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Executive Orders

EXECUTIVE ORDER MJF 99-19

Bond Allocation—Louisiana
Public Facilities Authority

WHEREAS, pursuant to the Tax Reform Act of 1986 (hereafter "the Act") and Act 51 of the 1986 Louisiana Legislature, Executive Order No. 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 1999 (hereafter "the 1999 Ceiling");

(2) the procedure for obtaining an allocation of bonds under the 1999 Ceiling; and

(3) a system of central record keeping for such allocations; and

WHEREAS, the Louisiana Public Facilities Authority has requested an allocation from the 1999 Ceiling to be used to finance the acquisition, construction, and equipping of a facility for the manufacture of fiberglass reinforced concrete buildings and related materials, and related facilities, to be located at 1300 Davenport Drive, Minden, parish of Webster, state of Louisiana, in accordance with the provisions of Section 146 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 1999 Ceiling as follows:

AMMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$7,500,000	Louisiana Public Facilities Authority	GE Capital Industrial Development Direct Placement Program Fibrebond Corp.

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 1999, provided that such bonds are delivered to the initial purchasers thereof on or before July 29, 1999.

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 3rd day May, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#028

EXECUTIVE ORDER MJF 99-20

Formosan Termite Task Force

WHEREAS, Executive Order No. MJF 98-48, signed on October 8, 1998, established the Formosan Termite Task Force (hereafter "Task Force"); and

WHEREAS, it is necessary to amend Executive Order No. MJF 98-48 in order to add an additional member to the Task Force;

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

SECTION 1: Section 4 of Executive Order No. MJF 98-48, is amended to provide as follows:

The Task Force shall consist of twenty-one (21) members who, unless otherwise specified, shall be appointed by, and serve at the pleasure of, the governor.

* * *

19. One (1) at-large member.

SECTION 2: All other sections and subsections of the Executive Order No. MJF 98-48 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 18th day of May, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#013

EXECUTIVE ORDER MJF 99-21

Bond Allocation—Louisiana Local
Government Environment Facilities and
Community Development Authority

WHEREAS, pursuant to the Tax Reform Act of 1986 (hereafter "the Act") and Act 51 of the 1986 session of legislature, Executive Order No. 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 1999 (hereafter "the 1999 Ceiling");
- (2) the procedure for obtaining an allocation of bonds under the 1999 Ceiling; and
- (3) a system of central record keeping for such allocations; and

WHEREAS, the Louisiana Local Government Environmental Facilities and Community Authority has requested an allocation from the 1999 Ceiling to be used to finance the acquisition, construction, improvements and development of a solid waste disposal facility for construction and demolition debris (the "project") located in the parish of Ouachita, state of Louisiana, in accordance with the provisions of Section 146 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 1999 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$2,000,000	Louisiana Local Government Environmental Facilities and Community Development Authority	CWI-White Oaks Landfill, L.L.C.

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 1999, provided that such bonds are delivered to the initial purchasers thereof on or before August 19, 1999.

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 21st day May, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#012

EXECUTIVE ORDER MJF 99-22

Bond Allocation—Louisiana
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 No. 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 1999 (hereafter "the 1999 Ceiling");
- (2) the procedure for obtaining an allocation of bonds under the 1999 Ceiling; and
- (3) a system of central record keeping for such allocations; and

WHEREAS, the Louisiana Housing Finance Agency has requested an allocation from the 1999 Ceiling to be used in connection with a program of financing mortgage loans for single family, owner-occupied residences owned by low and moderate income homebuyers throughout the state of Louisiana in accordance with the provisions of Section 146 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 1999 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$55,000,000	Louisiana Housing Finance Agency	Single Family Mortgage Revenue Bond Program

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 1999, provided that such bonds are delivered to the initial purchasers thereof on or before September 21, 1999.

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 2nd day of June, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#011

EXECUTIVE ORDER MJF 99-23

Flags at Half Staff

WHEREAS, the Honorable John J. McKeithen, Governor of the state of Louisiana from 1964 to 1972, died today, June 4, 1999, at the age of 81; and

WHEREAS, former Governor McKeithen left a legacy for Louisiana of economic expansion, industrial growth, improved racial relations, and governmental reforms;

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

SECTION 1: As an expression of respect of the citizens of the state of Louisiana for former Governor John J. McKeithen, effective immediately, the flags of the United States and the state of Louisiana shall be flown at half-staff over the State Capitol and all public building and institutions of the state of Louisiana until sunset on Friday, June 11, 1999.

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 4th June, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#027

EXECUTIVE ORDER MJF 99-24

Bond Allocation—The Industrial Development Board of the Parish of Iberia, Inc.

WHEREAS, pursuant to the Tax Reform Act of 1986 (hereafter the Act) and Act 51 of the 1986 Louisiana Legislature, Executive Order No. 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 1999 (hereafter the 1999 Ceiling);

(2) the procedure for obtaining an allocation of bonds under the 1999 Ceiling; and

(3) a system of central record keeping for such allocations; and

WHEREAS, The Industrial Development Board of the Parish of Iberia, Inc., has requested an allocation from the 1999 Ceiling to be used to finance the acquisition, construction, and equipping of a facility for the manufacture of pipe insulation, to be located at 4401 Curtis Lane, near the Port of Iberia, parish of Iberia, state of Louisiana, in accordance with the provisions of Section 146 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 1999 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$3,000,000	The Industrial Development Board of the Parish of Iberia	Cuming Insulation Corporation

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 1999, provided that such bonds are delivered to the initial purchasers thereof on or before September 7, 1999.

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 9th day June, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#071

EXECUTIVE ORDER MJF 99-25

Bond Allocation—Caddo-Bossier Parishes Port Commission

WHEREAS, pursuant to the Tax Reform Act of 1986 (hereafter the Act) and Act 51 of the 1986 Louisiana Legislature, Executive Order No. 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 1999 (hereafter the 1999 Ceiling);

(2) the procedure for obtaining an allocation of bonds under the 1999 Ceiling; and

(3) a system of central record keeping for such allocations; and

WHEREAS, the Caddo-Bossier Parishes Port Commission has requested an allocation from the 1999 Ceiling to be used to finance the cost of improving an approximately 30,000 sq. ft. building and acquiring equipment and machinery to be used in the manufacture of vessels, to be located at 10909 Attaway Boulevard, Shreveport, parish of Caddo, state of Louisiana, in

accordance with the provisions of Section 146 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 1999 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$1,500,000	Caddo-Bossier Parishes Port Commission	Shreveport Fabricators, L.L.C.

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 1999, provided that such bonds are delivered to the initial purchasers thereof on or before September 7, 1999.

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 9th day June, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#072

EXECUTIVE ORDER MJF 99-26

Bond Allocation—Louisiana Local Government Environmental Facilities and Community Development Authority

WHEREAS, pursuant to the Tax Reform Act of 1986 (hereafter the Act) and Act 51 of the 1986 Louisiana Legislature, Executive Order No. 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 1999 (hereafter the 1999 Ceiling); (2) the procedure for obtaining an allocation of bonds under the 1999 Ceiling; and (3) a system of central record keeping for such allocations; and

WHEREAS, the Louisiana Local Government Environmental Facilities and Community Development Authority has requested an allocation from the 1999 Ceiling to be used to finance the acquisition, construction, and equipping of improvements, extensions and additions to waste water facilities comprising a part of a waterworks system, to be located in an unincorporated area of the parish of Ouachita, state of Louisiana, in accordance with the provisions of Section 146 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 1999 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$1,570,000	Louisiana Local Government Environmental Facilities and Community Development Authority	Town and Country Service Co., Inc.

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 1999, provided that such bonds are delivered to the initial purchasers thereof on or before September 7, 1999.

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 9th day June, 1999.

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

ATTEST BY
THE GOVERNOR
Fox McKeithen
Secretary of State
9906#073

Policy and Procedure Memoranda

POLICY AND PROCEDURE MEMORANDUM

Office of the Governor
Division of Administration
Office of the Commissioner

General Travel—PPM 49

(Editor's Note: The following PPM 49 supersedes all prior issues of PPM 49 published on Pages 1062-1068 of the June 1998 issue of the *Louisiana Register*. This revised PPM 49 also supersedes and replaces PPM 49 which had been designated as Title 4, Part V, Chapter 15 of the *Louisiana Administrative Code*.)

General Travel—PPM Number 49

Section I. Authorization and Legal Basis

A. In accordance with the authority vested in the commissioner of administration by Section 231 of Title 39 of the Revised Statutes of 1950 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950-968 as amended, notice is hereby given of the revision of Policy and Procedures Memorandum No. 49, the state general travel regulations, effective July 1, 1999. These amendments are both technical and substantive in nature and are intended to clarify certain portions of the previous regulations or provide for more efficient administration of travel policies. These regulations apply to all state departments, boards and commissions created by the legislature or executive order and operating from funds appropriated, dedicated, or self-sustaining; federal funds; or funds generated from any other source.

B. Legal Basis—L.R.S. 39:231R

"The commissioner, with the approval of the governor, shall prescribe rules defining the conditions under which each of various forms of transportation may be used by state officers and employees and used by them in the discharge of the duties of their respective offices and positions in the state service and he shall define the conditions under which allowances will be granted for all other classes of traveling expenses and the maximum amount allowable for expenses of each class."

Section II. Definitions

For the purposes of this PPM, the following words have the meaning indicated.

Authorized Persons—

a. advisors, consultants and contractors or other persons who are called upon to contribute time and services to the state who are not otherwise required to be reimbursed through a contract for professional, personal, or consulting services in accordance with R.S. 39:1481 et seq.;

b. members of boards, commissions, and advisory councils required by federal or state legislation or regulation. Travel allowance levels for all such members and any staff shall be those authorized for state employees unless specific allowances are legislatively provided.

Conference/Convention—is herein defined as a meeting for a specific purpose and/or objective and requires payment of a registration fee. Documentation required is a formal agenda and/or program. Exception for the registration fee requirement can be approved by the department head on a

case by case basis. Participation as an exhibiting vendor in an exhibit /trade show also qualifies as a conference.

Emergency Travel—under extraordinary circumstances where the best interests of the state require that travel be undertaken not in compliance with these regulations, approval after the fact by the commissioner of administration may be given if appropriate documentation is presented promptly. Each department shall establish internal procedures for authorizing travel in emergency situations.

Extended Stays—of any assignment made for a period of 31 or more consecutive days at a place other than the official domicile.

In-State Travel—all travel within the borders of Louisiana or travel through adjacent states between points within Louisiana when such is the most efficient route.

International Travel—all travel to destinations outside the 50 United States, District of Columbia, Puerto Rico and the Virgin Islands.

Official Domicile—every state officer, employee, and authorized person, except those on temporary assignment, shall be assigned an official domicile.

a. Except where fixed by law, official domicile of an officer or employee assigned to an office shall be, at a minimum, the city limits in which the office is located. The department head or his designee should determine the extent of any surrounding area to be included, such as parish or region. As a guideline, a radius of at least 30 miles is recommended. The official domicile of an authorized person shall be the city in which the person resides, except when the department head has designated another location (such as the person's workplace).

b. A traveler whose residence is other than the official domicile of his/her office shall not receive travel and subsistence while at his/her official domicile nor shall he/she receive reimbursement for travel to and from his/her residence.

c. The official domicile of a person located in the field shall be the city or town nearest to the area where the majority of work is performed, or such city, town, or area as may be designated by the department head, provided that in all cases such designation must be in the best interest of the agency and not for the convenience of the person.

Out-of-State Travel—travel to any of the other 49 states plus District of Columbia, Puerto Rico and the Virgin Islands.

Per Diem—a flat rate paid in lieu of travel reimbursement for people on extended stays.

State Employee—employees below the level of state officer

State Officer—

a. state elected officials;

b. department head as defined by Title 36 of the Louisiana Revised Statutes (secretary, deputy secretary, under secretary, assistant secretary, and the equivalent

positions in higher education and the office of elected officials).

Temporary Assignment—any assignment made for a period of less than 31 consecutive days at a place other than the official domicile.

Travel Period—a period of time between the time of departure and the time of return.

Travel Routes—the most direct and usually traveled route must be used by official state travelers. Travelers may opt to use mileage as shown on the Mileage Table of Department of Transportation's Official Highway Map, or from a mileage chart provided by their department which has been approved by the Commissioner of Administration. For all other mileage, it shall be computed on the basis of odometer readings from point of origin to point of return. (See Mileage Chart on page 23)

Traveler—a state officer, state employee, or authorized person when performing authorized travel.

Section III. General Specifications

A. Department Policies

1. Department heads may establish travel regulations within their respective agencies, but such regulations shall not exceed the maximum limitations established by the commissioner of administration. Three copies of such regulations shall be submitted for prior review and approval by the commissioner of administration. One of the copies shall highlight any exceptions /deviations to PPM 49.

2. Department and agency heads will take whatever action necessary to minimize all travel to carry on the department mission.

3. Contracted Travel Services. The state has contracted for travel agency services which must be used unless exemptions have been granted by the Division of Administration prior to travel. Reservations for in-state hotel/motel accommodations are not required to be made through the contracted travel agencies.

4. When a state agency enters into a contract with an out-of-state public entity, the out-of-state public entity may have the authority to conduct any related travel in accordance with their published travel regulations.

5. Authorization to Travel

a. All travel must be authorized and approved in writing by the head of the department, board, or commission from whose funds the traveler is paid. A department head may delegate this authority in writing to one designated person. Additional persons within a department may be designated with approval from the commissioner of administration. A file shall be maintained on all approved travel authorizations.

b. An annual authorization for routine travel shall not cover travel between an employee's home and workplace, out-of-state travel, or travel to conferences or conventions.

6. Funds for Travel Expenses

a. Persons traveling on official business will provide themselves with sufficient funds for all routine travel expenses that cannot be covered by the corporate credit card. Advances of funds for travel shall be made only for extraordinary travel and should be punctually repaid when submitting the travel voucher covering the related

travel, not later than the fifteenth day of the month following the completion of travel.

b. Exemptions. Cash advances may be allowed for:

i. employees whose salary is less than \$15,000/year;

ii. employees who applied for the state-sponsored corporate credit card program but were rejected (proof of rejection must be available in agency travel file);

iii. employees who accompany and/or are responsible for students on group or client travel;

iv. new employees who have not had time to apply for and receive the card;

v. employees traveling for extended periods, defined as 31 or more consecutive days;

vi. employees traveling to remote destinations in foreign countries, such as jungles of Peru or Bolivia;

vii. advance ticket purchase (until a business travel account with a corporate credit card can be established);

viii. registration for seminars, conferences, and conventions;

ix. incidental costs not covered by the corporate credit card, i.e., taxi fares, tolls, registration fees; conference fees may be submitted on a preliminary request for reimbursement when paid in advance;

x. any ticket booked by a traveler 30 days or more in advance and for which the traveler has been billed, may be reimbursed by the agency to the traveler on a preliminary expense reimbursement request. The traveler should submit the request with a copy of the bill or invoice. All backup data (ticket stub or traveler's copy) must be attached to the final reimbursement request;

xi. employees who infrequently travel or travelers that incur significant out-of-pocket cash expenditures.

7. Expenses Incurred on State Business. Traveling expenses of travelers shall be limited to those expenses necessarily incurred by them in the performance of a public purpose authorized by law to be performed by the agency and must be within the limitations prescribed herein.

8. State Credit Cards (Issued in the Name of the Agency Only). Credit cards issued in the name of the state agency are not to be used for the purpose of securing transportation, lodging, meals, or telephone and telegraph service, unless prior written permission has been obtained from the commissioner of administration.

9. No Reimbursement When No Cost Incurred by Traveler. No claim for reimbursement shall be made for any lodging and/or meals furnished at a state institution or other state agency, or furnished by any other party at no cost to the traveler. In no case will a traveler be allowed mileage or transportation when he/she is gratuitously transported by another person.

B. Claims for Reimbursement

1. All claims for reimbursement for travel shall be submitted on state Form BA-12, unless exception has been granted by the commissioner of administration, and shall include all details provided for on the form. It must be signed by the person claiming reimbursement and approved by his/her immediate supervisor. The purpose for extra and unusual travel must be stated in the space provided on the front of the form. In all cases the date and hour of departure from and return to domicile must be shown.

2. Excepting where the cost of air transportation, conference, or seminar is invoiced directly to the agency/department, all expenses incurred on any official trip shall be paid by the traveler and his travel voucher shall show all such expenses in detail to the end that the total cost of the trip shall be reflected by the travel voucher. If the cost of air transportation is paid directly by the agency/department, a notation will be indicated on the travel voucher indicating the date of travel, destination, amount, and the fact that it has been paid by the agency/department. The traveler's copy of the passenger ticket shall be attached to the travel voucher.

3. In all cases, and under any travel status, cost of meals and lodging shall be paid by the traveler and claimed on the travel voucher for reimbursement, and not charged to the state department, unless otherwise authorized by the Division of Administration.

4. Claims should be submitted within the month following the travel, but preferably held until a reimbursement of at least \$10 is due.

5. Any person who submits a claim pursuant to these regulations and who willfully makes and subscribes to any claim which he/she does not believe to be true and correct as to every material matter, or who willfully aids or assists in, or procures, counsels or advises the preparation or presentation of a claim which is fraudulent or is false as to any material matter shall be guilty of official misconduct. Whoever shall receive an allowance or reimbursement by means of a false claim shall be subject to severe disciplinary action as well as being criminally and civilly liable within the provisions of state law.

6. Agencies are required to reimburse travel in an expeditious manner. In no case shall reimbursements require more than thirty (30) days to process from receipt of complete, proper travel documentation.

Section IV. Methods of Transportation

A. Cost-Effective Transportation. The most cost-effective method of transportation that will accomplish the purpose of the travel shall be selected. Among the factors to be considered should be length of travel time, cost of operation of a vehicle, cost and availability of common carrier services, etc.

B. Air

1. Common carrier shall be used for out-of-state travel unless it is documented that utilization of another method of travel is more cost-efficient or practical and approved in accordance with these regulations.

2. Before travel by privately-owned or by chartered aircraft is authorized by a department head, the traveler shall certify that: 1) at least one hour of working time will be saved by such travel; and 2) no other form of transportation, such as commercial air travel or a state plane, will serve this same purpose.

a. Chartering a privately-owned aircraft must be in accordance with the Procurement Code.

b. Reimbursement for use of a chartered or unchartered privately-owned aircraft under the above guidelines will be made on the basis of 28 cents per mile or the lesser of commercial air at state contract rate or coach/economy rates unless there are extenuating circumstances which must be approved by the commissioner of administration.

c. When common carrier services are unavailable and time is at a premium, travel via state aircraft shall be investigated, and such investigation shall be documented and readily available in the department's travel reimbursement files. Optimum utilization will be the responsibility of the department head.

3. Commercial air travel will not be reimbursed in excess of state contract air rates when available, or coach/economy class rates when contract rates are not available. The difference between contract or coach/economy class rates and first class or business class rates will be paid by the traveler. If space is not available in less than first or business class air accommodations in time to carry out the purpose of the travel, the traveler will secure a certification from the airline indicating this fact. The certification will be attached to the travel voucher.

a. The state encourages but does not require use of lowest priced airfares where circumstances which can be documented dictate otherwise. Lowest logical fares are penalty tickets that can have restrictions and charge penalty fees for changing/canceling ticket purchases.

b. Where a stopover is required to qualify for a low-priced airfare, the state will pay additional lodging and meals expense subject to applicable limits where a net savings in total trip expenses results from use of the low-priced airfare. For determining whether there is a savings, the state contract airfare should be used for comparison, or coach/economy fare if there is no contract rate. The comparison must be shown on the travel voucher.

c. The policy regarding airfare penalties is the state will pay the penalty incurred for a change in plans or cancellation only when the change or cancellation is required by the state. Certification of the requirement for the change or cancellation by the traveler's department head is required on the travel voucher.

d. For international travel only, when an international flight segment is more than 10 hours in duration, the state will allow the business class rate not to exceed 10 percent of the coach rate. The traveler's itinerary provided by the travel agency must document the flight segment as more than 10 hours and must be attached to the travel voucher.

4. A lost airline ticket is the responsibility of the person to whom the ticket was issued. The airline charge of searching and refunding lost tickets will be charged to the traveler. The difference between the prepaid amount and the amount refunded by the airlines must be paid by the employee.

5. If companion fares are purchased for a state employee and non-state employee, the reimbursement to the state employee will be the amount of the lowest logical fare.

6. Contract airfares are to be purchased only through the state's contracted travel agencies and are to be used for official state business. State contract airfares are non-penalty tickets. Therefore no penalty fees are charged for changes/cancellations, and no restrictions are imposed on flight schedules. The state contract airfares cannot be used for personal/companion or spouse travel. This is a requirement of the airlines and our failure to monitor the use of these contract airfares could cause their cancellation. Therefore, tickets booked for non-official business under the

contract rates will be subject to disciplinary action as well as payment of the difference between fare paid and full coach fare.

7. Traveler is to use the lowest logical airfare/state contract whether the plane is a prop or a jet.

8. Frequent Flyer miles and/or bump tickets accumulated from official state business must be used to purchase tickets for official business. Each individual is solely responsible for notification to their Agency or Department.

9. In order for the State to continue to receive State contracted airfares, it is necessary that the contract carrier be utilized when electing to use state contract rates. When using the Contract Airfares there are no restrictions or penalties. In many cases, airlines that did not win an award for a certain city, will now offer the same, lower price that was awarded to the contract vendor. This is known as a matched carrier. Matched carriers are not to be used unless there is two or more hours difference in the departure or arrival time. The State does not have a contract with the matched fare carriers; therefore, we do not have last seat availability and certain rules including cancellation penalties will apply to these fares.

10. When making airline reservations for a conference, inform the travel agency that you are attending a conference giving the name of the conference and the airline that is offering the discount rate, if available. In many instances, the conference registration form specifies that certain airlines have been designated as the official carrier offering discount rates. If so, giving this information to our contracted agencies could result in them securing that rate for your travel.

11. Use of Corporate Card

a. The State Travel Office contracts an official state corporate card to form one source of payments for all. All travelers or agencies shall make application through the State Travel Office.

b. If circumstances warrant that the corporate card or BTA account cannot be used, the department head must sign a letter stating that the traveler for that specific trip is on official state business. The traveler must carry this letter and his/her drivers license to the airport to facilitate boarding, or be subjected to non-boarding or being charged the difference from coach fare cost.

c. The corporate card is the liability of the employee and not the state. An employee terminating state service must return the card to the State Travel Office for cancellation. A retiree may no longer retain his/her card.

C. Motor Vehicle

1. No vehicle may be operated in violation of state or local laws. No traveler may operate a vehicle without having in his/her possession a valid state driver's license.

