good standing pending a ruling by the stewards, which shall not be made until the split portion of the original sample is confirmed positive by a laboratory chosen by the trainer from a list of referee laboratories. The horsemen's bookkeeper shall not release any purse monies until the results of the split portion of the sample are received by the commission. The horse allegedly to have been administered any such drug or substance shall not be allowed to enter in a race during the investigation and hearing.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:142 and R.S. 4:148.

HISTORICAL NOTE: Adopted by the Racing Commission in 1971, promulgated by the Department of Commerce, Racing Commission, LR 2:449 (December 1976), amended LR 3:45 (January 1977), repromulgated LR 4:287 (August 1978), amended LR 7:262 (May 1981), LR 9:755 (November 1983), amended by the Department of Economic Development, Racing Commission, LR 18:367 (April 1992), LR 23:

The domicile office of the Racing Commission is open from 8 a.m. to 4 p.m. and interested parties may contact Paul D. Burgess, Executive Director; C. A. Rieger, Assistant Director; or Tom Trenchard, Administrative Manager at

(504) 483-4000 (FAX 483-4898), holidays and weekends excluded, for more information. All interested persons may submit written comments relative to this proposed Rule through Friday, May 9, 1997, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Paul D. Burgess
Executive Director

- 4546 Other IASA Programs
- 113 Therapists/Specialists/Counselors
- 1510 Improving America's Schools Act (IASA)
- 1520 Bilingual (Title VII)
- 2211 Regular Education
- 2212 Special Education Programs

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Racing A Horse Under Investigation**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no costs to implement this action.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no effect on revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
This action benefits all racing groups in general by preventing a horse under investigation (usually for drugs present in its system) from racing until after a stewards' hearing is held and a determination is made in the case.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This action has no effect on competition nor employment.

Paul D. Burgess
Executive Director
9704#015

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

Board of Elementary and Secondary Education

**Bulletin 1929—Accounting and
Uniform Governmental Handbook**

In accordance with R.S. 49:950 et seq., the Board of Elementary and Secondary Education approved for advertisement, revised Bulletin 1929, Louisiana Accounting and Uniform Governmental Handbook for Local and State School Boards, revised 1996. The handbook is referenced in the *Louisiana Administrative Code*, Title 28. The only revisions to Bulletin 1929 are program title (heading) changes as follows:

- 4533 IASA
- 4540 Improving America's Schools Act
- 4541 Title I
- 4542 Title I, Part C - Migrant
- 4543 Title VI
- 4544 Title IV

**Title 28
EDUCATION**

**Part I. Board of Elementary and Secondary Education
Chapter 9. Bulletins, Regulations, and State Plans
§912. Accounting and Reporting Procedures**

Bulletin 1929

- 1. Bulletin 1929, Revised Louisiana Accounting and Governmental Handbook for Local School Boards, revised 1996 is adopted.
- 2. The primary purpose of the Louisiana Accounting and Uniform Governmental Handbook for Local School Boards is to serve as a vehicle for program cost accounting at the local and state levels. This handbook attempts to produce comprehensive and compatible sets of standardized terminology for use in education management for financial reporting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7 and 17:92.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 20:1097 (October 1994), amended LR 23:

Bulletin 1929 may be seen in its entirety in the Office of the State Register located on the Fifth Floor of the Capitol Annex, in the Office of Finance and Management in the State Department of Education, or in the Office of the Board of Elementary and Secondary Education located in the Education Building in Baton Rouge, LA.

Interested persons may submit comments until 4:30 p.m., June 10, 1997 to Jeannie Stokes, State Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Bulletin 1929—Louisiana Accounting and
Uniform Governmental Handbook**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There will be no cost of implementation of this change to either the schools or the department. BESE estimated cost for printing this policy change and the first page of the fiscal and economic impact statement in the *Louisiana Register* is approximately \$80. Funds are available.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
This policy has been in effect since 1980. There will be no effect on revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There will be no costs and/or economic benefits which directly affect persons or nongovernmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition and employment.

Marlyn Langley
Deputy Superintendent
9704#062

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Environmental Quality
Office of Air Quality and Radiation Protection
Radiation Protection Division**

Revision to General Conformity
(LAC 33:III.1405)(AQ152*)

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Air Quality Division Regulations, LAC 33:III.1405.B, (AQ152*).

This proposed Rule is identical to a federal law or Regulation which is applicable in Louisiana. No fiscal or economic impact will result from the proposed Rule. Therefore, the Rule will be promulgated in accordance with R.S. 49:953(F)(3) and (4). This proposed Rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 9:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

This revision to §1405 gives administrative authority to EPA, rather than to the state. This is in agreement with federal regulations at 40 CFR 51.859, and is required by EPA as a condition for full approval of the General Conformity State Implementation Plan (SIP). After promulgation, this revision will be submitted under the Governor's signature as a revision to the General Conformity SIP. The public hearing scheduled in this Notice is applicable to the rulemaking and the SIP revision.

**Title 33
ENVIRONMENTAL QUALITY
Part III. Air**

**Chapter 14. Conformity
Subchapter A. Determining Conformity of General
Federal Actions to State or Federal
Implementation Plans**

§1405. Applicability

* * *

[See Prior Text in A]

B. For federal actions not covered by Subsection A of this Section, a conformity determination under this Subchapter is required for each criteria pollutant where the total of direct and indirect emissions in a nonattainment or maintenance area caused by a federal action would equal or exceed any of the rates in Subsection B.1 or 2 of this Section. Emissions from federal actions must be determined using methods described in LAC 33:III.1411.

* * *

[See Prior Text in B.1-J]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:1270 (November 1994), amended LR 23:

A public hearing will be held on May 29, 1997, at 1:30 p.m. in the Maynard Ketcham Building, Room 326, 7290 Bluebonnet Boulevard, Baton Rouge, LA 70810. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Patsy Deaville at the address given below or at (504)765-0399.

All interested persons are invited to submit written comments on the proposed Regulations. Commentors should reference this proposed Regulation by AQ152*. Such comments should be submitted no later than May 29, 1997, at 4:30 p.m., to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA, 70810 or by FAX to (504)765-0486. The comment period for this Rule ends on the same date as the public hearing.

This proposed Regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 7290 Bluebonnet Boulevard, Fourth Floor, Baton Rouge, LA 70810; 804 Thirty First Street, Monroe, LA 71203; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 3519 Patrick Street, Lake Charles, LA 70605; 3501 Chateau Boulevard West Wing, Kenner, LA 70065; 100 Asma Boulevard, Suite 151, Lafayette, LA 70508. This regulation is also available on the Internet at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>.

Gus Von Bodungen, P.E.
Assistant Secretary

9704#078

NOTICE OF INTENT

**Department of Environmental Quality
Office of Solid and Hazardous Waste
Hazardous Waste Division**

Treatment Facilities Exemption
(LAC 33:V.105)(HW058*)

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Hazardous Waste Division Regulations, LAC 33:V.105.D (HW058*).

This proposed Rule is identical to a federal law or Regulation which is applicable in Louisiana. No fiscal or economic impact will result from the proposed Rule. Therefore, the Rule will be promulgated in accordance with R.S. 49:953(F)(3) and (4). This proposed Rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S.49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

This proposed Rule contains clarification to LAC 33:V.105.D.6 and 7, for the Chapters from which totally enclosed treatment facilities, elementary neutralization units, and wastewater treatment units are exempt.

Title 33

ENVIRONMENTAL QUALITY

Part V. Hazardous Waste and Hazardous Materials

Subpart 1. Department of Environmental Quality—Hazardous Waste

Chapter 1. General Provisions and Definitions

§105. Program Scope

These Rules and Regulations apply to owners and operators of all facilities that generate, transport, treat, store, or dispose of hazardous waste, except as specifically provided otherwise herein. The procedures of these Regulations also apply to denial of a permit for the active life of a hazardous waste management facility or TSD unit under LAC 33:V.706. Definitions appropriate to these Rules and Regulations, including *Solid Waste* and *Hazardous Waste*, appear in LAC 33:V.109. Those wastes which are excluded from regulation are found in this Section.

* * *

[See Prior Text in A-D.5]

6. The owner or operator of a totally enclosed treatment facility as defined by LAC 33:V.109 is exempt from the requirements of LAC 33:V.Chapters 15, 17, 19, 21, 35, and 37.

7. The owner or operator of an elementary neutralization unit or a wastewater treatment unit as defined by LAC 33:V.109 is exempt from the requirements of LAC 33:V.Chapters 15, 17, 19, 21, 35, and 37.

* * *

[See Prior Text in D.8-M.10]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2180 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Hazardous Waste Division, LR 10:200 (March 1984), amended LR 10:496 (July 1984), LR 11:1139 (December 1985), LR 12:319 (May 1986), LR 13:84 (February 1987), LR 13:433 (August 1987), LR 13:651 (November 1987), LR 14:790 (November 1988), LR 15:181 (March 1989), LR 16:47 (January 1990), LR 16:217 (March 1990), LR 16:220 (March 1990), LR 16:398 (May 1990), LR 16:614 (July 1990), LR 17:362 (April 1991), LR 17:368 (April 1991), LR 17:478 (May 1991), LR 17:883 (September 1991), LR 18:723 (July 1992), LR 18:1256 (November 1992), LR 18:1375 (December 1992), amended by the Office of the Secretary, LR 19:1022 (August 1993), amended by the Office of Solid and Hazardous Waste, Hazardous Waste Division, LR 20:1000 (September 1994), LR 21:266 (March 1995), LR 21:944 (September 1995), LR 22:813 (September 1996), LR 22:831 (September 1996), LR 23:.

A public hearing will be held on May 29, 1997, at 1:30 p.m. in the Maynard Ketcham Building, Room 326, 7290 Bluebonnet Boulevard, Baton Rouge, LA 70810. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Patsy Deaville at the address given below or at (504)765-0399.

All interested persons are invited to submit written comments on the proposed Regulations. Commentors should reference this proposed Regulation by HW058*. Such

comments should be submitted no later than May 29, 1997, at 4:30 p.m., to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70810 or by FAX to (504)765-0486. The comment period for this Rule ends on the same date as the public hearing.

This proposed Regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 7290 Bluebonnet Boulevard, Fourth Floor, Baton Rouge, LA 70810; 804 Thirty-first Street, Monroe, LA 71203; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 3519 Patrick Street, Lake Charles, LA 70605; 3501 Chateau Boulevard West Wing, Kenner, LA 70065; 100 Asma Boulevard, Suite 151, Lafayette, LA 70508. This Regulation is also available on the Internet at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>.

H. M. Strong
Assistant Secretary

9704#079

NOTICE OF INTENT

Department of Environmental Quality Office of Solid and Hazardous Waste Solid Waste Division

Financial Assurance for Local Governments (LAC 33:VII.315 and 727)(SW024)

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Solid Waste Division Regulations, LAC 33:VII.315 and 727 (SW024).

The existing Regulations specify several mechanisms by which owners and operators of municipal solid waste landfills may provide financial assurance for closure and post-closure of these facilities. These proposed Regulations increase the flexibility available to local governments to make the required demonstration of financial assurance. This action is necessary to make the state Regulations consistent with the federal Subtitle D Regulations.

This proposed Rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S.49:953(G)(3), therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33

ENVIRONMENTAL QUALITY

Part VII. Solid Waste

Subpart 1. Solid Waste

Chapter 3. Scope and Mandatory Provisions of the Program

§315. Mandatory Provisions

All persons conducting activities regulated under these regulations shall comply with the following provisions:

* * *

[See Prior Text in A-G.3.b]

4. Financial Assurance. Existing Types I, II, or III facilities that are owned or operated by local governments must comply with the financial assurance requirements in LAC 33:VII.727 no later than April 9, 1997. The administrative authority may waive the requirements of this Section for up to one year until April 9, 1998, for good cause if an owner or operator demonstrates that the April 9, 1997, effective date for the requirements of this Section does not provide sufficient time to comply with these requirements and that such a waiver will not adversely affect human health and the environment. All other facilities must comply by February 20, 1995.

* * *

[See Prior Text in G.5-R.2]

AUTHORITY NOTE: Promulgated in accordance with R.S.30:2001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Solid Waste Division, LR 19:187 (February 1993), amended LR 19:1143 (September 1993), LR 19:1315 (October 1993), repromulgated LR 19:1421 (November 1993), amended LR 22:279 (April 1996), LR 23:

Chapter 7. Solid Waste Standards
Subchapter E. Financial Assurance for All Processors and Disposers of Solid Waste

§727. Financial Assurance

* * *

[See Prior Text in A-A.2.i.ix.(I)]

SOLID WASTE FACILITY CORPORATE GUARANTEE FOR LIABILITY COVERAGE CLOSURE, AND/OR POST-CLOSURE CARE

Guarantee made this [date] by [name of guaranteeing entity], a business corporation organized under the laws of the state of [insert name of state], hereinafter referred to as guarantor, to the Louisiana Department of Environmental Quality, obligee, on behalf of our subsidiary [insert the name of the permit holder or applicant] of [business address].

Recitals

* * *

[See Prior Text in 1-12]

I hereby certify that the wording of this guarantee is identical to the wording specified in LAC 3:VII.727.A.2.i.ix.(I), effective on the date first above written.

Effective date: _____

[Name of Guarantor]

[Authorized signature for guarantor]

[Typed name and title of person signing]

Thus sworn and signed before me this [date].

j. Local Government Financial Test. An owner or operator that satisfies the requirements of Subsection A.2.j.i-iii of this Section may demonstrate financial assurance up to the amount specified in Subsection A.2.j.iv of this Section.

i. Financial Component

(a). The owner or operator must satisfy the following conditions, as applicable:

(i). if the owner or operator has outstanding, rated, general obligation bonds that are not secured by insurance, a letter of credit, or other collateral or guarantee, it must have a current rating of Aaa, Aa, A, or Baa, as issued by *Moody's*, or AAA, AA, A, or BBB, as issued by *Standard and Poor's*, on all such general obligation bonds; or

(ii). the owner or operator must satisfy the ratio of cash plus marketable securities to total expenditures being

greater than or equal to 0.05 and the ratio of annual debt service to total expenditures less than or equal to 0.20 based on the owner or operator's most recent audited annual financial statement.

(b). The owner or operator must prepare its financial statements in conformity with *Generally Accepted Accounting Principles* for governments and have its financial statements audited by an independent certified public accountant (or appropriate state agency).

(c). A local government is not eligible to assure its obligations under Subsection A.2.j of this Section if it:

(i). is currently in default on any outstanding general obligation bonds;

(ii). has any outstanding general obligation bonds rated lower than Baa as issued by *Moody's* or BBB as issued by *Standard and Poor's*;

(iii). operated at a deficit equal to 5 percent or more of total annual revenue in each of the past two fiscal years; or

(iv). receives an adverse opinion, disclaimer of opinion, or other qualified opinion from the independent certified public accountant (or appropriate state agency) auditing its financial statement as required under Subsection A.2.j.i.(b) of this Section. The administrative authority may evaluate qualified opinions on a case-by-case basis and allow use of the financial test in cases where the administrative authority deems the qualification insufficient to warrant disallowance of use of the test.

(d). The following terms used in this Subsection are defined as follows:

(i). *Deficit*—total annual revenues minus total annual expenditures.

(ii). *Total Revenues*—revenues from all taxes and fees, but does not include the proceeds from borrowing or asset sales, excluding revenue from funds managed by local government on behalf of a specific third party.

(iii). *Total Expenditures*—all expenditures, excluding capital outlays and debt repayment.

(iv). *Cash Plus Marketable Securities*—all the cash plus marketable securities held by the local government on the last day of a fiscal year, excluding cash and marketable securities designated to satisfy past obligations such as pensions.

(v). *Debt Service*—the amount of principal and interest due on a loan in a given time period, typically the current year.

ii. Public Notice Component. The local government owner or operator must place a reference to the closure and post-closure care costs assured through the financial test into its next comprehensive annual financial report (CAFR) after the effective date of this Section or prior to the initial receipt of waste at the facility, whichever is later. Disclosure must include the nature and source of closure and post-closure care requirements, the reported liability at the balance sheet date, the estimated total closure and post-closure care cost remaining to be recognized, the percentage of landfill capacity used to date, and the estimated landfill life in years. A reference to corrective action costs must be placed in the CAFR not later than 120 days after the corrective action

remedy has been selected in accordance with the requirements of LAC 33:VII.709.E.6. For the first year the financial test is used to assure costs at a particular facility, the reference may be placed in the operating record until issuance of the next available CAFR if timing does not permit the reference to be incorporated into the most recently issued CAFR or budget. For closure and post-closure costs, conformance with *Government Accounting Standards Board Statement 18* assures compliance with this public notice component.

iii. Recordkeeping and Reporting Requirements

(a). The local government owner or operator must place the following items in the facility's operating record:

(i). a letter signed by the local government's chief financial officer that lists all the current cost estimates covered by a financial test, as described in Subsection A.2.j.iv of this Section. It must provide evidence that the local government meets the conditions of Subsection A.2.j.i.(a), (b), and (c) of this Section, and certify that the local government meets the conditions of Subsection A.2.j.i.(a), (b), (c), ii, and iv of this Section;

(ii). the local government's independently audited year-end financial statements for the latest fiscal year (except for local governments where audits are required every two years and unaudited statements may be used in years when audits are not required), including the unqualified opinion of the auditor who must be an independent certified public accountant or an appropriate state agency that conducts equivalent comprehensive audits;

(iii). a report to the local government from the local government's independent certified public accountant or the appropriate state agency based on performing an agreed upon procedures engagement relative to the financial ratios required by Subsection A.2.j.i.(a)(ii) of this Section, if applicable, and the requirements of Subsection A.2.j.i.(b) and (c)(iii) and (iv) of this Section. The certified public accountant or state agency's report should state the procedures performed and the certified public accountant or state agency's findings; and

(iv). a copy of the comprehensive annual financial report (CAFR) used to comply with Subsection A.2.j.ii of this Section (certification that the requirements of *General Accounting Standards Board Statement 18* have been met).

(b). The items required in Subsection A.2.j.iii.(a) of this Section must be placed in the facility operating record as follows:

(i). in the case of closure and post-closure care, either before the effective date of this Section, which is April 9, 1997, or prior to the initial receipt of waste at the facility, whichever is later; or

(ii). in the case of corrective action, not later than 120 days after the corrective action remedy is selected in accordance with the requirements of LAC 33:VII.709.E.6.

(c). After the initial placement of the items in the facility's operating record, the local government owner or operator must update the information and place the updated information in the operating record within 180 days following the close of the owner or operator's fiscal year.

(d). The local government owner or operator is no longer required to meet the requirements of Subsection A.2.j.iii of this Section when:

(i). the owner or operator substitutes alternate financial assurance, as specified in this Section; or

(ii). the owner or operator is released from the requirements of this Section in accordance with Subsection A.1 or 2 of this Section.

(e). A local government must satisfy the requirements of the financial test at the close of each fiscal year. If the local government owner or operator no longer meets the requirements of the local government financial test, it must, within 210 days following the close of the owner or operator's fiscal year, obtain alternative financial assurance that meets the requirements of this Section, place the required submissions for that assurance in the operating record, and notify the administrative authority that the owner or operator no longer meets the criteria of the financial test and that alternate assurance has been obtained.

(f). The administrative authority, based on a reasonable belief that the local government owner or operator may no longer meet the requirements of the local government financial test, may require additional reports of financial condition from the local government at any time. If the administrative authority finds, on the basis of such reports or other information, that the owner or operator no longer meets the local government financial test, the local government must provide alternate financial assurance in accordance with this Section.

iv. Calculation of Costs to be Assured. The portion of the closure, post-closure, and corrective action costs for which an owner or operator can assure under Subsection A.2.j of this Section is determined as follows:

(a). if the local government owner or operator does not assure other environmental obligations through a financial test, it may assure closure, post-closure, and corrective action costs that equal up to 43 percent of the local government's total annual revenue;

(b). if the local government assures other environmental obligations through a financial test, including those associated with UIC facilities under 40 CFR 144.62, petroleum underground storage tank facilities under 40 CFR part 280, PCB storage facilities under 40 CFR part 761, and hazardous waste treatment, storage, and disposal facilities under 40 CFR parts 264 and 265, or corresponding state programs, it must add those costs to the closure, post-closure, and corrective action costs it seeks to assure under Subsection A.2.j of this Section. The total that may be assured must not exceed 43 percent of the local government's total annual revenue;

(c). the owner or operator must obtain an alternate financial assurance instrument for those costs that exceed the limits set in Subsection A.2.j.iv.(a) and (b) of this Section.

k. Local Government Guarantee. An owner or operator may demonstrate financial assurance for closure, post-closure, and corrective action, as required by Subsection A.1-2 of this Section, by obtaining a written guarantee provided by a local government. The guarantor must meet the requirements of the local government financial test in

Subsection A.2.j of this Section, and must comply with the terms of a written guarantee.

i. Terms of the Written Guarantee. The guarantee must be effective before the initial receipt of waste or before the effective date of this Section, whichever is later, in the case of closure and post-closure care, or no later than 120 days after the corrective action remedy has been selected in accordance with the requirements of LAC 33:VII.709.E.6. The guarantee must provide that:

(a) if the owner or operator fails to perform closure, post-closure care, and/or corrective action of a facility covered by the guarantee, the guarantor will:

(i). perform, or pay a third party to perform closure, post-closure care, and/or corrective action as required; or

(ii). establish a fully funded trust fund as specified in Subsection A.2.d of this Section in the name of the owner or operator;

(b) the guarantee will remain in force unless the guarantor sends notice of cancellation by certified mail to the owner or operator and to the administrative authority. Cancellation may not occur, however, during the 120 days beginning on the date of receipt of the notice of cancellation by both the owner or operator and the administrative authority, as evidenced by the return receipts; and

(c) if a guarantee is canceled, the owner or operator must, within 90 days following receipt of the cancellation notice by the owner or operator and the administrative authority, obtain alternate financial assurance, place evidence of that alternate financial assurance in the facility operating record, and notify the administrative authority. If the owner or operator fails to provide alternate financial assurance within the 90-day period, then the owner or operator must provide that alternate assurance within 120 days following the guarantor's notice of cancellation, place evidence of the alternate assurance in the facility operating record, and notify the administrative authority.

ii. Recordkeeping and Reporting

(a). The owner or operator must place a certified copy of the guarantee, along with the items required under Subsection A.2.j.iii of this Section, into the facility's operating record before the initial receipt of waste or before the effective date of this Section, whichever is later, in the case of closure or post-closure care, or no later than 120 days after the corrective action remedy has been selected in accordance with the requirements of LAC 33:VII.709.E.6.

(b). The owner or operator is no longer required to maintain the items specified in Subsection A.2.k.ii of this Section when:

(i). the owner or operator substitutes alternate financial assurance as specified in this Section; or

(ii). the owner or operator is released from the requirements of this Section in accordance with Subsection A.1-2 of this Section.

(c). If a local government guarantor no longer meets the requirements of Subsection A.2.j of this Section, the owner or operator must, within 90 days, obtain alternate assurance, place evidence of the alternate assurance in the facility operating record, and notify the administrative authority. If the owner or operator fails to obtain alternate

financial assurance within that 90-day period, the guarantor must provide that alternate assurance within the next 30 days.

1. Use of Multiple Mechanisms. An owner or operator may demonstrate financial assurance for closure, post-closure, and corrective action, as required by Subsection A.1-2 of this Section, by establishing more than one financial mechanism per facility, except that mechanisms guaranteeing performance, rather than payment may not be combined with other instruments. The mechanisms must be as specified in Subsection A.2.d-i of this Section, except that financial assurance for an amount at least equal to the current cost estimate for closure, post-closure care, and/or corrective action may be provided by a combination of mechanisms, rather than a single mechanism.

m. Discounting. The administrative authority may allow discounting of closure and post-closure cost estimates in Subsection A.2 of this Section, and/or corrective action costs in Subsection A.1 of this Section up to the rate of return for essentially risk-free investments, net of inflation, under the following conditions:

i. the administrative authority determines that cost estimates are complete and accurate and the owner or operator has submitted a statement from a registered professional engineer so stating;

ii. the state finds the facility in compliance with applicable and appropriate permit conditions;

iii. the administrative authority determines that the closure date is certain and the owner or operator certifies that there are no foreseeable factors that will change the estimate of site life; and

iv. discounted cost estimates must be adjusted annually to reflect inflation and years of remaining life.

[See Prior Text in B-B.2]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Solid Waste Division, LR 19:187 (February 1993), amended LR 19:1143 (September 1993), LR 19:1316 (October 1993), LR 23:

A public hearing will be held on May 29, 1997, at 1:30 p.m. in the Maynard Ketcham Building, Room 326, 7290 Bluebonnet Boulevard, Baton Rouge, LA 70810. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Patsy Deaville at the address given below or at (504) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by SW024. Such comments should be submitted no later than June 5, 1997, at 4:30 p.m., to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA, 70810 or to FAX (504) 765-0486.

This proposed Regulation is available for inspection from 8 a.m. until 4:30 p.m. at the following DEQ office locations: 7290 Bluebonnet Boulevard, Fourth Floor, Baton Rouge, LA 70810; 804 Thirty-first Street, Monroe, LA 71203; State Office Building, 1525 Fairfield Avenue, Shreveport, LA

71101; 3519 Patrick Street, Lake Charles, LA 70605;
3501 Chateau Boulevard West Wing, Kenner, LA 70065;
100 Asma Boulevard, Suite 151, Lafayette, LA 70508.

H. M. Strong
Assistant Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Financial Assurance for Local Governments

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no implementation costs to state governmental units because the job functions are already being performed. Local governmental units with solid waste facilities will be positively impacted by this Rule in that those parishes which have their own landfills will be able to utilize a less costly method of financial assurance for closure and post-closure care.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The estimated effect on revenue collections to the state governmental unit will be zero because the Rule only provides for alternate methods for local government to provide financial assurance.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no estimated costs to directly affected persons because the Rule is only providing for alternate financial assurance mechanisms for local governments.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no estimated effect on competition or employment to facilities or individuals within the state.

H. M. Strong
Assistant Secretary
9704#076

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Office of the Governor
Crime Victims Reparations Board**

Victim Compensation (LAC 22:XIII.103)

In accordance with the provisions of R.S. 46:1801 et seq., the Crime Victims Reparations Act, and R.S. 49:950 et seq., the Administrative Procedure Act, the Crime Victims Reparations Board hereby gives notice of its intent to amend Rules and Regulations relative to the awarding of compensation to applicants.

Title 22

**CORRECTIONS, CRIMINAL JUSTICE AND LAW
ENFORCEMENT**

Part XIII. Crime Victims Reparations Board

Chapter 1. Authority and Definitions

§103. Definitions

* * *

Victim—

* * *

b. a resident of Louisiana who is a victim of an act of terrorism (as defined in Section 2331 of Title 18, *United States Code*) occurring outside the U.S., or

c. a Louisiana resident who suffers personal injury or death as a result of a crime described in R.S. 46:1805 except that the criminal act occurred outside of this state. The resident shall have the same rights under this Chapter as if the act had occurred in this state upon a showing that the state in which the act occurred does not have an eligible crime victims reparations program and the crime would have been compensable had it occurred in Louisiana. In this Subparagraph, *Louisiana Resident* means a person who maintained a place of permanent abode in this state at the time the crime was committed for which reparations are sought.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Crime Victims Reparations Board, LR 20:538 (May 1994), amended LR 22:709 (August 1996), LR 23:

Interested persons may submit written comments on this proposed Rule no later than May 28, 1997, at 5 p.m. to Program Manager, Crime Victims Reparations Board, 1885 Wooddale Boulevard, Room 708, Baton Rouge, LA 70806.

A public hearing will be held May 28, 1997, at 4 p.m., at 1885 Wooddale Boulevard, Seventh Floor Conference Room, Baton Rouge, LA. Interested persons are invited to attend and submit oral comments on the proposed Rule.

Lamarr Davis
Chairman

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Victim Compensation

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed amendments expand the definition of a "victim" to include those Louisiana residents who are victims of an act of terrorism in another country. The proposed amendments also allow Louisiana residents to be eligible for compensation from Louisiana regardless of whether the state or country in which the terrorism act occurred has a compensation program. A \$50 million federal Victims of Crime Act (VOCA) reserve fund has been set up specifically to compensate victims of terrorism acts and provides sufficient funding for Louisiana to compensate victims. These federal funds do not require a state match. The proposed amendments will not result in additional costs to state or local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

When a Louisiana resident is a victim of an act of terrorism in another state or country, the victim will be eligible to receive compensation from Louisiana through the VOCA federal reserve fund. Revenue obtained by the state through the federal reserve fund will vary directly with the number of Louisiana residents who are victims, and the "damages" such residents suffer due to acts of terrorism. There will be no effect on local government revenue collections as a result of these proposed amendments.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Louisiana residents who are victims of an act of terrorism in another state or country will now be eligible to receive compensation from Louisiana through the federal VOCA reserve fund.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no effect on competition or employment in the public or private sector as a result of these proposed amendments.

Michael A. Ranatza
Executive Director
9704#032

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Office of the Governor
Office of Elderly Affairs**

Hearings (LAC 4:VII.1265-1269)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Governor's Office of Elderly Affairs (GOEA) intends to amend the GOEA Policy Manual, effective July 20, 1997. The purpose of this proposed Rule change is to establish procedures to provide due process to affected parties when GOEA initiates certain types of action.

Title 4

ADMINISTRATION

Part VII. Governor's Office

Chapter 11. Elderly Affairs

§1265. General Hearing Provisions

A. Purpose. The Governor's Office of Elderly Affairs (GOEA) shall provide the opportunity for a hearing, on request, to area agencies on aging submitting plans under Title III of the Older Americans Act, to any provider of a service under such a plan, or to any applicant to provide a service under such a plan; and to any unit of general purpose local government, region within the state recognized for area wide planning, metropolitan area, or Indian reservation that applies for designation as a planning and service area when GOEA initiates certain types of action or proceedings. This Section specifies the timing and procedures for the hearings.

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with OAA Section 305(b)(1), Section 307(a)(5) and 45 CFR 1321.29(a).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 11:618 (June 1985), amended LR 11:1078 (November 1985), LR 23:

§1267. Hearing Procedures for Area Agencies on Aging (AAAs)

A. Purpose. The purpose of this Section is to establish procedures that Governor's Office of Elderly Affairs (GOEA) will follow to provide due process to affected AAAs whenever GOEA initiates particular types of action or proceedings.

B. Right to a Hearing. GOEA shall provide affected AAAs reasonable notice and opportunity for a hearing whenever GOEA initiates an action or proceeding to:

1. revoke the designation of an AAA;
2. designate an additional planning and service area in the State;
3. divide the State into different planning and service areas; or
4. otherwise affect the boundaries of the planning and service areas in the State.

C. - K. ...

L. Final Decision

1. ...
2. Procedures for rehearing and appeal shall be governed by R.S. 49:959.

M. ...

N. Appeal to Assistant Secretary for Aging. Any AAA that is adversely affected by an action specified in Subsection B of this Section, and whom GOEA has provided a written decision, may appeal the decision to the assistant secretary for Aging in writing within 30 days following receipt of the state agency's decision. Such appeal shall be governed by the procedures outlined in the guidance issued by the assistant secretary for Aging.

AUTHORITY NOTE: Promulgated in accordance with OAA Section 305(b)(5)(C) and 307(a)(5).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 11:618 (June 1985), amended LR 11:1078 (November 1985), LR 23:

§1269. Hearing Procedures for Applicants for Planning and Service Area (PSA) Designation

A. ...

B. Right to a Hearing. The Governor's Office of Elderly Affairs shall provide an opportunity for a hearing, and issue a written decision to any unit of general purpose local government, region within the state recognized for purposes of area wide planning, metropolitan area, or Indian reservation whose application for designation as a PSA is denied.

C.1 - 2. ...

3. Petitioners shall be given no less than 10 days notice of the scheduled hearing. Notice shall be sent by registered or certified mail, return receipt requested.

D. ...

E. Hearing Examiner. The director or his designated representative shall be the hearing examiner and preside at the hearing, subject to the provisions of R.S. 49:960. The hearing examiner shall conduct the hearing in an orderly fashion and in accordance with the procedures outlined herein. The hearing examiner shall fully consider information relevant to the complaint and draft a fair decision based on such information.

F - M. ...

N. Appeal to Assistant Secretary for Aging. Any eligible applicant for PSA designation, as defined in Subsection B of this Section, whose application has been denied and who has been provided a written decision by GOEA, may appeal the denial to the assistant secretary for Aging in writing within 30 days following receipt of the state agency's decision. Such appeal shall be governed by the procedures outlined in the guidance issued by the Assistant Secretary for Aging.

AUTHORITY NOTE: Promulgated in accordance with OAA Section 305(b)(1), 305(b)(4), and 45 CFR 1321.29.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 11:618 (June 1985), amended LR 11:1078 (November 1985), LR 23:

Betty Johnson is responsible for responding to inquiries concerning this proposed Rule. Interested persons may submit written comments to the Governor's Office of Elderly Affairs, Box 80374, Baton Rouge, LA 70898-0374. Written comments will be accepted until 5 p.m. May 28, 1997.

A public hearing on this proposed Rule will be held on Wednesday, May 28, 1997 at the Louisiana State Archives Building Auditorium, 3851 Essen Lane, Baton Rouge, LA 70809 at 1:30 pm. All interested parties will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at this hearing.

Richard W. Collins
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Hearings**

- I. **ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**
Local governmental units whose applications for designation as Planning and Service Areas (PSAs) are denied will be entitled to a hearing from the Governor's Office of Elderly Affairs (GOEA) and to appeal the agency's decision to the U.S. Department of Health and Human Services Assistant Secretary for Aging. The costs associated with preparing and submitting the necessary paperwork will vary from agency to agency and cannot be determined at this time.
- II. **ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**
This Rule change will not affect revenue collections of state or local governmental units.
- III. **ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**
Designated Area Agencies on Aging (AAAs) who may be adversely affected when GOEA initiates an action or proceeding to revoke the designation of an AAA, designate an additional Planning and Service Area (PSA) in the state, divide the state into different PSAs, or otherwise affect the boundaries of the PSAs of the state will be eligible to receive a hearing from GOEA and to appeal the agency's decision to the U.S. Department of Health and Human Services Assistant Secretary for Aging. The costs associated with preparing and submitting the necessary paperwork will vary from agency to agency and cannot be determined at this time. There is the potential of economic benefits to an AAA resulting from a hearing and appeal in which the final decision is more favorable to the AAA than the original decision rendered by GOEA.
- IV. **ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**
The proposed Rule is not expected to affect competition and employment.

Richard W. Collins
Executive Director
9704#036

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Office of the Governor
Office of Elderly Affairs**

Planning and Service Areas and Area
Agencies on Aging (LAC 4:VII.1137 and 1139)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Governor's Office of Elderly Affairs (GOEA) intends to amend §§1137 and 1139 of the GOEA Policy Manual, effective July 20, 1997. The purpose of this Rule change is to establish policies governing the designation of Planning and Service Areas (PSAs) and Area Agencies on Aging (AAAs) as required by the Older Americans Act of 1965, as amended (P.L. 89-73).

Title 4

ADMINISTRATION

Part VII. Governor's Office

Chapter 11. Elderly Affairs

§1137. Planning and Service Area Designation

A. General Rules

1. In accordance with Section 305 of the Older Americans Act (the Act), GOEA shall divide the state into distinct Planning and Service Areas (PSAs) after considering the geographical distribution of individuals age 60 and older in the state; the incidence of the need for supportive services, nutrition services, multipurpose senior centers, and legal assistance; the distribution of older individuals who have greatest economic need (with particular attention to low-income minority individuals) residing in such areas; the distribution of older individuals who have greatest social need (with particular attention to low-income minority individuals) residing in such areas; the distribution of older Indians residing in such areas; the distribution of resources available to provide such services or centers; the boundaries of existing areas within the state that were drawn for the planning or administration of supportive service programs; the location of units of general purpose local government within the state; and any other relevant factors.

2. Starting with the state plan on aging beginning October 1, 1997, GOEA shall accept applications for PSA designation received from eligible applicants on or before November 1 of the year immediately preceding the final year of the state plan period. Any designation so approved shall become effective on the first day of the next area plan and shall remain in effect throughout the duration of the approved area plan.

3. GOEA may include in any Planning and Service Area such additional areas adjacent to the unit of general purpose local government, region, metropolitan area, or Indian reservation so designated as GOEA determines to be necessary for and will enhance the effective administration of the programs authorized by Title III of the Older Americans Act.

4. GOEA may include the area covered by the appropriate economic development district involved in any Planning and Service Area designated and may include all portions of an Indian reservation within a single Planning and Service Area.

B. Eligible Applicants. The governing body of any unit of general purpose local government, region within the state recognized for area-wide planning, metropolitan area, or Indian reservation may apply for its geographical area of jurisdiction to be a designated Planning and Service Area.

C. Application Procedure for Planning and Service Area (PSA) Designation

1. Eligible applicants requesting PSA designation shall submit applications based upon a uniform format prescribed by GOEA. Each such application shall include:

a. a signed resolution by the governing body of the applicant organization authorizing the request for designation of the unit of general purpose local government, region within the state recognized for area-wide planning, metropolitan area, or Indian reservation as a Planning and Service Area;

b. a narrative and statistical description of:

i. the number of individuals age 60 and older in the proposed PSA;

ii. the number of older individuals who have the greatest economic need (including low-income minority individuals) residing in the proposed PSA;

iii. the number of older individuals who have the greatest social need (including low-income minority individuals) residing in the proposed PSA;

iv. the number of older individuals who are Indians residing in the proposed PSA;

c. the incidence of need for supportive services, nutrition services, multipurpose senior centers, and legal assistance in the proposed PSA;

d. the distribution of resources available to provide such services or centers in the proposed PSA;

e. the boundaries of existing areas within the proposed PSA drawn for the planning or administration of supportive and/or nutrition services programs;

f. the location of units of general purpose local government within the proposed PSA; and

g. a list of multipurpose senior centers and agencies providing supportive and/or nutrition services in the proposed PSA including services supported by Title III of the Older Americans Act.

2. If the proposed PSA's boundaries are either a combination or subdivision of existing Planning and Service Areas, the application shall address the basis of need for the merger or separation.

3. Applications from units of general purpose local government shall include a statement of whether the unit desires to exercise the right to first refusal of an area agency on aging designation. If the unit chooses not to exercise this right, the application shall include a statement of preference for another agency or organization to be the designated area agency on aging for the proposed PSA.

4. Applications for PSA designation shall be signed by the chief elected official representing the unit of general purpose local government, region within the state recognized for area-wide planning, metropolitan area, or Indian reservation.

D. Criteria for Approval of PSA Designation Applications

1. The application must be received by GOEA within the time frame prescribed in Subsection A.2 of this Section.

2. The application must be completed, including all required documentation and signatures. Incomplete applications may be returned and refused for reconsideration at the discretion of the GOEA executive director.

3. The application must clearly demonstrate that the designation of the proposed PSA is necessary for and will enhance the effective administration of the programs authorized by Title III of the Older Americans Act.

E. Procedure for Due Process to Affected Parties

1. GOEA shall approve or disapprove any application received under Subsection C.1 of this Section.

2. Any applicant under Subsection B of this Section whose application for designation as a PSA is denied by GOEA may appeal the denial under the procedures specified in LAC 4:VII.1269.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:932, Section 305, of the Older Americans Act and Part 1321 of Chapter XIII, of Title 45, Subtitle B, *Code of Federal Regulations*.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 10:464 (June 1984), amended LR 11:1078 (November 1985), LR 23:

§1139. Area Agency on Aging (AAA) Designation

A. General Rules

1. The Governor's Office of Elderly Affairs (GOEA) shall designate a public or private nonprofit agency or organization as the AAA for each Planning and Service Area (PSA) after consideration of the views offered by the unit or units of general purpose local government in each such PSA.

2. GOEA shall not designate any regional or local office of the state as an AAA.

3. Whenever GOEA designates a new AAA, GOEA shall give the right of first refusal to a unit of general purpose local government if such unit can meet the requirements of Section 305 (c) of the Older Americans Act and the boundaries of such a unit and the boundaries of the PSA are reasonably contiguous.

4. If the unit of general purpose local government chooses not to exercise the right of first refusal, GOEA shall publicly solicit applications for designation as an area agency on aging and shall give preference to an established office on aging as defined in Subsection B.1.a of this Section.

5. GOEA shall take into account the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under the state plan when designating AAAs.

B. Eligible Applicants for AAA Designation. Any of the following may apply for designation as an AAA:

1. an established office on aging which is operating within the PSA. The term *Established Office on Aging* means a public or private nonprofit agency/organization that has functioned for at least one year for the purpose of planning, developing or administering aging service programs. The agency/organization must be capable of functioning effectively throughout the PSA designated by GOEA;

2. any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an AAA by the chief elected official of such unit;

3. any office or agency designated by the appropriate chief elected officials of any combination of units of general

purpose local government to act only in behalf of such combination for the purpose of serving as an AAA;

4. any other public or private nonprofit agency in a PSA, or any separate organizational unit within such agency, which is under GOEA's supervision or direction for this purpose and which can and will engage only in the planning or provision of a broad range of supportive services, or nutrition services within such PSA.

C. Application Procedure for AAA Designation

1. Eligible Applicants for AAA designation shall submit a written application in the format prescribed by GOEA.

2. Applications for AAA designation shall include:

a. the legal basis upon which the agency is organized;
b. a list of members serving on the governing body and the agencies/organizations they represent;
c. a copy of the agency's most recent audit;
d. a copy of the agency's current approved financial plan;

e. an organizational chart depicting the manner in which the agency's staff will be divided to fulfill its AAA responsibilities;

f. job descriptions reflecting the proposed AAA's intent to carry out the advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation functions;

g. assurances that the agency, once designated, shall provide for an adequate and qualified staff to perform all of the AAA functions prescribed in the Older Americans Act; and

h. such other information as GOEA deems necessary.

D. Criteria for Approval of Applications for AAA Designation

1. The application must be submitted in a timely manner, including all required documentation. Incomplete applications may be returned and refused for reconsideration at the discretion of the GOEA executive director.

2. The agency applying for AAA designation shall provide an opportunity for on-site review and assessment by GOEA to ensure that said organization has the capacity to perform the functions of an AAA.

3. Applications must demonstrate that the agency, if designated, will have the ability to fulfill the mission of an AAA.

E. Procedure for Due Process to Affected Parties

1. GOEA shall approve or disapprove any application received under Subsection C.1 of this Section.

2. Any applicant under Subsection B of this Section whose application for designation as an AAA is denied by GOEA may appeal the denial under the procedures specified in LAC 4:VII.1267.

F. Duration of AAA Designation. The designated AAA shall function in that capacity for the duration of the area plan unless the AAA informs GOEA that it no longer wishes to carry out the responsibilities of an AAA or GOEA withdraws the designation as provided in Subsection G of this Section.

G. Withdrawal of AAA Designation

1. The Governor's Office of Elderly Affairs shall withdraw the AAA designation whenever GOEA, after reasonable notice and opportunity for a hearing, finds that:

a. the AAA does not meet the requirements of 45 CFR 1321; or

b. the plan or plan amendment is not approved; or

c. there is substantial failure in the provisions or administration of an approved area plan to comply with any provision of 45 CFR 1321 or the GOEA Policy Manual; or

d. activities of the AAA are inconsistent with the statutory mission prescribed in the Act or in conflict with the requirement that it function only as an AAA.

2. If GOEA withdraws the AAA's designation, it shall:

a. provide a plan for the continuity of AAA functions and services in the affected Planning and Service Area; and

b. designate a new AAA in a timely manner.

3. If necessary to ensure continuity of service in a Planning and Service Area, GOEA may, for a period up to 180 days after its final decision to withdraw the designation of an AAA:

a. perform the responsibilities of the AAA; or

b. assign the responsibilities of the AAA to another agency in the Planning and Service Area.

4. The assistant secretary of the Administration on Aging may extend the 180-day period if GOEA:

a. notifies the assistant secretary in writing of its action;

b. requests an extension; and

c. demonstrates to the satisfaction of the assistant secretary a need for the extension.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:932, Section 305, of the Older Americans Act and Part 1321 of Chapter XIII, of Title 45, Subtitle B, *Code of Federal Regulations*.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 10:464 (June 1984), amended LR 11:1078 (November 1985), LR 23:

A public hearing on this proposed Rule will be held on Wednesday, May 28, 1997 at the Louisiana State Archives Building Auditorium, 3851 Essen Lane, Baton Rouge, LA 70809 at 1:30 pm. All interested parties will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at this hearing.

Betty Johnson is responsible for responding to inquiries concerning this proposed Rule. Interested persons may submit written comments to the Governor's Office of Elderly Affairs, Box 80374, Baton Rouge, LA 70898-0374. Written comments will be accepted until 5 p.m. May 28, 1997.

Richard W. Collins
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Planning and Service Areas and
Agencies on Aging**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The purpose of this Rule change is to establish policies governing the designation of Planning and Service Areas (PSAs) and Area Agencies on Aging (AAAs) in accordance with the Older Americans Act. The proposed Rule will allow local governmental units to apply for PSA designation and afford them the right to first refusal for AAA designation. Local

governmental units requesting PSA designation will be required to submit written applications to the Governor's Office of Elderly Affairs (GOEA) and will incur the associated costs. PSA designated local governmental units receiving AAA designation will be required to develop and administer an area plan on aging and will incur the associated costs. Ten percent of Older American Act Title III funds allocated to a AAA may be expended for administrative costs.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Older American Act (OAA) Title III funds are allocated among the PSAs by an intrastate funding formula based upon the geographical distribution of older individuals in the state and among PSAs with the greatest economic and social needs. Local governmental units of designated PSAs have the right to first refusal for AAA designation. If the AAA designation is awarded by GOEA, they will receive OAA Title III funding to develop and administer an area plan on aging.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

If the local governmental unit chooses not to exercise the right of first refusal, nonprofit agencies which are denied AAA designation may appeal GOEA's decision and will incur administrative costs associated with the appeals process.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Although nonprofit agencies are not in competition with each other, there is competition for funding. In a PSA in which the local governmental unit becomes the designated AAA, nonprofit agencies will not be able to apply for the AAA designation. Further, OAA Title III funds for supportive and nutrition services are administered by designated AAAs. The AAAs are required to procure services for persons age 60 and over through a competitive process. They must advertise the availability of funds and solicit proposals from service providers for supportive and nutrition services. Both profit and nonprofit agencies will be able to compete for subcontracts with AAAs to provide direct services under Title III of the OAA.

Richard W. Collins
Executive Director
9704#035

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Office of the Governor
Office of Elderly Affairs**

Service Procurement (LAC 4:VII.1143)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Governor's Office of Elderly Affairs (GOEA) intends to amend §1143 of the GOEA Policy Manual, "Service Procurement," effective July 20, 1997. The purpose of this Rule change is to add a Subsection regarding state agency approval of Area Agency on Aging (AAA) subcontracts. This topic was formerly covered in §1139, which is being amended to provide for the proposed Rule regarding the designation of AAAs.

The proposed Rule change modifies GOEA's policy regarding state agency approval of AAA proposed subcontracts with profit-making organizations. Previously,

AAAs were required to submit for prior approval any subcontracts with profit-making organizations to be full service providers under area plans. AAAs were not required to submit for prior approval subcontracts with profit-making organizations to be component service providers (i.e., those cases where the area agency is authorized by GOEA to provide a given service directly and the subcontractor is engaged to perform a supplemental function). The regional inspector general for Audit Services determined that this practice was inappropriate and in a report dated December 11, 1995, required GOEA to modify its policy and procedures accordingly.

Title 4

ADMINISTRATION

Part VII. Governor's Office

Chapter 11. Elderly Affairs

§1143. Service Procurement

A. - F. ...

(Editor's Note: A portion of this text was formerly promulgated in §1139.)

G. State Agency Approval of Area Agency Contracts

1. The area agency shall submit to the state agency for prior approval any proposed subcontracts with profit-making organizations to be full service providers under the area plan, including area agency subcontracts with profit-making component service providers when the area agency has been authorized to provide a service directly in accordance with Subsection B of this Section.

2. The state agency does not require the area agency to submit to it for prior review or approval any proposed subcontracts with public or private nonprofit agencies or organizations.

AUTHORITY NOTE: Promulgated in accordance with OAA Sections 212, 307(a)(10), OMB Circular A-110 and 45 CFR 1321.55.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 10:464 (June 1984), amended LR 11:621 (June 1985), LR 11:1078 (November 1985), LR 16:503 (June 1990), LR 18:610 (June 1992), LR 23:

Betty Johnson is responsible for responding to inquiries concerning this proposed Rule. Interested persons may submit written comments to the Governor's Office of Elderly Affairs, Box 80374, Baton Rouge, LA 70898-0374. Written comments will be accepted until 5 p.m., May 28, 1997.

A public hearing on this proposed Rule will be held on Wednesday, May 28, 1997 at the Louisiana State Archives Building Auditorium, 3851 Essen Lane, Baton Rouge, LA 70809 at 1:30 pm. All interested parties will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at this hearing.