2. If available, safety restraints shall be used by the driver and passengers of vehicles. All accidents, major and minor, shall be reported first to the local police department or appropriate law enforcement agency. An accident report form, available from the Office of Risk Management (ORM) of the Division of Administration, should be completed as soon as possible and returned to ORM, together with names and addresses of principals and witnesses. Any questions about this should be addressed to the Office of Risk Management of the Division of Administration. These

reports shall be in addition to reporting the accident to the Department of Public Safety as required by law.

3. State-Owned Vehicles

a. All purchases made on state gasoline credit cards must be signed for by the approved traveler making the purchase. The license number, the unit price, and quantity of the commodity purchased must be noted on the delivery ticket by the vendor. Items incidental to the operation of the vehicle may be purchased via state gasoline credit cards only when away from official domicile on travel status. In all instances where a credit card is used to purchase items or services which are incidental to the operation of a vehicle, a copy of the credit ticket along with a written explanation of the reason for the purchase will be attached to the monthly report mentioned in this subsection. State-owned credit cards will not be issued to travelers for use in the operation of privately-owned vehicles.

b. Travelers in state-owned automobiles who purchase needed repairs and equipment while on travel status shall make use of all fleet discount allowances and state bulk purchasing contracts where applicable. Each agency/department shall familiarize itself with the existence of such allowances and/or contracts and location of vendors by contacting the Purchasing Office, Division of Administration.

c. The travel coordinator/officer/user of each state-owned automobile shall submit a monthly report to the department head, board, or commission indicating the number of miles traveled, odometer reading, credit card charges, dates, and places visited.

d. State-owned vehicles may be used for out-of-state travel only if permission of the department head has been given prior to departure. If a state-owned vehicle is to be used to travel to a destination more than 500 miles from its usual location, documentation that this is the most cost-effective means of travel should be readily available in the department's travel reimbursement files.

e. Unauthorized persons should not be transported in state vehicles. Approval of exceptions to this policy may be made by the traveler's supervisor if he determines that the best interest of the state will be served and if the passenger (or passenger's guardian) signs a statement acknowledging the fact that the state assumes no liability for any loss, injury, or death resulting from said travel.

4. Personally-Owned Vehicles

a. When two or more persons travel in the same personally-owned vehicle, only one charge will be allowed for the expense of the vehicle. The person claiming reimbursement shall report the names of the other passengers.

b. A mileage allowance shall be authorized for travelers approved to use personally-owned vehicles while conducting official state business. Mileage shall be reimbursable on the basis of 28 cents per mile. (*See acceptable mileage chart on page 23.*)

c. An employee shall never receive any benefit from not living in his/her official domicile. In computing reimbursable mileage to an authorized travel destination from an employee's residence outside the official domicile, the employee is always to claim the lessor of the miles from their official domicile or from their residence. If an employee is leaving on a non-work day or leaving

significantly before or after work hours, the department head may determine to pay the actual mileage from the employee's residence.

d. The department head or his designee may approve an authorization for routine travel for an employee who must travel in the course of performing his/her duties; this may include domicile travel if such is a regular and necessary part of the employee's duties, but not for attendance at infrequent or irregular meetings, etc. Within the city limits where his/her office is located, the employee may be reimbursed for mileage only.

e. Reimbursements will be allowed on the basis of 28 cents per mile to travel between a common carrier/terminal and the employee's point of departure, i.e. home, office, etc., whichever is appropriate and in the best interest of the state.

f. When the use of a privately-owned vehicle has been approved by the department head for out-of-state travel for the traveler's convenience, the traveler will be reimbursed for in-route expenses on the basis of 28 cents per mile only. The total cost of the mileage may not exceed the cost of travel by State Contract air rate or lowest logical if no contract rate is available. The traveler is personally responsible for any other expenses in-route to and from destination which is inclusive of meals and lodging. If a traveler, at the request of the department, is asked to take their personally owned vehicle out-of-state for a purpose that will benefit the agency, then the department head may on a case-by-case basis determine to pay a traveler for all/part of in-route travel expenses. File should be justified accordingly.

g. When a traveler is required to regularly use his/her personally-owned vehicle for agency activities, the agency head may request authorization from the commissioner of administration for a lump sum allowance for transportation or reimbursement for transportation (mileage). Request for lump sum allowance must be accompanied by a detailed account of routine travel listing exact mileage for each such route. Miscellaneous travel must be justified by at least a three-month travel history to include a complete mileage log for all travel incurred, showing all points traveled to or from and the exact mileage. Requests for lump sum allowance shall be granted for periods not to exceed one fiscal year.

h. The traveler shall be required to pay all operating expenses of the vehicle including fuel, repairs, and insurance.

5. Rented Motor Vehicles

a. Written approval of the department head prior to departure is required for the rental of vehicles. Such approval may be given when it is shown that vehicle rental is the only or most economical means by which the purposes of the trip can be accomplished. In each instance, documentation showing cost effectiveness of available options must be readily available in the reimbursement files. This authority shall not be delegated to any other person.

b. Only the cost of rental of a compact model is reimbursable, unless 1) non-availability is documented, 2) the vehicle will be used to transport more than two persons or 3) the cost of a larger vehicle is no more than the rental rate for a compact.

c. Collision Deductible Waiver (CDW) is not reimbursable for domestic travel. At the discretion of the

department head, CDW costs may be reimbursed for international travel. Should a collision occur while on official state business, the cost of the deductible should be paid by the traveler and reimbursement claimed on a travel expense voucher. The accident should also be reported to the Office of Risk Management (see methods of transportation-motor vehicles).

d. Personal accident insurance when renting a vehicle is not reimbursable. Employees are covered under workmen's compensation while on official state business.

e. Any personal mileage or rental days on a vehicle rented for official state business is not reimbursable and shall be deducted.

D. Public Ground Transportation. The cost of public ground transportation such as buses, subways, airport limousines, and taxis is reimbursable when the expenses are incurred as part of approved state travel. For each transaction over \$15 a receipt is required.

Section V. Lodging and Meals

A. Eligibility

1. Official Domicile/Temporary Assignment. Travelers are eligible to receive reimbursement for travel only when away from "official domicile" or on temporary assignment unless exception is granted in accordance with these regulations. Temporary assignment will be deemed to have ceased after a period of thirty-one calendar days, and after such period the place of assignment shall be deemed to be his/her official domicile. He/she shall not be allowed travel and subsistence unless permission to extend the thirty-one day period has been previously secured from the commissioner of administration.

2. Travel Period. Travelers may be reimbursed for meals according to the following schedule:

a. breakfast—when travel begins at/or before 6 a.m. and extends beyond 9 a.m. on single day travel; or when travel begins at/or before 6 a.m. on the first day of travel or extends beyond 9 a.m. on the last day of travel, and for any intervening days;

b. lunch—reimbursement shall only be made for lunch when travel extends over at least one night or if traveler is in travel status for 12 hours or more in duration. If travel extends overnight, lunch may be reimbursed for those days where travel begins at/or before 10 a.m. on the first day of travel, or extends beyond 2 p.m. on the last day of travel, and for any intervening days;

c. dinner—when travel begins at/or before 4 p.m. and extends beyond 8 p.m. on single day travel; or when travel begins at/or before 4 p.m. on the first day of travel or extends beyond 8 p.m. on the last day of travel and for any intervening days.

3. Alcohol. Reimbursement for alcohol is prohibited.

B. Exceptions

1. Twenty Five Percent Over Allowances. Department heads may allow their employees to exceed the lodging and meals provisions of these regulations by no more than twenty five percent on a case-by-case basis. Each case must be fully documented as to necessity (e.g. proximity to meeting place) and cost effectiveness of alternative options. Documentation must be readily available in the department's travel reimbursement files. This authority shall not be delegated to any other person. Reimbursement requests must be accompanied by receipt.

2. Actual Expenses for State Officers. State officers and others so authorized by statute or individual exception will be reimbursed on an actual expenses basis for meals and lodging except in cases where other provisions for reimbursement have been made by statute. The request for reimbursement must be accompanied by a receipt or other supporting documents for each item claimed and shall not be extravagant and will be reasonable in relationship to the purpose of the travel. State officers entitled to actual expense reimbursements are only exempted from meals and lodging rates; they are subject to the time frames and all other requirements as listed in the travel regulations.

C. Traveler's Meals (Including Tax and Tips)

Travelers may be reimbursed up to the following amounts for meals.

	In-State	O/S Incl. N.O.	High Cost & NYC
Breakfast	\$6	\$6	\$8
Lunch	\$8	\$9	\$10
Dinner	<u>\$12</u>	<u>\$14</u>	<u>\$19</u>
	\$26	\$29	\$37

Receipts are not required for routine meals within these allowances. Number of meals claimed must be shown on travel voucher. Partial meals such as continental breakfasts or airline meals are not considered meals. If meals of state officials exceed these allowances, receipts are required.

D. Conference Meals

Cost of meals direct billed to and agency in conjunction with state-sponsored in-state conferences exclusive of tax and mandated gratuity.

Lunch In-State excluding New Orleans - \$10

Lunch New Orleans - \$12

Refreshment expenditures for a meeting, conference or convention are to be within the following rates: (note: refreshment expenses are not applicable to an individual traveler) served on state property: not to exceed \$2.00 per person, per morning and/or afternoon sessions served on hotel properties: not to exceed \$3.50 exclusive of tax and mandated gratuity per person, per morning and/or afternoon sessions.

E. Lodging (Employees will be reimbursed lodging rate, plus tax, Receipt Required)

\$55 In-state (except as listed)

\$60 Baton Rouge

\$70 Bossier City, Lake Charles (Sulphur will be considered a suburb of Lake Charles), Shreveport

\$80 New Orleans, (Gretna, Kenner, Metairie will be considered a suburbs of New Orleans, for lodging only)

\$65 Out-of-State (except those listed)

\$105 High cost (Atlanta, Baltimore, Boston, Chicago, Cleveland, Dallas, Detroit, Houston, Los Angeles, Miami, Nashville, Philadelphia, Phoenix, Pittsburgh, Portland, Or., San Diego, San Francisco, St. Louis, Seattle, Washington, D.C., all of Alaska or Hawaii)

\$165 New York City

The inclusion of suburbs for High Cost and New York City shall be determined by the department head on a case-by-case basis.

F. Conference Lodging

1. Travelers may be reimbursed expenses for conference hotel lodging per the following rates, if the reservations are made at the actual conference hotel. When reservations are not available at the conference hotel and multi-hotels are offered in conjunction with a conference, traveler shall seek prices and utilize the least expensive. In the event all conference hotels are unavailable, then the traveler is subject to making reservations within the hotel rates as allowed in Section E, above.

- \$65 In-state (except as listed)
- \$70 Baton Rouge
- \$80 Bossier City, Lake Charles, Shreveport
- \$100 New Orleans, state sponsored conferences
- \$140 out-of-state and New Orleans for non-state sponsored conferences

\$165 New York

*The inclusion of suburbs for New York City shall be determined by the department head on a case-by-case basis.

2. For Conferences hosted by the state you must either use the state contracted travel services or solicit three (3) competitive quotes to include sleeping rooms, meeting rooms, meals and breaks, etc.

3. No reimbursements are allowed for functions not relating to a conference, i.e. tours, dances, etc.

G. Extended Stays - For travel assignment involving duty for extended periods at a fixed location, the reimbursement rates indicated should be adjusted downward whenever possible. Claims for meals and lodging may be reported on a per diem basis supported by lodging receipt. Care should be exercised to prevent allowing rates in excess of those required to meet the necessary authorized subsistence expenses. It is the responsibility of each agency head to authorize only such travel allowances as are justified by the circumstances affecting the travel.

Section VI. Parking And Related Parking Expenses

The following expenses incidental to travel are reimbursable:

1. Parking for the Baton Rouge Airport - actual expense will be paid up to a maximum daily allowance of \$3.50. No receipt required. (Note: current contract rate is available from the Baton Rouge Airport Parking for the outside, fenced lot. Not in the parking garage.) (See parking instructions on page 24.)

2. Parking for the New Orleans Airport - actual expense will be paid up to a maximum daily allowance of \$5.75. No receipt required. (Note: current contract rates are available from Thrifty Parking for \$5.00 and from Park N Fly for \$5.75 (See parking instructions on page 24.)

3. Travelers using motor vehicles on official state business will be reimbursed for reasonable storage fees, for all other parking except as listed in #1 and #2 above, ferry fares, and road and bridge tolls. For each transaction over \$5, a receipt is required.

4. Tips for valet parking not to exceed \$1 per in and \$1 per out, per day.

Section VII. Reimbursement For Other Expenses

The following expenses incidental to travel may be reimbursed:

1. communications expenses relative to official state business (receipts required for over \$3). Employees on domestic overnight travel status can be reimbursed up to \$3 for one call home upon arrival at their destination and a call every second night after the first night if the travel extends several days. Employees on international travel can be reimbursed calls to their home for a maximum of five minutes per call upon arrival to and prior to departure from their destination (within the first or last 24 hours of the trip, respectively). For stays in excess of seven days, one call will be allowed for each additional week. An additional week will be defined to be at least four days in duration.

2. charges for storage and handling of equipment.
3. tips for baggage handling not to exceed \$1 per bag for a maximum of three (3) bags. For in-state baggage handling the above allowance may be paid one time upon arrival of each check in and one time upon departure of each check out where handling is applicable. For out-of-state and New Orleans baggage handling the above allowances may be paid twice upon arrivals and twice upon departures of each check in where applicable. (This is inclusive of the airport baggage handling.)
4. registration fees at conferences (meals that are a designated integral part of the conference may be reimbursed on an actual expense basis with prior approval by the department head.)
5. laundry services—employees on travel for more than seven days up to 14 days are eligible for \$20 of laundry services, and for more than 14 days up to 21 days an additional \$20 of laundry services, and so on. Receipts must be furnished.

Section VIII. Special Meals

A. Reimbursement designed for those occasions when, as a matter of extraordinary courtesy or necessity, it is appropriate and in the best interest of the state to use public funds for provision of a meal to a person who is not otherwise eligible for such reimbursement and where reimbursement is not available from another source.

1. Visiting dignitaries or executive-level persons from other governmental units, and persons providing identified gratuity services to the state. This explicitly does not include normal visits, meetings, reviews, etc., by federal or local representatives.

2. Extraordinary situations are when state employees are required by their supervisor to work more than a twelve-hour weekday or six-hour weekend (when such are not normal working hours to meet crucial deadlines or to handle emergencies).

B. All special meals must have prior approval from the commissioner of administration in order to be reimbursed, unless specific authority for approval has been delegated to a department head for a period not to exceed one fiscal year with the exception in C, as follows.

C. A department head may authorize a special meal within allowable rates to be served in conjunction with a working meeting of departmental staff.

D. In such cases, the department will report on a semi-annual basis to the commissioner of administration all special meal reimbursements made during the previous six months. These reports must include, for each special meal, the name and title of the person receiving reimbursement, the name and title of each recipient, the cost of each meal

and an explanation as to why the meal was in the best interest of the state. Renewal of such delegation will depend upon a review of all special meals authorized and paid during the period. Request to the commissioner for special meal authorization must include, under signature of the department head:

1. name and position/title of the state officer or employee requesting authority to incur expenses and assuming responsibility for such;
2. clear justification of the necessity and appropriateness of the request;
3. names, official titles or affiliations of all persons for whom reimbursement of meal expenses is being requested;
4. statement that allowances for meal reimbursement according to these regulations will be followed unless specific approval is received from the commissioner of administration to exceed this reimbursement limitation.

E. All of the following must be submitted for review and approval of the department head or their designee prior to reimbursement:

1. detailed breakdown of all expenses incurred, with appropriate receipts(s);
2. subtraction of cost of any alcoholic beverages;
3. copy of prior written approval from the commissioner of administration;
4. receipts.

Section IX. International Travel

A. All international travel must be approved by the commissioner of administration prior to departure, unless specific authority for approval has been delegated to a department head. Requests for approval must be accompanied by a detailed account of expected expenditures (such as room rate/date, meals, local transportation, etc.), the funding source from which reimbursement will be made, and an assessment of the adequacy of this source to meet such expenditures without curtailing subsequent travel plans.

B. International travelers will be reimbursed the high cost area rates for lodging and meals, unless U.S. State Department rates are requested and authorized by the commissioner of administration prior to departure. Receipts are required for reimbursement of meals and lodging claimed at the U.S. State Department rates.

Section X. Waivers

The commissioner of administration may waive in writing any provision in these regulations when the best interest of the state will be served.

Mark C. Drennen
Commissioner

9906#014

Emergency Rules

DECLARATION OF EMERGENCY

Department of Agriculture and Forestry Office of Agriculture and Environmental Sciences

Application of Azinphos-methyl (LAC 7:XXIII.143)

In accordance with the Administrative Procedures Act R.S. 49:953(B) and R.S. 3:3203(A), the Commissioner of Agriculture and Forestry is exercising the emergency provisions of the Administrative Procedure Act in adopting the following rules for the implementation of regulations governing the use of the pesticide, azinphos-methyl.

Azinphos-methyl is an essential pesticide in the control of sugarcane pests. Without its use a substantial portion of the sugarcane crop in Louisiana could be damaged by pests. Because of its effectiveness as a pesticide Azinphos-methyl poses a substantial threat to the environment if it is misapplied. It was the cause of substantial fish kills in 1991. Because of its substantial threat to the environment the Department has severely limited the use of Azinphos-methyl, even though its label allows a wider use. The application of Azinphos-methyl in accordance with its label, but inconsistent with the Department's rules and regulation and the misuse of this pesticide poses an imminent peril to the public health, safety and welfare and to the environment, especially if it gets into the waterways of this state.

The Department has, therefore, determined that these emergency rules are necessary in order to implement a monitoring program and registration and permitting requirements during the current crop year. Information will be gathered to determine whether the effectiveness of this chemical outweighs any potential risk to the public or the environment. The rule becomes effective upon signature and will remain in effect 120 days.

Title 7

AGRICULTURE AND ANIMALS

Part XXIII. Pesticide

Chapter 1. Advisory Commission on Pesticides

Subchapter I. Regulations Governing Application of Pesticides

§143. Restrictions on Application of Certain Pesticides

A. - M. ...

N. 1999 Regulations Governing Application of Azinphos-methyl

1. Registration Requirements

a. The Commissioner hereby declares that prior to making any aerial application of azinphos-methyl to sugarcane, the aerial owner/operator must first register such intent by notifying the Division of Pesticides and Environmental Programs ("DPEP") in writing.

b. The Commissioner hereby declares that prior to selling azinphos-methyl to be applied on sugarcane, the dealer must first register such intent by notifying the DPEP in writing.

c. The Commissioner hereby declares that prior to making recommendation for application of azinphos-methyl to sugarcane, the agricultural consultant must first register such intent by notifying the DPEP in writing.

2. Grower Liability

Growers of sugarcane shall not force or coerce applicators to apply azinphos-methyl to their crops when the applicators, conforming to the Louisiana Pesticide Laws and Rules and Regulations or to the pesticide label, deem it unsafe to make such applications. Growers found to be in violation of this section shall forfeit their right to use azinphos-methyl on their crops, subject to appeal to the Advisory Commission on Pesticides.

3. Azinphos-methyl Application Restriction

a. Application of Azinphos-methyl on sugarcane is limited to one (1) application per season.

b. Do not apply by ground within 25 feet, or by air within 150 feet of lakes; reservoirs; rivers; permanent streams, marshes or natural ponds; estuaries and commercial fish farm ponds.

4. Procedures for Permitting Applications of Azinphos-methyl

a. Prior to any application or recommendation for application of Azinphos-methyl, approval shall be obtained in writing from the Louisiana Department of Agriculture and Forestry ("LDAF"). Such approval is good for five (5) days from the date issued. Approval may be obtained by certified agricultural consultants from the DPEP. Where farmers do not use agricultural consultants, approval must be obtained by the private applicator or aerial applicators employed by such farmers from DPEP.

b. The determination as to whether a permit for application is to be given shall be based on criteria including but not limited to:

i. weather patterns and predictions;

ii. soil moisture;

iii. propensity for run-off;

iv. drainage patterns;

v. quantity of acreage to be treated;

vi. extent and presence of vegetation in the buffer zone between application site and water body;

vii. water monitoring results;

viii. targeted pest must exceed the following prescribed thresholds:

(a). Yellow sugarcane aphid, 20 - 25 live aphids per leaf or sugarcane borer - a three-fold threshold (15%) i.e. 1 or more live borers in 15 different stalks per 100 stalks;

ix. Azinphos-methyl total acreage target shall not exceed 80,000 acres; and

x. any other relevant data.

5. Monitoring of Azinphos-methyl

a. Agricultural consultants registered to recommend azinphos-methyl on sugarcane shall report daily to the DPEP, on forms prescribed by the Commissioner, all

recommendations for applications of azinphos-methyl to sugarcane.

b. Certified applicators registered to apply azinphos-methyl on sugarcane shall maintain a daily record of azinphos-methyl applications and provide a summary to the DPEP within 60 days of the end of the application season.

6. Determination of Appropriate Action

a. Upon determination by the Commissioner that a threat or reasonable expectation of a threat to human health or to the environment exists, he may consider:

- i. stop orders for use, sales, or application;
- ii. label changes;
- iii. remedial or protective orders;
- iv. any other relevant remedies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3203.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Advisory Commission on Pesticides, LR 9:169 (April 1983), amended LR 10:193 (March 1984), LR 11:219 (March 1985), LR 11:942 (October 1985), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, LR 18:953 (September 1992), amended LR 19:791 (September 1993), LR 21:668 (July 1993), LR 21:668 (July 1995), LR 24:281 (February 1998), LR 24:2076 (November 1998), LR 25:

Bob Odom
Commissioner

9906#031

DECLARATION OF EMERGENCY

Student Financial Assistance Commission Office of Student Financial Assistance

Student Tuition and Revenue Trust (START Saving)
Program (LAC 28:VI.107, 301, 307)

The Louisiana Tuition Trust Authority (LATTA) is exercising the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)] to amend rules of the Student Tuition Assistance and Revenue Trust (START Saving) Program (R.S. 17:3091-3099.2).

The emergency rules are necessary to allow the Louisiana Office of Student Financial Assistance and educational institutions to effectively administer these programs. A delay in promulgating rules would have an adverse impact on the financial welfare of the eligible students and the financial condition of their families. The commission has, therefore, determined that these emergency rules are necessary in order to prevent imminent financial peril to the welfare of the affected students.

This declaration of emergency is effective May 11, 1999, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act.

Title 28 EDUCATION

Part VI. Student Financial Assistance—Higher Education Savings

Chapter 1. General Provisions

Subchapter A. Student Tuition Trust Authority

§107. Applicable Definitions

Tuition Assistance Grant—a payment allocated to an education assistance account, on behalf of the beneficiary of the account, by the state. The grant amount is calculated based upon the account owner's annual federal adjusted gross income and total annual deposits of principal. The grant and interest earned may only be used to pay the beneficiary's tuition, or portion thereof, at an eligible educational institution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:712 (June 1997), amended LR 24:1268 (July 1998), LR 25:

Chapter 3. Education Savings Account

§301. Education Assistance Accounts (EAA)

A. ...

B. Program Enrollment Period. An account may be opened and an eligible beneficiary may be enrolled at any time during the calendar year. Tuition Assistance Grants shall be allocated only to those accounts which have been opened by November 1 of the calendar year preceding the allocation.