Richard W. Collins
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Service Procurement**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule will require prior approval by the Governor's Office of Elderly Affairs (GOEA) for area agency

on aging (AAA) subcontracts with profit-making organizations to be component service providers. Local governmental units designated as AAAs will incur costs associated with submitting all Older Americans Act Title III contracts with profit-making organizations to GOEA for prior approval. The costs will vary depending on the number of component subcontracts each AAA uses to provide services to the elderly. These costs will be paid for with Older Americans Act AAA administrative funds.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule will not affect revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

AAAs will incur costs associated with submitting all contracts with profit-making organizations to GOEA for prior approval. The costs will vary depending on the number of component contracts each AAA uses to provide services to the elderly. These costs will be paid for with Older Americans Act AAA administrative funds. The proposed Rule is not expected to provide economic benefits to directly affected persons or nongovernmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Rule is not expected to affect competition and employment.

Richard W. Collins
Executive Director
9704#037

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

Department of Health and Hospitals Board of Examiners of Psychologists

Licensure through Reciprocity (LAC 46:LXIII.201)

Notice is hereby given in accordance with R.S. 49:950 et seq., that the Board of Examiners of Psychologists intends to adopt the following Rule setting the requirements for licensure through reciprocity:

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXIII. Psychologists

Chapter 2. Reciprocity

§201. Licensure of Psychologists through Reciprocity

A. Upon application thereof, accompanied by such fee as determined by the board, the board shall issue a license to any person who furnishes, upon a form and in such manner as the board prescribes, evidence satisfactory to the board that:

1. he/she is licensed as a psychologist by another member jurisdiction of the Association of State and Provincial Psychology Boards (ASPPB) if the requirements for such licensure in that jurisdiction are the substantial equivalent of

those required by Chapter 3 of the LAC, or if that jurisdiction has entered into a similar agreement with this board;

2. he/she has met the requirements of such board including five years of satisfactory professional postdoctoral experience in psychology;

3. he/she has successfully passed written and oral examinations administered by such board;

4. his/her doctoral program involved at least one continuous academic year of full-time residency on the campus of the institution at which the degree was granted;

5. he/she has not been subject to any disciplinary action by a professional board, and does not have any pending complaints against him/her.

B. Applicants for reciprocal licensing must pass the Louisiana Jurisprudence Examination prior to the issuance of a Louisiana license, and the Louisiana board may require a meeting with the applicant to review and verify his/her satisfactory character, current fitness, and plans to practice.

AUTHORITY NOTE: Promulgated in accordance with 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 23:

Interested persons may submit data, views, arguments, information or comments on the proposed Rule, in writing, to Brenda Ward, Board of Examiners of Psychologists, 11924 Justice Avenue, Suite A, Baton Rouge, LA 70816 within 20 days of the date of this notice.

John E. Mendoza
Chairman

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Reciprocity

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The only cost anticipated to implement this Rule is the \$40 cost of publishing it in the *Louisiana Register*. The LSBEP publishes a newsletter which is distributed to all Louisiana licensed psychologists. This new Rule will be published in the next edition of that newsletter. The Rule is so short that no adjustments in workload or printing are necessary.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections with the implementation of this new Rule. The fee for this type of licensure is already collected through the regular application process.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

It is anticipated that there would be no fiscal or economic impact resulting from this Rule for any persons or nongovernmental group. This proposed Rule applies to applicants for licensure to practice psychology in Louisiana who apply through reciprocity. The fee to those applicants is already collected through the regular application process. This new Rule changes the process, but does not change the fee collected for that process.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed Rule applies to candidates for licensure to practice psychology in the state of Louisiana who must apply

through this examining board according to Title 37, Chapter 28 of the Louisiana Revised Statutes. There is no impact upon competition nor effect upon employment in the public and/or private sectors.

Brenda C. Ward
Executive Director
9704#074

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Board of Nursing

Licensure Eligibility and Educational Programs (LAC 46:XLVII.Chapter 33)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., that the Board of Nursing pursuant to the authority vested in the board by R.S. 37:918, R.S. 37:919 intends to amend Title 46:XLVII pertaining to the licensure eligibility requirements of the board. The proposed amendments are set forth below.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLVII. Nurses

Subpart 2. Registered Nurses

Chapter 33. General

Subchapter D. Registration and Licensure

§3349. Licensure by Examination

* * *

B. Requirements for eligibility to take the NCLEX-RN in Louisiana include:

1. evidence of good moral character;
2. successful completion of a nursing education program approved by the board, or successful completion of a nursing education program located in another country or approved by another board of nursing which program meets or exceeds the educational standards for nursing education programs in Louisiana;
3. recommendation by the director of the school of nursing;
4. completion of the application form to include criminal records check as directed by the executive director of the board;
5. remittance of the required fee;
6. freedom from violations of this Part or of LAC 46:XLVII.3354;
7. freedom from acts or omissions which constitute grounds for disciplinary action as defined in R.S. 37:921 and LAC 46:XLVII.3331; or if found guilty of committing such acts or omissions, the board finds, after investigation, that sufficient restitution, rehabilitation, and education have occurred; and
8. evidence of proficiency in the English language if a graduate of a nursing program offered in a foreign country. Graduates of foreign nursing schools (except Canadian schools) must produce evidence of successful completion of

the Commission on Graduates of Foreign Nursing Schools Examination (COGFNS).

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918, 37:920 and 37:921.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 7:77 (March 1981), amended LR 11:348 (April 1985), LR 13:254 (June 1987), LR 13:394 (July 1987), LR 13:436 (August 1987), amended by the Department of Health and Hospitals, Board of Nursing, LR 19:1572 (December 1993), LR 21:574 (June 1995), LR 21:804 (August 1995), LR 23:

§3351. Licensure by Endorsement

Requirements for licensure by endorsement include:

1. evidence of good moral character;
2. must be duly evidence of initial licensure under the laws of another state, territory, or country;
3. evidence of a current licensure issued directly from the jurisdiction of last employment;
4. successful completion of a nursing education program approved by the board, or successful completion of a nursing education program located in another country or approved by another board of nursing which program meets or exceeds the educational standards for nursing education programs in Louisiana;
5. successful completion of a licensing examination which is comparable to that required for licensure by examination in Louisiana at the time of applicant's graduation;
6. freedom from violations of this Part or of LAC 46:XLVII.3354;
7. has committed no acts or omissions which constitute grounds for disciplinary action as defined in R.S. 37:921 and LAC 46:XLVII.3331; or if found guilty of committing such acts or omissions, the board finds, after investigation, that sufficient restitution, rehabilitation, and education have occurred;
8. remittance of the required fee;
9. completion of the required application for endorsement, including a criminal records check and the submission of required documents, within one year. School records submitted by the applicant or a third party will not be accepted; and
10. evidence of proficiency in the English language if a graduate of a nursing program offered in a foreign country.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918, 920 and 921.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 7:77 (March 1981), amended by the Department of Health and Hospitals, Board of Nursing, LR 19:1572 (December 1993), LR 21:804 (August 1995), LR 23:

§3353. Temporary Permits

* * *

B. A 90-day permit to practice as a registered nurse may be issued to any nurse currently registered in another state, territory, or country, pending receipt of endorsement credentials providing that said nurse has filed a complete application for licensure by endorsement and provided that:

* * *

3. There is no evidence of violation of this Part or of LAC 46:XLVII.3354. If information relative to violations of this Part or of LAC 46:XLVII.3354, or an investigation of

same, is received during the 90-day permit interval, the permit shall be recalled and licensure denied or delayed in accordance with LAC 46:XLVII.3354.

4. There is no allegation of acts or omissions which constitute grounds for disciplinary action as defined in R.S. 37:921 and LAC 46:XLVII.3331. If information relative to such acts or omissions, is received during the 90-day permit interval, the permit shall be recalled and licensure denied until such time as the person requests to appear before the board to show cause as to why licensure should not be denied.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918, 920 and 921.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 7:78 (March 1981), amended by the Department of Health and Hospitals, Board of Nursing, LR 19:1573 (December 1993), LR 23:

§3354. Denial or Delay of Licensure, Reinstatement, or the Right to Practice Nursing as a Student Nurse

A. Denial of Licensure, Reinstatement, or the Right to Practice Nursing as a Student Nurse

1. Applicants for licensure, reinstatement, or the right to practice as a student nurse shall be denied approval for licensure, for reinstatement, to receive a temporary working permit, to be eligible for NCLEX-RN, or to enter or progress into any clinical nursing course, if the applicant:

a. knowingly falsifies any documents submitted to the board or the nursing school; or

b. has pled guilty, nolo contendere, been convicted of, or committed a:

i. "crime of violence" as defined in R.S. 14:2(13), or any of the following crimes: first degree feticide, second degree feticide, aggravated assault with a firearm, stalking, false imprisonment-offender armed with dangerous weapon, incest, aggravated incest, molestation of a juvenile, sexual battery of the infirm; or

ii. crime which involves distribution of drugs. For purposes of the above Section, a pardon, suspension of imposition of sentence, expungement, or pretrial diversion or similar programs shall not negate or diminish the requirements of this Section.

2. Applicants who are denied licensure, reinstatement, or the right to practice nursing as a student nurse shall not be eligible to submit a new application, unless the grounds for denial are falsification of records and until the following conditions are met:

a. a minimum of five years has passed since the denial was issued;

b. the applicant presents evidence that the cause for the denial no longer exists; and

c. a hearing or conference is held before the board to review the evidence, to afford the applicant the opportunity to prove that the cause for the denial no longer exists, and to provide an opportunity for the board to evaluate changes in the person or conditions.

B. Delay of Licensure, Reinstatement, or the Right to Practice Nursing as a Student Nurse

1. Applicants for licensure, reinstatement, and for practice as a student nurse shall be delayed approval for

licensure, for reinstatement, to receive a temporary working permit, to be eligible for NCLEX-RN, or to enter or progress into any clinical nursing course, if the applicant:

a. has any pending disciplinary action or any restrictions of any form by any licensing/certifying board in any state; or

b. has a pending criminal charge that involves any violence or danger to another person, or involves a crime which constitutes a threat to patient care; or

c. has pled guilty, nolo contendere, been convicted of or committed a crime that reflects on the ability of the person to practice nursing safely, and the conditions of the court have not been met, or is currently serving a court ordered probation or parole. If the crime is a "crime of violence" as defined in R.S. 14:2.(13) or any of the following crimes: first degree feticide, second degree feticide, aggravated assault with a firearm, stalking, false imprisonment-offender armed with dangerous weapon, incest, aggravated incest, molestation of a juvenile, sexual battery of the infirm, the applicant shall be denied.

For purposes of the above Section, a pardon, suspension of imposition of sentence, expungement, or pretrial diversion or similar programs shall not negate or diminish the requirements of this Section.

2. Applicants who are delayed licensure, reinstatement, or the right to practice nursing as a student nurse shall not be eligible to submit a new application until the following conditions are met:

a. the applicant presents sufficient evidence that the cause for the delay no longer exists; and

b. a hearing or conference is held before the board to review the evidence, to afford the applicant the opportunity to prove that the cause for the delay no longer exists, and to provide an opportunity for the board to evaluate changes in the person or conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918, 920 and 921.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Nursing, LR 23:

§3355. Renewal of License

* * *

C. An inactive or lapsed license may be reinstated by submitting a completed application, paying the required fee, and meeting all other relevant requirements, provided there is no evidence of violation of this Part or of LAC 46:XLVII.3354, or no allegations of acts or omissions which constitute grounds for disciplinary action as defined in R.S. 37:921 or LAC 46:XLVII.3331. Any person practicing as a registered nurse during the time one's license is inactive or has lapsed is considered an illegal practitioner and is subject to the penalties provided for violation of this Part and will not be reinstated until the disciplinary action is resolved.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918 and 920.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 7:78 (March 1981), amended by the Department of Health and Hospitals, Board of Nursing, LR 16:1061 (December 1990), LR 23:

Chapter 35. Nursing Educational Programs

§3517. Student Selection and Guidance

B. Qualified applicants shall be considered for admission without discrimination and in compliance with applicable state and federal laws and regulations.

I. Students shall not be eligible to enroll in a clinical nursing course based on evidence of grounds for denial of licensure in accordance with R.S. 37:921, LAC 46:XLVII.3331 and LAC 46:XLVII.3354.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 3:187 (April 1977), amended LR 10:1025 (December 1984), amended by the Department of Health and Hospitals, Board of Nursing, LR 19:1147 (September 1993), LR 23:

§3536. Approval for Nursing Education Programs whose Administrative Control is Located in Another State Offering Programs, Courses, and/or Clinical Experience in Louisiana

B. Course/Clinical Offerings. Out-of-state nursing programs offering courses/clinical experiences in Louisiana are expected to maintain the standards required of Louisiana-based programs. The board reserves the right to withdraw the approval of such offerings if adherence to these standards is not maintained. To receive approval by the Board of Nursing for course/clinical offerings in Louisiana by nursing programs whose administrative control is located in another state, the following criteria shall be met:

3. Students

a. ...

b. Students shall not be eligible to enroll in a clinical nursing course based on evidence of grounds for denial of licensure in accordance with R.S. 37:921, LAC 46:XLVII.3331 and LAC 46:XLVII.3354.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Nursing, LR 19:1145 (September 1993), amended LR 23:

Inquiries concerning the proposed amendments may be directed in writing to Barbara L. Morvant, Executive Director, Board of Nursing, at the address set forth below.

Interested persons may submit data, views, arguments, information or comments on the proposed Rules, in writing, to the Board of Nursing, 3510 N. Causeway Boulevard, Suite 501, Metairie, LA 70002. Written comments must be submitted to and received by the board no later than 4:30 p.m. on May 9, 1997.

Barbara L. Morvant
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Licensure Eligibility and Educational Programs

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
The anticipated cost will be \$12,414.52 per year for SFY 1997-1998; SFY 1998-1999; SFY 1999-2000. Consisting of \$12,024 for one additional clerk position, \$78 duplicating cost, and \$312.52 postage cost.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no anticipated effect on revenue collection of state or local governmental units. The board receives no revenue from this procedure. Applicants submit a check with their criminal records check form that is made out directly to the law enforcement agency. These checks are forwarded to the agency along with the form for processing. The Department of Public Safety and Corrections currently charges \$10 per individual to process a state criminal records check.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
Applicants for licensure will be required to complete a state criminal records check for which the Department of Public Safety and Corrections charges \$10 for the state check. We are anticipating that in the future a national records check will be required which will cost from \$10 to \$30.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There is no anticipated effect on competition or employment. Applicants are already required to document any criminal history. The new rules related to grounds for denial or delay of licensure in Louisiana are already currently used as a standard for denial of licensure. We anticipate that the addition of a criminal records check and subsequent denial or delay of individuals receiving licensure will not significantly effect the number of registered nurses in Louisiana. Such costs should be evaluated based on the benefit to the health and welfare of citizens.

Barbara L. Morvant, M.N., R.N.
Executive Director
9704#033

H. Gordon Monk
Legislative Fiscal Officer

NOTICE OF INTENT

**Department of Health and Hospitals
Board of Nursing**

Officers of the Board; Registration and Licensure; and License Renewal (LAC 46:XLVII.3303, 3347 and 3355)

Notice is hereby given, in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., that the Board of Nursing (board) pursuant to the authority vested in the board by R.S. 37:918, R.S. 37:919 intends to amend LAC 46:XLVII pertaining to the renewal dates of the board. Proposed amendments will establish the vice president title and functions and are set forth below.

Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS
Part XLVII. Nurses

Subpart 2. Registered Nurses

Chapter 33. General

Subchapter A. Board of Nursing

§3303. Officers of the Board

A. The officers of the board shall consist of a president and a vice president.

* * *

D. The duties of the officers shall be as follows:

* * *

2. The vice president shall prepare the annual budget, review financial records periodically and present a report at each regular meeting of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:914 and R.S. 37:918.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 7:73 (March 1981), amended by the Department of Health and Hospitals, Board of Nursing, LR 23:

Subchapter D. Registration and Licensure

§3347. Registration and Licensure

* * *

C. The board shall issue a certificate of registration, carrying a permanent registration number, designating the date of issuance, the authorization to practice as a registered nurse in Louisiana, and signed by the president and the vice president of the board, to all applicants who qualify for initial licensure.

D. The executive director, or a designee of the board, shall record the registration of the permanent records of the board and shall issue a license to practice, valid from the date of issuance until January 31. For individuals registered between January 1 and January 31, the board shall issue a license to practice, valid from the date of issuance until January 31 of the next year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918 and R.S. 37:920.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 7:77 (March 1981), amended by the Department of Health and Hospitals, Board of Nursing, LR 23:

§3355. Renewal of License

A. Every person holding a license to practice as a registered nurse, and intending to practice during the ensuing year, shall renew their license annually prior to the expiration of their license. The board shall mail an application for renewal of a license to every person who holds a current license. The licensee shall complete the renewal form and return to the board before January 1. Upon receipt of the application and the renewal fee as required under LAC 46:XLVII.3361, the board shall verify the accuracy of the application and issue to the licensee a license of renewal for the current year beginning February 1 and expiring January 31. Incomplete applications will be returned. Applications postmarked after December 31 will be considered late and subject to the fee as required under LAC 46:XLVII.3361 for late renewals. Failure to renew a

license prior to expiration subjects the individual to forfeiture of the right to practice.

1. Change of Address. Notify the office of the board in writing within 30 days if a change of address has occurred.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918 and R.S. 37:920.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 7:78 (March 1981), amended by the Department of Health and Hospitals, Board of Nursing, LR 16:1061 (December 1990), amended LR 23:

Inquiries concerning the proposed amendments may be directed in writing to Barbara L. Morvant, Executive Director, Board of Nursing, at the address set forth below.

Interested persons may submit data, views, arguments, information or comments on the proposed Rules, in writing, to the Board of Nursing, 3510 N. Causeway Boulevard, Suite 501, Metairie, LA, 70002. Written comments must be submitted to and received by the board no later than 4:30 p.m., May 9, 1997.

Barbara L. Morvant
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Officers of the Board; Registration and
Licensure; Renewal of License**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no anticipated cost to state or local governmental units. The deadline for renewals is currently December 31 of each year. The new deadline of January 31 of the following year is still in the same fiscal year, therefore, there will be no additional costs involved than would normally be incurred. The annual cost of producing, distributing, and processing renewals will remain the same during the fiscal year. Notification of the change will be published in the board's quarterly newsletter and in regularly scheduled mailing. The new date will also be printed on the renewal form which will be covered by the normal cost of updating the form annually.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no anticipated effect on revenue collection of state or local governmental units. There is no change to the annual renewal fee, therefore, there would be no additional revenues collected than would normally be collected during the renewal period.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There is no anticipated costs and/or economic benefits to directly affected persons or nongovernmental groups. The annual renewal fee remains the same. The change in annual renewal date only allows for 31 additional days to submit the application and fee to the board.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated effect on competition or employment. Renewal date has no bearing on competition and employment

of RNs in Louisiana. An RN must maintain an active license to practice regardless of annual renewal date.

Barbara L. Morvant
Executive Director
9704#034

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Board of Veterinary Medicine

Professional Conduct—Specialty List (LAC 46:LXXXV.1063)

The Board of Veterinary Medicine proposes to amend LAC 46:LXXXV.1063 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and the Louisiana Veterinary Practice Act, R.S. 37:1518 et seq. The effective date of this amendment will be August 1, 1997.

This Rule is intended to promote the public health, safety, and welfare by safeguarding the people of this state from veterinarians who may state or imply that they are certified or recognized specialists without appropriate board certification in such specialty. The Rule will insure that veterinarians who claim to be "specialists" have the appropriate credentials as recognized by the American Veterinary Medical Association (AVMA); that diplomates of the American Board of Veterinary Practitioners claim only a specialty for the class of animals in which they specialize; and that veterinary hospitals only use the term "specialty" or "specialists" when all veterinary staff are board-certified specialists.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXXXV. Veterinarians

Chapter 10. Rules of Professional Conduct

§1063. Specialty List

- A. ...
- B. A veterinarian may not use the term *specialist* for an area of practice for which there is not AVMA recognized certification.
- C. A diplomate of the American Board of Veterinary Practitioners can claim only a specialty for the class of animals in which he specializes, not for medical specialties unless he is board-certified in those medical specialties.
- D. The term *specialty* or *specialists* is not permitted to be used in the name of a veterinary hospital unless all veterinary staff are board-certified specialists.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518(A)(9).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:232 (March 1990), amended LR 23:

James R. Corley, D.V.M.
President

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Professional Conduct—Specialty List

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There will be no costs or savings to state or local governmental units, except for those associated with publishing the Rule (estimated \$80). The veterinary profession will be informed of this Rule change via the board's regular newsletter, which is already a budgeted cost of the board.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There will be no effect on revenue collections of state or local governmental units. There will be no revenue impact as no increase in fees will result from this Rule.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There will be no costs and/or economic benefits to directly affected persons or nongovernmental groups. License renewal forms already include space to indicate specialties held.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There will be no effect on employment, nor is any effect on competition expected.

Charles B. Mann
Executive Director
9704#025

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Case Management Services Reimbursement Infants and Toddlers with Special Needs

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to adopt the following Rule as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This proposed Rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides reimbursement for optional targeted case management services to infants and toddlers who are categorized as developmentally disabled under the ChildNet Program.

An Emergency Rule was adopted on September 24, 1996, limiting case management services to those infants and toddlers who either receive services under the MR/DD waiver or who receive two or more specified Medicaid services (*Louisiana Register*, Volume 22, Number 9). The department subsequently repealed the September 24, 1996 Emergency Rule and reduced the reimbursement rate for these services, effective December 1, 1996, in a subsequent Emergency Rule (*Louisiana Register*, Volume 22, Number 11).

After consultation with the Department of Education regarding ChildNet Services, the bureau has now determined it is necessary to increase the reimbursement for case management services for infants and toddlers. This action is necessary to maintain the health and welfare of these children by assuring continued access to case management services to assist their families in obtaining necessary medical, social and educational services.

Proposed Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing will increase the maximum reimbursement for case management services for infants and toddlers with special needs from \$98 to \$115.

Interested persons may submit written comments to Thomas D. Collins, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquires regarding this proposed Rule.

A public hearing on this proposed Rule is scheduled for Tuesday, May 27, 1997 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, LA. At that time, all interested persons will be afforded an opportunity to submit data, views or arguments, orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the day following the public hearing.

Bobby P. Jindal
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Case Management Services Reimbursement—Infants and Toddlers with Special Needs

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is estimated that implementation of this proposed Rule will increase state expenditures by approximately \$88,480 for the remainder of SFY 1996-1997. Total expenditures are \$1,794,000 for SFY 1997-1998 and \$1,847,820 for SFY 1998-1999. An administrative cost of \$80 is included for the printing of this proposed Rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Implementation of this proposed Rule will not increase federal revenue collections for SFY 1996-1997 due to the capped federal funding. There will be an increase of \$1,399,679 for SFY 1997-1998 and \$1,300,126 for SFY 1998-1999.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Providers of optional targeted case management services for infants and toddlers will experience increased reimbursements of \$88,400 for SFY 1997; \$1,794,000 for SFY 1998; and \$1,847,820 for SFY 1999. In addition, these recipients will experience continued access to case management services to assist in obtaining necessary medical, social, and educational services.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins
Director
9704#055

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Disproportionate Share Hospital Payment Methodologies

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt the following Rule under the Medical Assistance Program as authorized by R.S. 46:153 et seq. and pursuant to Title XIX of the Social Security Act.

Hospital Disproportionate Share (DSH) payment limits were established by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) which amended Section 1923 of the Social Security Act. In order to comply with the budgetary limitations imposed by that federal regulation and to avoid a budget deficit in the medical assistance programs, the bureau amended the payment methodologies for public state-operated hospitals, private hospitals, and public nonstate hospitals effective July 1, 1995. Under that methodology, public state-operated hospitals receive DSH payments equal to 100 percent of the hospital's net uncompensated costs, and private hospitals and public nonstate hospitals received DSH payments according to a formula based on an eight-pool methodology.

In order to assure continued fiscal viability of community hospitals, Act Number 17 (House Bill Number 1) of the 1996 Louisiana Legislative Session provides for separate treatment of disproportionate share funds for uncompensated costs in small (60 beds or less) nonstate-operated local government hospitals and small (60 beds or less) private rural hospitals. To accommodate this proviso, this proposed Rule provides that all hospitals other than public state-operated hospitals are separated into two groups:

the first is composed of small (60 beds or less) nonstate-operated local government hospitals and small (60 beds or less) private rural hospitals; and

the second contains all other hospitals.

The latter group is composed of two pools, acute care hospitals and psychiatric hospitals. Previous provisions concerning DSH methodology for public state-operated hospitals continues unchanged. There is no increase or decrease in DSH funds as the result of this Emergency Rule, therefore there is no fiscal impact to the state or federal government.

Proposed Rule

The Department of Health and Hospitals, Bureau of Health Services Financing replaces prior regulations governing

disproportionate share hospital payment methodologies excluding disproportionate share qualification criteria and establishes the following regulations to govern the disproportionate share hospital payment methodologies for public state-operated, private hospitals and public nonstate hospitals.