C. - J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:713 (June 1997), amended LR 24:1269 (July 1998), LR 25:

§307. Allocation of Tuition Assistance Grants

A. - D. ...

E.1. - 3. ...

4. have an account owner who is a resident of the State of Louisiana, as defined in §107 in the year for which a tuition assistance grant is disbursed.

F. - G. ...

H. Restriction on Use of Tuition Assistance Grants

1. Tuition assistance grants, and any interest which may accrue thereon, may only be expended in payment of the beneficiary's tuition, or a portion thereof, at an eligible educational institution.

2. Tuition assistance grants may not be used to pay for any qualified higher education expenses other than tuition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:715 (June 1997), amended LR 24:1271 (July 1998), LR 25:

Jack L. Guinn
Executive Director

9906#019

DECLARATION OF EMERGENCY

**Student Financial Assistance Commission
Office of Student Financial Assistance**

Tuition Opportunity Program for Students
(TOPS) (LAC 28:IV.301, 703, 803, 2115)

The Louisiana Student Financial Assistance Commission (LASFAC) is exercising the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)] to amend rules of the Tuition Opportunity Program for Students (R.S. 17:3042.1 and R.S. 17:3048.1).

The emergency rules are necessary to allow the Louisiana Office of Student Financial Assistance and state educational institutions to effectively administer these programs. A delay in promulgating rules would have an adverse impact on the financial welfare of the eligible students and the financial condition of their families. The commission has, therefore, determined that these emergency rules are necessary in order to prevent imminent financial peril to the welfare of the affected students.

This declaration of emergency is effective May 11, 1999, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act.

**Title 28
EDUCATION**

**Part IV. Student Financial Assistance—Higher
Education Scholarship and Grant Programs**

Chapter 3. Definitions

§301. Definitions

Eligible Non-Louisiana High School and Eligible Out of State High School—see §1701.A.3 and 1701.A.4, respectively.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:632 (April 1998), amended LR 24:1898 (October 1998), LR 25:

**Chapter 7. Tuition Opportunity Program for
Students (TOPS) Opportunity;
Performance and Honors Awards**

§703. Establishing Eligibility

A. To establish eligibility for a TOPS Opportunity, Performance or Honors Award, the student applicant must meet all of the following criteria:

1. - 5.a. ...

i. at the time of high school graduation, an applicant must have successfully completed 16.5 units of high school course work constituting a core curriculum as follows:

Units	Course
1	English I
1	English II
1	English III
1	English IV
1	Algebra I (one unit) or Applied Algebra 1A and 1B (two units)
1	Algebra II
1	Geometry, Trigonometry, Calculus or Comparable Advanced Math
1	Biology I
1	Chemistry I
1	Earth Science, Environmental Science, Physical Science, Biology II, Chemistry II or Physics, Physics II or Physics for Technology
1	American History
1	World History, World Culture, Western Civilization or World Geography
1	Civics and Free Enterprise (one unit combined) or Civics (one unit, nonpublic)
1	Fine Arts Survey; (or substitute two units Performance courses in Music, Dance and/or Theater; or two units of Studio Art or Visual Art; or one elective from among the other subjects listed in this core curriculum)
2	In the Same Foreign Language (one unit or credit for three or more hours of college foreign language for students graduating from high school during the 1996-97 and 1997-98 school years).
½	Computer Science, Computer Literacy or Business Computer Applications (or substitute at least one-half unit of an elective course related to computers that is approved by the State Board of Elementary and Secondary Education; (or substitute at least one-half unit of an elective from among the other subjects listed in this core curriculum)

or

b. graduate from a BESE approved, provisionally-approved or probationally-approved public or nonpublic Louisiana high school or eligible non-Louisiana high school as defined in §1701.A.3 and have completed the core curriculum defined in §703.A.5.a.i, unless the following exceptions apply:

i. ...

ii. for a Disabled Student or an Exceptional Child, as defined in §301, who have met the criteria set forth in §2115, one or more core units are waived;

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:632 (April 1998), amended LR 24:1898 (October 1998), LR 24: 2237 (December 1998), LR 25:

**Chapter 8. TOPS-TECH Award
§803. Establishing Eligibility**

A.1 - 6.b. ...

c. for a student who is a Disabled Student or an Exceptional Child, as defined in §301, one or more core units may be waived if the student has met the criteria set forth in §2115;

A.1 - 7.a. ...

b. if qualifying under §703.A.5.b, c, or d, the state's reported prior year average ACT composite score, rounded, plus 3 points, but never less than 22; and

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance,

Chapter 21. Miscellaneous Provisions and Exceptions
§2115. Procedures for Disabled Students and
Exceptional Children

A. As provided for in §703.A.5.b.ii, a core curriculum course shall be waived for a student who is a Disabled Student or an Exceptional Child, as defined in §301, whose school certifies that it has the following documentation:

1. For a student claiming the status of a Disabled Student:

a. a written diagnosis from a person licensed or certified to diagnose the disability of the student, which diagnosis specifies the need for special accommodation by the student's high school; and

b. a written statement from the principal of the high school that a plan of accommodation under Section 504 of the Rehabilitation Act of 1973 (§504 Plan) has been established, and the high school was unable to provide the special accommodation, or, if the special accommodation was provided by the high school, the failure to complete the specified core curriculum course was due solely to the student's diagnosed disability.

2. For a student claiming the status of an Exceptional Child:

a. a written Individual Education Program (IEP) in accordance with R.S. 17:1941 et seq. and Louisiana Department of Education Bulletin 1706; and

b. a written statement from the principal of the high school that the failure to complete the specified core curriculum course was due solely to the student's exceptionality.

B. For Disabled Students graduating prior to the 1999-2000 high school academic year and who are requesting a waiver of a core curriculum course based upon their status as a Disabled Student, those students must provide the documentation provided in §2115.A.1, above, however, those students need not establish the existence of a 504 Plan.

C. A school official must obtain the consent from the student's parent or legal guardian, as required by law, prior to the release of information concerning a student who is requesting a waiver of a core course by reason of that student being a Disabled Student or an Exception Child.

D. If a core curriculum course is waived based upon the determination that a student's disability or exceptionality, then the grade achieved for that course will not be included in the determination of the student's grade point average for purposes of qualifying for a TOPS award.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 25:

Jack L. Guinn
Executive Director

9906#003

DECLARATION OF EMERGENCY

Office of the Governor
Division of Administration
Board of Trustees of the State Employees
Group Benefits Program

EPO Plan Document

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of La R.S. 49:953(B).

The text of this emergency rule may be viewed in its entirety at the office of Board of Trustees for the State Employees Group Benefits Program, 5825 Florida Boulevard, Second Floor, Baton Rouge, Louisiana, or the Office of the State Register, 1051 N. Third Street, Baton Rouge, Louisiana.

The Board finds that it is necessary to adopt an entire new Plan Document for the State Employees Group Benefits Program, designating it as the EPO Plan Document. The EPO Plan Document sets forth the terms and conditions pursuant to which eligibility and benefit determinations are made with regard to the self-insured health and accident benefits plan, designated as the EPO Plan, to be implemented July 1, 1999, for state employees and their dependents pursuant to R.S. 42:851 et seq. Failure to adopt this rule on an emergency basis will result in a financial impact adversely affecting the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state. Accordingly, the following Emergency Rule is effective July 1, 1999, and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

Jack W. Walker, Ph.D.
Chief Executive Officer

9906#037

DECLARATION OF EMERGENCY

Office of the Governor
Division of Administration
Board of Trustees of the State Employees
Group Benefits Program

Fee Schedule

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the

responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, and in order to comply with R.S. 42:851.5 which requires the Board to adopt and promulgate a schedule of maximum fees for medical and surgical services and for professional services provided in hospitals, the Board of Trustees hereby invokes the Emergency Rule provisions of La R.S. 49:953(B).

Failure to adopt this rule on an emergency basis will result in a financial impact adversely affecting the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state. Accordingly, the following Emergency Rule is effective July 1, 1999, and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

The maximum fees for medical and surgical services and for professional services provided in hospitals, when such medical, surgical, or professional services are rendered by providers who have not entered into contracts with the State Employees Group Benefits Program establishing the allowed charges for the services, shall be the 60th percentile of MDR's MediCode allowed charge. In the event that an allowed fee for the CPT code is not found in MDR's Medicode schedule, the maximum fee will be 75 percent of the provider's billed charge.

Jack W. Walker, Ph.D.
Chief Executive Officer

9906#039

DECLARATION OF EMERGENCY

Office of the Governor Division of Administration Board of Trustees of the State Employees Group Benefits Program

PPO Plan Document

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, and in accordance with R.S. 40:2204(D), the Board of Trustees hereby invokes the Emergency Rule provisions of La R. S. 49:953(B).

The text of this emergency rule may be viewed in its entirety at the office of the Board of Trustees for State Employees Group Benefits Program, 5825 Florida Boulevard, Second Floor, Baton Rouge, Louisiana, and the Office of the State Register, 1051 N. Third Street, Baton Rouge, Louisiana.

The Board finds that it is necessary to repeal the previous Plan Document and promulgate the new Plan Document for the State Employees Group Benefits Program, designating it as the PPO Plan Document. The PPO Plan Document sets forth the terms and conditions pursuant to which eligibility and benefit determinations are made with regard to the self-insured health and accident benefits plan, designated as the

PPO Plan, effective July 1, 1999, provided for state employees and their dependents pursuant to R.S. 42:851 et seq. Failure to adopt this rule on an emergency basis will result in a financial impact adversely affecting the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule is effective January 1, 1999, and shall remain in effect for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

Jack W. Walker, Ph.D.
Chief Executive Officer

9906#038

DECLARATION OF EMERGENCY

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, Office of the Secretary, Bureau of Health Services Financing will adopt the following emergency rule in the Medical Assistance Program as authorized by LA. 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. 49:953B(1) et seq. and shall be in effect for the maximum period allowed under the Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a rule March 20, 1998 governing the disproportionate share payment methodologies for hospitals (*Louisiana Register*, Volume 24, Number 3). This rule was adopted pursuant to Act 19 of 1998 (General Appropriations Act) and Act 1485 of 1997. Act 19 provides for different treatment of disproportionate share funds for uncompensated costs in small non-state operated local government hospitals and private rural hospitals with 60 beds or less. Act 1485 allows rural hospitals to meet less stringent criteria in order to receive the maximum disproportionate share funding available in accordance with the amounts appropriated by the Legislature and to the extent authorized by federal law.

The Department adopted an emergency rule effective March 1, 1999 (*Louisiana Register*, Volume 25, No. 2) which increased the disproportionate share payment for large public non-state rural hospitals for state fiscal year 1999 only, by allowing these qualifying hospitals to certify uncompensated care expenditures as match and receive the equivalent of Federal Financial Participation (FFP) in the same manner as small public non-state rural hospitals. This payment is in lieu of a lower payment that these hospitals would have otherwise been paid under the disproportionate share payment methodologies for other hospitals receiving

disproportionate share payments contained in the March 20, 1998 rule.

In addition, Senate Concurrent Resolution No. 48 directs the Department to amend the date by which hospitals qualify for status as small rural hospitals. Therefore, Item III.B.1.a) of the May 20, 1999 rule is amended to modify the date by which hospitals had no more than sixty hospital beds to October 1, 1994 (*Louisiana Register*, Volume 25, Number 5).

This action is necessary to enhance federal revenues and is in accordance with the Joint Legislative Budget Committee's directive of October 16, 1998 to change the disproportionate share payment methodology for large public non-state rural hospitals for state fiscal year 1999. It is estimated that the expenditures necessary to implement this rule will be \$3,236,885 in federal funds only for state fiscal year 1999. This rule will not require the expenditure of any additional state general funds.

Emergency Rule

Effective June 21, 1999, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing establishes an additional disproportionate share hospital group designed for state fiscal year 1999 only, for large public non-state rural hospitals having at least twenty-five percent (25%) Medicaid inpatient days utilization, by allowing these qualifying hospitals to certify uncompensated care expenditures as match and receive the equivalent of Federal Financial Participation (FFP) in the same manner as small public non-state rural hospitals. Qualifying hospitals must meet qualifying criteria contained in II. A, B, or C and E in the May 20, 1999 rule. The provisions contained in the May 20, 1999 rule otherwise remain intact.

A large public non-state rural hospital is a hospital owned by a local government that is not included in section III.A or B of the May 20, 1999 rule and did not qualify for DSH payment in accordance with the March 1, 1999 emergency rule and meets the following criteria:

(1) is located in a parish with a population of less than fifty thousand, or

(2) is located in a municipality with a population of less than twenty thousand, and

(3) has Medicaid inpatient days utilization rate in excess of 25 percent for the hospital's fiscal year end cost report ending during the period April 1, 1997 through March 31, 1998. The Medicaid inpatient days utilization percentage is derived from Medicaid reported days per the hospital's fiscal year end cost report ending during the period April 1, 1997 through March 31, 1998. Non-covered Medicaid days or days for which another payor is primary to Medicaid coverage may not be included in order to qualify for this payment. This designation includes distinct-part psychiatric units, but excludes long-term, rehabilitation, or free-standing psychiatric hospitals.

Disproportionate share payments for state fiscal year 1999 to each qualifying large public non-state rural hospital are equal to that hospital's pro rata share of uncompensated costs for all hospitals meeting these criteria for the cost reporting period ended during the period April 1, 1997 through March 31, 1998 multiplied by the amount set for this pool. If the cost reporting period is not a full period (twelve months),

actual uncompensated cost data for the previous cost reporting period may be used on a pro rata basis to equate to a full year.

A pro rata adjustment necessitated by the conditions specified in section I.B of the May 20, 1999 rule for hospitals described in this section will be calculated using the ratio determined by dividing the qualifying hospital's uncompensated costs by the uncompensated costs for all qualifying large public non-state rural hospitals, 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.

In addition Item III.B.1.a) of the May 20, 1999 rule is modified to read "had no more than sixty hospital beds as of October 1, 1994; and."

Interested persons may submit written comments to the following address: Thomas D. Collins, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to all inquiries regarding this emergency rule. A copy of this emergency rule is available for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

9906#041

DECLARATION OF EMERGENCY

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

Durable Medical Equipment Program—Augmentative and Alternative Communication (AAC) Devices

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following emergency rule as authorized by LA. R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This emergency rule is 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.

The Department of Health and Hospitals, Bureau of Health Service Financing currently provides coverage for durable medical equipment under the Medicaid Program. All medical equipment, appliances and supplies must be prior authorized in order to determine medical necessity. Currently, augmentative and alternative communication devices are approved for prior authorization for rental or purchase under the durable medical equipment program according to specific criteria set forth in the Medicaid Eligibility Manual. However, only recipients under the age of 21 are eligible to receive these devices (*Louisiana Register*, Volume 22, No. 5). The Department has determined that it is necessary to amend the current rule regarding prior authorization of augmentative

communication devices by removing the age restriction for rental or purchase by eligible recipients, which will ensure availability to recipients of all ages, and by expanding the criteria for consideration of these devices for prior authorization. This change is necessary to avoid imminent peril to the public health, safety or welfare. It is estimated that implementation of this rule will increase expenditures in the Durable Medical Equipment Program by approximately \$60,250 for state fiscal year 1999-2000.

Emergency Rule

Effective June 5, 1999 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing removes the age restriction for rental or purchase of augmentative and alternative communication devices by eligible recipients and expands the criteria for consideration of these devices for prior authorization under the Durable Medical Equipment Program.

I. Definitions

Augmentative and Alternative Communications (AAC) Devices—electronic or non-electronic aids, devices, or systems that assist a Medicaid beneficiary to overcome or ameliorate (reduce to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities. Examples of AAC devices include:

1. communication boards or books, speech amplifiers, and electronic devices that produce speech and/or written output;
2. devices that are constructed for use as communication devices as well as systems that may include a computer, when the primary use of the computer serves as the beneficiary's communication device; and
3. related components and accessories, including software programs, symbol sets, overlays, mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, printers, and necessary supplies, such as rechargeable batteries.

Meaningful Participation—effective and efficient communication of messages in any form the beneficiary chooses.

Speech-Language Pathologist—an individual who has:

1. a certificate of clinical competence from the American Speech-Language-Hearing Association;
2. completed the equivalent educational requirements and work experience necessary for the certificate; or
3. completed the academic program and is acquiring supervised work experience to qualify for the certificate.

II. General Provisions

Consideration shall be given for Medicaid reimbursement for AAC devices for Medicaid recipients of all ages if the device is considered medically necessary, the recipient has the ability to physically and mentally use a device and its accessories, and if any one or more of the following criteria is met.

A. Medical Necessity Determinations

1. The following medically necessary conditions shall be established for recipients who/whose:
 - a. have a diagnosis of a significant expressive or receptive (language comprehension) communication impairment or disability;

- b. impairment or disability either temporarily or permanently causes communication limitations that preclude or interfere with the recipient's meaningful participation in current and projected daily activities; and

- c. had a speech-language pathologist (and other health professional, as appropriate):

- i. perform an assessment and submit a report pursuant to the criteria set forth in sub-section C. Assessment/Evaluation; and

- ii. recommend speech-language pathology treatment in the form of AAC devices and services; and

- iii. document the mental and physical ability of a recipient to use, or learn to use, a recommended AAC device and accessories for effective and efficient communication; and

- iv. prepare a speech-language pathology treatment plan that describes the specific components of the AAC devices and the required amount, duration, and scope of the AAC services that will overcome or ameliorate communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities; and

- d. requested AAC devices constitute the least costly, equally effective form of treatment that will overcome or ameliorate communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

2. The following are additional general principles relating to medical necessity determinations for AAC devices.

- a. The cause of the recipient's impairment or disability (e.g., congenital, developmental, or acquired), or the recipient's age at the onset of the impairment or disability, are irrelevant considerations in the determination of medical need.

- b. Recipient participation in other services or programs (e.g., school, early intervention services, adult services programs, employment) is irrelevant to medical necessity determination for AAC devices.

- c. No cognitive, language, literacy, prior treatment, or other similar prerequisites must be satisfied by a recipient in advance of a request for AAC devices.

- d. The unavailability of an AAC device, component, or accessory for rental will not serve as the basis for denying a prior approval request for that device, component, or accessory.

3. When the medical necessity cannot be determined for an AAC device pursuant to the criteria stated above and to the information submitted in support of a prior authorization request, the following steps shall be taken.

- a. If Medicaid determines that any essential information in establishing medical necessity for the AAC device is incomplete, or has been omitted in the prior authorization request as required in sub-section C. Assessment/Evaluation, Medicaid will make direct contact with the speech-language pathologist who conducted the assessment for the recipient. Medicaid will then identify the specific, additional information that is needed and request that the additional information be submitted; and/or

- b. If Medicaid determines that an additional interpretation of information in the prior authorization

request is needed by the medical reviewer in establishing medical necessity for an AAC device, Medicaid will seek the advice of speech language pathologist(s) with extensive AAC experience recommended to Medicaid by the American Speech Language & Hearing Association (ASHA), the United States Society for Augmentative & Alternative Communication (USSAAC), and/or RESNA, who shall provide the required interpretation.

i. Only one request for additional information by direct contact with the speech/language pathologist and/or only one interpretation will be made per prior authorization request;

ii. If additional information requested by Medicaid from the speech/language pathologist who conducted the assessment, or if an additional interpretation requested from a consulting speech-language pathologist, is not received by Medicaid within the 25 day time frame required of Medicaid for a prior authorization determination, a decision will be made by the medical reviewer for Medicaid based on the information that has been submitted with the prior authorization request and on the reviewer's interpretation of that information. If the additional information or additional interpretation is provided at a later time, another request will need to be submitted by the provider to the Prior Authorization Unit for additional review.

B. Assessment/Evaluation

1. An assessment, or evaluation, of individual functioning and communication limitations that preclude or interfere with meaningful participation in current and projected daily activities must be completed by a speech-language pathologist with input from other health professionals, (e.g., occupational therapists and rehabilitation engineers) based on the recommendation of the speech language pathologist and a physician's prescription, as appropriate.

2. Requests for AAC devices must include a description of the speech-language pathologist's qualifications, including a description of the speech-language pathologist's AAC services training and experience.

3. An assessment (augmentative & alternative communication evaluation) must include the following information about the recipient:

a. Identifying Information

i. name;

ii. Medicaid identification number;

iii. date of the assessment;

iv. medical and neurological; diagnoses (primary, secondary, tertiary);

v. significant medical history;

vi. mental or cognitive status; and

vii. educational level and goals;

b. Sensory Status

i. vision and hearing screening (no more than one year prior to AAC evaluation);

ii. if vision screening is failed, a complete vision evaluation;

iii. if hearing screening is failed, a complete hearing evaluation;

iv. description of how vision, hearing, tactile, and/or receptive communication impairments or disabilities affect expressive communication;

c. Postural, Mobility, & Motor Status

i. gross motor assessment;

ii. fine motor assessment;

iii. optimal positioning;

iv. integration of mobility with AAC devices;

v. beneficiary's access methods (and options) for AAC devices;

d. Current Speech, Language, & Expressive Communication Status

i. identification and description of the beneficiary's expressive or receptive (language comprehension) communication impairment diagnosis;

ii. speech skills and prognosis;

iii. language skills and prognosis;

iv. communication behaviors and interaction skills (i.e., styles and patterns);

v. functional communication assessment, including ecological inventory;

vi. indication of past treatment, if any;

vii. description of current communication strategies, including use of an AAC device, if any;

NOTE: If an AAC device is currently used, describe the device, when and by whom it was previously purchased, and why it is no longer adequate for communication needs).

e. Communication Needs Inventory

i. description of beneficiary's current and projected communication needs;

ii. communication partners and tasks, including partners' communication abilities limitations, if any;

iii. communication environments and constraints which affect AAC device selection and/or features (e.g., verbal and/or visual output and/or feedback; distance communication needs);

f. Summary of Communication Limitations. Description of the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities (i.e., why the beneficiary's current communication skills and behaviors prevent meaningful participation in the beneficiary's current and projected daily activities);

g. AAC Devices Assessment Components

i. vocabulary requirements;

ii. representational system(s);

iii. display organization and features;

iv. rate enhancement techniques;

v. message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output;

vi. access techniques and strategies; and

vii. portability and durability concerns, if any;

h. Identification of AAC Devices Considered for Beneficiary

i. identification of the significant characteristics and features of the AAC devices considered for the beneficiary;

ii. identification of the cost of the AAC devices considered for the beneficiary (including all required

components, accessories, peripherals, and supplies, as appropriate);

i. AAC Device Recommendation

i. identification of the requested AAC devices including all required components, accessories, software, peripheral devices, supplies, and the device vendor;

ii. identification of the beneficiary's and communication partner's AAC devices preference, if any;

iii. assessment of the beneficiary's ability (physically and mentally) to use, or to learn to use, the recommended AAC device and accessories for effective and efficient communication;

iv. justification stating why the recommended AAC device (including description of the significant characteristics, features, and accessories) is better able to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities, as compared to the other AAC devices considered;

v. justification stating why the recommended AAC device (including description of the significant characteristics, features, and accessories) is the least costly, equally effective, alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities;

j. Treatment Plan and Follow-Up

i. description of short term communication goals (e.g., 6 months);

ii. description of long term communication goals (e.g., 1 year);

iii. assessment criteria to measure beneficiary's progress toward achieving short and long term communication goals;

iv. description of amount, duration, and scope of AAC services required for the beneficiary to achieve short and long term communication goals;

v. identification and experience of AAC service provider responsible for training (these service providers may include, e.g.: speech-language pathologists, occupational therapists, rehabilitation engineers, the beneficiary's parents, teachers and other service providers);

k. Summary of Alternative Funding Source for AAC Device;

i. description of availability or lack of availability, of purchase of AAC device through other funding sources.