I. General Provisions

A. Reimbursement will no longer be provided for indigent care as a separate payment in hospitals qualifying for disproportionate share payments.

B. Disproportionate share payments cumulative for all DSH payments under all DSH payment methodologies shall not exceed the federal disproportionate share state allotment for each federal fiscal year or the state appropriation for disproportionate share payments for each state fiscal year. The department shall make necessary downward adjustments to hospitals' disproportionate share payments to remain within the federal disproportionate share allotment or the state disproportionate share appropriated amount.

C. Appropriate action shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.

D. DSH payments to a hospital determined under any of the methodologies below shall not exceed the hospital's uncompensated cost for the state fiscal year to which the payment is applicable.

E. Qualification is based on the hospital's latest year end cost report for the year ended during the period July 1 through June 30 of the previous year. Only hospitals that return DSH qualification documentation timely will be considered for disproportionate share payments. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization.

F. Hospitals/units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle and thereafter.

G. Net Uncompensated Cost—cost of furnishing inpatient and outpatient hospital services net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payor payments, and all other inpatient and outpatient payments received from patients. It is mandatory that qualifying hospitals seek all third-party payments including Medicare, Medicaid, and other third-party carriers. Hospitals not in compliance with free care criteria will be subject to recoupment.

H. Disapproval of any one of these payment methodology(ies) by the Health Care Financing Administration does not invalidate the remaining methodology(ies).

II. Reimbursement Methodologies

A. Public State-Operated Hospitals

1. Definitions:

Public State Operated Hospital—a hospital that is owned or operated by the State of Louisiana.

2. Payment Methodology. DSH payments to individual public state-owned or operated hospitals are equal to 100 percent of the hospital's net uncompensated costs subject to

the adjustment provision in 3 below. Final payment will be based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year.

3. In the event it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment each year or the state DSH appropriated amount, the department shall calculate a pro rata decrease for each public (state) hospital based on the ratio determined by dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying public hospitals during the state fiscal year and then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment or state DSH appropriated amount.

B. Small Nonstate-Operated Local Government Hospitals and Small Private Rural Hospitals

1. Criteria for hospitals to be included in this group are as follows:

Qualifying hospitals must be 1) small and 2) either a nonstate public-owned and operated or a private rural hospital as defined below. Hospitals/beds located outside the service district area or rural area may not be included in this pool, but will be included in the all other hospitals pools. Beds located outside the service district will be used by DHH to determine qualification, but costs associated with these beds will not be used to determine reimbursement. Freestanding psychiatric hospitals are not included.

2. Definitions

Public Local Government Acute Hospitals—local government-owned acute care general, rehabilitation, and long term care hospitals including distinct part psychiatric units are qualified for this designation. Only uncompensated costs attributable to beds/units located within the service district area qualify for inclusion.

Private Rural Hospitals—privately owned acute care general, rehabilitation and long-term care hospitals designated as rural hospitals by Medicare, including distinct part psychiatric units are qualified for this designation. Only uncompensated cost attributable to beds/units located within the rural area qualify for inclusion.

Small—having 60 or less licensed beds as of July 1 of the state fiscal year to which the payment is applicable. The number of beds includes distinct part psychiatric beds, and excludes nursery and skilled nursing beds.

3. Payment is based on each qualifying hospital's pro rata share of uncompensated cost for the previous state fiscal year for all hospitals meeting these criteria multiplied by the amount set for these facilities.

4. A pro rata decrease necessitated by conditions specified in I.B for nonstate hospitals described in this Section will be calculated based on the ratio determined by dividing the hospitals' uncompensated costs by the uncompensated costs for all qualifying nonstate hospitals in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH apportioned amount.

C. All Other Hospitals (Private Rural Hospitals over 60 Beds, All Private Urban Hospitals, Public Nonstate Hospitals over 60 Beds, and All Free-standing Psychiatric Hospitals Exclusive of State Hospitals)

1. Annualization of days for the purposes of the Medicaid days pools is not permitted. Payment is based on actual paid Medicaid days for a six-month period ending on the last day of the latest month at least 30 days preceding the date of payment which will be obtained by DHH from a report of paid Medicaid days by service date.

2. Payment is based on Medicaid days provided by hospitals in the following two pools:

a. Acute Care Hospital—acute care, rehabilitation, and long-term care hospitals not described in B.2 (excluding distinct part psychiatric units) are qualified for this designation. Acute care, rehabilitation, and long-term care hospitals/beds of small nonstate-operated local government hospitals (defined in B.2) located outside the service district area are included in this pool. Acute care, rehabilitation, and long-term care hospitals/beds of small private rural hospitals (defined in B.2) located outside the rural area are included in this pool.

b. Psychiatric Hospital—Freestanding psychiatric hospitals and distinct part psychiatric units not included in B.2 are qualified for this designation. Psychiatric hospitals/beds of small nonstate-operated local government hospitals (defined in B.2) located outside the service district area are included in this pool. Psychiatric hospitals/beds of small private rural hospitals (defined in B.2) located outside the rural area are included in this pool.

3. Disproportionate share payments for each pool shall be calculated based on the product of the ratio determined by dividing each qualifying hospital's actual paid Medicaid inpatient days for a six-month period ending on the last day of the month preceding the date of payment (which will be obtained by DHH from a report of paid Medicaid days by service date) by the total Medicaid inpatient days obtained from the same report of all qualified hospitals in the pool, and multiplying by an amount of funds for each respective pool to be determined by the director of the Bureau of Health Services Financing. Total Medicaid inpatient days include Medicaid nursery days but do not include skilled nursing facility or swing-bed days. Pool amounts shall be allocated based on the consideration of the volume of days in each pool or the average cost per day for hospitals in each pool.

4. No additional payments shall be made if an increase in days is determined after audit. Recoupment of overpayment from reductions in pool days originally reported shall be redistributed to the hospital that has the largest number of inpatient days attributable to individuals entitled to benefits under the State Plan of any hospitals in the state for the year in which the recoupment is applicable.

5. A pro rata decrease necessitated by conditions specified in I.B for hospitals described in this Section will be calculated based on the ratio determined by dividing the hospitals' Medicaid days by the Medicaid days for all qualifying hospitals in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or the state disproportionate share appropriated amount.

Interested persons may submit written comments to Thomas D. Collins, Office of the Secretary, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is

responsible for responding to inquiries regarding this proposed Rule.

A public hearing for this proposed Rule is scheduled for Tuesday, May 27, 1997 at 9:30 a.m. in the auditorium of the Department of Transportation and Development, 1201 Capitol Access Road, Baton Rouge, LA. At this time, all interested parties will be afforded an opportunity to submit data, views or arguments, orally, or in writing. The deadline for the receipt of comments is 4:30 p.m. on the day following the public hearing.

Bobby P. Jindal
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**
**RULE TITLE: Disproportionate Share of Hospital Payment
Methodologies**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
Implementation of this proposed Rule will not result in additional costs or savings to the state, other than the administrative expense of \$320 for the printing of this proposed Rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no increase in federal revenue collections expected from the implementation of this proposed Rule.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
Qualifying hospitals shall receive disproportionate share hospital payments in accordance with the provisions of this proposed Rule.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There is no known effect on competition and employment.

Thomas D. Collins
Director
9704#054

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Home and Community Based
Services—Elderly Home Care

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to adopt the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule shall be adopted in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing administers four Home and Community Based Services Waiver Programs.

Participation in each home and community based services waiver is limited to a specific number of participants based on the approval of the waiver application by the Health Care Financing Administration. Home and community based services waiver programs are based on federal criteria which allows services to be provided in a home or community based setting for a recipient who would otherwise require institutional care. Costs for participants of the program must not exceed the costs for recipients of institutional care. Currently, daily costs in the Home Care for the Elderly waiver are exceeding the costs of comparable residents of nursing homes, thus jeopardizing the program. Therefore, in order to be able to continue this program the bureau is making changes in admissions criteria, the target population, management of services, and types of services available.

The following Rule is necessary to maintain federal financial participation for the Home Care for the Elderly waiver program and to preserve the health and welfare of individuals participating in that program.

Proposed Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following regulations governing the Home Care for the Elderly waiver program to:

- 1) redefine the target population served by the waiver and rename the waiver;
- 2) establish an average cost per day limit each participant of the waiver;
- 3) establish and define new services;
- 4) establish methodology for the assignment of slots; and
- 5) clarify admission and discharge criteria, mandatory reporting requirements and the reimbursement requirement for the prior approval of the plan of care.

The total number of slots assigned shall not exceed the maximum number of slots approved by the Health Care Financing Administration. The assignment of vacated and previously unoccupied waiver slots; admission and discharge criteria; the array of services; calculation of waiver costs; mandatory reporting requirements and reimbursement for services provided prior to the approval of the plan of care shall be determined in accordance with the following guidelines.

Definition of Targeted Population for the Waiver

This home and community based services waiver is targeted at persons who qualify for admission to a nursing facility and are over age 65 or adults, age 21 or over, who are disabled according to Medicaid standards. It shall be called the Elderly and Disabled Adult waiver.

Guarantee of Waiver Costs

In order to assure the cost effectiveness of this entire home and community based services waiver each participant shall be limited to an array of services whose average cost per day shall not exceed a limit set by the bureau. This figure shall be set annually at a percentage of the average costs borne by the Medicaid program for the equivalent population receiving nursing facility services, with an allowance for temporary, brief periods of excess costs in order to maintain a participant in the community. Case managers shall complete a budget analysis form as part of each care plan which shall list the types and number of services necessary to maintain the waiver

participant safely in the community, the cost of those services and the average cost per day covered by the care plan.

Programmatic Allocation of Waiver Slots

The waiting list shall be used to protect the individual's right to be evaluated for waiver eligibility. Each waiver slot may be filled only once during each waiver year. When funding becomes available for a new waiver slot or a slot that has been vacated in the previous waiver year, staff of the Intake Offices at the local Councils on Aging shall notify the next individual in order of application on the waiting list in writing that a slot is available and that they are next in line to be evaluated for possible waiver slot assignment. A copy of the notification letter shall be forwarded to the Health Standards Section of BHSF. A case manager assists in the gathering of the documents needed for both the financial and medical certification eligibility process. If the individual is determined to be ineligible either financially or medically, that individual is notified in writing and a copy of the notice is forwarded to the Council on Aging office. The next person on the waiting list is notified as stated above and the process continues until an eligible person is encountered. A waiver slot is assigned to an individual when eligibility is established and the individual is certified.

Waiver Admission Criteria

Admission to this Waiver Program shall be determined in accordance with the following criteria.

1. initial and continued Medicaid eligibility as determined by the parish BHSF Office;
2. initial and continued eligibility for a nursing facility level of care as determined by the Health Standards Section of BHSF;
3. the plan of care must provide justification that the waiver services are appropriate, cost effective and represent the least restrictive treatment alternative for the individual; and
4. assurance that the health and safety of the individual can be maintained in the community with the provision of reasonable amounts of waiver services as determined by the Health Standards Section of BHSF.

Waiver Discharge Criteria

Participants shall be discharged from this Waiver Program if one of the following criteria is met:

1. loss of Medicaid eligibility as determined by the parish BHSF Office;
2. loss of eligibility for a nursing facility level of care as determined by the Health Standards Section of BHSF;
3. incarceration or placement under the jurisdiction of penal authorities, or courts;
4. change of residence to another state with the intent to become a resident of that state;
5. admission to a nursing facility or any other long term care institutional setting;
6. the health and welfare of the waiver participant cannot be assured in the community through the provision of amounts of waiver services within the cost cap as determined by the Health Standards Section of BHSF, i.e., the waiver participant presents a danger to himself or others;
7. failure to cooperate in either the eligibility determination process or the performance of the care plan; or
8. continuity of services is interrupted as a result of the participant not receiving waiver services during a period of 14

or more consecutive days. This does not include interruptions in services because of hospitalization.

Mandatory Reporting Requirements

Case managers and waiver service providers are obligated to report changes that could affect the waiver participant's eligibility, including but not limited to those changes cited in the discharge criteria, to either the parish BHSF Office or the Health Standards Section of BHSF within five working days. In addition, case managers and waiver service providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and well-being of the waiver participant and completing an incident report. The incident report shall be submitted to the Health Standards Section of BHSF within five working days of the incident.

Definition of Services

The following services will be made available to participants in this waiver by employees of Personal Attendant Provider agencies in half hour increments:

1. *Personal Care Attendant*—assistance with eating, bathing, dressing, personal hygiene, or activities of daily living.

2. *Household Supports*—services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

3. *Personal Supervision (day)*—non-medical care, supervision and socialization, provided to a functionally impaired adult. Personal supervisors may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services as the household support worker does. The provision of this service does not entail hands-on nursing care.

4. *Personal Supervision (night)*—this type of supervision is to provide for the safety of individuals living alone who are limited in mobility or cognitive function to such an extent that they may not be able to preserve their own safety in dangerous situations.

Reimbursement of Waiver Services

Reimbursement shall not be made for waiver services provided prior to the BHSF approval of the care plan.

Interested persons may submit written comments to Thomas D. Collins, Office of the Secretary, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule.

A public hearing on this proposed Rule is scheduled for Tuesday, May 27, 1997 at 9:30 p.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, LA. At that time, all interested parties will be afforded the opportunity to submit data, views, and arguments, orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the next day following the public hearing.

Bobby P. Jindal
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Home and Community Based Services—Elderly Home Care

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that implementation of this proposed Rule will result in decreased expenditures for Home Care for the Elderly Waiver services by approximately \$501,018 for SFY 1997-1998; \$715,566 for SFY 1998-1999; and \$737,087 for SFY 1999-2000. A cost of \$240 is included for SFY 1997-1998 for the printing of this proposed Rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that federal revenue collections for services will decrease by approximately \$408,205 for SFY 1997-1998; \$558,285 for SFY 1998-1999 and \$575,075 for SFY 1999-2000.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

It is anticipated that the providers of the waiver services will experience the combined state and federal expenditure decreases shown above for the provision of these services; however, the waiver program will remain cost effective allowing it to continue to receive federal approval.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins
Director
9704#053

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Labor Office of Workers' Compensation

Individual Self-Insurer (LAC 40:I.1732)

Under the authority of the Workers' Compensation Act, particularly R.S. 23:1021 et seq., and in accordance with the provision of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Labor, Office of Workers' Compensation hereby gives notice that rulemaking procedures have been initiated to amend the Office of Workers' Compensation Rules, LAC 40:I.Chapter 17.

The amendment to this Rule will allow employers to post a surety bond so that the amount of the bond would be considered as part of the employer's net worth when seeking to be qualified as a self-insurer.

Title 40

LABOR AND EMPLOYMENT

Part I. Workers' Compensation Administration

Chapter 17. Fiscal Responsibility Unit §1723. Individual Self-Insurer—Application

A. ...

B. Before considering the application, the office will require:

1. financial statement of a current date showing a net worth of not less than \$750,000 and a current ratio of more than 1.5 to 1 and a working capital of an amount establishing strength and liquidity of the business to pay normal compensation promptly. A surety bond as provided in §1725 shall be considered to be part of the net worth of the employer. However, companies qualified to be self-insured prior to the implementation of these Rules who do not meet the requirement of a net worth of \$750,000 may nonetheless qualify for continued certification upon a showing that they meet all other requirements of these Rules and that they have been continually operating as an approved self-insurer. The requirement for more than 1.5 to 1 current ratio may be waived in the case of a public utility or in those instances where generally recognized accounting principles peculiar to a particular industry make this requirement unreasonable. In no event shall the net worth be less than three times the annual loss fund, or in the event that aggregate excess insurance is not maintained, then the net worth shall be at least three times the self-insurer's annual standard premium. Financial statements dated six months or more prior to the date of application must be accompanied by an affidavit stating that there has been no material lessening of net worth nor significant deterioration of current ratio since the date of the statement.

An employer going through or recently acquired through a highly leveraged buy-out is not eligible to self-insure until the company has a well established and acceptable financial capacity. Judgment of the company's financial capacity will be based upon financial ratio analysis. This type of company must operate on an insured basis until the financial status is fully known.

2. - 7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1168.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:959 (October 1991), amended by the Louisiana Department of Labor, Office of Workers' Compensation, LR 23:

All interested persons are invited to submit written comments on the proposed regulations. Such comments should be submitted no later than May 20, 1997 at 4:15 p.m., to Ronald L. Menville, Director, Office of Workers' Compensation, 94040, Baton Rouge, LA 70804-9040 or 1001 North 23rd Street, Baton Rouge, LA 70802 or to FAX number (504) 342-5665.

Ronald L. Menville
Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Individual Self-Insurer**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no additional identifiable costs or savings accruing in aggregate to state or local governmental units as a result of implementing this Rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no expected effect on revenue collection of state and governmental units as a result of implementing this Rule.

- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This amendment to the existing Rule may increase participation on the self-insurer program. By self-insuring a portion of their insurance exposure, qualified employers have the opportunity to lower their overall insurance expense.

- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This amendment to the current Rule may encourage more businesses to become self-insured for the purposes of workers' compensation coverage as opposed to purchasing workers' compensation insurance from the insurance providers.

Ronald L. Menville
Director
9704#030

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Department of Natural Resources
Office of the Secretary**

**Oyster Lease Damage Evaluation Board
Proceedings (LAC 43:I.Chapters 37 and 39)**

The Department of Natural Resources, Office of the Secretary hereby gives notice that it intends to adopt rules governing the administration of the Oyster Lease Damage Evaluation Board, in accordance with R.S. 56:700.10 et seq., and the Administrative Procedure Act, R.S. 49:950 et seq.

Title 43

NATURAL RESOURCES

Part I. Office of the Secretary

**Subpart 3. Oyster Lease Damage Evaluation Board
Proceedings**

Chapter 37. General

§3701. Purpose

These rules are adopted pursuant to L.R.S. 56:700.10 et seq. to provide for the filing and processing, and the fair and expeditious settlement, of claims made pursuant to Part XV of Chapter 1 of Title 56 of the Louisiana Revised Statutes of 1950. These rules are designed to insure that the claims procedure is as simple as possible, and these rules shall be interpreted in that spirit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 23:

§3703. Definitions

As used in these rules, unless the context requires otherwise, the terms set forth below shall have the following meanings:

Biological Survey—a survey made to determine the biological test data, which is reported on a form prescribed by the board.

Biological Test Data—surveys of oyster beds and grounds by a certified biologist to determine the quality, condition and value of oyster beds and grounds.

Board—the Oyster Lease Damage Evaluation Board.

Certified Biologist—a biologist certified by the board as qualified to make biological surveys.

Department—the Department of Natural Resources.

Final Biological Survey—the biological survey made and filed by the owner or leaseholder, as applicable, pursuant to §3903.C hereof.

Initial Biological Survey—the biological survey made and filed by the owner or leaseholder, as applicable, pursuant to §3903.A hereof.

Intervenor—a party having an interest in the proceedings who is granted permission by the board to take part in the proceedings to the extent reasonable and necessary to assert or protect such party's interests.

Leaseholder—an owner of an oyster lease granted by the Department of Wildlife and Fisheries.

Mineral Activity—exploration (including all seismic operations) production, transportation (of equipment or product) and any other activity associated with the production of oil and gas. Also referred to as *Oil and Gas Activity*.

Owner—an owner or operator of a mineral activity.

Party—leaseholder, owner or intervenor.

Secretary—the secretary of the Department of Natural Resources, or his designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

Chapter 39. Damage Evaluation Process

§3901. Application for Arbitration

A. A leaseholder who has been requested by an owner to enter into a settlement for damage to the leasehold which may occur due to the owner's proposed oil and gas activity which is expected to intrude upon the leasehold may file with the board an application for arbitration of his claim for damage in accordance with R.S. 56:700.10 et seq. and these rules.

B. The application shall contain the information required by an application in form prescribed by the board. A copy of the application and any annexed documents shall be served on the owner by the leaseholder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3903. Biological Surveys

A. The initial biological survey shall be based on onsite inspection and evaluation and shall be made to determine the quality and value of the beds and grounds expected to be affected by the proposed oil and gas activity. This survey shall include at least the following:

1. the name, address and telephone number of the owner;

2. the name, address and telephone number of the leaseholder;

3. the name, address and telephone number of any person or entity claiming or possessing any interest in the oyster lease, or in any oysters growing or bedded thereon, together with a certification by the leaseholder that such person or entity has been provided with a copy of the application for arbitration;

4. the description of the oil and gas activity proposed to intrude upon the leasehold;

5. the identifying number of the oyster lease, together with a copy of the official oyster lease survey plat, or other description thereof; and

6. the date of the last written offer submitted to the leaseholder by the owner.

B. If the owner does not file the initial biological survey report within 60 days of the notice to the owner, the leaseholder may have the initial biological survey made and filed. The reasonable cost of this survey shall be assessed against the owner as part of the actual damage sustained by the leasehold.

C. Upon completion of the oil and gas activity proposed by the owner, the owner shall have a final biological survey made and filed, at the owner's expense, within 60 days of completion of the oil and gas activity, to furnish a basis for determination of the actual damage to the leasehold sustained as a result of the oil and gas activity.

D. If the leaseholder believes that the oil and gas activity proposed by the owner has been completed, and that the final biological survey has not been timely made and filed by the owner, the leaseholder may call for a hearing to determine whether the owner has complied with §3903.C hereof. If upon hearing the board finds that the owner has not so complied, the board shall permit the leaseholder to have a final biological survey made and filed, and the reasonable cost of this survey shall be assessed against the owner as part of the actual damage sustained by the leasehold.

E. The board shall engage experts to assist the board in establishing a uniform evaluation method to be followed by certified biologists in determining the quality, condition and value of the oyster beds and grounds before the oil and gas activity takes place and in determining the estimated damage or loss to the leasehold after the activity is completed.

F. The uniform evaluation method adopted by the board shall be made available to all parties and all certified biologists for use in proceedings before the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3905. Certification of Biologists

A. Biologists having a minimum educational attainment of a degree in a biological science, or having been accepted by a federal or state court in Louisiana as an expert witness in the field of oyster biology or oyster ecology may apply to the board for certification. The application for certification shall be accompanied by certified copies of pertinent academic degrees or evidence of expert witness qualification.

B. The board shall maintain a list of certified biologists from which a party may select a biologist to make any biological survey provided for by R.S. 56:700.10 et seq. or these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3907. Estimated Damage Deposit

A. Upon filing of the initial biological survey, the board shall determine the amount of the damage estimated to be sustained by the leasehold as a result of the proposed oil and gas activity, and shall notify the parties of the board's determination.

B. Upon a showing of urgent circumstances, the board will expedite to the extent practicable its determination of estimated damage.

C. Upon payment of a deposit with the board of the amount of the damage estimate made by the board, the owner may proceed with the proposed oil and gas activity. The deposit shall be invested with the state treasury as security for payment of any damage award and for payment of interest earned on the amount of the award.

D. If the deposit is not made within 30 days after notice of the board's estimated damage determination, the board may, in its discretion, dismiss the proceeding and order the owner to reimburse the leaseholder the amount of the filing fee and the reasonable cost of any biological survey undertaken by the leaseholder pursuant to §3903.B hereof.

E.1. The owner may, at any time prior to payment of the deposit, withdraw the owner's original request to the leaseholder to enter into a settlement, and proceedings hereunder shall thereupon terminate.

2. Withdrawal shall be effective upon notice to the board and the leaseholder, and upon reimbursement by the owner to the leaseholder of the filing fee and the reasonable cost of any biological survey undertaken by the leaseholder pursuant to §3903.B hereof.

F. If, after the deposit is made, the owner does not commence the proposed activity within a reasonable time, the board may, upon hearing, award the leaseholder the filing fee and the reasonable cost of any survey undertaken by the leaseholder, pay such award out of the deposit, and return the balance of the deposit to the owner, with interest earned on such balance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3909. Hearings and Determination of Actual Damage

A. Upon filing of the final biological survey, the secretary shall call for a hearing to determine the actual damage sustained by the leasehold as a result of the oil and gas activity.

1. The amount of actual damage determined by the board after hearing shall be due by the owner to the board for the benefit of the leaseholder.

2. If the damage award does not exceed the amount of the deposit made by the owner in accordance with §3907.B and D hereof, the board shall pay the amount of the award out of the deposit, together with interest earned thereon, to the leaseholder, and the balance, if any, shall be paid to the owner, together with interest earned on such balance.

3. If the award exceeds the amount of the deposit the board shall pay the entire amount of the deposit, together with the interest earned thereon, to the leaseholder and shall order the owner to pay the leaseholder the amount of the difference

between the award and the deposit together with legal interest thereon from the date of the initial deposit.

B. The secretary shall be the sole arbiter of the damage sustained by the leasehold as a result of the oil and gas activity by the owner. The three additional board members shall evaluate the information regarding damage and shall consult with the secretary to assist in the final determination made by the secretary of the damage award.