C. Trial Use Periods

1. In instances where the appropriateness of a specific AAC device is not clear, a trial use period for an AAC device may be recommended (although it is not required) by the speech-language pathologist who conducts the AAC evaluation.

2. Prior authorization for rental of AAC devices shall be approved for trial use periods when the speech-language pathologist prepares a request consistent with the established requirements. The reasons for a trial use period request include, but are not limited to:

a. the characteristics of the recipient's communication limitations;

b. lack of familiarity with a specific AAC device; and

c. whether there are sufficient AAC services to support the beneficiary's use of the AAC device, or other factors.

3. If the speech-language pathologist seeks a trial use period, s/he must prepare a trial use period request that includes the following information:

a. the duration of the trial period;

b. the speech-language pathologist information and the beneficiary information as required in B. Assessment/Evaluation;

c. the AAC device to be examined during the trial period, including all the necessary components (e.g., mounting device, software, switches, or access control mechanism);

d. the identification of the AAC services provider(s) who will assist the beneficiary during the trial period;

e. the identification of the AAC services provider(s) who will assess the trial period; and

f. the evaluation criteria, specific to the beneficiary, that will be used to determine the success or failure of the trial period.

4. Trial use period requests must request Medicaid funding for the rental of all necessary components and accessories of the AAC device. If an accessory necessary for the trial use of a device by a recipient is not available for rental, but the communication device is available for rental for trial use, Medicaid may consider the purchase of the accessory for the trial use of the communication device by that recipient.

5. Trial periods may be extended and/or different AAC devices provided, when requested by the speech-language pathologist responsible for evaluating the trial use period.

6. Results of trial use periods must be included with any subsequent request for prior authorization of purchase of the AAC device. Recommendations for the purchase of an AAC device, as a result of a trial use period of the device, must clearly indicate the patient's ability to use the device during the trial period.

D. Repairs

1. Medicaid will cover repairs to keep AAC devices, accessories, and other system components in working condition. Medicaid coverage for repairs will include the cost of parts, labor, and shipping, when not otherwise available without charge pursuant to a manufacturer's warranty.

a. Providers of AAC devices are expected to comply with the Louisiana New Assistive Devices Warranty Act.

i. One of the provisions of this law is that all persons who make, sell, or lease assistive devices, including AAC devices, must provide those who buy or lease the equipment with a warranty which lasts at least one year from the time the equipment is delivered to the customer.

ii. If, during the warranty period, the equipment does not work, the manufacturer or dealer must make an attempt to repair the equipment.

b. Medicaid additionally requires providers to provide the recipient with a comparable, alternate AAC device while repairing the recipient's device during a warranty period.

c. Medicaid coverage may be provided for rental of an alternate AAC device during a repair period after expiration of the warranty.

d. Medicaid will not cover repairs, or rental of a loaner device, when repairs are made during a warranty period.

2. When a device is received by the provider for the purpose of repair, the provider will conduct an assessment of the device to determine whether it can be repaired, and if so, prepare a written estimate of the parts, labor, and total cost of the repair, as well as the effectiveness (i.e., estimated durability) of the repair. If the manufacturer or provider concludes that the device is not repairable and the replacement device is needed, written notice will be provided to the recipient.

3. Medicaid coverage for repairs greater than \$300.00 must be accompanied by a statement from the speech-language pathologist. The statement must indicate:

a. whether there have been any significant changes in the sensory status (e.g., vision, hearing, tactile); postural, mobility or motor status; speech, language, and expressive communication status; or any other communication need or limitation of the recipient as described in B.2. (b through g, and j); and

b. whether the device remains the speech language pathologist's recommendation for recipient's use.

E. Replacement or Modification

1. Modification or replacement of AAC devices will be covered by Medicaid subject to the following limitations:

a. requests for modification or replacement of AAC devices and/or accessories may be considered for coverage after the expiration of three (3) or more years from the date of purchase of the current device and accessories in use;

b. requests for modification or replacement require prior authorization and must include the recommendation of the speech-language pathologist;

c. requests for replacements of AAC devices may be submitted for identical or different devices;

d. requests for replacements of identical AAC devices must be accompanied by a statement from the provider that the current device can not be repaired or that replacement will be more cost effective than repair of the current device. Data must be provided about the following:

i. age;

ii. repair history;

(a) frequency,

(b) duration, and

(c) cost; and

iii. repair projections (estimated durability of repairs);

e. requests for modification or replacement of AAC devices with different devices must include the following additional information:

i. a significant change has occurred in the recipient's expressive communication, impairments, and/or communication limitations. Modification or replacement requests due to changed individual circumstances must be supported by a new assessment of communication limitations by a speech-language pathologist, and may be submitted at any time; or

ii. even though there has been no significant change in the recipient's communication limitations, there

has been a significant change in the features or abilities of available AAC devices (i.e., a technological change) that will overcome or permit an even greater amelioration of the recipient's communication limitations as compared to the current AAC device. A detailed description of all AAC device changes and the purpose of the changes must be provided with the results of a re-evaluation by a speech-language pathologist;

f. requests for replacements of AAC devices due to loss or damage (either for identical or different devices) must include a complete explanation of the cause of the loss or damage and a plan to prevent the recurrence of the loss or damage.

III. Prior Authorization

A. All requests for AAC devices and accessories must be prior authorized by Medicaid in accordance with the criteria described in this rule.

B. Medicaid will not consider purchase of an AAC device when an alternative means of funding through another agency or other source (e.g., Louisiana Rehabilitation Services, school systems, private insurance, etc.) is available for the recipient. All requests should indicate the availability, or lack of availability, of purchase through other funding sources.

Interested persons may submit written comments to the following address: Thomas D. Collins, Bureau of Health Services Financing, P. O. Box 91030, Baton Rouge, Louisiana 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

9906#042

DECLARATION OF EMERGENCY

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

Inpatient Hospital Reimbursement—Medicare Part A Claims

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted 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.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted an emergency rule effective April 1, 1999 to amend the reimbursement methodology under the Louisiana Medicaid Program for Medicare Part A claims for inpatient hospital services. This rule limited the reimbursement of Medicare Part A claims for inpatient hospital services rendered to dually eligible Medicare/Medicaid recipients and Qualified Medicare Beneficiaries (QMBs) to the Medicaid maximum payment.

Small rural hospitals, as defined in state law, were exempted from this limitation on payment of Medicare Part A claims to the Medicaid maximum payment. As a result of a legislative oversight hearing, the Department has been directed to withdraw this emergency rule. Therefore, the following emergency rule is being adopted to repeal the April 1, 1999 emergency rule that limited the reimbursement for Medicare Part A claims to the Medicaid maximum payment for inpatient hospital services rendered to dually eligible Medicare/Medicaid recipients and Qualified Medicare Beneficiaries.

Emergency Rule

Effective June 8, 1999, the Department of Health and Hospitals, Bureau of Health Services Financing repeals the April 1, 1999 emergency rule that amended the reimbursement methodology for Medicare Part A claims for inpatient hospital services rendered to dually eligible Medicare/Medicaid recipients and Qualified Medicare Beneficiaries by limiting the reimbursement to the Medicaid maximum payment. The April 1, 1999 emergency rule was published in the March 31, 1999 editions of the state's major newspapers.

David Hood
Secretary

9906#043

DECLARATION OF EMERGENCY

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

Targeted Case Management Services

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

The Department of Health and Hospitals, Bureau of Health Services Financing adopted a rule in June of 1997 governing the provision of case management services to targeted populations and certain home and community based services waiver groups (*Louisiana Register*, Vol. 23, Number 6). This rule addressed programmatic requirements including general provisions, standards for provider participation, standards for payment, consumer eligibility and reimbursement methodology.

The Department has subsequently determined it is necessary to restructure targeted case management services under the Medicaid Program in order to enhance the quality of services and assure statewide access to services. Section 4118(I) of the "Omnibus Budget Reconciliation Act of 1987" permits the State to limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or chronic mental illness in order to ensure that the case managers are capable of ensuring that such individuals receive needed

services. Therefore, the Department has decided to limit the number of case management agencies that may be enrolled to provide services to recipients in the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver Program by means of a selective contract. The participation of case management agencies providing service to other targeted and waiver populations will also be limited contingent on the approval of a 1915(b)(4) waiver by the Health Care Financing Administration (HCFA). In addition, all case management agencies shall be required to incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. [An emergency rule was promulgated effective March 1, 1999 establishing the above provisions for case management services (*Louisiana Register*, Volume 25, Number 2.)] This subsequent emergency rule shall continue the provisions for case management services in force.

Emergency Rule

Effective June 28, 1999 the Department of Health and Hospitals, Bureau of Health Services Financing repeals the June 20, 1997 rule and adopts the following rule governing the provision of case management services to targeted population groups and certain home and community based services waiver groups. The number of case management agencies that may be enrolled to provide services to recipients in the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver Program shall be limited to those agencies who have been awarded a contract by the Department. The participation of case management agencies providing service to other targeted and waiver populations will also be limited contingent on the approval of a 1915(b)(4) waiver by the Health Care Financing Administration (HCFA). In addition, all case management agencies shall be required to incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. All case management agencies must comply with the policies contained in this rule and the Medicaid Case Management Services Provider Manual issued March 1, 1999 and all subsequent changes.

I. General Provisions

A. Case Management Agency Responsibilities. Case Management is defined as services provided to individuals to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services. The Department utilizes a broker model of case management in which recipients are referred to other agencies for the specific services they need. These services are determined by individualized planning with the recipient's family, and other persons/professionals deemed appropriate. Services are provided in accordance with a written comprehensive plan of care which includes measurable person-centered outcomes. All Medicaid enrolled case management agencies are required to perform the following core elements of case management services.

1. Case Management Intake. The purpose of intake is to serve as an entry point for case management services and to gather baseline information to determine the recipient's need, appropriateness, eligibility and desire for case management.

2. Case Management Assessment. Assessment is the process of gathering and integrating formal and informal information regarding a recipient's goals, strengths, and needs to assist in the development of a person centered comprehensive plan of care. The purpose of the assessment is to establish a contract between the case manager and recipient for the provision of service. The assessment shall be performed in the recipient's home.

3. Comprehensive Plan of Care Development. The comprehensive plan of care (CPOC) is a written plan based upon assessment data (which may be multidisciplinary), observations and other sources of information which reflect the recipient's needs, capacities and priorities. The purpose of the CPOC is to identify the services required and the resources available to meet these needs.

a. The CPOC must be developed through a collaborative process involving the recipient, family, case manager, other support systems, appropriate professionals and service providers. It shall be developed in the presence of the recipient; therefore, it cannot be completed prior to a meeting with the recipient. The recipient, family, case manager, support system and appropriate professional personnel must be directly involved and agree to assume specific functions and responsibilities.

b. The CPOC must be completed and submitted for approval within 35 calendar days of the referral for case management services.

4. Case Management Linkage. Linkage is the arranging of services agreed upon with the recipient and identified in the CPOC. Upon the request of the recipient or responsible party, attempts must be made to meet service needs with informal resources as much as possible.

5. Case Management Follow-Up/Monitoring. Follow-up/monitoring is the mechanism used by the case manager to assure the appropriateness of the CPOC. The purpose of follow-up/monitoring contacts is to determine if the services are being delivered as planned; are effective and adequate to meet the recipient's needs; and whether the recipient is satisfied with the services. Through follow-up/monitoring activity, the case manager not only determines the effectiveness of the CPOC in meeting the recipient's needs, but identifies when changes in the recipient's status necessitate a revision in the CPOC.

6. Case Management Reassessment. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall CPOC. At least every quarter, a complete review of the CPOC must be performed to assure that the goals and services are appropriate to the recipient's needs as identified in the assessment/reassessment process. A reassessment is also required when a major change occurs in the status of the recipient and/or his family.

7. Case Management Transition/Closure. Discharge from a case management agency must occur when the recipient no longer requires services, desires to terminate services, becomes ineligible for services, or chooses to transfer to another case management agency; provided that the recipient has satisfied the requirements of linkage under Section B below. The closure process must ease the transition to other services or care systems. The agency shall not retaliate in any way against the recipient for terminating

services or transferring to another agency for case management services.

8. Maintenance of Records. All agency records must be maintained in an accessible, standardized order and format at the DHH enrolled office site. The agency must have sufficient space, facilities and supplies to ensure effective record keeping.

a. Administrative and recipient records must be maintained in a manner to ensure confidentiality and security against loss, tampering, destruction or unauthorized use.

b. The case management agency must retain its records for the longer of the following time frames:

(1) Five years from the date of the last payment; or

(2) Until the records are audited and all audit questions are answered.

c. Agency records must be available for review by the appropriate state and federal personnel at all reasonable times.

B. Monitoring Provision. The Department of Health and Hospitals and the Department of Health and Human Services have the authority to monitor and audit all case management agencies in order to determine continued compliance with the rules, regulations, policies, and procedures governing case management services.

C. Agency Caseload Limitations. Under the terms of the contractual agreement, case management agencies have a restriction on the total number of recipients it may serve. In a region where there are two agencies providing services, the maximum number of recipients that any one agency may serve is sixty percent (60 percent) of the available recipient population. In a region where there are three agencies providing services, the maximum number of recipients that any one agency may serve is forty percent (40 percent) of the available recipient population.

D. Recipient Freedom of Choice. Selection of Case Management Agency. Recipients have the right to select the provider of their case management services from among those available agencies enrolled to participate in the Program. Recipients are requested to indicate a first and second choice of a provider from among those available providers in the region. If the recipient fails to respond or fails to indicate a second choice of provider and their first choice is full, the Department will automatically assign them to an available provider. Recipients who are auto-assigned may change once, after 30 days but before 45 days of auto assignment, to an available provider.

Recipients must be linked to a case management agency for a six-month period before they can transfer to another agency unless there is good cause for the transfer. Good cause is determined to exist under the following circumstances: 1) the recipient moves to another DHH Region or 2) there are irreconcilable differences between the agency and the recipient. Approval of good cause shall be made by the DHH Case Management Administrator.

Recipients who are being transitioned from a developmental center into the MD/DD Waiver Program shall receive their case management services through the Office for Citizens with Developmental Disabilities (OCDD).

Recipients who are under the age of 21 and require ventilator assisted care may receive case management services through the Children's Hospital Ventilator Assisted Care Program.

II. Standards of Participation

A. In order to participate as a case management services provider in the Medicaid Program, an agency must comply with licensure and certification requirements, provider enrollment requirements, the case management manual, and the specific terms of individual contractual agreements.

B. Provider Enrollment Requirements. A separate PE-50 and Disclosure of Ownership form is required for each targeted or waiver population and DHH designated region that the agency plans to serve, as well as for each office site it plans to operate. The agency shall provide services only in the parishes of the DHH administrative region for which approval has been granted. The following enrollment requirements are applicable to all case management agencies, regardless of the targeted or waiver group served and failure to comply with these requirements may result in sanctions and/or recoupment and disenrollment.

To serve the MR/DD waiver recipients the agency must have a contract with Medicaid and comply with the terms of the contract.

1. demonstrate direct experience in successfully serving the target population and have demonstrated knowledge of available community services and methods for accessing them including the following:

a. maintain a current file of community resources available to the target population and have established linkages with those resources;

b. demonstrate knowledge of the eligibility requirements and application procedures for federal, state, and local government assistance programs which are applicable to the target population served;

c. employ a sufficient number of case manager and supervisory staff to comply with the staff coverage, staffing qualifications and maximum caseload size requirements described in Section III.A, B, and D;

2. demonstrate administrative capacity and financial resources to provide all core elements of case management services and ensure effective service delivery in accordance with DHH licensing and programmatic requirements;

3. submit a yearly audit of case management costs only and have no outstanding or unresolved audit disclaimer(s) with DHH;

4. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations. The subcontracting of individual case managers and/or supervisors is prohibited. However, those agencies who have been awarded Medicaid contracts for case management services may subcontract with another licensed case management agency for case manager and/or supervisory staff if prior approval has been obtained from the Department;

5. assure that all new staff satisfactorily completes an orientation and training program in the first 90 days of employment. All case managers must attend all training mandated by the Department. Each case manager and supervisor must satisfactorily complete case management related training annually to meet the minimum training requirements;

6. implement and maintain an ongoing quality assurance plan and a self-evaluation plan evidenced by written documentation approved by the Department to determine program compliance and effectiveness;

7. document and maintain recipient records in accordance with federal and state regulations governing confidentiality and licensing requirements;

8. assure the recipient's right to elect to receive or terminate case management services (except for recipients in the MR/DD or Elderly and Disabled Adult Waiver Programs). Assure that each recipient has freedom of choice in the selection of an available case management agency (every six months), a qualified case manager, or other service providers and the right to change providers or case managers; all the above are subject to the recipient's freedom of choice requirements contained in Section I.B. of this rule;

9. assure that the agency and case managers will not provide case management and Medicaid reimbursed direct services to the same recipient(s) unless by an affiliate agency with a separate board of directors;

10. with the recipient's permission, agree to maintain regular contact, share relevant information and coordinate medical services with the recipient's attending physician;

11. demonstrate the capacity to participate in the department's electronic data gathering system(s). All requirements for data submittal must be followed and participation is required for all enrolled case management agencies. The software is the property of the department;

12. complete management reports as described in the provider manual.

C. Agencies serving certain specific target groups must meet the following additional participation requirements:

1. Case management agencies serving high risk pregnant women must also demonstrate successful experience with the coordination and/or delivery of services for pregnant women; have a working relationship with a local obstetrical provider and acute care hospital that provides deliveries for 24-hour medical consultation; and have a multidisciplinary team which consists, at a minimum, of the following professionals: a physician, primary nurse associate or certified nurse manager, registered nurse, social worker, and nutritionist. The team members must meet the licensure and perinatal experience requirements applicable for services to high-risk pregnant women; and

2. Case managers serving HIV-infected individuals must also satisfactorily complete a one-day training approved by the Department's HIV Program Office.

III. Standards for Payment. In order to be reimbursed by the Medicaid Program, an enrolled provider of targeted or waiver case management service must comply with all of the requirements listed below.

A. Staff Coverage

1. Case management agencies must maintain sufficient staff to serve recipients within the mandated caseload size of 35 with a supervisor to staff ratio of no more than eight case managers per supervisor. All case managers must be employed by the agency at least 40 hours per week and work at least 50 percent of the time during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday). Case management supervisors must be full time employees and must be continuously available to case managers by telephone or beeper at all other times when not

on site when case management services are being provided. All exceptions to the maximum caseload size or full time employment of staff requirements must be prior authorized by the Bureau. The agency must have a written policy to ensure service coverage for all recipients during the normal absences of case managers and supervisors or prior to the filling of vacated staff positions.

2. The agency must maintain a toll-free telephone number to ensure that recipients have access to case management services 24 hours a day, seven days a week. Recipients must be able to reach an actual person in case of an emergency, not a recording.

B. Staff Qualifications. Each Medicaid-enrolled agency must ensure that all staff providing case management services meet the following qualifications, skills and training requirements prior to assuming any full caseload responsibilities.

1. Education and Experience for Case Managers. All case managers must meet one of the following minimum education and experience qualifications.

a. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and one year of paid experience in a human-service-related field providing direct services or case management services; or

b. a licensed registered nurse with one year of paid experience as a registered nurse in public health or a human-service-related field providing direct services or case management services; or

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.

The above-referenced minimum qualifications for case managers are applicable for all targeted and waiver groups. Thirty hours of graduate level course credit in a human-service-related field may be substituted for the one year of required paid experience.

In addition, case managers serving High-Risk Pregnant Women must demonstrate knowledge about perinatal care and meet either one of the qualifications cited above or the following qualification:

d. a registered dietician with one year of paid experience in providing nutrition services to pregnant women.

2. Education and Experience for Case Management Supervisors. All case management supervisors must meet one of the following education and experience requirements. Supervisors of case managers for High-Risk Pregnant Women must demonstrate knowledge about perinatal care in addition to meeting one of these qualifications:

a. a master's degree in social work, psychology, nursing, counseling, rehabilitation counseling, education (with special education certification), occupational therapy, speech therapy or physical therapy from an accredited college or university and two years of paid post-master's degree experience in a human-service related field providing direct services or case management services. One year of this experience must be in providing direct services to the target population served; or

b. a bachelor's degree in social work from a social work program accredited by the Council on Social Work

Education and three years of paid post-bachelor's degree experience in a human-service related field providing direct services or case management services. One year of this experience must be in providing direct services to the target population served; or

c. a licensed registered nurse with three years of paid post-licensure experience as a registered nurse in public health or a human service-related field providing direct services or case management services. Two years of this experience must be in providing direct services to the target population served; or

d. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and four years of paid post-bachelor's degree experience in a human service related field providing direct services or case management services. Two years of this experience must be in providing direct services to the target population served.

The above minimum qualifications for case management supervisors are applicable for all targeted and waiver groups.

Thirty hours of graduate level course credit in a human-service-related field may be substituted for one year of the required paid experience.

3. Training. Training for case managers and supervisors must be provided or arranged for by the case management agency at its own expense. Agencies must send the appropriate staff to all training mandated by DHH.

a. Training for New Staff. A minimum of sixteen (16) hours of orientation must be provided to all staff, volunteers, and students within one week of employment. A minimum of eight hours of the orientation training must address the target population including, but not limited to, specific service needs, available resources and other topics. In addition to the required 16 hours of orientation, all new employees who have no documentation of previous training must receive a minimum of 16 hours of training during the first 90 calendar days of employment related to the target population and the skills and techniques needed to provide case management to that population.

b. Annual Training. Case managers and supervisors must satisfactorily complete a minimum of forty (40) hours of case-management related training annually which may include updates on subjects covered in orientation and initial training. The 16 hours of orientation training required for new employees are not included in the annual training requirement of at least 40 hours.

c. Documentation. All training required in a. and b. above must be evidenced by written documentation and provided to the Department upon request.

C. Supervisory Responsibilities. Each case management supervisor shall be responsible for assessing staff performance, reviewing individual cases, providing feedback, and assisting staff to develop problem solving skills using two or more of the following methods:

1. individual, face-to-face sessions with staff;

2. group face-to-face sessions with all case management staff; or

3. sessions in which the supervisor accompanies a case manager to meet with recipients.

IV. Reimbursement. The reimbursement methodology for optional targeted and waiver case management services is a

fixed monthly rate for the provision of the core elements of case management services as described in Section I. A. and in acceptance with the terms of contract with the Bureau. The primary objective of case management is the attainment of the personal outcomes identified in the recipient's comprehensive plan of care.

In addition to the provision of the core elements, a minimum of one home visit per quarter is required for all recipients of optional targeted and waiver case management services. The agency shall ensure that more frequent home visits are performed if indicated in the recipient's CPOC. The purpose of the home visit is to assess the effectiveness of support strategies and to assist the individual to address problems, maximize opportunities and/or revise support strategies or personal outcomes if it is determined necessary.

The case management agency shall also be responsible for monitoring service providers quarterly through telephone monitoring, on-site observation of service visits and review of the service providers' records. The agency must also ensure that the service provider and recipient are given a copy of the recipient's most current CPOC and any subsequent updates.

A technical amendment (Public Law 100-617) in 1988 specifies that the Medicaid Program is not required to pay for case management services that are furnished to consumers without charge. This is in keeping with Medicaid's longstanding position as the payer of last resort. With the statutory exceptions of case management services included in the Individualized Education Programs (IEP'S) or Individualized Family Service Plans (IFSP's) and services furnished through Title V public health agencies, reimbursement by Medicaid payment for case management services cannot be made when another third party payer is liable, nor may payments be made for services for which no payment liability is incurred.

David W. Hood
Secretary

9906#040

DECLARATION OF EMERGENCY

Department of Natural Resources Office of Conservation

Pollution Control—Statewide Order No. 29-B
(LAC 43:XIX.129)

Order requiring testing of exploration and production (E&P) waste upon receipt by a commercial facility, and identification of acceptable storage, treatment and disposal methods for certain E&P waste types.

Pursuant to the power delegated under the laws of the State of Louisiana, and particularly Title 30 of the Revised Statutes of 1950, as amended, and in conformity with the provisions of the Louisiana Administrative Procedure Act, Title 49, Sections 953(B)(1) and (2), 954(B)(2), as amended, the following Emergency Rule and reasons therefor are now adopted and promulgated by the Commissioner of Conservation as being necessary to protect the public health,

safety and welfare of the people of the State of Louisiana, as well as the environment generally, by continuing a procedure for testing E&P waste after receipt at a commercial facility and identifying acceptable storage, treatment and disposal methods for certain E&P wastes at commercial facilities.

Need and Purpose

Certain oil and gas exploration and production waste (E&P waste) is exempt from the hazardous waste regulations under the Resource Conservation and Recovery Act (RCRA). This exemption is based on findings from a 1987-1988 Environmental Protection Agency (EPA) study and other studies that determined this type of waste does not pose a significant health or environmental threat when properly managed. The EPA, in its regulatory determination, found that these wastes are adequately regulated under existing federal and state programs.

Existing Louisiana State regulations governing the operations of commercial E&P waste disposal facilities (Statewide Order No. 29-B) require only very limited testing of the waste received for storage, treatment and disposal at each commercial facility. Such limited testing finds its basis in the above-mentioned national exemption for E&P waste recognized by the EPA. However, public concern warranted the Commissioner of Conservation to issue a first Emergency Rule effective May 1, 1998 (May 1, 1998 Emergency Rule), the purpose of which was to gather technical data regarding the chemical and physical makeup of E&P waste disposed of at permitted commercial E&P waste disposal facilities within the State of Louisiana. The May 1, 1998 Emergency Rule had an effective term of 120 days. However, technical experts under contract with the Office of Conservation determined during the term of the May 1, 1998 Emergency Rule that sampling and testing should be extended for an additional 30 days for the purpose of receiving additional data in order to strengthen the validity of the inferred concentration distributions within the various E&P waste types. Therefore, a Second Emergency Rule was issued on August 29, 1998, and effective through September 30, 1998.

The second Emergency Rule required continued comprehensive analytical testing of E&P waste at the site of generation together with verification testing at the commercial E&P waste disposal facility. During the terms of the first and second Emergency Rules, approximately 1,800

E&P waste testing batches were analyzed, with the raw data results being filed with the Office of Conservation. Technical experts under contract with the Office of Conservation, together with staff of the Office of Conservation, determined that the number of raw data sets of E&P waste types, along with other published analytical results of E&P waste testing, provided adequate numbers of validated test results of the various generic E&P waste types to reach statistically valid conclusions regarding the overall chemical and physical composition of each type of E&P waste.

Therefore, continued testing of E&P waste at the site of generation was unnecessarily redundant, and was discontinued. The third Emergency Rule adopted on October 1, 1998 required continued testing of each E&P waste shipment at the commercial disposal facility according to

procedures described in Section D. Such continued testing was required to assure that E&P waste shipments received for disposal at commercial facilities were consistent with evolving E&P waste profiles.

The fourth Emergency Rule, adopted January 29, 1999, provided requirements for continued testing of all E&P waste shipments received for disposal at commercial E&P waste disposal facilities, as well as identifying acceptable methods of storage, treatment and disposal of certain E&P waste types at such commercial facilities. However, since evaluation of data generated by Emergency Rules 1 and 2 has not been completed and a permanent rule has not been promulgated, it is necessary to adopt a Fifth Emergency Rule, effective May 29, 1999, to continue the requirements of the Fourth Emergency Rule.

Concurrent with implementation of this Emergency Rule, the Office of Conservation will continue development of a permanent rule for the management and disposal of E&P waste at commercial facilities within the State of Louisiana. Best E&P waste management practices, based on established E&P waste profiles, will be incorporated into the permanent rule. Such permanent rule will also address specific storage, treatment and disposal options for the various categories of E&P waste.

Synopsis

1. E&P Waste Will be Transported With Identification

Each load of E&P waste transported from the site of generation to a commercial facility for disposal will be accompanied by an Oilfield Waste Shipping Control Ticket (Form UIC-28) and presented to the operator before offloading. Copies of completed Form UIC-28 are required to be timely filed with the Office of Conservation.

Produced water, produced formation fresh water and other E&P waste fluids are exempt from certain provisions of the testing requirements provided they are:

- 1) transported in enclosed tank trucks, barges, or other enclosed containers;
- 2) stored in enclosed tanks at a commercial facility;
- and
- 3) disposed by deepwell injection.

Such provision is reasonable because, provided the above conditions are met, exposure to the public and to the environment would be minimal.

2. Each Load of E&P Waste Will Be Tested At Commercial Facility

Before offloading at a commercial E&P waste disposal facility and in order to verify that the waste qualifies for the E&P category, each load of E&P waste shall be sampled for required parameters. Additionally, the presence and concentration of BTEX (benzene, toluene, ethyl benzene and xylene) compounds and hydrogen sulfide must be determined. Appropriate records of tests shall be kept at each commercial facility for review by the Office of Conservation.

3. Identification of Acceptable Storage, Treatment and Disposal Methods (Options) for E&P Waste

It is required that all offsite storage, treatment and disposal methods for E&P waste utilize approved technologies that are protective of public health and the environment. This Fifth Emergency Rule requires that

injection in Class II wells, after storage in a closed system, shall be utilized for Waste Types 01 and 14. The remainder of the E&P waste types are currently under study to confirm acceptable storage, treatment and disposal methods. Any additional acceptable storage, treatment and disposal methods will be promulgated in the near future.

Reasons

Recognizing the potential advantages of a testing program that is fully protective of public health and the environment and that adequately characterizes such waste as to its potentially toxic constituents, and by the identification of acceptable storage, treatment and disposal methods for certain types of E&P waste, it has been determined that failure to establish such procedures and requirements in the form of an administrative rule may lead to the existence of an imminent peril to the public health, safety and welfare of the people of the State of Louisiana, as well as the environment generally.

Protection of the public and our environment therefore requires the Commissioner of Conservation to take immediate steps to assure that adequate testing is performed and acceptable storage, treatment and disposal methods for certain types of E&P waste are employed at commercial facilities. The Emergency Rule, Amendment to Statewide Order No. 29-B (Emergency Rule) set forth hereinafter, is now adopted by the Office of Conservation.

Title 43

NATURAL RESOURCES

Part XIX. Office of Conservation - General Operations

Subpart 1. Statewide Order No. 29-B

Chapter 1. General Provisions

§129. Pollution Control

M. Off-site Storage, Treatment and/or Disposal of E &P Waste Generated From Drilling and Production of Oil and Gas Wells

1. Definitions

Commercial Facility—a legally permitted waste storage, treatment and/or disposal facility which receives, treats, reclaims, stores, or disposes of exploration and production waste for a fee or other consideration, and shall include the term "transfer station".

Exploration and Production (E&P) Waste—drilling fluids, produced water, and other waste associated with the exploration, development, or production of crude oil or natural gas and which is not regulated by the provisions of the Louisiana Hazardous Waste Regulations and the Louisiana Solid Waste Regulations. Such wastes include, but are not limited to, the following:

Waste Type	Waste Description
01	salt water (produced brine or produced water), except for salt water whose intended and actual use is in drilling, workover or completion fluids or in enhanced mineral recovery operations
02	oil-base drilling mud and cuttings
03	water-base drilling mud and cuttings
04	workover and completion fluids
05	production pit sludges
06	production storage tank sludges

07	produced oily sands and solids
08	produced formation fresh water
09	rainwater from ring levees and pits at production and drilling facilities
10	washout water generated from the cleaning of containers that transport E&P waste and are not contaminated by hazardous waste or material
11	washout pit water and solids from oilfield related carriers that are not permitted to haul hazardous waste or material
12	natural gas plant processing (E&P) waste which is or may be commingled with produced formation water
13	waste from approved salvage oil operators who only receive oil (BS&W) from oil and gas leases
14	pipeline test water which does not meet discharge limitations established by the appropriate state agency, or pipeline pigging waste, i.e., waste fluids/solids generated from the cleaning of a pipeline
15	wastes from permitted commercial facilities
16	crude oil spill clean-up waste
50	salvageable hydrocarbons
99	other approved E&P waste

NOW—exploration and production waste

* * *

M.2. - 5. ...

i. Receipt, Sampling and Testing of E&P Waste

i. ...

ii. Testing Requirements

(a). Before offloading E&P waste at a commercial facility, including a transfer station, each load of E&P waste shall be sampled and analyzed by commercial facility personnel for the following:

(i). pH, electrical conductivity (EC - mmhos/cm) and chloride (Cl) content; and

(ii). The presence and concentration of BTEX (benzene, toluene, ethyl benzene, and xylene) compounds using an organic vapor monitor or other procedures sufficient to identify and quantify BTEX;

(iii). The sample temperature (degrees Fahrenheit) representing actual testing conditions of the sample obtained for BTEX analysis by methodology that will assure sufficient accuracy; and

(iv). The presence and concentration of hydrogen sulfide (H₂S) using a portable gas monitor.

(b). The commercial facility operator shall enter the pH, electrical conductivity, chloride (Cl) content, BTEX, BTEX sample temperature and hydrogen sulfide measurements on the manifest (Form UIC-28) which accompanies each load of E&P waste.

(c). Produced water, produced formation fresh water, and other E&P waste fluids are exempt from organic vapor monitoring measurement (BTEX), and the H₂S measurement in (a) above if the following conditions are met:

(i). if transported by the generator or transporter in enclosed tank trucks, barges, or other enclosed containers; and

(ii). if stored in an enclosed container at a commercial facility; and

(iii). if disposed by deep well injection.

(d). Records of these tests shall be kept on file at each commercial facility for a period of three years and be available for review by the Commissioner or his designated representative. Copies of completed Form UIC-28 shall be filed with the Office of Conservation as provided in 129.M.6.d.

M.5.i.iii - 5.l. ...

m. It is required that all offsite storage, treatment and disposal methods for E&P waste utilize approved technologies that are protective of public health and the environment. The following chart includes acceptable and required storage, treatment and disposal methods for each type of E&P waste disposed of at commercial facilities within the State of Louisiana:

Waste Type	Required Storage, Treatment and Disposal Method(s)
01	Injection in Class II well utilizing a closed system
02	(reserved)
03	(reserved)
04	(reserved)
05	(reserved)
06	(reserved)
07	(reserved)
08	(reserved)
09	(reserved)
10	(reserved)
11	(reserved)
12	(reserved)
13	(reserved)
14	Pipeline test water - Injection in Class II well utilizing a closed system Pipeline pigging waste - (reserved)
15	(reserved)
16	(reserved)
50	Commercial salvage oil facility
99	(reserved)

M.6. - S. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30.4 et seq.

HISTORICAL NOTE: Adopted by the Department of Conservation (August 1943), promulgated by the Department of Natural Resources, Office of Conservation, LR 6:307 (July 1980), amended LR 8:79 (February 1982), LR 9:337 (May 1983), LR 10:210 (March 1984), LR 12:26 (January 1986), LR 16:855 (October 1990), LR 17:382 (April 1991), LR 25:

Summary

The Emergency Rule hereinabove adopted evidences the finding of the Commissioner of Conservation that failure to adopt the above rules may lead to an imminent risk to public health, safety and welfare of the citizens of Louisiana, and that there is not time to provide adequate notice to interested parties. However, the Commissioner of Conservation notes again that a copy of the permanent Amendment to Statewide Order No. 29-B will be developed in the immediate future, with a public hearing to be held as per the requirements of the Administrative Procedure Act.

The Commissioner of Conservation concludes that the above Emergency Rule will better serve the purposes of the Office of Conservation as set forth in Title 30 of the Revised Statutes, and is consistent with legislative intent. The adoption of the above Emergency Rule meets all the requirements provided by Title 49 of the Louisiana Revised Statutes. The adoption of the above Emergency Rule is not intended to affect any other provisions, rules, orders, or

regulations of the Office of Conservation, except to the extent specifically provided for in this Emergency Rule.

Within five days from date hereof, notice of the adoption of this Emergency Rule shall be given to all parties on the mailing list of the Office of Conservation by posting a copy of this Emergency Rule with reasons therefor to all such parties. This Emergency Rule with reasons therefor shall be published in full in the *Louisiana Register* as prescribed by law. Written notice has been given contemporaneously herewith notifying the Governor of the State of Louisiana, the attorney general of the State of Louisiana, the Speaker of the House of Representatives, the President of the Senate and the State Register of the adoption of this Emergency Rule and reasons for adoption.

Effective Date and Duration

1. The effective date for this emergency rule shall be May 29, 1999.
2. The Emergency Rule herein adopted as a part thereof, shall remain effective for a period of not less than 120 days hereafter, or until the adoption of the final version of an Amendment to Statewide Order No. 29-B as noted herein, whichever occurs first.

Signed at Baton Rouge, Louisiana, this 1st day of June, 1999.

Philip N. Asprodites
Commissioner

9906#022

Rules

RULE

Department of Agriculture and Forestry Office of Animal Health Services Livestock Sanitary Board

Livestock Auction Market Requirements (LAC 7:XXI.305-311)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., The Department of Agriculture and Forestry, Office of the Commissioner adopts regulations governing livestock auction market requirements. These rules comply with and are enabled by R.S. 3:2093, R.S. 3:2221, and R.S. 3:2228.

Title 7

AGRICULTURE AND ANIMALS

Part XXI. Diseases of Animals

Chapter 3. Cattle

§305. Brucellosis Vaccination and Fee

A. - C. ...

D. All heifer calves between 4 and 12 months of age not vaccinated for brucellosis which are to be sold through an approved livestock auction market must be vaccinated with USDA approved brucellosis vaccine prior to being sold. There shall be a fee to be paid by the seller of \$2 for each heifer calf required to be vaccinated for brucellosis, which fee shall be known as the brucellosis vaccination fee. The brucellosis vaccination fee shall be collected on the date of the sale from the seller by the approved livestock auction market and forwarded to the Louisiana Department of Agriculture and Forestry no later than the tenth day of the month following the month in which the fee was collected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2221 and R.S. 3:2223.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 15:75 (February 1989), amended LR 22:960 (October 1996), LR 25:1083 (June 1999).

§307. Livestock Auction Market Requirements

A. - A.1.c.iv. ...

d. All heifer calves, between 4 and 12 months of age not vaccinated for brucellosis must be vaccinated with USDA approved Brucellosis vaccine prior to being sold. Failure to accomplish this vaccination shall be a violation of this regulation and violators shall be subject to penalties which may be imposed by the Louisiana Livestock Sanitary Board as granted in R.S. 3:2093.

d.i. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2093, R.S. 3:2221, and R.S. 3:2228.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Livestock Sanitary Board, LR 11:237 (March 1985), amended LR 11:615 (June 1985), amended LR 12:501 (August 1986), LR 12:598 (September 1986), LR 13:556 (October 1987), LR 14:220 (April 1988), LR 14:695 (October 1988), LR 15:813 (October 1989), LR 17:30 (January 1991), LR 18:837 (August

1992), amended LR 22:960 (October 1996), LR 25:1083 (June 1999).

§309. Governing the Sale of Cattle in Louisiana by Livestock Dealers

A. - 2.b.ii. ...

3.a. All heifer calves between 4 and 12 months of age must be vaccinated with USDA approved Brucellosis vaccine prior to being sold. Failure to accomplish this vaccination shall be a violation of this regulation and violators shall be subject to penalties which may be imposed by the Louisiana Livestock Sanitary Board as granted in R.S. 3:2093.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:562, R.S. 3:2221 and R.S. 3:2228.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 11:237 (March 1985), LR 11:651 (June 1985), amended LR 12:502 (August 1986), LR 13:558 (October 1987), LR 14:221 (April 1988), LR 17:31 (January 1991), LR 18:838 (August 1992), LR 22:960 (October 1996), LR 25:1083 (June 1999).

§311. Governing the Sale of Purchases, within Louisiana, of All Livestock not Governed by Other Regulations (Brucellosis Requirements)

A. ...

1. Heifer calves 4 to 12 months of age, must be official brucellosis calfhood vaccinates to be eligible to be sold other than to slaughter or to a quarantined feedlot.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2093, R.S. 2221 and R.S. 3:2228.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Livestock Sanitary Board, LR 11:238 (March 1985), LR 11:615 (June 1985), amended 12:502 (August 1986), LR 13:559 (October 1987), LR 17:31 (January 1991), LR 18:837 (August 1992), LR 25:1083 (June 1999).

Bob Odom

Commissioner

9906#021

RULE

Department of Economic Development Office of the Secretary Division of Economically Disadvantaged Business Development

Economically Disadvantaged Business Development Program—Eligibility Requirements (LAC 19:II.107)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Department of Economic Development, Office of the Secretary, Division of Economically Disadvantaged Business Development, hereby promulgates amendments of changes to its rules relative to the

**Title 19
CORPORATIONS AND BUSINESS
Part II. Economically Disadvantaged Business
Development Program**

Chapter 1. General Provisions

§107. Eligibility Requirements for Certification

A. - B. ...

1. - 2. ...

3. Net Worth. Each individual owner's net worth may not exceed \$200,000. The market value of individual owner's personal residence will be excluded from the networth calculation.

4. ...

C.1. - 6. ...

7. Diminished Capital and Credit

a. A firm will be considered to have diminished capital and credit if its ability to compete in the free enterprise system has been impaired due to diminished capital and credit opportunities as compared to other firms in the same or similar line of business, and whose diminished opportunities have precluded, or are likely to preclude, such firm from successfully competing in the open market. Examples of diminished capital and credit are lack of access to long-term financing or credit, working capital financing, equipment trade credit, raw materials, supplier trade credit, and bonding. The applicant must furnish documentation that credit was denied. An applicant firm that scores poorly on all financial measurements published by the Robert Morris Associates for liquidity, leverage, operating efficiency, and profitability is considered to be economically disadvantaged. Factors to be considered are:

7.a.i. - D.6 ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1751,1752, and 1754.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, Division of Economically Disadvantaged Business Development, LR 23:50 (January 1997), amended LR 24:430 (March 1998), LR 25:1084 (June 1999).

Henry J. Stamper
Executive Director

9906#029

RULE

Board of Elementary and Secondary Education

Bulletin 741—Accountability System (LAC 28:I.901)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education adopted an amendment to Bulletin 741, referenced in LAC 28:I.901.A, promulgated by the Board of Elementary and Secondary Education in LR 1:483 (November 1975). The amendment adds the School Accountability System as a part of Bulletin 741.

**Title 28
EDUCATION**

**Part I. Board of Elementary and Secondary Education
Chapter 9. Bulletins, Regulations, and State Plans
Subchapter A. Bulletins and Regulations
§901. School Approval Standards and Regulations**

A. Bulletin 741

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

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education LR 1:483 (November 1975), amended by the Board of Elementary and Secondary Education LR 24:1085 (June 1998), LR 25:1084 (June 1999).

Bulletin 741

Louisiana Handbook for School Administrators

I. Preface

A. The Louisiana Public Education Accountability system is intended to drive fundamental changes in classroom teaching by helping schools and communities focus on improved student achievement. The system is designed to encourage and support school improvement by:

- 1. clearly establishing the state's goals for schools and students;
- 2. creating an easy way to communicate to schools and the public how well a school is performing;
- 3. recognizing schools for their effectiveness in demonstrating growth in student achievement; and
- 4. focusing attention, energy, and resources on those schools that need help improving student achievement.

B. The accountability system is based on the concept of continuous growth. Every school can improve. Every school is expected to show academic growth. Every school is compared to itself.

1. The underlying beliefs of the accountability system are:

- a. all students can and must learn at significantly higher levels;
- b. the need to improve student achievement is urgent;
- c. continuous growth in student achievement must occur in all schools;
- d. the focus must be on measurable student achievement results;
- e. poverty impacts student learning; however, it does not prevent students from achieving;
- f. low-performing schools must receive technical assistance and necessary resources to improve;
- g. rewards and corrective actions can motivate educators, communities, and students to improve student learning;
- h. parents, educators, and community members should be involved in the ongoing development and revision of school and district improvement plans;
- i. districts and school sites must have the flexibility to improve learning in schools;
- j. the general public must be kept involved in and informed about the accountability process;

k. it is essential that all stakeholders (i.e., students, parents, educators, and community) work together to reach the state education goals;

l. the accountability system must be kept simple;

m. the State must provide adequate funding to support the accountability system and not back down on funding or standards once instituted.

2.006.00 Every School shall participate in a school accountability system based on student achievement as approved by the State Board of Elementary and Secondary Education.