C. The determination of damage by the secretary shall be based on the values shown in the biological surveys and shall reflect true and actual damage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3911. Conduct of Hearings

A. The board shall give reasonable notice of all hearings to all parties.

B. The notice shall include:

1. a statement of the time, place, and nature of the hearing;

2. a statement of the legal authority and jurisdiction under which the hearing is to be held;

3. a reference to the particular sections of the statutes and rules involved;

4. a short and plain statement of the matters asserted. If the board is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished.

C. At the hearing, all parties shall have the opportunity to respond and to present evidence on all issues of facts involved and argument on all issues of law and policy involved and to conduct such cross-examination as may be required for a full and true disclosure of the facts.

D. The hearing record shall include:

1. all pleadings, motions, and intermediate rulings;

2. evidence received or considered or a résumé thereof if not transcribed;

3. a statement of matters officially noticed except matters so obvious that statement of them would serve no useful purpose;

4. offers of proof, objections, and rulings thereon;

5. proposed findings and exceptions; and

6. any decision, opinion, or report by the board or the secretary.

E. The board shall, at the request of any party or person, have prepared and furnish him with a copy of the transcript or any part thereof upon payment of the cost thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3913. Discovery

A. Parties may obtain discovery by written interrogatories, production of documents and things, requests for admission, and permission to enter upon land or other property for inspection and other purposes, limited in scope to the following matters:

1. the oil and gas activity conducted or to be conducted by the owner;
2. the quality and value of the oyster beds and grounds expected to be affected by the proposed oil and gas activity; and
3. the actual damage sustained as a result of the oil and gas activities.

B. The board in its discretion may allow discovery as to other matters, and in exceptional circumstances may allow discovery by deposition.

C. Interrogatories

1. A party may serve upon any other party written interrogatories to be answered separately and fully under oath, unless objection upon stated grounds is made to an interrogatory.

2. Interrogatories may be served with the application for arbitration or at any time after filing of the application, and shall be answered within 30 days after service.

D.1. Any party may serve on any other party a request to produce and permit the party making the request to:

a. inspect and copy any designated documents including writings, drawings, graphs, charts, photographs, and other data compilations from which information can be obtained; or

b. inspect and copy, test, or sample any tangible things which constitute or contain matters within the scope of permissible discovery and which are in the possession, custody, or control of the party upon whom the request is served; or

c. permit entry upon designated land or other property in the possession or control of the party upon whom the request is served for the purpose of inspection and measuring, surveying, photographing, testing, or sampling the property or any designated object or operation thereon, within the scope of permissible discovery.

2. The request:

a. may be served with the application for arbitration or at any time after filing the application;

b. shall describe each item or category of items to be inspected with reasonable particularity; and

c. shall specify a reasonable time, place, and manner of making the inspection and performing the related acts.

3. The party upon whom the request is served shall serve a written response within 15 days after service of the request stating that inspection and related activities will be permitted as requested unless the request is objected to in whole or in part, on stated grounds.

E.1. A party may serve upon any other party a written request for the admission, for purposes of the pending arbitration proceeding only, of the truth of any matters within the scope of permissible discovery set forth in the request, including the genuineness of any documents described in the request.

2. Copies of documents shall be served with the request unless they have been or are otherwise furnished or made available for inspection and copying.

3. The request may be served with the application for arbitration or at any time after filing the application.

4. Each matter of which an admission is requested shall be separately set forth.

5. The matter is admitted unless, within 30 days after service of the request, the party to whom the request is directed serves upon the party requesting the admission a written answer or objection upon stated grounds addressed to the matter.

6. The answer shall specifically deny the matter or set forth in detail the reasons why the answering party cannot truthfully admit or deny the matter.

7. A denial shall fairly meet the substance of the requested admissions; and when good faith requires that a party qualify his answer or deny only a part of the matter of which an admission is requested, he shall specify so much of it as is true and qualify or deny the remainder.

8. An answering party may not give lack of information or knowledge as a reason for failure to admit or deny unless he states that he has made reasonable inquiry and that the information known or readily obtainable by him is insufficient to enable him to admit or deny. Any matter admitted is conclusively established unless withdrawn or amended prior to a hearing on the merits, or thereafter if not substantially prejudicial to the requesting party.

F. Discovery Proceedings

1. Discovery proceedings shall be conducted under the supervision of the board and any party may apply to the board for an order or other relief as justice may require.

2. The board may, after hearing, impose upon any party who fails unreasonably to comply with discovery rules or with an order of the board the reasonable expenses, including attorney fees, incurred by the other party or parties as a result of such failure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3915. Duration of Oil and Gas Activity by the Owner

A proposed oil and gas activity shall be deemed completed when the last damaging event occurs during the course of the activity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3917. Limitations for Filing of Claims

The leaseholder must file his application for arbitration within two months of the date of receipt from the owner of the owner's request to the leaseholder to enter into a settlement for the damage which may be sustained due to the owner's proposed oil and gas activity expected to intrude upon the leasehold.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3919. Intervention by the State

The state shall have the right to intervene in pending proceedings to assert any claim it may have to recover its share of the damage caused by the oil and gas activity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3921. Notices, Filings, and Service of Copies

All notices, filings and service of copies provided for herein shall be in writing and shall be effective upon physical delivery to the proper recipient or upon placing same in the U.S. mail, certified, with receipt requested, addressed to the proper recipient. Notices, filings and service of copies may also be transmitted by facsimile equipment and shall be effective upon transmittal, if followed by delivery or mailing of the original document within a reasonable time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3923. Fees

The filing fee of \$500 shall be paid by the leaseholder to the board upon filing the application for arbitration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

§3925. Judicial Review

A. Any party who is aggrieved by the secretary's final decision or order in these proceedings is entitled to judicial review thereof.

B. Proceedings for judicial review of the secretary's final decision or order shall be instituted by filing a suit for judicial review in the district court of the parish in which the oyster lease is situated within 30 days of service of the notice of the final decision or order by the secretary. Copies of the petition for judicial review shall be served upon the secretary and all parties to these proceedings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:700.10 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of the Secretary, LR 23:

Comments and views regarding these proposed Rules should be directed in written form, to be received no later than 5 p.m., May 26, 1997 to Jack C. Caldwell, Secretary, Department of Natural Resources, Box 94396, Baton Rouge, LA 70804-4396.

Jack C. Caldwell
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Oyster Lease Damage Evaluation
Board Proceedings (LAC 43:I.Chapters 37 and 39)**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

Implementation cost to the state is \$85,000 for the first year 1997-98. There will be no implementation cost or savings to local governmental units.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

§3901 Applications for Arbitration	150 @ \$500 each	\$75,000
Certifications	15 @ \$200 each	3,000
§3921 Applications	15 @ \$500 each	7,500

TOTAL \$85,500

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS
TO DIRECTLY AFFECTED PERSONS OR
NONGOVERNMENTAL GROUPS (Summary)**

Estimated additional cost to producers of oil and gas is:

Fees assessed in FY 97-98	\$85,000
Fees assessed in FY 98-99	\$85,000
Fees assessed in FY 99-2000	\$85,000

There could be some savings in damage payments by oil and gas producers.

**IV. ESTIMATED EFFECT ON COMPETITION AND
EMPLOYMENT (Summary)**

There will be no effect on competition. There may be increased employment of biologists in the private sector to perform biological surveys.

Robert D. Harper
Undersecretary
9704#039

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

**Department of Public Safety and Corrections
Office of State Police
Division of Charitable Gaming Control**

Charitable Bingo, Keno, Raffle;
Progressive Mega Jackpot Bingo
(LAC 42:I.1791)

The Department of Public Safety and Corrections, Office of State Police, Division of Charitable Gaming Control, in accordance with R.S. 33:4861.26, R.S. 36:408, R.S. 40:1485.4, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., gives notice that rule making procedures have been instituted to amend LAC 42:I.1791 which provides for the play of a form of bingo known as progressive mega jackpot bingo and for related matters. The proposed Rule was adopted as an Emergency Rule effective March 20, 1997, and published in this issue of the *Louisiana Register*.

**Title 42
LOUISIANA GAMING
Part I. Charitable Gaming
Chapter 17. Charitable Bingo, Keno and Raffle
Subchapter G. Civil Penalties
§1791. Progressive Mega Jackpot Bingo**

* * *

C. Requirements Prior to Start-Up. Each location, hall, commercial lessor or noncommercial lessor that has any licensed organization(s) participating in the progressive mega bingo jackpot game shall transmit by facsimile to the division and to the respective governing authority of the parish or municipality or the certified public accountant contracted to oversee the progressive mega jackpot bingo game, if applicable, the following information and documentation prior to the start-up of a progressive mega jackpot bingo game or before any additional organizations are allowed to enter:

1. list of names and license numbers of licensed charitable organizations participating in the progressive mega jackpot bingo game and the respective gaming location's name and physical address, and the designated organization

representative as provided in Paragraph 2 of Subsection I and any subsequent changes;

2. list of all members holding, operating, or conducting or assisting in holding, operating, or conducting any game or games of chance, if different from the list submitted with the most current license application, as well as an affidavit from each such member confirming membership as a bona fide active member and other related information as otherwise provided by the division;

* * *

5. the name of the governing authority of the parish or municipality, or the certified public accountant contracted to oversee the progressive mega jackpot bingo game, if applicable;

* * *

D. Entry and Withdrawal. Each participating organization shall provide a start up fee in the amount of \$200 at the commencement of or entry into a progressive mega jackpot bingo game for deposit into a "Charitable Gaming Progressive Mega Jackpot Bingo Account." All organizations electing to participate in a progressive mega jackpot bingo game shall contribute an additional \$100 prior to the commencement of a progressive mega jackpot bingo game which shall constitute the progressive mega jackpot bingo prize for the first 24-hour period. This contribution is nonrefundable and shall also be considered part of the total amount of prizes awarded for each organization's first scheduled session of the progressive mega jackpot bingo game.

1. Each participating organization shall submit a check made payable from the organization's charitable gaming checking account to the designated hall, commercial lessor or noncommercial lessor representative in the amount of \$100 during its licensed four-hour session and prior to the commencement of the organization's first scheduled call bingo game made payable to the "Charitable Gaming Progressive Mega Jackpot Bingo Account." This \$100 contribution is nonrefundable and shall constitute part of the progressive mega jackpot bingo prize for the following day and shall be considered part of the total amount of prizes awarded during that session. In no instance shall participating organizations be allowed to make any contributions or submit any start-up fees in the form of cash or money order.

* * *

3. The \$200 start-up fee deposit shall remain in the account until the progressive mega jackpot bingo game is discontinued by the organizations and shall be refundable upon discontinuance of the progressive mega jackpot bingo blackout game or to any single organization withdrawing, whether voluntarily or involuntarily, from the progressive mega jackpot bingo game within three calendar days of withdrawal or as otherwise provided by the division.

* * *

E. Structure of Game. The progressive mega jackpot bingo game shall be conducted in conjunction with the organization's regular blackout bingo games and the structure of such game shall be as follows:

1. A separate additional 3 on 1 up sealed vertical disposable bingo card shall be sold at \$2 per card for the play of only the progressive mega jackpot bingo game. Also,

participating organizations may offer only to those patrons who purchase a 3 on 1 up sealed vertical disposable bingo card for \$2 per card a separate additional 3 on 1 up sealed vertical disposable bingo card at no (zero) value for the purchase of each such card. Such 3 on 1 up sealed vertical disposable bingo cards shall afford patrons a chance to win the progressive mega jackpot bingo game and the regular blackout bingo prize. Participating organizations shall assign a fixed value or price structure for the 3 on 1 up sealed vertical disposable bingo cards with the division in writing on forms provided by the division and receive written approval from the division prior to purchasing any such bingo cards from a licensed distributor and prior to the start up or entry into a progressive mega jackpot bingo game.

2. Only those patrons who have purchased a minimum buy-in package for the organization's regular session games shall be allowed to purchase separate 3 on 1 up sealed vertical disposable bingo cards for the progressive mega jackpot bingo game at that session. The minimum buy-in package shall not contain disposable bingo cards that entitle a patron to win the progressive mega jackpot bingo prize, but the purchase of any such package shall afford a patron the opportunity to win only the respective organization's regular blackout bingo prize.

3. Any disposable bingo card that is altered from the original manufacturer's cut, collation, or print shall be invalid.

4. No progressive mega jackpot bingo game 3 on 1 up sealed vertical disposable bingo cards shall be sold after the announcement by the caller that the progressive mega jackpot bingo game shall commence at least five minutes before the first ball is called. Such progressive mega jackpot disposable bingo cards shall:

a. be purchased by the organization on a separate invoice from a licensed distributor;

b. have an assigned fixed value or price structure for each participating organization approved by the division in writing prior to the purchase from a licensed distributor and prior to the start up or entry into any progressive mega jackpot bingo game and shall only be good for the session date stamped;

* * *

F. Amount of Prizes Awarded. A progressive mega jackpot bingo account consists of all contributions made by participating organizations excluding the \$200 start-up fee as provided in Subsection D of this Section during the progressive mega jackpot bingo game.

* * *

2. The dollar amount of any progressive mega jackpot bingo game shall not exceed the sum of \$50,000. Participating organizations may establish a maximum progressive mega jackpot or cap which does not exceed the sum of \$50,000 only upon written application to and receipt of written approval from the division. Once approved by the division, any subsequent change to the maximum jackpot or cap shall require written approval from the division. Once the maximum jackpot or cap is reached for any progressive mega jackpot bingo game, participating organizations may continue to make contributions in the amount of \$100 to the progressive mega jackpot bingo account to accumulate a second or subsequent jackpot and shall establish with the

division the amount of the next maximum jackpot or cap to be offered. However, in the event that the maximum jackpot or cap is reached, organizations shall not offer any subsequent progressive mega jackpot bingo prize until such time that the first progressive mega jackpot bingo prize is won. Only one progressive mega jackpot bingo prize of participating organizations shall be awarded during any 24-hour period as provided in Subsection G of this Section. Unless otherwise provided by the division, the request for written approval as set forth herein shall be submitted on forms prescribed by the division.

* * *

H. Winner(s). A progressive mega jackpot bingo game shall be won when any player(s) achieves a blackout in 48 balls called or less only on the 3 on 1 up sealed vertical disposable bingo card and only during the 24-hour period described in Subsection G of this Section. Each face on any 3 on 1 up sealed vertical disposable bingo card shall be considered when determining the number of winners.

1. In the event that a patron achieves a blackout in 47 balls called or less on a card from a minimum buy-in package, that patron shall win only the regular blackout bingo prize of the respective organization and that regular blackout bingo game shall end. If such a blackout is achieved in 47 balls called or less, play shall resume until the forty-eighth ball is called, and once called, the progressive mega jackpot bingo game shall end. If no blackout is achieved, the game shall continue until a consolation prize is won as provided in Paragraph 5 of this Subsection.

2. In the event a patron achieves a blackout on cards from a minimum buy-in package on the same number of balls called as a patron who achieves a blackout on a 3 on 1 up sealed vertical disposable bingo card, the regular blackout bingo prize of the respective organization shall be divided equally between all verified winners of the progressive mega jackpot bingo game at that session. The progressive mega jackpot bingo game shall be won only by a patron(s) who achieves a blackout on the 3 on 1 up sealed vertical disposable bingo card as provided in this Subsection.

3. In the event there is more than one winner of the progressive mega jackpot bingo game during the 24-hour period as provided in Subsection G of this Section, the progressive mega jackpot bingo prize shall be divided equally between all verified winners of that progressive mega jackpot bingo game. Once the progressive mega jackpot prize is won, the number of balls called to achieve a winner for the next 24-hour period shall revert to 48 balls unless otherwise provided by the division.

4. A patron who achieves a blackout on a 3 on 1 up sealed vertical disposable bingo card in fewer balls called than a patron who achieves a blackout on a 3 on 1 up sealed vertical disposable bingo card at another licensed session of a participating organization shall share the progressive mega jackpot bingo prize equally with all verified winners during the 24-hour period as provided in Subsection G of this Section.

5. If no blackout is achieved in 48 balls called or less, the organization's progressive mega jackpot bingo game shall continue until a consolation prize is won. The consolation

prize shall be the respective organization's regular blackout bingo prize and shall constitute part of the total amount of prizes awarded during that called bingo session.

* * *

7. The division may, upon written request and adequate justification, issue a written approval allowing participating organizations in a progressive mega jackpot bingo game to increase the number of balls called to achieve a progressive mega jackpot bingo prize winner. In the event such request is granted by the division to increase the number of balls called to achieve a winner, the method of determining a winner as provided in this Subsection shall be modified accordingly.

I. Noninterest Bearing Account. A separate noninterest bearing checking account shall be opened by the participating organizations for the progressive mega jackpot bingo game.

* * *

2. Each location, hall, commercial lessor, or noncommercial lessor that has any licensed organization(s) participating in the progressive mega jackpot bingo game shall designate in writing and submit to the division a representative who shall make deposits and obtain bank receipts of all monies contributed and deposited into the progressive mega jackpot bingo game account before 11:30 a.m. on the next banking day.

3. Unless as otherwise provided by the division, at least two designated representatives of each participating organization shall be authorized signatories on the progressive mega jackpot bingo bank account.

4. Monthly bank statements for the progressive mega jackpot bingo game account shall be mailed directly to the division, governing authority of the parish or municipality, or the contracted certified public accountant overseeing the progressive mega jackpot bingo game, if applicable.

* * *

K. All revenues related to the progressive mega jackpot bingo game, and all checks written to and issued from the "Charitable Gaming Progressive Mega Jackpot Bingo Account" shall be reported by each participating organization in a manner acceptable to the division.

L. Any licensed charitable organizations playing bingo within the state who participate in a progressive mega jackpot bingo game may contract a certified public accountant selected by the participating organizations and who shall be approved by the division to oversee the progressive mega jackpot bingo game and bank account in the event that the governing authority of the parish or municipality does not have a regulatory body to oversee the game.

1. The division, governing authority of the parish or municipality, or if applicable, the contracted certified public accountant approved by the division shall be responsible for, but not limited to the following:

- a. reconciling bank statements monthly;
- b. ensuring that each \$100 contribution for each session played has been properly deposited in a timely manner, as provided in Subsection R of this Section;
- c. ensuring that all banking fees and other related costs as provided in Subsection N of this Section are recovered from the proper parties;

d. ensuring that checks written on the account are disbursed only to verified progressive mega jackpot bingo blackout prize winners, to organizations requesting refunds of the \$200 start up fee due to voluntary or involuntary withdrawal from the progressive mega jackpot bingo game as provided in Subsection D of this Section, or for those purposes as may be necessary, if approved in writing by the division;

e. immediately notifying by facsimile all organizations participating in the progressive mega jackpot bingo game that the maximum progressive mega jackpot or cap has been reached;

f. notifying by facsimile each day all participating locations, halls, commercial lessors, or noncommercial lessors of the amount of the estimated progressive mega jackpot bingo prize; and

g. notifying the division of any discrepancies, problems, violations, or deficiencies in the reporting, conduct of the game, or compliance requirements of this Part.

2. The division shall have the right to approve any contracts or agreements, and the terms or conditions thereof entered into with a certified public accountant contracted to oversee a progressive mega jackpot bingo game. The division may, at any time, revoke any such approval granted and declare any such contract void with or without cause, upon written notice to any such certified public accountant.

M. Equipment. Each location, hall, commercial lessor or noncommercial lessor that has any licensed organization(s) participating in the progressive mega jackpot bingo game shall have at least the following equipment on site and operational at all times.

1. Facsimile machine at each such location capable of transmitting to the division, the governing authority of the parish or municipality, or the certified public accountant contracted to oversee the progressive mega jackpot bingo game, if applicable.

2. A minimum of at least one camera and one monitor at each such location that is capable of televising the first and the next ball to be called including the letter and number on the bingo balls, and the winning card(s) of the progressive mega jackpot bingo game(s) to the patrons at that session.

3. A video cassette recorder at each such location capable of monitoring and recording any winning card and all bingo balls including the letter and number on the bingo balls, as they are extracted from the bingo machine and announced to the patrons along with any hand movement of the caller during the entire progressive mega jackpot bingo game.

N. Costs. Each location, hall, commercial lessor or noncommercial lessor that has any licensed organization(s) participating in the progressive mega jackpot bingo game shall bear all costs, related to, but not limited to, the following:

1. facsimile machine installation at each such location capable of transmitting the required data and information to the division, the governing authority of the parish or municipality, or the certified public accountant contracted to oversee the progressive mega jackpot bingo game for the parish or parishes, if applicable.

2. banking fees and other related costs, accounting fees of the certified public accountant contracted to oversee all deposits, disbursements, and reporting and tax requirements of the progressive mega jackpot bingo game bank account(s), if applicable. Unless as otherwise provided by the division, these costs shall be shared by each such location proportionate to the number of sessions held at each site.

3. attorney fees as may be required for any progressive mega jackpot bingo game. Unless as otherwise provided by the division, these costs shall be shared by each such location proportionate to the number of sessions held at each site.

4. a minimum of at least one camera and one monitor at each such location that is capable of televising the first and next ball to be called, including the letter and number on the bingo balls, and the winning card(s) of the progressive mega jackpot bingo game to patrons at that session.

5. a video cassette recorder capable of monitoring and recording any winning card and all bingo balls, including the letter and number on the bingo balls, as they are extracted from the bingo machine and announced to the patrons along with any hand movement of the caller during the entire progressive mega jackpot bingo game.

O. Organization Requirements and Verification Procedures. All licensed charitable organizations participating in a progressive mega jackpot bingo game shall use the following procedures in verifying the play and winner(s) of the progressive mega jackpot bingo game.

1. Use at each of its games the required camera, monitor, and video cassette recorder at its gaming location to televise and record the following:

a. the caller announcing the information as set forth in Paragraph 5 of this Subsection;

b. all bingo balls as they are extracted from the bingo machine and announced to the patrons along with any hand movement of the caller during the entire progressive mega jackpot bingo game. Each ball, including the letter and number on the ball should be visible to the patrons prior to being extracted from the bingo machine hopper;

c. the winning card(s) of the progressive mega jackpot bingo game and to display on the monitor such card(s) to the patrons at that session.

5. The caller shall announce:

a. the organization's name, license number, session date, session time, the name of the location of the game, and record this information on the video cassette prior to calling the first ball of the progressive mega jackpot bingo game;

b. the dollar amount of the progressive mega jackpot bingo prize and the number of balls to be called for the progressive mega jackpot bingo game prior to the start of each gaming session;

c. that the progressive mega jackpot bingo game shall commence at least five minutes before the first ball is called for the progressive mega jackpot bingo game;

d. when the forty-eighth ball is called or subsequent ball is called as provided in accordance with Paragraph 7 of Subsection H and ask if there are any winners and then state that the progressive mega jackpot bingo game has ended;

e. any progressive mega jackpot bingo game winners from another organization's licensed session for the 24-hour period as provided in Subsection H of this Section prior to the first called bingo game of a session, the start of the progressive mega jackpot bingo game, and upon receipt of the facsimile as provided in Paragraph 12 of this Subsection;

f. in order to be eligible to win the progressive mega jackpot bingo game and to collect the prize, one must possess two of the four types of personal identification as provided in Subsection P of this Section;

g. each bingo ball by letter and number as it is extracted from the bingo machine and placed on the bingo board for view by all patrons during the progressive mega jackpot bingo game.

6. A person, other than the caller, working in a managerial capacity with the licensed organization conducting the progressive mega jackpot bingo game shall reduce to writing the sequence that the bingo balls are actually called for the progressive mega jackpot bingo game. Such record shall be in ink and shall become part of the session records and shall be maintained for a period of three years as required by this Part.

7. In the event that there is a progressive mega jackpot bingo game winner as provided in Subsection H of this Section, the video cassette tape shall immediately be rendered incapable of further recording, and secured by the session manager of that organization.

a. The organization shall verify that the winning progressive mega jackpot bingo card(s) compares to the actual balls called. Such verification shall be made by at least three separate persons working in a managerial capacity on behalf of the licensed organization.

b. The organization shall use at each of its games the master verification checkbook or similar verification device at its gaming location to compare to the winning card(s) of the progressive mega jackpot bingo game to ensure that such winning card(s) is a valid winner and has not been altered. Such verification shall be made by at least three separate persons working in a managerial capacity on behalf of the licensed organization.

c. The organization shall make available such cassette to the division or to the governing authority of the parish or municipality within three business days where it shall be reviewed and retained for a period of one year.

8. In the event that a licensed bingo session is not held by any participating organization, such organization shall transmit by facsimile a license modification form immediately to the division and the governing authority of the parish or municipality or the contracted certified public accountant, if applicable, stating that a licensed session was not held and the reason why the session was not held. The modification form shall be signed by the organization's member-in-charge.