Refer to R.S. 17:10.1

Indicators for School Performance Scores

2.006.01 A school's School Performance Score shall be determined using a weighted composite index derived from three or four indicators: criterion-referenced tests (CRT), norm-referenced tests (NRT), and student attendance for grades K-12, and dropout rates for grades 7-12.

Louisiana's 10- and 20-Year Education Goals

2.006.02 Each school shall be expected to reach 10- and 20-Year Goals that depict minimum educational performances.

Indicators	Grades Administered	10-Year Goal	20-Year Goal
CRT Tests (60 percent K-12)	Grades 4, 8, 10, 11	Average student score at BASIC	Average student score at PROFICIENT
NRT Tests (30 percent K-12)	Grades 3, 5, 6, 7, 9	Average composite standard score corresponding to the 55th percentile rank in the tested grade level	Average composite standard score corresponding to the 75th percentile rank in the tested grade level
Attendance (10 percent K-6; 5 percent 7-12)		95 percent (grades K-8) 93 percent (grades 9-12)	98 percent (grades K-8) 96 percent (grades 9-12)
Dropout Rate (5 percent 7-12)		4 percent (grades 7-8) 8 percent (grades 9-12)	2 percent (grades 7-8) 4 percent (grades 9-12)

School Performance Scores

2.006.03 A School Performance Score (SPS) shall be calculated for each school. This score shall range from 0-100 and beyond, with a score of 100 indicating a school has reached the 10-Year Goal and a score of 150 indicating a school has reached the 20-Year Goal. The lowest score that a given school can receive for each individual indicator index and/or for the SPS as a whole is "0."

Every year of student data shall be used as part of a school's SPS. The initial school's SPS shall be calculated using the most recent year's NRT and CRT test data and the prior year's attendance and dropout rates. Subsequent calculations of the SPS shall use the most recent two years' test data and attendance and dropout rates from the two years prior to the last year of test data used.

A baseline School Performance Score shall be calculated in Spring 1999 for Grades K-8 and in Spring 2001 for Grades 9-12.

During the summer of 1999 for K-8 schools and summer of 2001 for 9-12 schools, each school shall receive two School Performance Scores as follows:

- A score for regular education students, including gifted, talented, speech or language impaired, and 504 students.
- A score including regular education students AND students with disabilities eligible to participate in the CRT and/or NRT tests.
- For the purpose of determining Academically Unacceptable Schools, during the summer of 1999 for K-8 schools and during the summer of 2001 for 9-12 schools, the School Performance Score that includes only regular education students shall be used.

Formula for Calculating an SPS

The SPS for a sample school is calculated by multiplying the index values for each indicator by the weight given to that indicator and adding the total scores. In the example, [(66.0 * 60 percent) + (75.0 * 30 percent) + (50.0 * 10 percent)] = 67.1

Indicator	Index Value	Weight	Indicator Score
CRT	66.0	60 percent	39.6
NRT	75.0	30 percent	22.5
Attendance	50.0	10 percent	5.0
Dropout	N/A	0 percent	0
			SPS = 76.1

Criterion-Referenced Tests (CRT) Index Calculations

A school's CRT Index score equals the sum of the student totals divided by the number of student eligible to participate in state assessments. For the CRT Index, each student who scores within one of the following five levels shall receive the number of points indicated.

Advanced =	200 points
Proficient =	150 points
Basic =	100 points
Approaching Basic =	50 points
Unsatisfactory =	0 points

Formula for Calculating a CRT Index for a School

1. Calculate the total number of points by multiplying the number of students at each performance level times the points for those respective performance levels, for all content areas.
2. Divide by the total number of students eligible to be tested times the number of content area tests.
3. Zero shall be the lowest CRT Index score reported for accountability calculations.

Initial Transition Years

To accommodate the phase-in of Social Studies and Science tests for K-8 schools, the following CRT scores shall be used for each year:

1999 Baseline CRT Score =	1999 Math and English Language Arts (Grades 4 and 8)
2001 Comparison CRT Score =	2000 and 2001 Math and English Language Arts (both years averaged for each subject and each grade)
2001 <i>New</i> Baseline CRT Score =	2000 and 2001 Math, English, Social Studies, and Science (both years averaged for each subject and each grade)
2003 Comparison CRT Scores =	2002 and 2003 Math, English, Social Studies, and Science (both years averaged for each subject and each grade)

This re-averaging shall result in a re-calculated baseline to include science and social studies for K-8 schools in 2001. A similar schedule shall be used for 9-12 schools to begin with a 2001 baseline year.

<p>Norm-Referenced Tests (NRT) Index Calculations For the NRT Index, standard scores shall be used for computing the SPS. Index scores for each student shall be calculated, scores totaled, and then averaged together to get a school's NRT Index score.</p>						
<i>NRT Goals and Equivalent Standard Scores</i>						
Composite Standard Scores Equivalent to Louisiana's 10- and 20-Year Goals, by Grade Level *						
Grade						
Goals	Percentile Rank	3	5	6	7	9
10-Year Goal	55th	189	220	232	245	264
20-Year Goal	75th	201	237	252	267	288
* Source of percentile rank-to-standard score conversions: <i>Iowa Tests of Basic Skills, Norms and Score Conversions, Form M (1996) and Iowa Test of Educational Development, Norms and Score Conversions, with Technical Information, Form M (1996), Chicago, IL: Riverside Publishing Company.</i>						

<p>NRT Formulas Relating Student Standard Scores to NRT Index Where the 10-year and 20-year goals are the 55th and 75th percentile ranks respectively and where SS = a student's standard score, then the index for that student is calculated as follows:</p>	
Grade 3:	Index 3rd grade = $(4.167 * SS) - 687.6$ SS = $(\text{Index 3rd grade} + 687.6)/4.167$
Grade 5:	Index 5th grade = $(2.941 * SS) - 547.0$ SS = $(\text{Index 5th grade} + 547.0)/2.941$
Grade 6:	Index 6th grade = $(2.500 * SS) - 480.0$ SS = $(\text{Index 6th grade} + 480.0)/2.500$
Grade 7:	Index 7th grade = $(2.273 * SS) - 456.9$ SS = $(\text{Index 7th grade} + 456.9)/2.273$
Grade 9:	Index 9th grade = $(2.083 * SS) - 449.9$ SS = $(\text{Index 9th grade} + 449.9)/2.083$

<p>Formula for Calculating a School's NRT Index</p> <ol style="list-style-type: none"> Calculate the index for each student, using the grade-appropriate formula relating standard score to NRT Index. Compute the total number of index points in all grades in the school. Divide the sum of NRT Index points by the total number of students eligible to be tested. Zero shall be the lowest NRT Index score reported for accountability calculations.

<p>Attendance Index Calculations An Attendance Index score for each school shall be calculated. The initial year's index shall be calculated from the prior year's attendance rates. Subsequent years' indices shall be calculated using the prior two years' average attendance rates as compared to the state goals.</p>		
<i>Attendance Goals</i>		
	10-Year Goal	20-Year Goal
Grades K-8	95 percent	98 percent
Grades 9-12	93 percent	96 percent
<p>Attendance Index Formulas Grades K-8 Indicator (ATT K-8) = $(16.667 * ATT) - 1483.4$ Grades 9-12 Indicator (ATT 9-12) = $(16.667 * ATT) - 1450.0$ Where ATT is the attendance percentage, using the definition of attendance established by the State Department of Education</p>		

<p>Lowest Attendance Index Score Zero shall be the lowest Attendance Index score reported for accountability calculations.</p>
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<p>Dropout Index Calculations A Dropout Index score for each school shall be calculated. The initial year's index shall be calculated from the prior year's dropout rates. Subsequent years' indices shall be calculated using the prior two year's average dropout rates as compared to the state goals.</p>		
<i>Dropout Goals</i>		
	10-Year Goal	20-Year Goal
Grades 7 and 8	4 percent	2 percent
Grades 9-12	8 percent	4 percent

<p>Dropout Index Formulas Non-Dropout Rate (NDO) = 100 - Dropout Rate (DO) (expressed as a percentage)</p>	
Grades 7 and 8	Dropout Index (7-8) = Indicator (DO Gr 7-8) = $(25 * NDO) - 2300.0$ NDO = $(\text{Indicator DO Gr 7-8} + 2300.0) / 25$
Grades 9-12	Dropout Index (9-12) = Indicator (DO Gr 9-12) = $(12.5 * NDO) - 1050.0$ NDO = $(\text{Indicator DO Gr 9-12} + 1050.0) / 12.5$
<p>Lowest Dropout Index Score Zero shall be the lowest Dropout Index score reported for accountability calculations.</p>	

Data Collection

2.006.04 A test score shall be entered for all eligible students within a given school. For any eligible student who does not take the test, including those who are absent, a score of "0" on the CRT and NRT shall be calculated in the school's SPS. To assist a school in dealing with absent students, the State Department of Education shall provide an extended testing period for test administration. The only exception to this policy is a student who was sick during the test and re-testing periods AND who has formal medical documentation for that period.

Growth Targets

2.006.05 Each school shall receive a Growth Target that represents the amount of progress it must make every two years to reach the state 10- and 20-Year Goals.

In establishing each school's Growth Target, the SPS inclusive of students with disabilities shall be used as the baseline. However, the percentage of students with disabilities varies significantly across schools and the rate of growth for such students, when compared to regular education students, may be different. Therefore, the proportion of students with disabilities eligible to participate in the CRT or NRT test in each school will be a factor in determining the Growth Target for each school.

Growth Targets

During the first ten years, the formula is the following:
[PropRE * (100 - SPS)/N] + [PropSE * (100 - SPS)/2N], or 5 points,
whichever is greater
where

PropSE = the number of special education students in the school who are eligible to participate in the NRT or CRT tests, divided by the total number of students in the school who are eligible to participate in the NRT or CRT tests. For purposes of this calculation, gifted, talented, speech or language impaired, and 504 students shall not be counted as special education students, but shall be included in the calculations as regular education students.

PropRE = 1-PropSE. PropRE is the proportion of students not in special education.

SPS = School Performance Score

N = Number of remaining accountability cycles in the 10-Year Goal period

During the second ten years, the formula is the following:

[PropRE * (150 - SPS)/N] + [PropSE * (150 - SPS)/2N], or 5 points,
whichever is greater

Growth Labels

2.006.06 A school shall receive a label based on its success in attaining its Growth Target.

Growth Labels

A school exceeding its Growth Target by 5 points or more shall receive a label of *Exemplary Academic Growth*.

A school exceeding its Growth Target by fewer than 5 points shall receive a label of *Recognized Academic Growth*.

A school improving, but not meeting its Growth Target, shall receive a label of *Minimal Academic Growth*.

A school with a flat or declining SPS shall receive a label of *School in Decline*.

When a school's SPS is greater than or equal to the state goal, "Minimal Academic Growth" and "School in Decline" labels shall no longer apply.

Performance Labels

2.006.07 A Performance Label shall be given to a school that qualifies, in addition to Growth Labels.

A school with an SPS of 30 or below shall be identified as an Academically Unacceptable School. This school immediately enters Corrective Actions.

For purpose of determining Academically Unacceptable Schools, during the summer of 1999 for K-8 schools and during the summer of 2001 for 9-12 schools, the SPS that includes only regular education students shall be used. Any school with an SPS of 30 or less, based on the test scores of regular education students only, shall be deemed an Academically Unacceptable School.

A school with an SPS of 100.0 - 124.9 shall be labeled a *School of Academic Achievement*.

A school with an SPS of 125.0 - 149.9 shall be labeled a *School of Academic Distinction*.

A school with an SPS of 150.0 or above shall be labeled a *School of Academic Excellence* and shall have no more Growth Targets.

A school with these labels shall no longer be subject to Corrective Actions and shall not receive "negative" growth labels, i.e., School in Decline and Minimal Academic Growth. This school shall continue to meet or exceed Growth Targets to obtain "positive" growth labels, recognition, and possible rewards.

Rewards/Recognition

2.006.08 A school shall receive recognition and possible monetary awards when it meets or surpasses its Growth Targets and when it shows growth in the performance of students who are classified as high poverty.

School personnel shall decide how any monetary awards shall be spent; however, possible monetary rewards shall not be used for salary or stipends. Other forms of recognition shall also be provided for a school that meets or exceeds its Growth Targets.

Corrective Actions

2.006.09 A school that does not meet its Growth Target shall enter into Corrective Actions. A school that enters Corrective Actions shall receive additional support and assistance, with the expectation that extensive efforts shall be made by students, parents, teachers, principals, administrators, and the school board to improve student achievement at the school. There shall be three levels of Corrective Actions.

Corrective Actions Level I: Working with District Assistance Teams, a school shall utilize a state diagnostic process to identify school needs, redevelop school improvement plans, and examine the use of school resources.

Corrective Actions Level II: A highly trained Distinguished Educator (DE) shall be assigned to a school by the state. The DE shall work in an advisory capacity to help the school improve student performance. The DE shall make a public report to the school board of recommendations for school improvement. Districts shall then publicly respond to these recommendations. If a school is labeled as Academically Unacceptable, parents shall have the right to transfer their child to a higher performing public school (See Transfer Policy Standard Number 2.006.11).

Corrective Actions Level III: The DE shall continue to serve the school in an advisory capacity. Parents shall have the right to transfer their child to a higher performing public school (See Transfer Policy, Standard Number 2.006.11). A district must develop a Reconstitution Plan for the school at the beginning of the first year in this level and submit the plan to SBESE for approval.

If a Corrective Actions Level III school has achieved at least 40 percent of its Growth Target or 5 points, whichever is greater, during its first year, then that school may proceed to a second year in Level III. If such minimum growth is not achieved during the first year of Level III, but SBESE has approved its Reconstitution Plan, then the school shall implement the Reconstitution Plan during the beginning of the next school year. If SBESE does not approve the Reconstitution Plan AND a given school does not meet the required minimum growth, the school shall lose state approval and all state funds.

Any reconstituted School's SPS and Growth Target shall be re-calculated utilizing data from the end of its previous year. SBESE shall monitor the implementation of the Reconstitution Plan.

A school initially enters Corrective Actions Level I if it has an SPS of 30 or less or if it has an SPS of less than 100 and fails to reach its Growth Target.

A school moves into a more intensive level of Corrective Actions when adequate growth is not demonstrated during each 2-year cycle.

A school with an SPS of 30 or less, i.e., Academically Unacceptable School, shall move to the next level of Corrective Actions as long as its score is 30 or less.

A school with an SPS of 30.1 to 50.0 shall move to the next level of Corrective Actions if it grows fewer than 5 points. If it grows 5 points or more each cycle, but less than its Growth Target, a school may remain in Corrective Actions Level I for two cycles and Corrective Actions Level II for one cycle.

A school with an SPS of 50.1 to 99.9 shall remain in Corrective Actions Level I as long as its growth is at least its Growth Target minus 5 points, but not less than 0.1 points. During the first 10-year cycle, there is no maximum number of cycles that such a school can stay in Level I as long as this minimum growth is shown each cycle.

A school exits Corrective Actions if its School Performance Score is above 30 and the school achieves its Growth Target.

Corrective Actions Summary Chart

School Level Tasks

Level I

- 1) Utilize state diagnostic process to identify needs; and
- 2) Develop/implement a consolidated improvement plan, including an integrated budget; process must include: a) opportunities for significant parent and community involvement, b) public hearings, and c) at least two-thirds teacher approval

Level II

- 1) Work with advisory Distinguished Educator, teachers, parents, and others to implement revised School Improvement Plan; and
- 2) Distinguished Educator works with principals to develop capacity for change

Level III

- 1) Distinguished Educator continues to assist with improvement efforts and the design of that school's Reconstitution Plan

Reconstitution or No State Approval/No Funding

- 1) If Reconstitution Plan is approved by SBESE: a) implement Reconstitution Plan, and b) utilize data from the end of the previous year to re-calculate school performance goals and Growth Targets. If Reconstitution Plan is not approved, no state approval/no state funding

District Level Tasks

Level I

- 1) Create District Assistance Teams to assist schools;
- 2) Publicly identify existing and additional assistance being provided by districts, such as funding, policy changes, and greater flexibility;
- 3) As allowed by law, reassign or remove school personnel as necessary; and
- 4) For Academically Unacceptable schools, ensure schools receive at least their proportional share of applicable state, local, and federal funding.

Level II

- 1) District Assistance Teams continue to help schools;
- 2) Hold public hearing and respond to Distinguished Educators' written recommendations;
- 3) As allowed by law, local boards reassign or remove personnel as necessary; and
- 4) For Academically Unacceptable Schools, authorize parents to send their children to other public schools

Level III

- 1) District Assistance Teams shall continue to help schools;
- 2) Authorize parents to send their children to other public schools;
- 3) Design Reconstitution Plan; and
- 4) At the end of year one, one of the following must occur: a) schools must make adequate growth of at least 40 percent of the Growth Target or 5 points, whichever is greater; b) District shall develop Reconstitution Plan to be approved by SBESE; and c) SBESE grants non-school approval status

Reconstitution or No State Approval/Funding

- 1) If Recommendation Plan is approved by SBESE, provide implementation support. If the Reconstitution Plan is not approved, no state approval/no state funding

State Level Tasks

Level I

- 1) Provide diagnostic process for schools;
- 2) Provide training for District Assistance Teams;
- 3) For some Academically Unacceptable Schools only, SBESE assigns advisory Distinguished Educators to schools; and
- 4) Work to secure new funding and/or redirect existing resources to help schools implement their improvement plans

Level II

- 1) Assign advisory Distinguished Educator to schools; and
- 2) Work to secure new funding and/or redirect existing resources to help schools implement their improvement plans

Level III

- 1) Assign advisory Distinguished Educator to schools for one additional year;
- 2) At end of Year 1, SBESE approves or disapproves Reconstitution Plans; and
- 3) Work to secure new funding and/or redirect existing resources to help schools implement their improvement plans

Reconstitution or No State Approval/No Funding

- 1) If Reconstitution Plan is approved by SBESE, a) monitor implementation of reconstitution plan; and b) provide additional state improvement funds; and
- 2) If Reconstitution Plan is not approved, no state approval/state funding

Reconstitution Plan

2.006.10 Districts shall develop and submit a Reconstitution Plan to SBESE for approval for any school in Correction Actions Level III during the first year in that level. This Reconstitution Plan indicates how the district shall remedy the school's inadequate growth in student performance. The plan shall specify how and what reorganization shall occur and how/why these proposed changes shall lead to improved student performance.

If a Corrective Actions Level III school has grown at least 40 percent of its Growth Target or 5 points, whichever is greater, during its first year, then that school may continue another year in Level III. If such minimum growth is not achieved during the first year, but SBESE has approved its Reconstitution Plan, then the school shall implement the Reconstitution Plan during the beginning of the next school year. If SBESE does not approve the Reconstitution Plan AND a given school does not meet the required minimum growth, it shall lose state approval and all state funds.

Transfer Policy

2.006.11 Parents shall have the right to transfer their child to another public school when an Academically Unacceptable School begins Correction Actions Level II or any other school begins Correction Actions Level III.

Transfers shall not be made to Academically Unacceptable Schools or any school undergoing Corrective Actions Level II or Level III.

Upon parental request, districts shall transfer the child to the nearest acceptable school prior to the October 1 student membership count.

If no academically acceptable school in the district is available, the student may transfer to a neighboring district. Parents shall provide the transportation to the school. State dollars shall follow the child when such a transfer occurs.

Schools and districts may refuse to accept a student if there is insufficient space, if a desegregation order prevents such a transfer, or if the student has been subjected to disciplinary actions for behavioral problems.

Progress Report

2.006.12 The SBESE shall report annually on the state's progress in reaching its 10- and 20-Year Goals. The State Department of Education shall publish an individual School Report Card to provide information on every school's performance. The School Report Card shall include the following information: School Performance Scores, school progress in reaching Growth Targets, school performance when compared to similar (like) schools, and subgroup performances.

Appeals Procedures

2.006.13 The State Department of Education shall define "appeal" what may be appealed, and the process that the appeal shall take.

Student Mobility

2.006.14 As a general rule, the test score of every eligible student who takes a test at a given school shall be included in that school's performance score regardless of how long that student has been enrolled in that school. A school that has at least 10 percent of its students transferring from outside the district and enrolled in the school after October 1 may request that the State Department of Education calculate what its SPS would have been if such out-of-district enrollees had not been included. If there is at least a 5 point difference between the two School Performance Scores, then the school may appeal any negative accountability action taken by the state, e.g., movement into Corrective Actions, application of growth labels.

Pairing/Sharing of Schools with Insufficient Test Data

2.006.15 In order to receive an SPS, a given school must have at least one grade level of CRT testing and at least one grade level of NRT testing. A school that does not meet this requirement must either be "paired or shared" with another school in the district as described below. For the purpose of the State Accountability System, such a school shall be defined as a "non-standard school."

A school with a grade-level configuration such that it participates in neither the CRT test nor in the NRT test (e.g., a K, K-1, K-2 school) must be "paired" with another school that has at least one grade level of CRT testing and one grade level of NRT testing. This "pairing" means that a single SPS shall be calculated for both schools by averaging both schools' attendance and/or dropout data and using the test score data derived from the school that has at least two grade levels of testing.

A school with a grade-level configuration where students participate in either CRT or NRT testing, but not both (e.g., a K-3, 5-6 school), must "share" with another school that has at least one grade level of the type of testing missing. Both schools shall "share" the missing grade level of test data. This shared test data must come from the grade level closest to the last grade level in the non-standard school. The non-standard school's SPS shall be calculated by using the school's own attendance, dropout, and testing data AND the test scores for just one grade from the other school.

A district must identify the school where each of its non-standard schools shall be either "paired or shared." The "paired or shared" school must be the one that receives by promotion the largest percentage of students from the non-standard school. In other words, the "paired or shared" school must be the school into which the largest percentage of students "feed." If two schools receive an identical percentage of students from a non-standard school, the district shall select the "paired or shared" school.

Once the identification of "paired or shared" schools has been made, this decision is binding for 10 years. An appeal to SBESE may be made to change this decision prior to the end of 10 years, only if a redistricting or other significant attendance change occurs.

New Schools and/or Significantly Reconfigured Schools

2.006.16 For a newly formed school, the school district may petition SBESE, following existing procedures, to have a new site code assigned to that school. Once the site code is assigned, the school shall receive its initial baseline SPS the summer following its second year of operation, since it shall need two years of testing data and one year of attendance and/or dropout data.

The district may also petition SBESE for a new SPS for a school with significant reconfiguration from the previous year, where such significant reconfiguration varies at least 50 percent from the previous year's grade structure and/or size. For example, a K-4 school changes to a K-8 school, or a given school's population decreases in half or doubles in size from one year to the next. If SBESE grants a new SPS and agrees that this is a significant reconfiguration, this school would receive a new baseline SPS during the summer following its second year of operation.