9. Ensure that the contracted certified public accountant, if applicable, receives a copy of the participating organization's licensed scheduled sessions prior to beginning the progressive mega jackpot bingo game and any subsequent changes to said license. Unless as otherwise provided by the division, all proposed modifications to licensed schedules

shall be submitted to the division for approval at least 72 hours in advance of any proposed change.

10. Vouchers. All organizations participating in a progressive mega jackpot bingo game shall utilize the same type of carbon copy voucher when awarding progressive mega jackpot bingo prize winners. All required information on the voucher(s) shall be accurately completed and properly signed immediately after the winning progressive mega jackpot bingo card(s) has been verified as provided by this Subsection. The voucher(s) shall contain, but shall not be limited to, the following information:

a. organization name, license number, session date, and session starting time;

b. printed names and signatures of at least three separate persons working in a managerial capacity on behalf of the licensed organization;

c. name and physical address of the hall;

d. number of winners for the session;

e. dollar amount of the progressive mega jackpot bingo prize and the number of balls called for the winning card; and

* * *

11. Any winner(s) of the progressive mega jackpot bingo game shall be given the original voucher, and the carbon copy voucher(s) shall be retained along with the winning 3 on 1 up sealed vertical disposable bingo cards by the organization awarding the progressive mega jackpot bingo prize. The progressive mega jackpot bingo winner(s) printed name(s), signature(s), and social security number(s) shall be affixed to the back of the winning card(s) in order to be valid.

12. Any participating organization(s) which has a progressive mega jackpot bingo winner(s) at its licensed session shall immediately transmit by facsimile the completed voucher(s), the session record as provided in Paragraph 6 of this Subsection and the winning card(s) of the progressive mega jackpot bingo game to the following:

a. the division;

b. governing authority of the parish or municipality, if applicable;

c. the contracted certified public accountant approved by the division for that progressive mega jackpot bingo game, if applicable; and

d. all locations, halls, commercial lessors and noncommercial lessors whose organizations participate in the progressive mega jackpot bingo game.

P. Payment of the Winner(s). The original voucher(s), the carbon copy voucher(s), and the original winning 3 on 1 up sealed vertical disposable bingo card(s) shall be presented to the division or the governing authority of the parish or municipality, or the contracted certified public accountant(s), if applicable, within three working days for verification. No winner(s) of the progressive mega jackpot bingo prize shall be certified and no winner shall be paid until verified by the division or the governing authority of the parish or municipality. Any winner of the progressive mega jackpot bingo game shall be paid only by check from the charitable gaming progressive mega jackpot bingo account.

1. No winner(s) of the progressive mega jackpot bingo prize shall be paid unless two of the following types of

personal identification are presented by the winner(s) to the division, governing authority of the parish or municipality or the certified public accountant overseeing the progressive mega jackpot bingo account, if applicable:

- a. Social Security card;
- b. valid driver's license or other valid state issued picture identification;
- c. voter registration card; or
- d. birth certificate.

2. Failure to provide a valid Social Security card and a valid driver's license or other state issued picture identification may result in the withholding of taxes from any prize awarded. The organization that sponsored the progressive mega jackpot bingo game at which the progressive mega jackpot bingo prize was won shall submit to each respective taxing authority the taxes withheld and the appropriate forms indicating the amount of any such withholdings.

* * *

R. Each location, hall, commercial lessor, or noncommercial lessor that has any licensed organization participating in the progressive mega jackpot bingo game shall:

1. prepare a detailed deposit slip(s) for all participating organizations' contributions to the progressive mega jackpot bingo game to be deposited from the previous calendar day indicating each licensed organization's name, license number, and the amount to be deposited. Contributions shall only be accepted in the form of a check made payable from the participating organization's charitable gaming checking account made payable to the Charitable Gaming Progressive Mega Jackpot Bingo Account. Contributions in the form of cash and money orders are prohibited;

2. deposit all participating organizations' contributions to the progressive mega jackpot bingo game from the previous calendar day(s) into the progressive mega jackpot bingo account before 11:30 a.m. on the next banking day, and maintain a detailed log of such deposits;

3. transmit daily by facsimile the detailed deposit slip and proof of deposit as provided in Paragraphs 1 and 2 of this Subsection to the division, governing authority of the parish or municipality or the contracted certified public accountant overseeing the progressive mega jackpot bingo account for that game, if applicable;

4. immediately and conspicuously display at each participating progressive mega jackpot bingo game site for a period of one week after the awarding of the progressive mega jackpot bingo game prize at least the following information concerning the progressive mega jackpot bingo winner;

* * *

d. the dollar amount of the progressive mega jackpot bingo prize awarded;

* * *

10. immediately notify by facsimile the division, governing authority of the parish or municipality, or the contracted certified public accountant, if applicable, of any problems, suspected violations of any provision of this Part, deficiencies, breakdowns, discrepancies, or malfunctions with equipment or the conduct of the progressive mega jackpot bingo game;

11. transmit daily by facsimile on forms prescribed by the division, a list of all progressive mega jackpot bingo

games scheduled indicating whether such games were conducted. Such forms shall be transmitted by facsimile to the division, the governing authority of the parish or municipality, or the contracted certified public accountant, if applicable, and must be transmitted prior to the end of the last session held within each respective 24-hour period.

S. The following persons shall be strictly prohibited from playing for the progressive mega jackpot bingo prize.

1. No charitable gaming employee or volunteer shall play for the progressive mega jackpot bingo prize while on duty at any gaming session where a progressive mega jackpot bingo game is being conducted. For purposes of this Section, a gaming employee or volunteer is any member of the licensed organization who participates in the holding, operating or conducting of any game or games of chance or any member of another licensed organization assisting in the holding, operating or conducting of any game or games of chance. A charitable gaming employee or volunteer working any part of a session or taking a temporary break shall be considered on duty for that gaming session.

* * *

3. No licensed distributor owners, or its shareholders, directors, employees or agents shall play the progressive mega jackpot bingo game at any participating organization's licensed session.

4. No licensed manufacturer owners, or its shareholders, directors, employees or agents shall play the progressive mega jackpot bingo game at any participating organization's licensed session.

5. No licensed private casino contractor owners, or its shareholders, directors, employees or agents shall play the progressive mega jackpot bingo game at any participating organization's licensed session.

6. No employee who regulates charitable games of chance for any state, parish, or municipal governing authority, shall play the progressive mega jackpot bingo game at any participating organization's licensed session.

* * *

U. Any licensed charitable organization, commercial or noncommercial lessor, or the respective officers, agents, or employees thereof who violate any provision of this Section shall be subject to civil penalties, the suspension, restriction, or revocation of its gaming license, and a finding of unsuitability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:4861.26 and R.S. 40:1485.4.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, Charitable Gaming Division, LR 22:116 (February 1996), amended by the Division of Charitable Gaming Control, LR 23:

Interested persons may submit written comments on the proposed rule to Lieutenant Riley Blackwelder, Director, Division of Charitable Gaming Control, Department of Public Safety and Corrections, Office of State Police, Box 66614 (Number 52), Baton Rouge, LA 70896-6614. Written comments will be accepted through the close of business, 4:30 p.m., on May 20, 1997.

Colonel R.W. "Rut" Whittington
Superintendent

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

RULE TITLE: Charitable Bingo, Keno, Raffle
Progressive Mega Jackpot Bingo

Title 61

REVENUE AND TAXATION

Part I. Taxes Collected and Administered by the
Secretary of Revenue and Taxation

Chapter 44. Sales and Use Tax Exemptions

§4401. Various Exemptions from the Tax

* * *

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is a one-time printing and mailing cost in the amount of \$1,780 incurred by the state for implementation of the proposed rule. It will have no impact on local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the division and local governmental units that permit the play of progressive mega bingo may experience an increase in revenue collections in the form of use fees collected on nondisposable bingo paper. This is contingent upon the play of the progressive mega bingo game being enhanced due to the anticipated increase in organizational patronage at the licensed bingo sessions of participating organizations.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS
TO DIRECTLY AFFECTED PERSONS OR
NONGOVERNMENTAL GROUPS (Summary)

It is anticipated that participating charitable organizations may experience an increase in gaming revenues as a result of the proposed amendment to LAC 42:II.1791.

IV. ESTIMATED EFFECT ON COMPETITION AND
EMPLOYMENT (Summary)

No effect on competition or employment is estimated.

Thomas H. Normile
Undersecretary
9704#077

Richard W. England
Assistant to the
Legislative Fiscal Office

NOTICE OF INTENT

Department of Revenue and Taxation
Sales Tax Division

Sales and Use Tax Exemption—
Intrastate/Interstate Commerce
(LAC 61:I.4401 and 4403)

Under the authority of R.S. 47:305(E) and R.S. 47:305.1, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue and Taxation, Sales Tax Division proposes to amend LAC 61:I.4401.H pertaining to the sales tax exclusion for sales made in interstate commerce and LAC 61:I.4403.C pertaining to the sales tax exemption for sales made to vessels operating in interstate coastwise commerce.

These proposed amendments are to clarify those sales that are considered to have been made in intrastate commerce and do not fall within the definition of interstate commerce.

H. Interstate Commerce

1. Revised Statute 47:305(E) makes it clear that the taxes imposed under this Chapter do not apply to tangible personal property manufactured or produced in this state or imported into this state for export outside the state. The exemption applies solely to the property for export and does not apply to tangible personal property used, consumed, or expended in the manufacturing process, unless the conditions for exemption set forth in R.S. 47:301(10) are met. Specific pieces of property that have been clearly labeled for shipment outside the state of Louisiana at the time of their manufacture or importation into the state would meet the exemption requirements even though the property may be stored for an indefinite period of time. Any disposition of the property for a purpose contrary to that originally intended would immediately subject the property to the tax.

2. Neither does this Chapter levy a tax on bona fide interstate commerce. *Interstate Commerce* means trade or commerce between a point in one state (e.g., Louisiana) and a point in another state, federal territory, or foreign territory. When property comes to rest in Louisiana and has become a part of the mass of property in this state, it is no longer involved in interstate commerce and its sale, use, consumption, distribution or storage for use here will be taxable.

3. *Intrastate Commerce* includes trade or commerce between a point in Louisiana and any other point in Louisiana, regardless of the route traversed and regardless of where the parties enter into the contract. Intrastate commerce includes but is not limited to:

a. trade or commerce that originates in Louisiana and passes through another state, federal territory, or foreign territory before delivery is made in Louisiana;

b. trade or commerce that includes a pickup in Louisiana for delivery in Louisiana;

c. trade or commerce between a point in Louisiana and a point offshore in the Gulf of Mexico, unless the offshore point is beyond the territorial boundaries of Louisiana; and

d. drop shipments within Louisiana.

I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:305.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Sales Tax Division LR 13:107 (February 1987), amended LR 23:

§4403. Ships and Ships' Supplies

A. - B. ...

C. For the purposes of this Regulation, the following words, terms and phrases shall have the meaning ascribed to them in this Section.

1. - 3. ...

4. *Owner or Operator* means any person who has title to or possession of or control over the operation of any ship or vessel as defined herein.

5. - 8. Repealed.

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:305.1.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Sales Tax Division LR 13:107 (February 1987), amended LR 23:

Interested persons are invited to submit written comments on these proposed amendments. Comments should be submitted no later than Wednesday, May 28, 1997, at 4:30 p.m., to Raymond Tangney, Director of the Sales Tax Division, Box 201, Baton Rouge, LA 70821-0201 or by FAX to (504) 925-3860.

Interested persons are also invited to attend the public hearing on these proposed amendments, which will be held on Thursday, May 29, 1997, at 9 a.m., in the Secretary's Conference Room, at 330 North Ardenwood Drive, Baton Rouge, LA.

John Neely Kennedy
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Sales and Use Tax Exemption—
Intrastate/Interstate Commerce**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no increase in state or local governmental costs to implement these amendments.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no effect on state or local revenue collections if these amendments are implemented.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS
TO DIRECTLY AFFECTED PERSONS OR
NONGOVERNMENTAL GROUPS (Summary)**

If these amendments are implemented, there will be no effect on the costs or economic benefits of directly affected persons or nongovernmental groups.

**IV. ESTIMATED EFFECT ON COMPETITION AND
EMPLOYMENT (Summary)**

These proposed amendments will have no effect on competition or employment.

John Neely Kennedy
Secretary
9704#005

Richard W. England
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Social Services
Office of Family Support**

Electronic Benefits Transfer (LAC 67:III.401)

The Department of Social Services, Office of Family Support proposes to amend LAC 67:III.Subpart 1, General Administrative Procedures.

In accordance with the standards of approval detailed by the United States Departments of Agriculture and Health and Human Services, and pursuant to R.S. 46:450.1 which authorized the agency to devise and pilot an electronic benefits transfer issuance system (EBT) as an alternative to issuing both food stamps and certain cash benefits, the Office of Family Support has begun the process of implementation.

This proposed Rule changes the implementation process of EBT by adding the number of "roll-in" phases and redistributing the parishes originally planned for Phase 2 and Phase 3. The purpose of the change is to more evenly distribute the workload to enable the vendor to complete statewide implementation within a specified time period. EBT can only begin full implementation with authorization by Concurrent Resolution of the Legislature, by appropriation or by legislative act. EBT will be the method for delivery of benefits replacing checks and food stamp authorization cards.

Title 67

SOCIAL SERVICES

Part III. Office of Family Support

Subpart 1. General Administrative Procedures

Chapter 4. Electronics Benefits Issuance System

§401. Electronic Benefits Transfer (EBT)

* * *

B. The EBT system will expand beyond the pilot parish in the following manner:

1. Phase 1 consists of the parishes of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Sabine, Winn, East and West Baton Rouge, East and West Feliciana, Livingston, St. Helena, and Tangipahoa.

2. Phase 2 consists of the parish of Orleans (five district offices).

3. Phase 3 includes the parishes of Jefferson, Plaquemines, St. Bernard, St. Tammany and Washington.

4. Phase 4 consists of the parishes of Ascension, Assumption, Iberville, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne, Iberia, Pointe Coupee, St. Landry and St. Martin.

5. Phase 5 consists of the parishes of Acadia, Allen, Beauregard, Calcasieu, Cameron, Evangeline, Jefferson Davis, Lafayette, Vermilion and Vernon.

6. Phase 6 consists of the parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Lincoln, Red River, Webster, Caldwell, East and West Carroll, Franklin, Jackson, Madison, Morehouse, Ouachita, Richland, Tensas and Union.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:450.1, 7 CFR 274.12 and 45 CFR 95(F).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 22:1231 (December 1996), amended LR 23:

Interested persons may submit written comments within 30 days of this publication to Vera W. Blakes, Assistant Secretary, Office of Family Support, Box 94065, Baton Rouge, LA 70804-9065. She is responsible for responding to inquiries regarding this proposed Rule.

A public hearing on the proposed Rule will be held on May 27, 1997 in the Second Floor Auditorium at the Department of Social Services, 755 Third Street, Baton Rouge, LA beginning at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in

writing, at said hearing. Individuals with disabilities who require special services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call (504)342-4120 (Voice and TDD).

Madlyn B. Bagneris
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Electronic Benefits Transfer**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Since the original Rule/Fiscal Impact statement which provided estimates on costs and savings, the Agency now has contracted with an EBT vendor and has begun the pilot system in Natchitoches Parish. Phase 1 parishes begin operation in July. Although the proposed Rule change will have minimal fiscal impact, the Office of Family Support takes this opportunity to report the actual current and projected amounts for statewide implementation of EBT, the Electronic Benefits Transfer system. EBT will cost the state \$153,619 in FY 97/98, and will result in savings of \$465,291 in FY 98/99 and \$435,125 in FY 99/00. Since the food stamp issuing offices will be phased out, there are estimated savings to local governmental units of \$2,403,717 in FY 97/98, and \$3,844,904 in FY 98/99 and in FY 99/00.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

State government will need an approximate additional \$1.2 million in state funds and reduce its need for federal funds by approximately \$1 million in FY 97/98. For FY 98/99 the increase in state funds will be \$1.6 million and a reduction in federal funds of \$2 million. For FY 99/00 the increase in state funds will be \$1.5 million and a reduction in federal funds of \$1.9 million.

For FY 97/98 the local food stamp issuing offices will be phased out as EBT is implemented. This will result in the loss of approximately \$2.4 million in federal funds to local governments and a savings of \$2.4 million in local funds which were used for match. In FY 98/99 and 99/00 the amounts would be \$3.8 million in federal funds and the same in local funds.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This Rule change should improve delivery of benefits to recipients. There will be minimal impact on retailers, grocers, etc. who purchase and prepare to use the EBT equipment as the rule only subdivides the original timeframe for implementation.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Since the actual issuance of paper food stamps will end with implementation, this change in the phase-in of parishes will have minimal effect on issuing office employees by changing their employment status by one or two months.

Vera W. Blakes
Assistant Secretary
9704#072

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Transportation and Development
Board of Registration for Professional
Engineers and Land Surveyors**

Seal and Signature (LAC 46:LXI.1701)

In accordance with R.S. 49:950 et seq., notice is hereby given that the Board of Registration for Professional Engineers and Land Surveyors intends to revise LAC 46:LXI.1701.

Due to an administrative oversight, the hereinabove Rule was inadvertently omitted during a recent Rule change. Accordingly, this Rule change is necessitated solely to reinsert the previously omitted text.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

**Part LXI. Professional Engineers and Land Surveyors
Chapter 17. Use of Seals
§1701. Seal and Signature**

The following Rules for the use of seals to identify work performed by a registered professional engineer or professional land surveyor shall be binding on every registrant:

1. - 2.e. ...

3. The application of the registrant's seal, signature, and date shall constitute certification that the work thereon was done by him or under his direct supervision.

a. Drawings and Plats. In case of multiple sealings, the first or title page shall be sealed and signed by the registrant or registrants in responsible charge. In addition, each sheet shall be sealed by the registrant or registrants responsible for each sheet. In the case of a firm, partnership or corporation, each sheet shall be sealed and signed by the registrant or registrants responsible for that sheet and the registrant(s) in responsible charge shall sign and seal the title or first sheet.

b. Specifications, Reports, Design Calculations and Information. In the case of specifications of multiple pages, the first or title page of each document shall be sealed and signed by the registrant or registrants involved. Subsequent revisions shall be dated and initialed by the registrant in responsible charge whose seal and signature appears on the first or title page. In the case of a firm, partnership or corporation, the registrant in responsible charge shall sign and seal the title or the first sheet.

4. No registrant shall affix his seal or signature to reports, plats, sketches, working drawings, specifications, design calculations or other engineering and land surveying documents developed by others not under his complete direction and control and not subject to the authority of that registrant, except as stated in Paragraph 8 below.

5. Plans, specifications, drawings, reports or other documents will be deemed to have been prepared under the personal supervision and complete direction and control of a registrant only when:

a. the client or any public or governmental agency requesting preparation of such plans, specifications, drawings, reports or other documents makes the request directly to the registrant, or the registrant's employee as long as the employee works in the registrant's place(s) of business; and

b. the registrant supervises the preparation of the plans, specifications, drawings, reports or other documents and has input into their preparation prior to their completion; and

c. the registrant reviews the final plans, specifications, drawings, reports or other documents; and

d. the registrant has the authority to, and does, make any necessary and appropriate changes to the final plans, specifications, drawings, reports or other documents.

6. No registrant shall affix his seal or signature to documents having titles or identities excluding the registrant's name unless:

a. such documents were indeed developed by the registrant under the registrant's personal supervision and direct control;

b. the registrant shall exercise full authority to determine their development; and

c. except as set forth in Paragraph 8 below.

7. In the case of a temporary permit issued to a registrant of another state, the registrant shall affix the seal of his state of registration, his signature, the date of execution and his Louisiana temporary permit number to all of his work.

8. In the case of an individual registrant checking the work of and taking the professional responsibility for an out of state individual registrant, the Louisiana registrant shall completely check and have complete dominion and control of the design. Such complete dominion and control shall include possession of the sealed and signed reproducible construction drawings, with complete signed and sealed design calculations indicating all changes in design. .

9. Seal Design Requirements

a. The design of the seal shall have the following minimum information:

State of Louisiana

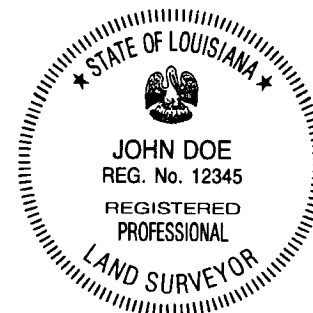
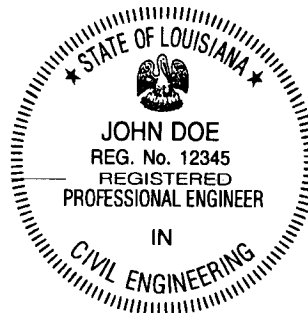
Registrant's name

Registrant's Registration Number

Contain the words "Professional Engineer in

_____ Engineering" or "Registered Professional Land Surveyor."

b. Indicated below is a sample of the seal design authorized by the board. Seals of two different sizes will be acceptable, a pocket seal, the size commercially designated as 1 5/8-inch seal, or a desk seal, commercially designated as a two-inch seal. Rubber stamps or computer generated stamps of the same design and size are acceptable for use. Facsimile signatures are not acceptable (Paragraph 2).



NOTE THAT FIRM SEALS ARE NOT AUTHORIZED IN LOUISIANA
AUTHORITY NOTE: Promulgated in accordance with R.S. 37:696

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Board of Registration for Professional Engineers and Land Surveyors, LR 8:112 (April 1982), amended LR 12:692 (October 1986), LR 16:774 (September 1990), LR 17:273 (March 1991), LR 19:58 (January 1993), LR 22:287 (April 1996), LR 23:

Interested persons may call the office at (504)295-8522 to make arrangements to review the Rules. Written comments will be accepted through May 19, 1997. Send comments to H. Glen Kent, Jr., P.L.S., Executive Secretary, Louisiana State Board of Registration for Professional Land Surveyors Office, 10500 Coursey Boulevard, Suite 107, Baton Rouge, LA 70816.

H. Glen Kent, Jr., P.L.S.
Executive Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Use of Seals**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no implementation costs (savings) to state or local governmental units.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is on effect on revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There are no estimated costs and/or economic benefits to directly affected persons or nongovernmental groups. Due to an administrative oversight, this Rule was inadvertently omitted during a recent Rule change. This Rule change is necessitated solely to reinsert the text previously omitted in the *Louisiana Register*, Volume 22, Number 4, April 20, 1996, page 287.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There are no estimated effects on competition and employment.

H. Glen Kent, Jr., P.L.S.
Executive Secretary
9704#040

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Black Bass—Atchafalaya Basin
Complex (LAC 76:VII.165)

The Wildlife and Fisheries Commission hereby advertises its intent to amend a Rule for Black Bass.

The secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this Notice of Intent and the final Rule, including but not limited to, the filing of the Fiscal and Economic Impact Statement, the filing of the Notice of Intent and final Rule and the preparation of reports and correspondence to other agencies of government.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 1. Freshwater Sports and Commercial Fishing §165. Black Bass Regulations—Atchafalaya River Basin, Lake Verret, Lake Palourde Complex

The daily creel limit (daily take) for Black Bass (*Micropterus spp.*) is 10 fish and the minimum total length limit is 14 inches in the area south of U.S. 190 from the West Atchafalaya Basin Protection Levee to the intersection of LA 1 and U.S. 190 due north of Port Allen, east of the West Atchafalaya Basin Protection Levee from U.S. 190 to U.S. 90, north of U.S. 90 from the West Atchafalaya Basin Protection Levee to LA 20, north and west of LA 20 from U.S. 90 to LA 1 in Thibodaux, south and west of LA 1 from LA 20 to U.S. 190.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6(25)(a), 325(C), 326.3.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 19:361 (March 1993), amended LR 21:960 (September 1995), LR 23:

Interested persons may comment on the proposed Rule in writing to Bennie Fontenot, Administrator, Inland Fisheries Division, Department of Wildlife and Fisheries, Box 98000, Baton Rouge, LA 70898-9000 until 4:30 p.m., June 5, 1997.

Daniel J. Babin
Chairman

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Black Bass Minimum Size Regulations in the Atchafalaya Basin Complex

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule will have no implementation costs. Enforcement of the proposed Rule will be carried out using existing staff.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule will have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed Rule to extend the current 14 inch minimum size limit on Black Bass in the hurricane recovery area beyond September 30, 1997 should continue to increase the quality of Black Bass harvested by recreational anglers. It should also provide, over time, additional economic benefits to area businesses and persons who benefit directly and indirectly from increased recreational fishing and related activities. No cost increases, workload adjustment or additional paperwork is anticipated to occur as a result of the proposed action.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Rule may result in a slight increase in competition and employment in the private sectors due to the anticipated increased fishing effort in the impacted area over time.

Ronald G. Couvillion
Undersecretary
9704#027

Richard W. England
Assistant to the
Legislative Fiscal Officer

NOTICE OF INTENT

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Toledo Bend Reservoir Reciprocal
Agreement (LAC 76:VII.110)

The Wildlife and Fisheries Commission hereby advertises its intent to amend a Rule modifying regulations for Toledo Bend Reservoir.

The secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this Notice of Intent and the final Rule, including but not limited to, the filing of the Fiscal and Economic Impact Statement, the filing of the Notice of Intent and final Rule and the preparation of reports and correspondence to other agencies of government.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 1. Freshwater Sports and Commercial Fishing §110. Toledo Bend Reservoir Reciprocal Agreement

A. The daily creel limit (daily take) for black bass (*Micropterus spp.*) is set at eight fish, in aggregate. The minimum total length limit for largemouth bass (*M. salmoides*) is 14 inches and the minimum total length limit for spotted bass (*M. punctulatus*) is 12 inches. For enforcement purposes, a spotted bass shall be defined as a black bass with a tooth patch.

B. The daily creel limit for white bass (*Morone chrysops*) is 25 fish and there is no minimum total length limit.

C. The minimum total length limit for crappie (*Pomoxis spp.*) from March 1 to November 30 is 10 inches. From December 1 through the last day in February, there will be no minimum total length limit on crappie. From December 1 through the last day in February, culling of crappie is prohibited. All crappie caught must be counted toward the daily creel limit of 50 fish.

D. For all species of fish, the possession limit for recreational anglers, while on the water, shall be a one day's creel limit.

E. This Rule will become effective September 1, 1997.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6(25)(a), 325(C) 326.3, 673.

HISTORICAL NOTE: Promulgated by Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 14:548 (August 1988), amended LR 17:278 (March 1991), LR 17:1123 (November 1991), LR 19:790 (June 1993), LR 23:

Interested persons may comment on the proposed Rule in writing to Bennie Fontenot, Administrator, Inland Fisheries Division, Department of Wildlife and Fisheries, Box 98000, Baton Rouge, LA 70898-9000 until 4:30 p.m., June 5, 1997.

Daniel J. Babin
Chairman

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Toledo Bend Reservoir Reciprocal Agreement

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The proposed Rule will have no implementation costs. Enforcement of the proposed Rule will be carried out using existing staff.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF
STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The proposed Rule may positively impact revenue collections of state or local governmental units. The impact would be an increase in sales tax revenues if participation in fishing on Toledo Bend Reservoir increases.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS
TO DIRECTLY AFFECTED PERSONS OR
NONGOVERNMENTAL GROUPS (Summary)**

The proposed Rule may benefit local businesses that cater to sport fisherman if the number of anglers that visit Toledo Bend increases.

**IV. ESTIMATED EFFECT ON COMPETITION AND
EMPLOYMENT (Summary)**

The proposed Rule will have no effect on competition and employment.

Ronald G. Couvillion
Undersecretary
9704#029

Richard W. England
Assistant to the
Legislative Fiscal Officer

Administrative Code Update

CUMULATIVE ADMINISTRATIVE CODE UPDATE January - March, 1997

LAC Title	Part.Section	Effect	Location LR 23 Month Page					
				48	I.Chapter 23	Amended	Jan	74
					V.6303	Amended	Mar	301
					VII.Chapter 9	Adopted	Feb	200
7	V.Chapter 15	Amended	Mar 293	58	III.	Amended	Jan	85
	XV.9903,9914,9919,9921	Amended	Feb 195					
	XXI.11715, 11717	Amended	Feb 196	61	I.5301	Amended	Jan	78
	XXIII.Chapter 131	Amended	Feb 192		V.Chapters 7-35	Amended	Feb	204
	XXVII.14728	Amended	Feb 196					
10	I.201	Amended	Mar 297	67	III.101, 103	Amended	Jan	79
	III.591	Adopted	Jan 47		III.1113, 1133	Amended	Jan	79
					III.Chapter 19	Amended	Jan	79
13	I.Chapter 9	Amended	Mar 295		III.1909	Repealed	Jan	79
					III.1938,1940	Adopted	Jan	80
19	II.Chapters 1-13	Adopted	Jan 49		III.1943	Repealed	Jan	82
	VII.Chapter 1	Amended	Jan 40		III.1988, 1994	Adopted	Jan	83
	VII.117,119,121	Repealed	Jan 43		III.2514	Adopted	Mar	304
	VII.Chapter 81	Adopted	Jan 43		III.2541	Amended	Feb	210
	VII.Chapter 91	Adopted	Jan 36		III.2753	Repealed	Feb	210
25	XI.101	Adopted	Jan 35	70	I.509	Amended	Jan	85
					I.513	Adopted	Jan	84
28	I.1709	Amended	Jan 55		III.1103	Adopted	Feb	210
33	I.Chapter 9	Adopted	Mar 297	76	VII.329	Amended	Jan	86
	III.504	Amended	Feb 197		VII.349	Repromulgated	Feb	211
	III.2122	Repromulgated	Feb 197					
	III.Chapter 51	Amended	Jan 56					
	III.5116, 5122	Adopted	Jan 61					
	III.5301	Amended	Jan 63					
	III.5311	Adopted	Jan 63					
	V.105	Amended	Mar 298					
	V.2271	Amended	Mar 299					
	V.2515	Amended	Mar 299					
	IX.2301	Amended	Feb 199					
	IX.2560	Adopted	Feb 199					
	XV.112	Amended	Mar 299					
34	I.3103	Amended	Jan 67					
	XI.103	Amended	Mar 300					
37	III.Chapters 1,5,7,9	Amended	Jan 67					
40	I.2123	Amended	Jan 77					
	IV.113	Adopted	Jan 76					
42	XI.2423	Repealed	Jan 77					
	XIII.2167	Repealed	Jan 77					
	XV.Chapter 1	Repromulgated	Jan 63					
	XV.141	Amended	Jan 67					
46	XXXIII.301	Repromulgated	Feb 199					
	XXXIII.303	Repealed	Feb 200					
	LXVI.Chapters 9,12,13	Amended	Jan 71					
	LXVI.1221	Repealed	Jan 74					

Potpourri

POTPOURRI

Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences Horticulture Commission

1997 Annual Quarantine Listing

In accordance with LAC 7:XV.9507 and 9509, the Horticulture Commission hereby publishes the annual quarantine.

1.0 Sweetpotato Weevil (*Cylas formicarius elegantulus* Sum)

(a) In the United States: the states of Alabama, California, Florida, Georgia, Mississippi, North Carolina, South Carolina and Texas.

(b) In the State of Louisiana:

1) The entire parishes of: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Cameron, DeSoto, East Baton Rouge, East Feliciana, Evangeline, Grant, Iberia, Iberville, Jefferson, Jefferson Davis, Lafayette, Lafourche, Livingston, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Rapides, Red River, Sabine, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Terrebonne, Vermilion, Vernon, Washington, Webster, West Baton Rouge, West Feliciana.

2.0 Pink Bollworm (*Pectinophora gossypiella* Saunders)

Pink bollworm quarantined areas are divided into generally infested and/or suppressive areas as described by USDA-PPQ.

ARIZONA

(1) Generally infested area: the entire state.

CALIFORNIA

(1) Generally infested area: The entire counties of: Imperial, Inyo, Los Angeles, Orange, Riverside, San Bernardino, and San Diego.

(2) Suppressive area: The entire counties of: Fresno, Kern, Kings, Madera, Merced, San Benito, and Tulare.

MISSOURI

(1) Generally infested area: None

(2) Suppressive area: The entire counties of: Dunklin and Madrid.

NEVADA

(1) Generally infested area: The entire counties of Clark and Nye.

(2) Suppressive area: None.

NEW MEXICO

(1) Generally infested area: The entire state.

OKLAHOMA

(1) Generally infested area: The entire state.

TENNESSEE

(1) Generally infested area: None

(2) Suppressive area: The entire counties of Dyer and Lauderdale.

TEXAS

(1) Generally infested area: The entire state.

3.0 Phytophagous Snails

The states of California and Arizona.

4.0 Sugarcane Pests and Diseases

All states outside of Louisiana.

5.0 Lethal Yellowing

The states of Florida and Texas.

6.0 Tristeza, Xyloporosis, Psorosis, Exocortis.

All citrus growing areas of the United States.

7.0 Burrowing Nematode (*Radopholus similis*)

The States of Florida and Hawaii and the Commonwealth of Puerto Rico.

8.0 Oak Wilt (*Ceratocystis fagacearum*)

ARKANSAS

Infected counties: Baxter, Benton, Boone, Carroll, Clay, Craighead, Crawford, Franklin, Fulton, Independence, Izard, Johnson, Lawrence, Logan, Madison, Marion, Mississippi, Nevada, Newton, Poinsett, Pope, Randolph, Scott, Searcy, Sharp, Stone, Washington, and Yell.

ILLINOIS

Entire state.

INDIANA

Entire state.

IOWA

Entire state.

KANSAS

Infected counties: Anderson, Atchison, Cherokee, Doniphan, Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Linn, Miami, Neosho, Pottawatomie, Shawnee, and Wyandotte.

KENTUCKY

Infected counties: Adair, Allen, Ballard, Bath, Bell, Boyd, Breathitt, Breckinridge, Bullitt, Butler, Caldwell, Calloway, Carter, Casey, Christian, Clay, Clinton, Cumberland, Daviess, Edmonson, Elliott, Estill, Fleming, Floyd, Graves, Grayson, Green, Greenup, Hancock, Hardin, Harlan, Hart, Henderson, Hopkins, Jefferson, Johnson, Knott, Knox, Lawrence, Lee, Leslie, Letcher, Lewis, Logan, McCracken, McLean, Magoffin, Marshall, Martin, Menifee, Metcalfe, Montgomery, Morgan, Muhlenberg, Nelson, Ohio, Oldham, Owsley, Perry, Pike, Powell, Pulaski, Rowan, Russell, Taylor, Todd, Trigg, Union, Warren, Wayne, and Webster.

MARYLAND

Infected Counties: Allegany, Frederick, Garrett, and Washington.

MICHIGAN

Infected counties: Barry, Barrien, Calhoun, Cass, Clare, Clinton, Grand Traverse, Kalamazoo, Kent, Lake, Livingston, Manistee, Missaukee, Muskegon, Oakland, Roscommon, St. Joseph, Van Buren, Washtenaw, Wyne, and Menominee.

MINNESOTA

Infected counties: Anoka, Aitkin, Blue Earth, Carver, Cass, Chicago, Crow Wing, Dakota, Dodge, Fillmore, Freeborn, Goodhue,

Hennepin, Houston, Le Sueur, McLeod, Mille Lacs, Morrison, Mower, Nicollet, Olmsted, Ramsey, Rice, Scott, Sherburne, Sibley, Steele, Wabasha, Waseca, Washington, Winona, and Wright.

MISSOURI

Entire state.

NEBRASKA

Infected counties: Cass, Douglas, Nemaha, Otoe, Richardson, and Sarpy.

NORTH CAROLINA

Infected counties: Buncombe, Burke, Haywood, Jackson, Lenoir, Macon, Madison, and Swain.

OHIO

Entire state.

OKLAHOMA

Infected counties: Adair, Cherokee, Craig, Delaware, Haskell, Latimer, LeFlore, Mayes, McCurtain, McIntosh, Ottawa, Pittsburg, Rogers, Sequoyah, and Wagoner.

PENNSYLVANIA

Infected counties: Adams, Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Centre, Clarion, Clinton, Cumberland, Erie, Fayette, Franklin, Fulton, Greene, Huningdon, Indiana, Jefferson, Juniata, Lawrence, Mifflin, Perry, Somerset, Venango, Washington, and Westmoreland.

SOUTH CAROLINA

Infected counties: Chesterfield, Kershaw, Lancaster, Lee, and Richland.

TENNESSEE

Infected Counties: Blount, Carter, Cocke, Cumberland, Grainger, Greene, Hamblen, Hancock, Hardeman, Hawkins, Jefferson, Knox, Lincoln, Loudon, Montgomery, Rhea, Roane, Robertson, Sevier, Sullivan, Union, Washington, and White.

TEXAS

Infected counties: Bandera, Bastrop, Bexar, Blanco, Basque, Burnett, Dallas, Erath, Fayette, Gillespie, Hamilton, Kendall, Kerr, Lampasas, Lavaca, McLennan, Midland, Tarrant, Travis, Williamson.

VIRGINIA

Infected counties: Aleghany, Augusta, Bath, Botetoust, Clarke, Frederick, Giles, Highland, Lee, Loudoun, Montgomery, Page, Rockbridge, Rockingham, Scott, Shenandoah, Smyth, Warren, Washington, Wise, and Wythe.

WEST VIRGINIA

Infected counties: all counties *except* Tucker and Webster.

WISCONSIN

Infected counties: Adams, Brown, Buffalo, Chippewa, Clark, Columbia, Crawford, Dane, Dodge, Dunn, Eau Claire, Fond du Lac, Grant, Green, Green Lake, Iowa, Jackson, Jefferson, Juneau, Kenosha, La Crosse, Lafayette, Lincoln, Marquette, Milwaukee, Monroe, Oconto, Outagamie, Ozaukee, Pepin, Pierce, Polk, Portage, Racine, Richland, Rock, St. Croix, Sauk, Shawano, Trempealeau, Vernon, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago, and Wood.

9.0 Phony Peach

ALABAMA

Entire state.

ARKANSAS

Counties of Arkansas, Ashley, Bradley, Chicot, Columbia, Crittendon, Cross, Desha, Drew, Hempstead, Howard, Jefferson,

Lafayette, Lee, Lincoln, Little River, Miller, Monroe, Nevada, Phillips, Pike, Poinsett, St. Francis, Sevier, Union, and Woodruff.

FLORIDA

Entire state.

GEORGIA

Entire state.

KENTUCKY

County of McCracken.

LOUISIANA

Parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Jackson, Lincoln, Morehouse, Natchitoches, Ouachita, Red River and Union.

MISSISSIPPI

Entire state.

MISSOURI

County of Dunklin.

NORTH CAROLINA

Counties of Anson, Cumberland, Gaston, Hoke, Polk and Rutherford.

SOUTH CAROLINA

Counties of Aiken, Allendale, Bamberg, Barnwell, Cherokee, Chesterfield, Edgefield, Greenville, Lancaster, Laurens, Lexington, Marlboro, Orangeburg, Richland, Saluda, Spartanburg, Sumter, and York.

TENNESSEE

Counties of Chester, Crockett, Dyer, Fayette, Hardman, Hardin, Lake, Lauderdale, McNairy, Madison, and Weakley.

TEXAS

Counties of Anderson, Bexar, Brazos, Cherokee, Freestone, Limestone, McLennan, Milan, Rusk, San Augustine, Smith, and Upshur.

10.0 Citrus Canker (*Xanthomonas axonopodis* pv. *citri*)

Any areas designated as quarantined under the Federal Citrus Canker quarantine 7 CFR 301.75 et seq.

11.0 Pine Shoot Beetle [*Tomicus piniperda* (L.)]

ILLINOIS

Counties of Boone, Cook, Champaign, DuBage, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, Lee, Livingston, McHenry, Platt, Will, Winnebago and Vermillion.

INDIANA

Counties of Adams, Allen, Benton, Blackford, Cass, Dekalb, Delaware, Elkhart, Fulton, Grant, Huntington, Jasper, Jay, Kosciusko, Lagrange, Lake, LaPorte, Marshall, Miami, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Tippecanoe, Wabash, Wells, White, and Whitley.

MARYLAND

County of Allegany.

MICHIGAN

Counties of Allegan, Barry, Bay, Berrien, Branch, Calhoun, Cass, Clare, Clinton, Eaton, Genesee, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Kalamazoo, Kent, Lenawee, Lapeer, Livingston, Macomb, Midland, Monroe, Montcalm, Oakland, Saginaw, Sanilac, St. Clare, St. Joseph, Shiawassee, Tuscola, Van Buren, Washtenaw, and Wayne.

NEW YORK

Counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Oswego, Steuben, Wayne and Wyoming.

OHIO

Counties of Allen, Ashland, Ashtabula, Auglaize, Cameron, Carroll, Columbiana, Crawford, Cuyahoga, Delaware, Erie, Fulton, Geauga, Holmes, Huron, Knox, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Richland, Sandusky, Seneca, Stark, Summit, Trumbull, Tuscarawas, Wayne, Williams, Wood and Wyndot.

PENNSYLVANIA

Counties of Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, Lawrence, McKean, Mercer, Venango, Warren and Westmoreland.

WEST VIRGINIA

Counties of Hancock and Ohio.
Any other areas designated as quarantined under the Federal Pine Shoot Beetle quarantine 7 CFR 301.50 et seq.

Bob Odom
Commissioner

9704#026

POTPOURRI

Department of Agriculture and Forestry
Rice Promotion Board

Rice Referendum Election Results
(February 18, 1997 Minutes)

The Rice Promotion Board met at the LSU Rice Research Station in Crowley, LA at 10 a.m., February 18, 1997. The purpose of the meeting was to certify the recent rice referendum election results.

Members present were: Ralph Cowen; Edwin Leonards; Fred Denison; Ed Wild; J.C. Griffin; Mike Unkel; Jimmy Hoppe. Others present were Bryce Malone and Shelby Robert, Louisiana Department of Agriculture; Blair Michel, Broadhurst Krielow and Hamilton; and Chuck Wilson, USA Rice Federation.

Chairman Ralph Cowen called the meeting to order and established that a quorum was present.

Blair Michel gave a financial report stating:

a cash balance as of February 17, 1997	\$161,735;
assessments collected	\$490,158;
payments to USA Rice Council	\$310,000
other expenditures	\$23,926
revenue in excess of expenditures	\$156,232

It was moved and seconded, that

RESOLVED: to accept and pass the financial report presented. Motion carried.

It was announced that the governor had made the appointments to the LA Rice Research Board but none have been announced for the LA Rice Promotion Board.

The results of the recent Louisiana rice referendum were discussed. A report showing that the vote:

to continue the current \$.03 per hundred weight for research	passed by 94 percent
to add \$.02 per hundred weight for research	passed by 83 percent
to continue the \$.03 per hundred weight for rice promotion	passed by 88 percent

(Included as Appendix A)

It was moved and seconded, that

RESOLVED: to accept the numbers and percentages as presented as the official result of the 1997 Louisiana Rice Referendum. Motion Carried.

Discussion of whether the board should continue its plans to have Dr. Rouse Caffey conduct a survey in Central and South America on the potential for selling Louisiana rough rice followed. It was consensus of the board, that since the referendum passed by the large percentage, it would look bad to now drop this objective. It was moved and seconded, that

RESOLVED: Bryce Malone of the Louisiana Department of Agriculture is to initiate the development of a contract with Dr. Rouse Caffey to conduct a survey in Central and South America on the potential to sell Louisiana rough rice into those markets. Motion carried.

Shelby Robert, Louisiana Department of Agriculture was introduced and he informed the board that he will be working with several commodity organizations in Louisiana and looked forward to working with this board.

Chairman Cowen requested that board members who were present at this meeting (and addresses) be included with the minutes.

The next board meeting will be scheduled when the contract with Dr. Cathy is ready to be reviewed by the board. There being no further business, the meeting adjourned.

Board members present at this meeting: Fred Denison, 2503 Dennison Road, Iowa, LA 70647-3411; J.C. Griffin, 12119 LA Highway 693, Abbeville, LA 70510-8627; Jimmy Hoppe, P. O. Drawer 59, Fenton, LA 70640-0059; Edwin Leonards, 9421 F and L Lane, Morganza, LA 70759-3204; Ralph Cowen, 517 East Third Street, Crowley, LA 70526-5221; Mike Unkel, P. O. Box 338, Kinder, LA 70648-0338; Edward Wild, 12071 Wild Road, Welsh, LA 70591-5804.

Appendix A
CHECK LIST OF REFERENDUM MATERIALS
(x = material not received)
Louisiana Rice Referendum - January 27, 1997

Parish	Committee Certification form	Commissioner's Ballot Certification forms		Register of Producers Voting	Research Ballots continue 3¢ additional 2¢	Promotion Ballots
		Research	Promotion			
Acadia						
Allen						
Avoyelles						
Beauregard						
Bossier	only 1 producer		did not vote			
Caddo	no votes					
Calcasieu						
Caldwell	no votes					
Cameron						
Catahoula				x mail in votes		
Concordia	no votes					
East Carroll						
Evangeline						
Franklin						
Iberia						
Jeff Davis						
Lafayette						
Madison						
Morehouse	(receipt for postage)					
Natchitoches						
Ouachita						
Pointe Coupee	(made own forms)					
Rapides						
Red River	no votes					
Richland						
St. Landry						
St. Martin						
Tensas						
Vermillion						
West Carroll	(receipt for postage)					

RICE REFERENDUM TOTALS AND PERCENTAGES
January 27, 1997

Parish	Rice Research					Rice Promotion			
	continue 3¢		Total "continue"	additional 2¢		Total "additional"	continue 3¢		Total Promotion Votes
	Yes	No		Yes	No		Yes	No	
Votes		Votes		Votes		Votes			
Acadia	93	6	99	85	13	98	87	13	100
Allen	45	1	46	40	5	45	41	4	45
Avoyelles	13	0	13	11	2	13	13	0	13
Beauregard	5	0	5	5	0	5	5	0	5
Bossier	-	-	-	-	-	-	-	-	-
Caddo	-	-	-	-	-	-	-	-	-
Calcasieu	40	0	40	40	0	40	40	0	40
Caldwell	-	-	-	-	-	-	-	-	-
Cameron	10	0	10	10	0	10	10	0	10
Catahoula	2	2	4	2	2	4	2	2	4
Concordia	-	-	-	-	-	-	-	-	-
East Carroll	12	0	12	7	5	12	12	0	12
Evangeline	41	10	51	14	37	51	28	23	51
Franklin	6	0	6	6	0	6	6	0	6
Iberia	4	0	4	4	0	4	4	0	4
Jeff Davis	45	3	48	40	9	49	46	3	49
Lafayette	5	0	5	5	0	5	5	0	5
Madison	5	1	5	4	2	5	5	1	6
Morehouse	11	1	12	12	0	12	10	2	12
Natchitoches	6	0	5	3	2	5	5	0	5
Ouachita	8	0	8	8	0	8	8	0	8
Pointe Coupee	17	0	17	17	0	17	17	0	17
Rapides	13	0	13	13	0	13	13	0	13
Red River	-	-	-	-	-	-	-	-	-
Richland	3	0	3	3	0	3	3	0	3
St. Landry	31	0	31	29	2	31	22	9	31
St. Martin	2	0	2	2	0	2	2	0	2
Tensas	3	0	3	3	0	3	3	0	3
Vermilion	111	11	122	105	17	122	109	13	122
West Carroll	7	0	7	6	1	7	7	0	7
Totals	537	36	572	474	97	571	503	70	573
Percentages	94 percent		83 percent			88 percent			

9704#031

Ralph Cowen
Chairman

POTPOURRI

Department of Environmental Quality Office of Air Quality and Radiation Protection Air Quality Division

Air Quality Compliance Certification

The federal air quality operating permits program, 40 CFR Part 70, requires that facilities operating under a Part 70 air quality permit submit a compliance certification annually, 40 CFR 70.6(c)(5), and submit reports of required compliance monitoring semiannually, 40 CFR 70.6(a)(3). The *Louisiana Administrative Code* incorporates those federal requirements at LAC 33:III.507.H.5 and LAC 33:III.507.H.1, respectively. While both federal and state law specify the required frequency of such reporting, neither code established a specific schedule for submittal.

Affected industry trade groups have requested that DEQ clarify the reporting schedule through a *Louisiana Register* notice. In implementing the operating permits program, DEQ wishes to establish a coordinated schedule for submittal of Part 70 annual compliance certifications and semiannual reports. A common submittal schedule for all Part 70 facilities will facilitate coordination of the program and reduce resources required by DEQ to track compliance. Establishing the submittal date concurrent with required annual air quality emissions reporting is desirable to affected industry. For these reasons, DEQ is establishing a schedule for submittal of annual compliance certifications on March 31 of each year, and a schedule for submittal of semiannual reports on March 31 and September 30 of each year for Part 70 sources. To ease the early implementation of the program, DEQ is allowing facilities permitted in 1996 to submit all initial reports (including the first annual certification and the first two semiannual reports) by September 30, 1997. In addition, DEQ is now including the specified reporting schedule of March 31 and September 30 in Part 70 permits as they are issued.

The following paragraphs provide further clarification of the reporting schedule which will satisfy the Part 70 reporting requirements described above.