A school that has population and/or grade configuration change from the previous year of less than 50 percent, but more than 25 percent, is not eligible for a new SPS. Instead, such school may appeal any state accountability decisions made as a result of not meeting its Growth Targets, e.g., movement into Corrective Actions.

Inclusion of Alternative Education Students

2.006.17 Each superintendent, in conjunction with the alternative school director, shall choose from one of two options for including alternative education students in the State Accountability System for the system's alternative education schools.

Option I The score for every alternative education student at a given alternative school shall be returned to ("sent back") and included in the home-based school's SPS. The alternative school itself shall receive a "diagnostic" SPS, not to be used for rewards or Corrective Actions, if a statistically valid number of students were enrolled in the school at the time of testing.

Option II The score for every alternative education student shall remain at the alternative school. The alternative school shall be given its own SPS and Growth Target, which makes the alternative school eligible for rewards and Corrective Actions.

In order to be eligible for Option II, an alternative school shall meet all of the following requirements:

- The alternative school must have its own site code and operate as a school;
- The alternative school must have a required minimum number of students in the tested grade levels. The definition of "required minimum" is to be determined; and
- At least fifty percent (50 percent) of the total school population must have been enrolled in the school for the entire school year, October 1 - May 1.

Once an option is selected for an alternative school, it shall remain in that option for at least 10 years. An appeal to SBESE may be made to change the option status prior to the end of 10 years if a school's purpose and/or student eligibility changes.

An alternative school that chooses Option II shall receive an initial baseline SPS during summer of 1999 if the majority of its students are in grades K-8. If the majority of its students are in grades 9-12, an alternative school shall receive its baseline SPS during the summer of 2001.

All students pursuing a regular high school diploma, working in curriculum developed from Louisiana Content Standards, shall be included in the state-testing program, with those scores included in an SPS.

Students 16 years of age and older who are enrolled in a Pre-GED program, not pursuing a regular high school diploma, shall not be included in the state-testing program nor in an SPS. Information on these students, e.g., number receiving a GED, shall be reported in the school's report card as a sub-report.

An alternative school in Corrective Actions II may request some flexibility in obtaining assistance from either a Distinguished Educator (DE) or a team designed to address the special needs of the alternative school population, as long as the total costs for the team do not exceed that for the DE. Sample team members could include the following: social workers, psychologists, educational diagnosticians, and counselors, etc.

Inclusion of Lab Schools and Charter Schools

Such schools shall be included in the State Accountability System following the same rules that apply to traditional and/or alternative schools. The only exceptions are that Lab Schools and Type 1, 2, and 3 Charter Schools are "independent" schools and cannot be "paired" or "shared" with another school if they do not have at least one CRT and one NRT grade level, and/or if there is no "home-based" district school to which a given student's scores can be returned if all three conditions for Option II cannot be met. Therefore, if they do not have the required grade levels and/or required minimum number of students, such schools cannot receive an SPS. Instead, the state shall publish the results from pre- and post-test student achievement results, as well as other relevant accountability data, as part of that school's report card. This policy is to be revisited during the year 2001.

For the 1999-2000 academic school year, detention and Department of Corrections facilities shall NOT receive an SPS.

Inclusion of Students with Disabilities

2.006.18 All students, including those with disabilities, shall participate in Louisiana's new testing program. The scores of all students who are eligible to take the CRT and the NRT tests shall be included in the calculation of the SPS. Most students with disabilities, approximately 80 percent of students with disabilities, shall take the CRT and the NRT tests with accommodations, if required by their

Individualized Education Plan (IEP). A small percentage of students with very significant disabilities, approximately 20 percent of students with disabilities, shall take an alternate assessment, as required by their IEP.

Weegie Peabody
Executive Director

9906#065

RULE

Board of Elementary and Secondary Education

Bulletin 746—Alternative Process Issuance of Permanent Regular Teacher Certificate Non-Public Schools (LAC 28:I.903)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education adopted an amendment to Bulletin 746, Louisiana Standards for State Certification of School Personnel, referenced in LAC 28:I.903.A. The amendment adds an alternative process for the issuance of a permanent regular teacher certificate for non-public school teachers.

Title 28

EDUCATION

Part I. Board of Elementary and Secondary Education
Chapter 9. Bulletins, Regulations, and State Plans
Subchapter A. Bulletins and Regulations
§903. Teacher Certification Standards and Regulations

A. Bulletin 746

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A) (10) (11) (15); R.S. 17:7 (6); R.S. 17:10, R.S. 17:22 (6) R.S. 17:391.1-391.10; R.S. 17:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education in LR 1:183, 311, 399, 435, 541 (April, July, September, October, December 1975), amended LR 24:283 (February 1998), LR 24:1091 (June 1998), LR 24:2078 (November 1998), LR 25:1090 (June 1999).

Bulletin 746—Teacher Certification Standards and Regulations

HIGHER CERTIFICATES FOR TEACHERS IN NON-PUBLIC SCHOOLS WHO HAVE NOT COMPLETED THE STATE TEACHER ASSESSMENT PROGRAM

I. Louisiana state certified teachers teaching in any approved non-public school shall be awarded a permanent teaching certificate provided they have successfully:

1. taught for three (3) years in the teacher's area of certification;

2. completed a teacher assessment program for three consecutive years at the same non-public school. This assessment shall be performed by the non-public school principal and shall, as a minimum, include satisfactory assessment of the teacher's performance in the following areas: planning, management, instruction and professional development.

The three years of teaching in the area of certification and the three consecutive years of teacher assessment may be

accomplished concurrently or during different school years. The principal of the non-public school shall certify when the above criteria have been met.

Teachers in a non-public school who have taught three consecutive years in the same non-public school and who have completed the school based teacher assessment program successfully are eligible for a "B*" certificate which is valid in non-public schools only. The asterisk behind the "B" would refer to a statement at the bottom of the certificate which reads:

If this teacher enters a public school system in Louisiana, he/she will be required to successfully complete the state teacher assessment program.

The same asterisk would appear on the "A" certificate. The accumulation of the required three (3) years of experience begins with the 1998-99 school year.

II. Any non-public school that would like for its teachers to participate in state teacher assessment will be allowed to do so.

Weegie Peabody
Executive Director

9906#063

RULE

**Student Financial Assistance Commission
Office of Student Financial Assistance**

Commission Bylaws (LAC 28:V.113)

The Louisiana Student Financial Assistance Commission (LASFAC), the statutory body created by R.S. 17:3021 et seq., in compliance with §952 of the Administrative Procedure Act, hereby revises its governing bylaws, as follows.

**Title 28
EDUCATION**

**Part V. Student Financial Assistance—Higher
Education Loan Program**

**Chapter 1. Student Financial Assistance Commission
Bylaws**

**§113. Rights Duties and Responsibilities of the
Executive Staff of the Commission**

A. - B.6. ...

7. Annually, on or before September 30, an evaluation of the executive director's job performance and compensation shall be conducted by the commission. These evaluations shall be conducted using a format adopted by the commission for these purposes. Changes to the compensation structure adopted by the commission shall be effective on July 1 of the year in which the evaluation is performed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:321.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:810 (September 1996), amended LR 24:1265 (July 1998), LR 25:1091 (June 1999).

Jack L. Guinn
Executive Director

9906#006

RULE

**Student Financial Assistance Commission
Office of Student Financial Assistance**

Tuition Opportunity Program for Students (TOPS)
Maintaining Eligibility (LAC 28:IV.705, 805, 907)

The Louisiana Student Financial Assistance Commission (LASFAC) hereby revises the provisions of the Tuition Opportunity Program for Students (TOPS), effective for TOPS recipients beginning with the spring semester, 1999.

**Title 28
EDUCATION**

**Part IV. Student Financial Assistance—Higher
Education Scholarship and Grant Programs
Chapter 7. Tuition Opportunity Program for
Students (TOPS) Opportunity;
Performance and Honors Award**

§705. Maintaining Eligibility

A.1. - 5. ...

6. continue to enroll and accept the TOPS award as a full-time undergraduate student in an eligible postsecondary institution, as defined in §1901, and maintain an enrolled status throughout the academic term, unless granted an exception for cause by LASFAC; and

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:642 (April 1998), amended LR 24:1911 (October 1998), LR 25:1091 (June 1999).

Chapter 8. TOPS-TECH Award

§805. Maintaining Eligibility

A.1. - 5. ...

6. continue to enroll and accept the TECH award as a full-time student in an eligible postsecondary institution, as defined in §1901, and maintain an enrolled status throughout the school term, unless granted an exception for cause by LASFAC; and

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:642 (April 1998), amended LR 24:1911 (October 1998), LR 25:1091 (June 1999).

Chapter 9. TOPS Teacher Award

§907. Maintaining Eligibility

A.1. - 4. ...

5. continue to enroll each subsequent semester or quarter as a full-time student in a degree program or course of study leading to a degree in education or alternative program leading to regular certification as a teacher at the elementary or secondary level, and maintain an enrolled status throughout the academic term, unless granted an exception for cause by LASFAC; or

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:642 (April 1998), amended LR 24:1911 (October 1998), LR 25:1092 (June 1999).

Jack L. Guinn
Executive Director

9906#005

RULE

**Tuition Trust Authority
Office of Student Financial Assistance**

Recording Secretary (LAC 28:VI.213)

The Louisiana Tuition Trust Authority (LATTA), the statutory body created by R.S. 17:3093 et seq., in compliance with the Administrative Procedure Act, R.S. 49:950 et seq., hereby revises its governing bylaws, as follows.

**Title 28
EDUCATION**

Part VI. Student Tuition Trust Authority

Chapter 2. Bylaws

§213. Rights, Duties and Responsibilities of Executive Staff of the Authority

A. - E. ...

F. Recording Secretary. The executive director shall appoint a recording secretary whose duties shall include giving or causing to be given notice of all meetings of the authority and its committees as required by the Administrative Procedure Act or these Bylaws, to record and prepare the minutes of all authority meetings and meetings of its committees and to maintain and provide for the safekeeping of all minutes and other official documents of the authority. The recording secretary shall have the authority to provide copies of the official records of the authority as required by the public records laws of the State of Louisiana or as otherwise directed by the authority or the executive director and to certify the authenticity of such records and the signatures of members of the authority, the executive directors or others acting in their official capacity on behalf of the authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3093 et seq.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:1657 (December 1997), amended LR 25:1092 (June 1999).

Jack L. Guinn
Executive Director

9906#007

RULE

**Department of Environmental Quality
Office of Water Resources
Water Pollution Control Division**

Procedures for Modifying Approved
POTW Pretreatment Programs
(LAC 33:IX.2715, 2721 and 2735)(WP031*)

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 has amended the Water Quality regulations, LAC 33:IX.2715, 2721, and 2735 (WP031*).

This rule is identical to a federal regulation found in 62 FR 38405-38415, Number 137, July 17, 1997, which is applicable in Louisiana. For more information regarding the federal requirement, contact the Investigations and Regulation Development Division at the address or phone number given below. No fiscal or economic impact will result from the rule; therefore, the rule will be promulgated in accordance with R.S. 49:953(F)(3) and (4).

This rule corrects typographical errors and omissions made in WP030*, which was a final rule in November 1998. These changes will equate Louisiana regulations for streamlined procedures for modifying approved pretreatment programs to the EPA federal regulations. The basis and rationale for this rule are to mirror the federal regulations.

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 IX. Water Quality Regulations
Chapter 23. The Louisiana Pollutant Discharge
Elimination System (LPDES) Program
Subchapter T. General Pretreatment Regulations for
Existing and New Sources of Pollution
§2715. Pretreatment Program Requirements:
Development and Implementation by POTW**

* * *

[See Prior Text in A - F.5.d]

6. The POTW shall prepare and maintain a list of its industrial users meeting the criteria in LAC 33:IX.2705.*Significant Industrial User*.a. The list shall identify the criteria in LAC 33:IX.2705.*Significant Industrial User*.a applicable to each industrial user and, for industrial users meeting the criteria in LAC

33:IX.2705.*Significant Industrial User*.a.ii shall also indicate whether the POTW has made a determination in accordance with LAC 33:IX.2705.*Significant Industrial User*.b that such industrial user should not be considered a significant industrial user. The initial list shall be submitted to the approval authority in accordance with LAC 33:IX.2717 as a nonsubstantial program modification in accordance with LAC 33:IX.2735.D. Modifications to the list shall be submitted to the approval authority in accordance with LAC 33:IX.2723.I.1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 24:2122 (November 1998), LR 25:1092 (June 1999).

§2721. Approval Procedures for POTW Pretreatment Programs and POTW Granting of Removal Credits

The following procedures shall be adopted in approving or denying requests for approval of POTW Pretreatment Programs and applications for removal credit authorization.

* * *

[See Prior Text in A - B.1.a]

i. mailing notices of the request for approval of the submission to designated 208 planning agencies, federal and state fish, shellfish, and wildlife resource agencies (unless such agencies have asked not to be sent the notices); and to any other person or group who has requested individual notice, including those on appropriate mailing lists; and

ii. publication of a notice of request for approval of the submission in a newspaper(s) of general circulation within the jurisdiction(s) served by the POTW that provides meaningful public notice.

* * *

[See Prior Text in B.1.b - F]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 25:1093 (June 1999).

§2735. Modification of POTW Pretreatment Programs

* * *

[See Prior Text in A - B.1]

a. modifications that relax POTW legal authorities (as described in LAC 33:IX.2715.F.1), except for modifications that directly reflect revision to the general pretreatment regulations, LAC 33:IX.Chapter 23.Subchapter T or Subchapter N, and reported in accordance with Subsection D of this Section;

b. modifications that relax local limits, except for the modifications to local limits for pH and reallocations of the Maximum Allowable Industrial Loading of a pollutant that do not increase the total industrial loadings for the pollutant, which are reported in accordance with Subsection D of this Section. Maximum Allowable Industrial Loadings mean the total mass of a pollutant that all industrial users of a POTW (or a subgroup of industrial users identified by the POTW) may discharge in accordance with limits developed under LAC 33:IX.2709.C;

* * *

[See Prior Text in B.1.c - B.1.g]

C. Approval Procedures for Substantial Modifications

* * *

[See Prior Text in C.1 - C.2]

3. The approval authority need not publish a notice of decision under LAC 33:IX.2721.E, provided the notice of request for approval under LAC 33:IX.2721.B.1 states that the request will be approved if no comments are received by a date specified in the notice, no substantial comments are received, and the request is approved without change.

* * *

[See Prior Text in C.4 - D.3]

E. Incorporation in the Permit. All modifications shall be incorporated into the POTW's LPDES permit upon approval. The permit will be modified to incorporate the approved modification in accordance with LAC 33:IX.2385.A.7.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 24:2122 (November 1998), LR 25:1093 (June 1999).

Linda Korn Levy
Assistant Secretary

9906#015

RULE

**Office of the Governor
Office of Elderly Affairs**

FY 1998-99 State Plan on Aging
(LAC 4:VII.1317)

In accordance with Louisiana Revised Statutes 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Governor's Office of Elderly Affairs (GOEA) hereby amends LAC 4:VII.1317, the FY 1998-1999 Louisiana State Plan on Aging, effective July 1, 1999. This rule change is in accordance with the Code of Federal Regulation, 45 CFR 1321.19 "Amendments to the State Plan," and 45 CFR 1321.35 "Withdrawal of area agency designation" (Vol. 53. Number 169 pages 33769 and 33770). The purposes of this rule change are: (1) to reverse the designation of the Governor's Office of Elderly Affairs as the Area Agency on Aging for the Planning and Service Area (PSA) of Calcasieu parish; (2) to designate Calcasieu parish as the Planning and Service Area; and (3) to designate Calcasieu Council on Aging, Inc. as the Area Agency on Aging for the Calcasieu PSA.

The FY 1998-1999 Louisiana State Plan on Aging was adopted and published by reference in the September 20, 1997 issue of the *Louisiana Register*, Volume 23, Number 9. The full text of the State Plan may be obtained from the Office of the State Register at 1051 North Third Street, Room 512, Baton Rouge, LA 70802.

Title 4
ADMINISTRATION
Part VII. Governor's Office
Chapter 13. State Plan on Aging
§1317. Area Agencies on Aging

Area Agency on Aging	Planning and Service Area (Parishes Served)
Allen COA	Allen
Beauregard COA	Beauregard
Bienville COA	Bienville
Bossier COA	Bossier
Caddo COA	Caddo
CAJUN Area Agency on Aging (AAA)	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary, Vermilion
Calcasieu COA	Calcasieu
Caldwell COA	Caldwell
Cameron COA	Cameron
Capital Area Agency on Aging (AAA)	Ascension, Assumption, East Feliciana, Iberville, Pointe Coupee, St. Helena, Tangipahoa, Washington, West Baton Rouge, West Feliciana
CENLA Area Agency on Aging (AAA)	Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Winn
Claiborne COA	Claiborne
DeSoto COA	DeSoto
East Baton Rouge COA	East Baton Rouge
Jefferson COA	Jefferson
Jefferson Davis COA	Jefferson Davis
Lafourche COA	Lafourche
Lincoln COA	Lincoln
Livingston COA	Livingston
Madison COA	Madison
Morehouse COA	Morehouse
Natchitoches COA	Natchitoches
North Delta (AAA)	East Carroll, Franklin, Jackson, Richland, Tensas, Union
New Orleans COA	Orleans
Ouachita COA	Ouachita
Plaquemines COA	Plaquemines
Red River COA	Red River
Sabine COA	Sabine
St. Bernard COA	St. Bernard
St. Charles COA	St. Charles
St. James AAA	St. James

St. John COA	St. John
St. Tammany COA	St. Tammany
Terrebonne COA	Terrebonne
Vernon COA	Vernon
Webster COA	Webster
West Carroll COA	West Carroll

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:932(8).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 19:1317 (October 1993), repealed and promulgated LR 23:1146 (September 1997), amended LR 24:1110 (June 1998), LR 25:1094 (June 1999).

Paul F. "Pete" Arceneaux, Jr.
Executive Director

9906#020

RULE

**Department of Health and Hospitals
Board of Examiners in Dietetics and Nutrition**

Dietetics and Nutrition
(LAC 46:LXIX.Chapter 1)

The Louisiana Board of Examiners in Dietetics and Nutrition adopts the following rules into the Board's General Rules.

The rules define and clarify terms that are currently included in the Louisiana Dietetic/Nutrition Practice Act. Further, the rules outline in accordance with the Administrative Procedure Act and the Disciplinary Manual for Occupational Licensing Boards, the procedures that the Board will use in the investigation of complaints, the process for holding compliance and disciplinary hearings, and a list of the disciplinary options available to the Board for sanctioned licensees.

Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS

Part LXIX. Registered Dietitians
Chapter 1. Dietitians/Nutritionists
§101. Definitions

* * *

Application—any person who has applied to the board for a license or permit to engage in the practice of dietetics/nutrition in the state of Louisiana.

* * *

Diet Instruction—the process of imparting knowledge related to a specific nutrition plan. It does not include the dynamics of interpretation of the nutrition assessment, deliberation, development or change in a nutrition plan, all of which are within the scope of *Dietetics/Nutrition Practice*.

Dietetic Nutrition Practice and Medical Nutrition Therapy—may be used interchangeably.

* * *

Incidental to the Practice of Their Profession—as specified in that profession's practice act or licensure law in

the State of Louisiana as interpreted by that profession's regulatory board or agency.

* * *

Nutrition Counseling—the provision of individualized guidance on appropriate food and nutrient intake for those with special needs, taking into consideration health, cultural, socioeconomic, functional and psychological facts from the nutrition assessment. Nutrition counseling may include advice to increase or decrease nutrients in the diet; to change the timing, size of composition of meals; to modify food textures; and in extreme instances, to change the route of administration.

Nutrition Education—imparts information about food and nutrients, diet lifestyle factors, community nutrition resources and services to people to improve their nutrition.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 25:1094 (June 1999).

§113. Rules for Professional Conduct

Licensees, under the act shall perform their professional duties using the following Code of Ethics which reflect the ethical principles of the dietetic/nutrition professional and outline obligations of the licensee to self, client, society and the profession.

A. - C. ...

D. The licensee will not be negligent in his practice and assumes responsibility and accountability for personal competence in practice through continuing education and recognition of the limits of his ability and adherence to accepted standards of practice.

E. - G. ...

H. The licensee shall not be addicted to or dependent upon alcohol or other habit-forming drugs or be a habitual user of narcotics, barbiturates, amphetamines, hallucinogenics, or other drugs having similar effects upon the competency of the licensee. When such substances are prescribed by a physician, the licensee will not practice if the medications adversely affects his mental competency.

I. ...

J. A failure to adhere to the above Code of Ethics, or a violation of the above Rules for Professional Conduct constitutes unprofessional conduct and a violation of lawful rules and regulations adopted by the board and further constitutes grounds for disciplinary action specified in R.S. 37:3090 of the Dietitian/Nutritionist Practice Act and these Rules and Regulations and also constitutes grounds for a denial of licensure or a renewal of licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:437 (July 1988), amended LR 25:1095 (June 1999).

§115. Denial, Suspension or Revocation of License

A. Certificate denial, suspension or revocation shall be accomplished in accordance with Section 3090(A) of R.S.

37:3081-3093, the State Administrative Procedure Act, and the Procedural Rules provided in 46:LXIX.Chapter 5.

B. The board may refuse to issue a license or provisional license, or suspend, revoke or impose probationary conditions and restrictions on the license or provisional license of a person on a finding of any of the causes provided by §3090.A and B of the Dietitian/Nutritionist Practice Act.

C. A suspended license shall be subject to expiration and may be renewed as provided in §115, but such renewal shall not entitle the licensee, while the license remains suspended and until he is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order of judgment by which the license was suspended. If a license is revoked on disciplinary grounds and is reinstated, the licensee, as a condition of reinstatement, shall pay the renewal fee and any late fee that may be applicable.

D. Disciplinary Options Available to the Board. In accordance with R.S. 37:3085; R.S. 37:3088 and R.S. 37:3090, the following disciplinary options are available to the board.

1. Revocation. The involuntary termination of the licensee's license.

2. Suspension. The licensee is not permitted to practice for a specified period of time. Rehabilitative conditions may be imposed to run concurrently with the suspension period.

3. Probation. The licensee is permitted to practice, but the board has imposed conditions upon the practice or the practitioner including, but not limited to, rehabilitation. Once the time period has elapsed, and the licensee has complied with the terms of probation and/or rehabilitation, the board will allow the practitioner to resume practice unconditionally.

4. Restriction of License. A reduction in the scope of practice.

5. Censure. The board makes an official statement of censure ship concerning the individual.

6. Reprimand. Similar to censure. The board reprovcs the licensee. There may be public or private reprimands.

7. Restitution. Requirement imposed upon the licensee that he make financial or other restitution to a client or other injured party.

E. Publication of Disciplinary Action. The board will notify the professional community within 30 days of any disciplinary action, including the disciplined licensee's name, location, offense and sanction imposed. A notice of disciplinary action will also be published in the board's newsletter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:438 (July 1988), amended LR 25:1095 (June 1999).