For initial Part 70 permits issued on or after January 1, 1997 (and for General Permits, for approvals to operate granted on or after January 1, 1997), annual compliance certifications as required by 40 CFR 70.6(c) for all Part 70 Sources will be due March 31 annually, beginning in the year after the initial Part 70 permit is issued for the facility. The compliance certification will report the compliance status for the previous calendar year. For example, if a facility receives the initial Part 70 permit on October 2, 1997, the first annual compliance certification will be due March 31, 1998 and will cover the period January 1, 1997 through December 31, 1997. For requirements which did not apply over the entire calendar year, certification of compliance status is required only for the period during which the requirements are effective.

For initial Part 70 permits issued on or after January 1, 1997 (and for General Permits, for approvals to operate granted on

or after January 1, 1997), semiannual reports as required by 40 CFR 70.6(a)(3), (LAC 33:III.507.H.1) regarding monitoring and related recordkeeping and reporting requirements for Part 70 Sources will be due March 31 and September 30 each year, beginning in the first semiannual calendar period after the initial Part 70 permit is issued for the facility. The semiannual monitoring reports will summarize the required monitoring and recordkeeping and will report deviations for the previous semiannual calendar year. The March 31 report will cover the previous July through December period, and the September 30 report will cover the previous January through June period. For example, if the initial Part 70 permit is issued on April 15, 1997, the first semiannual report is due no later than September 30, 1997 and will cover the period January 1 through June 30, 1997. If the initial Part 70 permit is issued on October 2, 1997, the first semiannual report is due no later than March 31, 1998 and will cover the period July 1, 1997 through December 31, 1997. Semiannual reports will cover all federal requirements which apply to the source, including SIP approved requirements. For requirements which did not apply over the entire semiannual period, the semiannual report is required to cover only the period during which the requirements are effective.

For initial Part 70 permits issued on or before December 31, 1996 (and for General Permits, for approvals to operate granted on or before December 31, 1996), the first annual compliance certification is due no later than September 30, 1997 and will report the compliance status for calendar year 1996. Beginning in 1998, all subsequent annual compliance certifications will be due on March 31 and will cover the previous calendar year period. For example, if a facility received the initial Part 70 permit on August 15, 1996, the first annual compliance certification would be due no later than September 30, 1997 and would cover the period January 1, 1996 through December 31, 1996. (For requirements which did not apply over the entire calendar year, certification of compliance status is required only for the period during which the requirements are effective.) The next annual compliance certification would be due no later than March 31, 1998 and would cover the 1997 calendar year.

For initial Part 70 permits issued on or before December 31, 1996 (and for General Permits, for approvals to operate granted on or before December 31, 1996), the initial semiannual report is due no later than September 30, 1997 and will cover the period July through December 1996. The second semiannual report will also be due September 30, 1997 and will cover January through June 1997. All subsequent semiannual reports will be submitted on the March 31 and September 30 schedule, beginning March 31, 1998.

All annual compliance certifications and semiannual reports should be submitted to the DEQ Headquarters office, with a copy to the appropriate DEQ Regional Office. The original should be submitted to the DEQ Headquarters office at the following address: Louisiana Department of Environmental Quality, Air Quality Engineering Section, Box 82135, Baton Rouge, LA 70884-2135.

Gus Von Bodungen, P.E.
Assistant Secretary

9704#080

POTPOURRI

**Department of Environmental Quality
Office of Air Quality and Radiation Protection
Air Quality Division**

Air Toxics Program

This notice pertains to all facilities subject to any 40 CFR part 61 or 40 CFR part 63 Rule incorporated by reference in LAC 33:III Chapter 51. Affected facilities are requested to submit copies of all notifications and reports to the Environmental Protection Agency Region 6 Office, the Department of Environmental Quality (headquarters in Baton Rouge), and the appropriate DEQ Regional Office. A list of Rules incorporated by reference can be found in the January 1997 *Louisiana Register*.

Contact the Air Toxics Section at (504) 765-0902 for additional information.

Gus Von Bodungen, P.E.
Assistant Secretary

9704#085

POTPOURRI

**Department of Environmental Quality
Office of Air Quality and Radiation Protection
Air Quality Division**

Consolidated Fugitive Emission Programs

On April 17, 1996, a Memorandum of Understanding Between EPA Region 6 and LDEQ was signed to implement a consolidated fugitive emission control program for industrial facilities in Louisiana. The program consolidates overlapping state and federal equipment leak control programs based on an "overall most stringent program" approach.

This notice serves to provide the names of those facilities that have submitted a Source Notice and Agreement during the period of January 7, 1997 to March 5, 1997 to consolidate fugitive emission programs for specified units:

Formosa Plastics Corporation - East Baton Rouge Parish

This notice also serves to provide the names of those facilities that have submitted a Source Notice and Agreement to consolidate fugitive emission programs for specified units prior to January 7, 1997 but were omitted in the January 20, 1997 Potpourri:

Conoco, Inc., Lake Charles Refinery - Calcasieu Parish
Dupont Pontchartrain Works - Saint John the Baptist Parish
PPG Industries, Inc. - Calcasieu Parish
Union Texas Petroleum - Ascension Parish

Contact Jim Courville at (504)765-0219 for additional information.

Gus Von Bodungen, P.E.
Assistant Secretary

9704#084

POTPOURRI

**Department of Environmental Quality
Office of Legal Affairs and Enforcement
Investigations and Regulation Development Division**

Semiannual Regulatory Agenda

The Department of Environmental Quality (DEQ) announces the availability of the spring 1997 edition of the Semiannual Regulatory Agenda prepared by the Investigations and Regulation Development Division. The current agenda contains information on rules which have been proposed but have not been published as final and rules which are scheduled to be proposed in 1997. Check or money order in the amount of \$2.37 is required in advance for each copy of the agenda. Interested persons may obtain a copy by contacting Lula Alexander, Department of Environmental Quality, Office of Legal Affairs and Enforcement, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884-2282 or by calling (504) 765-0399. The agenda is also available on DEQ's Regulations page on the Internet at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>

Tim B. Knight
Administrator

9704#082

POTPOURRI

**Department of Environmental Quality
Office of the Secretary**

Risk Based Corrective Action Program (OS21)

The Louisiana Department of Environmental Quality (LDEQ) requests comments on the March 14, 1997, proposed Risk Based Corrective Action (RCBA) Program. This draft proposal, based on revisions to the 1995 proposed Program, was developed by the Department to initiate comments and discussion on implementing a risk based corrective action program within the LDEQ. Risk based corrective action uses risk assessment: (1) to determine if remediation is necessary for the protection of human health and the environment; and (2) to identify constituent levels in impacted media that do not pose unacceptable risks to human health or the environment, e.g., risk based Corrective Action Levels.

The proposed approach for the 1997 LDEQ RBCA Program was developed by the LDEQ Corrective Action Group (CAG). The CAG was formed under the direction of the Office of the Secretary in October 1994, and is comprised of representatives from the Groundwater Protection, Hazardous Waste, Inactive and Abandoned Sites, Solid Waste, Legal, Underground Storage Tanks, and Water Resources Divisions and a toxicologist under contract with the Office of the Secretary. The proposed 1997 LDEQ RBCA Program, like the 1995 proposed Program, provides three Corrective Options, but the Options are defined differently.

CORRECTIVE OPTION 1: provides Department-derived Corrective Action Levels that are protective of human health and the environment.

CORRECTIVE OPTION 2: provides the option of using site-specific environmental fate and transport data with standard exposure assumptions to develop site-specific Corrective Action Levels.

CORRECTIVE OPTION 3: provides the option of conducting a baseline health risk assessment using site-specific data for the assessment of exposure and the evaluation of constituent fate and transport.

Several key issues to the 1997 LDEQ RBCA Program were discussed extensively during the development of the proposed approach. Comments received from the 1995 RBCA draft were considered and used to assist in revising the document. Changes in the 1997 RBCA Program include revisions to guidelines concerning groundwater/aquifer use classifications, land use, data QA/QC requirements, TPH indicator/surrogate approach, dilution and attenuation factors, point of exposure/compliance, closure and post-closure requirements. Additional guidelines provided in the 1997 program include site ranking, site assessment, the identification of the chemicals of concern, the assessment of lead exposure and polycyclic aromatic hydrocarbons, the estimation of exposure concentrations, defining acceptable risk levels, self implementation, probabilistic risk assessment, the development of toxicity values, submittal requirements for each option, the assessment of ecological risk, and addressing additive exposures.

The department desires public review of this document and is certain that the constructive comments that are received will be instrumental in the continued development of this proposed program. In addition to comments on the technical content of the document, the department specifically requests comments on cost/benefit and fiscal impact of the proposed program. The department has invested many hours in the development of this document. However, the priority for this draft was technical content rather than presentation. Therefore, the department apologizes for any typographical, grammatical, or formatting errors. It is requested that any such errors be noted in the comments to be sent to the department, in order to assist LDEQ in further refinement of the document.

It is the department's intent to incorporate this risk based corrective action protocol into existing regulations. This is a preliminary step in the rulemaking process; official rulemaking will be initiated after review and consideration of the comments received on this advance notice.

Comments are due by June 20, 1997, and must be mailed, hand-delivered or FAXED to Patsy Deaville, Investigations and Regulation Development Division (IRDD):

Mailed: Box 82282
Baton Rouge, LA 70884-2282

Hand Delivered: 7290 Bluebonnet Boulevard
Fourth Floor
Baton Rouge, LA 70810

FAXED: (504) 765-0486

Commentors should reference this document as OS 21.

Copies of this document may be purchased at the IRDD's main office at a cost of \$8.50, or \$10 if mailed. A check or money order is required in advance. The IRDD may be contacted at (504) 765-0399. The document will also be available on the Internet on LDEQ's home page at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>.

Contact one of the following members of the RBCA committee regarding content or status of the RBCA document.

Bijan Sharifkhani	Solid Waste	(504) 765-0249
Steve Chustz	Groundwater	(504) 765-0585
John Halk	Inactive and Abandoned Sites	(504) 765-0487
Narendra Dave	Hazardous Waste	(504) 765-0361
Durwood Franklin	Underground Tanks	(318) 362-5439
Keith Hall	Groundwater	(504) 765-0585
Stephen Tassin	Water Pollution Control	(504) 765-0634
Chris Ratcliff	Legal Division	(504) 765-0236

Tim B. Knight
Administrator

9704#083

POTPOURRI

Department of Environmental Quality Office of Solid and Hazardous Waste Hazardous Waste Division

Public Hearing—Substantive Changes (LAC 33:V.105 and Chapter 49.Appendix E)(HW057)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that the agency is seeking to incorporate substantive changes to the proposed amendments to the Hazardous Waste Division Regulations, LAC 33:V.105.M and Chapter 49.Appendix E (HW057), which were originally proposed on February 20, 1997.

This proposed Rule contains substantive changes to proposed Rule HW057, to grant Marathon Oil's petition, specifically in LAC 33:V.Chapter 49.Appendix E.Table 1. The substantive changes affect the proposed reference of constituents of concern for EPA hazardous waste numbers K048-K051, F037, and F038 identified in the first paragraph of LAC 33:V.Chapter 49.Appendix E.Table 1 and the proposed delisting levels listed in conditions (3)(A) and (3)(B). Changes are also made to complete the listing of Marathon's optional testing requirements in conditions (4) and (4)(A) of the proposed exclusion conditions.

This proposed substantive change meets the exceptions listed in R.S. 30:2019(D)(3) and R.S.49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

A public hearing on the substantive changes will be held on May 29, 1997, at 1:30 p.m. in the Maynard Ketcham Building, Room 326, 7290 Bluebonnet Boulevard, Baton Rouge, LA 70810. Interested persons are invited to attend and submit oral comments on the proposed substantive changes. Should individuals with a disability need an accommodation in order to participate, contact Patsy Deaville at the address given below or at (504)765-0399.

All interested persons are invited to submit written comments on the proposed substantive changes. Commentors should reference the proposed substantive changes by HW057S. Such comments should be submitted no later than June 5, 1997, at 4:30 p.m., to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70810 or by FAX to (504)765-0486. Copies of the proposed substantive changes can be purchased at the above referenced address. Contact the Investigations and Regulation Development Division at (504)765-0399 for pricing information. Check or money order is required in advance for each copy of HW057S.

HW057 and HW057S are available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 7290 Bluebonnet Boulevard, Fourth Floor, Baton Rouge, LA 70810; 804 Thirty-first Street, Monroe, LA 71203; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101, 3519 Patrick Street, Lake Charles, LA 70605; 3501 Chateau Boulevard, West Wing, Kenner, LA 70065; 100 Asma Boulevard, Suite 151, Lafayette, LA 70508.

These regulations are also available on the Internet at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>.

H.M. Strong
Assistant Secretary

9704#086

POTPOURRI

Department of Natural Resources Office of Conservation

Orphaned Oilfield Sites

Office of Conservation records indicate that the Oilfield Sites listed in the table below have met the requirements as set forth by Section 91 of Act 404, R.S. 30:80 et seq., and as such are being declared Orphaned Oilfield Sites.

Operator	Field	Well Name	Well Number	Serial Number
Caddo Western Development, Inc.	Caddo-Pine Island	R B Williamson	001	150503
Caddo Western Development, Inc.	Caddo-Pine Island	R B Williamson	002	150540
D. C. Carnes	Caddo-Pine Island	Booth	001	067999
Charleston Oil and Gas, Inc.	Bayou Choupique	8800 RA SUA;JJ and OB Vincent	001	177642
Charleston Oil and Gas, Inc.	West Avondale	Marsh Investment Corp	001	216770
Hughes Energy Resources	Port Barre	Sibille Co Inc	001	073052
Hughes Energy Resources	Port Barre	Sibille Co Inc	002	095807
Hughes Energy Resources	Port Barre	Sibille Co Inc	004	101914
Hughes Energy Resources	Port Barre	Sibille Co Inc	005	104345
Hughes Energy Resources	Port Barre	Sibille Co Inc SWD	003	097843
Mallard Drilling Corporation	Red River-Bull Bayou	JEN A RA SUB;Dill	001	201075
Mallard Drilling Corporation	Red River-Bull Bayou	LAF RC SUA;Dill	002	201900
Mallard Drilling Corporation	Red River-Bull Bayou	JEN A RB SUA;Dill	003	201978
Mallard Drilling Corporation	Red River-Bull Bayou	JEN A RA SUA;Bundrick	001	202347
Mallard Drilling Corporation	Caddo-Pine Island	Branch	001	164072
Mallard Drilling Corporation	Caddo-Pine Island	Branch	002	164944
Pine Top Energy, Inc.	Caddo-Pine Island	C W Lane Co Inc	002	054243
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	003	056444
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	009	056445
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	011	059240
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	013	062278
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	010	062532
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	006	066994
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	005	066995
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	008	077668
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	012	077670
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	014	082408
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	015	082409
Pine Top Energy Inc.	Caddo-Pine Island	Brown-Holt	002	110720
Pine Top Energy Inc.	Caddo-Pine Island	Brown-Holt	001	110721

POTPOURRI

Department of Natural Resources
Office of Conservation
Injection and Mining Division

Public Hearing—Oilfield Waste Facility

Pursuant to the provisions of the laws of the State of Louisiana and particularly Title 30 of the Louisiana Revised Statutes of 1950 as amended, and the provisions of Statewide Order No. 29-B, notice is hereby given that the public hearing under Docket No. IMD 97-04 to consider an application by Growth Resources, Inc., which was previously scheduled for 6 p.m., Monday, April 28, 1997, at the Houma Municipal Auditorium, 800 Verrett Street, Houma, LA, has been changed to 6 p.m., Wednesday, May 21, 1997, at the Gibson Community Center, 5575 Bayou Black Drive, Gibson, LA.

At such hearing, the commissioner, or his designated representative will hear testimony relative to the application of Growth Resources, Inc., 200 A. Burgess Drive, Broussard, LA 70518. The applicant requests to operate a commercial nonhazardous oilfield waste (NOW) storage, treatment, reclamation and disposal facility in parts of Sections 50 and 51, Township 16S, Range 14E, approximately two miles southwest of Gibson, LA off Geraldine Road.

The application is available for inspection by contacting Pierre Catrou, Office of Conservation, Injection and Mining Division, Room 257 of the State Land and Natural Resources Building, 625 North Fourth Street, Baton Rouge, LA, or by visiting the Terrebonne Parish Council office in Houma, LA or the Parish Library in Gibson, LA. Verbal information may be received by calling Pierre Catrou at (504)342-5567.

All interested persons will be afforded an opportunity to present data, views or arguments, orally or in writing, at said public hearing. Written comments which will not be presented at the hearing must be received no later than 4:30 p.m., May 28, 1997, at the Baton Rouge office. Comments should be directed to the Office of Conservation, Injection and Mining Division, Box 94275, Baton Rouge, LA 70804, Re: Docket No. IMD 97-04, Commercial Facility, Terrebonne Parish.

Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	018	147297
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	017	147311
Pine Top Energy Inc.	Caddo-Pine Island	C W Lane Co Inc	019	147349
Pine Top Energy Inc.	Caddo-Pine Island	Brown-Holt	003	156521
Pine Top Energy Inc.	Caddo-Pine Island	Brown-Holt	004	156522
Pine Top Energy Inc.	Caddo-Pine Island	Brown-Holt B	001	157968
Pine Top Energy Inc.	Caddo-Pine Island	Brown-Holt B	002	158921
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas A	001	199493
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas A	002	200828
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas A	003	201132
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas	001	205114
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas	002	205115
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas	003	205291
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas	004	205292
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas	005	205401
Pine Top Energy Inc.	Caddo-Pine Island	R T Douglas	006	205483
Pine Top Energy Inc.	Caddo-Pine Island	Roberson	003	206719
Pine Top Energy Inc.	Caddo-Pine Island	Roberson	001	207452
Pine Top Energy Inc.	Caddo-Pine Island	Roberson	002	207914
Pine Top Energy Inc.	Red River-Bull Bayou	NAC RB SUG;Adeline S Jackson	001	182440
Robert W. Rea, Jr.	Monroe	Jinks	001	154129
Robert W. Rea, Jr.	Monroe	Wall	001	154068
C. R. Schuster	Caddo-Pine Island	Pearl Hobbs	006	039335
Merl Wiggins et al	University	Knox-Amis-Farnbacher SWD	A1	029898

George L. Carmouche
Commissioner

George L. Carmouche
Commissioner

9704#087

9704#073

POTPOURRI

**Department of Natural Resources
Office of Conservation
Injection and Mining Division**

Public Hearing—Oilfield Waste Facility

Pursuant to the provisions of the laws of the State of Louisiana and particularly Title 30 of the Louisiana Revised Statutes of 1950 as amended, and the provisions of Statewide Order No. 29-B, notice is hereby given that the commissioner of Conservation will conduct a hearing at 6 p.m., Wednesday, May 28, 1997, in the City of Lake Charles, City Council Chambers, located on the first floor, 526 Pujoe in Lake Charles, LA.

At such hearing, the commissioner, or his designated representative, will hear testimony relative to the application of Newpark Environmental Services, Box 31480, Lafayette, LA 70593-1480. The applicant intends to construct and operate a commercial nonhazardous oilfield waste (NOW) disposal well in Section 28, Township 9S, Range 11W within the Edgerly oil and gas field, approximately two miles from Edgerly, LA.

The application is available for inspection by contacting Pierre Catrou, Office of Conservation, Injection and Mining Division, Room 257 of the State Land and Natural Resources Building, 625 North Fourth Street, Baton Rouge, LA, or by visiting the Calcasieu Parish Police Jury Office in Lake Charles, LA. Verbal information may be received by calling Pierre Catrou at (504)342-5567.

All interested persons will be afforded an opportunity to present data, views or arguments, orally or in writing, at said public hearing. Written comments which will not be presented at the hearing must be received no later than 4:30 p.m., June 6, 1997, at the Baton Rouge office. Comments should be directed to the Office of Conservation, Injection and Mining Division, Box 94275, Baton Rouge, LA 70804, Re: Docket No. IMD 97-05, Commercial NOW Disposal Well, Calcasieu Parish.

George L. Carmouche
Commissioner

9704#064

POTPOURRI

**Department of Revenue and Taxation
Severance Tax Division**

Natural Gas Base Rate Adjustment

Pursuant to the authority granted by R.S. 47:633(9)(d)(ii), the Department of Natural Resources has determined the "gas base rate adjustment" for the 12-month period ending March 31, 1997 to be 1.4446. Accordingly, the Department of Revenue and Taxation has determined the severance tax rate on natural gas and related products described in R.S. 47:633(9)(a) to be 10.1 cents per 1,000 cubic feet measured at

a base pressure of 15.025 pounds per square inch absolute and at the temperature base of 60° Fahrenheit, effective July 1, 1997. This rate was derived by multiplying the "gas base rate adjustment" by \$0.07.

The reduced rates provided for in R.S. 47:633(9)(b) and (c) remain the same.

The determination of this "gas base rate adjustment" and corresponding tax rate and their publication in the *Louisiana Register* shall not be considered rulemaking within the intention of the Administrative Procedure Act, R.S. 49:950 et seq.

Questions should be directed to Linda Denney, Director of the Severance Tax Division, at (504)925-7497.

John Neely Kennedy
Secretary

9704#013

POTPOURRI

**Department of Social Services
Office of Community Services**

Public Hearing—Social Services Block Grant (SSBG)

The Department of Social Services (DSS) announces opportunities for public review of the state's pre-expenditure report on intended uses of Social Services Block Grant (SSBG) funds for the state fiscal year (FY) beginning July 1, 1997 and ending June 30, 1998. The proposed FY 97-98 SSBG Intended Use Report has been developed in compliance with the requirements of Section 2004 of the Social Security Act, as amended, and includes information on the types of activities to be supported and the categories or characteristics of individuals to be served through use of the state's allocation of SSBG funds. Section 2004 of the Social Security Act further requires that the SSBG pre-expenditure report shall be "made public within the state in such manner as to facilitate comment by any person." The Department of Social Services (DSS) as the designated State Services Agency will continue to administer programs funded under the Social Services Block Grant in accordance with applicable statutory requirements and federal regulations. The DSS/Office of Community Services (OCS) will be responsible for provision of social services, by direct delivery and vendor purchase, through use of federal SSBG funds. Estimated SSBG expenditures for FY 1997-98 total \$39,633,203.

Louisiana, through the DSS Office of Community Services, will utilize its allotted funds to provide comprehensive social services on behalf of children and families in fulfillment of legislative mandates for child protection and child welfare programs. These mandated services, and certain other essential social services, are provided without regard to income (WRI) to individuals in need. Individuals to be served also include low-income persons as defined in the Intended Use Report who meet eligibility criteria for services provided through SSBG funding.

Services designated for provision through SSBG funding for State Fiscal Year 1997-98 are:

Adoption (pre-placement to termination of parental rights);

Child Protection (investigation of child abuse/neglect reports, assessment, evaluation, social work intervention, shelter care, counseling, referrals, and follow-up);

Day Care for Children (direct care for portion of the 24-hour day);

Family Services (social work intervention subsequent to validation of a report of child abuse/neglect, counseling to high risk groups);

Foster Care/Residential Habilitation Services (foster, residential care and treatment on a 24-hour basis).

Definitions for the proposed services are set forth in the Intended Use Report.

Persons eligible for SSBG funded services include:

Persons without regard to income, who are in need of Adoption Services, Child Protection, Family Services, and Foster Care/Residential Habilitation services;

Individuals without regard to income who are recipients of Title IV-E Adoption Assistance;

Recipients of Supplemental Security Income (SSI) and recipients of Temporary Assistance for Needy Families (TANF) and those persons whose needs were taken into account in determining the needs of TANF recipients;

Low-income persons (income eligibles) whose gross monthly income is not more than 125 percent of the poverty level. A family of four with gross monthly income of not more than \$1,672 would qualify as income eligible for services;

Persons receiving Title XIX (Medicaid) benefits and certain Medicaid applicants identified in the proposed plan as group eligibles.

The proposed SSBG Intended Use Report for FY 1997-98 is available for public review at OCS parish and regional offices Monday through Friday from 8:30 a.m. to 4 p.m. Copies are available without charge by telephone request to (504)342-6640 or by writing the Assistant Secretary, Office of Community Services, Box 3318, Baton Rouge, LA 70821.

Inquiries and comments on the proposed plan may be submitted until May 31, 1997 to the Assistant Secretary, OCS, at the above address.

A public hearing on the proposed SSBG Intended Use Report for FY 1997-98 is scheduled for 10 a.m. on Wednesday, May 7, 1997 at the Office of Community Services, Conference Room 806, Commerce Building, 333 Laurel Street, Baton Rouge. At the public hearing all interested persons will have the opportunity to provide recommendations on the proposed SSBG plan, orally or in writing. Written comments will be accepted through May 31, 1997.

Post-expenditure reports for the SSBG program for state fiscal years 1994-95 and 1995-96 are included in the SSBG Intended Use Report for FY 97-98 and are available for public review at the Office of Community Services, 333 Laurel Street, Room 802, Baton Rouge.

Madlyn B. Bagneris
Secretary

9704#067

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