Chapter 5. Procedural Rules

§501. Authority

A. Consistent with the legislative purpose enumerated in R.S. 37:3081-3093, and to further protect the safety and welfare of the public of this state against unauthorized, unqualified and improper practice of dietetics and nutrition,

the following rules of procedure are established under this board's specific rulemaking authority of R.S. 37:3085 and R.S. 49:952 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1095 (June 1999).

§503. Investigation of Complaints

A. The board is authorized to receive complaints against licensees or applicants from any person.

B. Any complaint bearing on a licensee's professional competence, conviction of a crime, unauthorized practice, violation of provisions of the Dietitian/Nutritionist Practice Act or Board Rules and Regulations, mental competence, neglect of practice or violation of the state law or ethical standards where applicable to the practice of dietetics and nutrition, should be submitted to the board.

C. Once a written and signed complaint is received, the board will initiate a review of the allegations. The board may dispose of the complaint informally through correspondence or conference with the licensee and/or the complainant which may result in a consent order agreeable to both parties. If the licensee stipulates to the complaint and waives his right to formal hearing, the board may impose appropriate sanctions without delay. If the board finds that a complaint cannot be resolved informally, the written complaint will be forwarded to the board's designated Complaint Investigation Officer (hereinafter referred to as the CIO) for investigation.

D. The board's CIO shall have authority to investigate the nature of the complaint through conference and correspondence directed to those parties or witnesses involved. The officer shall send the involved licensee notice of the investigation, containing a short summary of the complaint and any questions the officer may direct to the licensee relative to the complaint. All letters to the involved licensee, the complainant, or any other witness, shall be sent by registered mail, with the designation "Personal and Confidential" clearly marked on the outside of the envelope.

E. The CIO shall conclude the investigation as quickly as possible without compromising thoroughness. Unless good cause is shown by the CIO satisfactory to the board, which may extend the time for the investigation, the investigation and recommended action shall be completed within 60 days of the date the CIO first receives the complaint.

F. The CIO shall make a recommendation to the board for disposition by informal hearing, formal hearing or dismissal of the complaint. When the CIO's recommended action might lead to denial, suspension, or revocation of the certificate, the board shall immediately convene a formal adjudication hearing, pursuant to R.S. 37:3090.B. The officer may determine that the licensee's explanation satisfactorily answers the complaint and may recommend to the Board that the matter be dropped. The recommended remedial action or dismissal of the complaint shall be forwarded to the involved complainant and licensee.

G. The CIO may also resolve the complaint through a consent order entered into by the licensee and the complainant. If the order contains any agreement by the licensee to some remedial course of action, the agreement must be signed by the complainant, the licensee and the board. The CIO will make note of any settlement arrived at between the complainant and the licensee, but such a settlement does not necessarily preclude further disciplinary action by the board.

H. If the CIO's recommendation for informal hearing is accepted by the board, the officer shall notify the licensee of the time and place of the conference and of the issues to be discussed. The licensee shall appear on a voluntary basis. The licensee shall be advised that the hearing will be informal, no lawyers will be utilized and no transcript of the hearing made. Any witnesses used will not be placed under oath, and no subpoenas will be issued. The licensee shall be informed that any statements made at the informal hearing may not be used or introduced at a formal hearing, unless all parties consent, in the event the complaint cannot be resolved informally. If the licensee notifies the CIO that he does not wish such an informal hearing, none shall be held. In that event, the CIO shall recommend to the board the initiation of a formal disciplinary hearing.

I. If the investigation disclosed any of the following:

1. that the complaint is sufficiently serious to require formal adjudication;

2. the licensee fails to respond to the CIO's correspondence concerning the complaint;

3. the licensee's response to the CIO's letter discloses that further action is necessary; an informal hearing is held but does not resolve all the issues; or the licensee refuses to comply with the recommended remedial action, the CIO shall recommend to the board the initiation of a formal disciplinary hearing.

J. In any recommended action submitted to the board by the CIO, the recommended action should be submitted in brief, concise language, without any reference to the particulars of the investigation, or any findings of fact or conclusions of law arrived at during the investigative process.

K. The board shall also have authority to delegate to the CIO the investigation of any alleged violations of R.S. 37:3090.A, prior to board action on such alleged violations. In that event, the CIO shall submit to the board the complete details of the investigation, including all facts and the complete investigation file, if requested by the board. Final authority for appropriate action rests solely with the board.

L. At no time shall the CIO investigate any case as authorized by the board or §503 where said officer has any personal or economic interest in the outcome of the investigation, or is personally related to or close friends with the complainant, the licensee, or any of the involved witnesses. In such event, the officer shall immediately contact the board, who shall have authority to appoint a CIO ad hoc for disposition of that case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12

(January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1096 (June 1999).

§505. Conduct of Hearing

A. The board shall be authorized to conduct two types of hearings: compliance hearings and formal disciplinary hearings.

1. Compliance Hearing

a. The board will provide a compliance hearing to an applicant for a regular or provisional license whose application was disapproved by the board pursuant to §111.G of these Rules and Regulations, providing such applicant requests a compliance hearing in writing within thirty (30) days after the receipt of the notice of the disapproval, in which request the applicant shall state the opposition to the disapproved application.

b. A licensee, whose license is deemed expired because of a failure to timely renew, under R.S. 37:3088, shall be entitled to a compliance hearing, provided the licensee requests same in writing, within ten days after the receipt of the notice of the expired license; or in the event the licensee did not receive notice of the expired license within 30 days of the date upon which the license would have expired by operation of law.

c. Whenever possible, the board shall schedule a compliance hearing on a disapproved application in such a manner that the applicant is given an opportunity to present evidence of compliance and the board to rule thereon in sufficient time to allow the applicant to take the next scheduled examination, if the board decides in favor of the applicant. If this is not possible, and the board has reason to believe that the applicant's opposition has merit, the applicant shall be allowed to take the examination provisionally, pending the hearing and determination of the board. In no event shall the compliance hearing be conducted later than 30 days after requested. This time limitation applies to rejected applicants, as well as licensees with lapsed certificates.

d. The purpose and intent of the compliance hearing is to provide a forum for the applicant or licensee to present documentary evidence in the form of affidavits, court records, official records, letters, etc., along with under-oath testimony to establish that they do, in fact, meet the lawful requirements for the application or the retention of the license. The board shall have the authority to administer oaths, hear the testimony and conduct the hearing. No transcript of the hearing is required. The applicant or licensee may be represented by counsel, or may represent themselves in proper person.

e. In any compliance hearing, the burden shall be on the applicant or licensee to establish that he meets the criteria for licensure or that his certificate was timely renewed.

f. Within 30 days after the compliance hearing, the board will forward its final decision, including findings of fact and conclusions of law, by certified mail, to unsuccessful applicant or licensee.

g. Thereafter, the unsuccessful applicant or licensee may apply for a rehearing, as provided in R.S. 49:959, subject to further judicial review, pursuant to R.S. 49:964, 965.

2. Formal Disciplinary Hearing

a. The board shall also be authorized to conduct formal disciplinary hearings pursuant to R.S. 37:3090.B. The board shall promptly notify the Attorney General, who is authorized and requested to appear on behalf of the State.

b. The hearing shall be held before the board only after the involved licensee is given at least 30 days notice by certified mail. The content of the notice, as well as the conduct of the hearing, shall be governed by R.S. 49:955, being further provided that the licensee be advised of his right to be represented by legal counsel; and that the board shall arrange for a court reporter to make an accurate recording of all testimony presented at the hearing. By bringing a complaint, the client waives the privilege of confidentiality for the purposes of the hearing.

c. The rules of evidence, notice, authority to administer oaths, issue subpoenas, conduct depositions and control confidential or privileged information, will apply to the formal adjudication hearing in the form specified by R.S. 49:956.

d. It is the licensee's continuing obligation to keep the board informed of his whereabouts. Accordingly, if notice of the hearing cannot be delivered by mail because of a change of address and the new address is not provided to the board, the board may hold the hearing in the licensee's absence, after making reasonable efforts to obtain the licensee's new address.

e. When the licensee receives notice, he may file an answer to the notice denying some or all of the charges, or offering any explanation or assert whatever defense is deemed applicable.

f. For good cause shown, the board has discretion to extend or continue the time set for the hearing for such reasons as ill health, inability to obtain counsel, the complexities of the case, or such other matters deemed by the board to present good cause.

g. The board shall elect from its membership a person to act as Presiding Officer at the hearing, to make rulings on objections, the admissibility of evidence, and to insure that the conduct of the hearing proceeds without delay and pursuant to law. The other board members may not delegate their decision-making and fact-finding duties to the Presiding Officer; nor shall the Presiding Officer have any greater weight in the decision-making process. The board's findings of fact and conclusions of law shall be signed by the majority of the board finding those findings of fact and conclusions of law. Any board member disagreeing with those findings of fact and conclusions of law may also file in the record a dissent.

h. Any board member having reason to believe that he or she is biased or prejudiced against one of the parties to the proceeding or has a personal interest in the outcome shall immediately notify the remaining board members and request to be disqualified. Likewise, any party to such a hearing may file with the board an affidavit requesting a disqualification because of bias or personal interest. As soon as possible, but not later than the beginning of the hearing, the majority of the board must pass upon the requests for disqualification. The concerned board member shall not participate in the action to disqualify and shall not vote on

the issue. If the board is quite certain that there is no merit to the requests for disqualification, the board will proceed with the hearing. However, any doubt should be resolved in favor of disqualification. In that event, the board should immediately contact the Governor to appoint a board member pro tem to replace the disqualified member for the hearing in progress only.

i. The parties to the hearing are urged to confer prior to the hearing through their respective counsel, or personally to attempt to reduce or simplify the issues to be heard. This procedure is not required. The board will, however, honor any stipulations arrived at between the parties as proven fact at the hearing. The purpose of the prehearing conference is to insure that the hearing is not unusually delayed by receiving testimony or other evidence on matters which are not seriously in dispute.

j. The board shall have discretion to consolidate one or more cases for hearing involving the same or related parties, or substantially the same questions of law or fact. The board may also grant separate hearings if such a joint hearing would be prejudicial to one or more of the parties. If hearings are to be consolidated, notice must be given to all parties in advance of the hearing.

k. The Presiding Officer shall consider a motion to modify or quash any subpoena issued in connection with the hearing, provided that such motion is filed, by registered mail, with the board not later than three days prior to the hearing date, or the date scheduled for the deposition. Possible grounds to quash or limit the subpoena include, but are not limited to, testimony or material protected by privilege of statute, regulation, or other law; burdensomeness that would not be justified in light of the evidence's importance to the case, undue hardship on a witness; vagueness; and immateriality.

l. The procedures to be followed in conducting the hearing governing the order of proceedings, rulings on evidence, and the board's decision are contained in Chapters 11 through 14, respectively, of the Disciplinary Action Manual for Occupational Licensing Boards, prepared by the Louisiana Department of Justice, 1979, through the office of the Attorney General. A copy of these pertinent chapters will be provided to an interested party involved with a hearing, by written request submitted to the board.

m. The burden of proof rests upon the Attorney General who is bringing the charge before the board. No sanctions shall be imposed or order be issued, except upon consideration of the whole record, as supported by and in accordance with reliable, probative and substantial evidence as cited in R.S. 49:957.

n. Any party or person deemed to be governed by or under the jurisdiction of R.S. 37:3081-3093, may apply to the board for a declaratory order or ruling in order to determine the applicability of a statutory provision or rule of this board to said party or person. The board shall issue the declaratory order or ruling in connection with the request by majority vote of the board, signed and mailed to the requesting party within 30 days of the request, except that the board may seek legal counsel or an Attorney General's opinion in connection with the request, in which case the declaratory order or ruling may be issued within 60 days of its request.

o. Judicial review and appeal of any decision or order of the board shall be governed by R.S. 49:964, 965.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1097 (June 1999).

JoAnn M. Puls, LDN, RD
Chairperson

9906#004

RULE

Department of Health and Hospitals Board of Examiners of Psychologists

Acceptable Sponsorship, Offerings and Activities (LAC 46:LXIII.805)

In accordance with R.S. 49:950 et seq., the Board of Examiners of Psychologists amends §§805 and 807, its continuing education rule, as follows.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXIII. Psychologists

Chapter 8. Continuing Education

§805. Acceptable Sponsorship, Offerings and Activities

A. - G. ...

H. Licensees can earn CE hours equal to six times the credit hours granted students for the preparation and teaching of a graduate level psychology course in an accredited institution of higher education. This CE credit may be claimed only once for a course. Subsequent teaching of the same course will not qualify for CE credit.

I. Licensees can earn CE hours equal to four times the CE hours given participants for the preparation and presentation of a workshop which has an acceptable sponsor and otherwise meets the criteria for acceptable continuing education. This CE credit may be claimed only once for the initial presentation of a workshop. Repeated presentations of the same or similar workshops will not qualify for CE credit.

J. If continuing education is taught by more than one person, the number of hours earned by each shall be equal to the number that would be earned if taught by a sole presenter divided by the number of presenters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2354.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 16:770 (September 1990), amended LR 19:46 (January 1993), LR 22:1131 (November 1996), LR 25:1098 (June 1999).

§807. Unacceptable Offerings and/or Activities

A. - B. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2354.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR

C. Gary Pettigrew, Ph.D.
Chairman

9906#069

RULE

**Department of Health and Hospitals
Office of Public Health**

Sanitary Code—Eating and Drinking Establishments
(Chapter XXIII)

Sanitary Code

Chapter XXIII. Eating and Drinking Establishments

* * *

23:002 Interpretation/Certification

23:002-1 Interpretation:

* * *

23:002-2 Food Safety Certification:

(1) It shall be required that the owner or a designated employee of a food service establishment hold a "food safety certificate" on behalf of the food service establishment.

(2) This shall not apply to establishments with food sales of less than one hundred and twenty-five thousand dollars annually.

(3) The Office of Public Health shall approve all training programs. These programs shall include but not be limited to the standards set forth in the Applied Food Service Sanitation Program established by the Education Foundation of the National Restaurant Association, or other programs recognized by the food service industry and the Office of Public Health. The Office of Public Health shall maintain a list of these training programs.

(4) Instructors/trainers shall meet the criteria established by the Educational Foundation of the National Restaurant Association or other instructor/trainer requirements established by the food service industry and the Office of Public Health.

(5) The Office of Public Health shall approve training programs administered or approved by another state, political subdivision, or other jurisdiction with standards that meet or exceed those established in this Code.

(6) Testing: a person must pass a written exam approved by the Office of Public Health before qualifying for the certificate. This test will meet the standards as described in section three.

(7) Certificate: a food safety certificate shall be issued by the Office of Public Health to any individual who files an application with satisfactory evidence that he/she has completed an approved training program which includes passing a written examination.

(8) Fees: a fee of twenty-five dollars will be collected from each individual or food service establishment for each certificate.

(9) Certificate renewal: certificates from the Office of Public Health shall be required to be renewed every five years for a twenty-five dollar fee. A person shall pass another written exam as described in section six before the certificate is renewed.

(10) Display of certificate: a certificate issued by the Office of Public Health shall be displayed in each food service establishment where required.

(11) No parish or municipality in Louisiana shall enforce any ordinance or regulation requiring a food service establishment or any of its employees to complete a Food Safety training program or test.

(12) This section shall be enforced in accordance with Chapter 1 of this Code.

David Hood
Secretary

9906#055

RULE

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

Private Hospital—Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the following rule in the Medical Assistance Program as authorized by LA. 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, Bureau of Health Services Financing amends the reimbursement methodology for private hospitals contained in the June 20, 1994 rule to discontinue the practice of automatically applying an inflationary adjustment to the current reimbursement rates for non-fixed costs in those years when the rates are not rebased. The subsequent application of the inflationary adjustment to the reimbursement rates for private hospitals shall be contingent on the allocation of funds by the Legislature in the Appropriation Bill.

David W. Hood
Secretary

9906#058

RULE

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

Private Intermediate Care Facilities for the Mentally Retarded—Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends 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, Bureau of Health Services Financing amends the reimbursement methodology contained in the October 20, 1989 rule for private intermediate care facilities for the mentally retarded to discontinue the practice of automatically applying an inflationary adjustment to the current reimbursement rates for non-fixed costs in those years when the rates are not rebased. Subsequent application of an inflationary adjustment to the reimbursement rates for private intermediate facilities for the mentally retarded shall be contingent on the allocation of funds by the Legislature in the Appropriation Bill.

David W. Hood
Secretary

9906#059

RULE

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

Private Nursing Facilities—Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the following rule in the Medical Assistance Program as authorized by LA. 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 amends the reimbursement methodology for private nursing facilities contained in the June 20, 1984 rule to discontinue the practice of automatically applying an inflationary adjustment to the current reimbursement rates for non-fixed costs in those years when the rates are not rebased. The subsequent application of an inflationary adjustment to the reimbursement rates for private nursing facilities shall be contingent on the allocation of funds by the Legislature in the Appropriation Bill.

David W. Hood
Secretary

9906#060

RULE

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

Standards for Payment for Adult Day Health Care (ADHC) Services (LAC 50:II.10905 and 10907)

The Department of Health and Hospitals, 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. The rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amends §10905 entitled Definitions and §10907 entitled Licensure as follows.

Title 50

PUBLIC HEALTH - MEDICAL ASSISTANCE

Part II. Medical Assistance Program

Subpart 3. Standards for Payment

Chapter 109. Standards for Payment—Adult Day Health Care Services

§10905. Definitions

DHCBSW—Division of Home and Community-Based Services Waivers of the Bureau of Health Services Financing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1100 (June 1999).

§10907. Licensure

A. Enrolled Title XIX Adult Day Health Care Centers shall be licensed by the Department of Health and Hospitals.

B. A Provider Agreement must be executed wherein the applicant agrees to comply with the Standards for Payment for Adult Day Health Care Centers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary LR 14:793 (November 1988), repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1150 (September 1997), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1099 (June 1999).

David W. Hood
Secretary

9906#057

RULE

**Department of Insurance
Office of the Commissioner**

Regulation 33—Medicare Supplement Insurance Minimum Standards (LAC 37:XIII.Chapter 5)

Pursuant to the provisions of R.S. 49:951 et seq. and R.S. 22:224, the Commissioner of Insurance gives notice of his intent to amend Regulation 33. This action is necessary to bring the Medicare Supplement Insurance Minimum Standards Regulation in line with the requirements of the

Social Security Act, mandated by the Balanced Budget Act of 1997.

Title 37
INSURANCE

Part XIII. Regulations

Chapter 5. Regulation 33—Medicare Supplement Insurance Minimum Standards

§501. Purpose

A. The purpose of this regulation is:

1. to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

2. to facilitate public understanding and comparison of such policies;

3. 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

4. to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999).

§502. Applicability and Scope

A. Except as otherwise specifically provided in §§510, 540, 545, 560 and 585, this Regulation shall apply to:

1. all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999).

§503. Definitions

A. For purpose of this regulation:

Applicant—means:

a. in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

b. in the case of a group Medicare supplement policy, the proposed certificate holder.

Bankruptcy—means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

Certificate—means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

Certificate Form—means the form on which the certificate is delivered or issued for delivery by the issuer.

Continuous Period of Creditable Coverage—means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

Creditable Coverage—

a. means with respect to an individual, coverage of the individual provided under any of the following:

i. a group health plan;

ii. health insurance coverage;

iii. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

iv. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

v. Chapter 55 of Title 10 United States Code (CHAMPUS);

vi. a medical care program of the Indian Health Service or of a tribal organization;

vii. a State health benefits risk pool;

viii. a health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

ix. a public health plan as defined in federal regulation; and

x. a health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

b. creditable coverage shall not include one or more, or any combination of, the following:

i. coverage only for accident or disability income insurance, or any combination thereof;

ii. coverage issued as a supplement to liability insurance;

iii. liability insurance, including general liability insurance and automobile liability insurance;

iv. workers' compensation or similar insurance;

v. automobile medical payment insurance;

vi. credit-only insurance;

vii. coverage for on-site medical clinics; and

viii. other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

c. creditable coverage shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

i. limited scope dental or vision benefits;

ii. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

iii. such other similar, limited benefits as are specified in federal regulations.

d. creditable coverage shall not include the following benefits if offered as independent, noncoordinated benefits:

i. coverage only for a specified disease or illness; and

ii. hospital indemnity or other fixed indemnity insurance.

e. creditable coverage shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

- i. Medicare supplemental health insurance as defined under section 1882 (g)(1) of the Social Security Act;
- ii. coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and
- iii. similar supplemental coverage provided to coverage under a group health plan.

Employee Welfare Benefit Plan—means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

Insolvency—means the inability to pay its obligations when they are due, or a condition when its admitted assets do not exceed its liabilities plus the greater of:

- a. any capital and surplus required by law for its organization; and
- b. the total par or stated value of its authorized and issued capital stock.
- c. for purposes of this subsection, liabilities shall include but not be limited to reserves required by statute, by general regulations of the Department of Insurance or by specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

Issuer—includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity authorized to deliver or issue for delivery in this state Medicare supplement policies or certificates.

Medicare—means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare+Choice Plan—means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

- a. coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
- b. medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
- c. Medicare+Choice private fee-for-service plans.

Medicare Supplement Policy—means 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 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), 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. Also, it includes those plans commonly known as health care prepayment plans (HCPPs).

Policy Form—means the form on which the policy is delivered or issued for delivery by the issuer.

Qualified Actuary—means an actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

Secretary—means the Secretary of the United States Department of Health and Human Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 43 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999).

§504. Policy Definitions and Terms

A. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

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.

a. 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."

b. The 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.

Benefit Period or Medicare Benefit Period—shall not be defined more restrictively than as defined in the Medicare program.

Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility—shall not be defined more restrictively than as defined in the Medicare program.

Health Care Expenses—means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Expenses shall not include:

- a. home office and overhead costs;
- b. advertising costs;
- c. commissions and other acquisition costs;
- d. taxes;
- e. capital costs;
- f. administrative costs; and
- g. claims processing costs.

Hospital—may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

Medicare—shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

Medicare Eligible Expenses—shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Physician—shall not be defined more restrictively than as defined in the Medicare program.

Sickness—shall not be defined to be more restrictive than the following.

a. Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

b. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999).

§505. Policy Provisions

A. Except for permitted preexisting condition clauses as described in §510.A.1. and §515.A.1. of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999).

§506. Reserved.

§507. Reserved.

§508. Reserved.

§509. Reserved.

§510. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 20, 1992

A. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

1. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. A noncancellable, guaranteed renewable, or noncancellable and guaranteed renewable Medicare supplement policy shall not:

i. provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

ii. be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e.i. Except as authorized by the Commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

ii. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in §510.A.1.e.iv., the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(a) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(b) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in §515.A.2. of this regulation.

(c) Group contracts in force prior to the effective date of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may have existing contractual obligations to continue benefits contained in the group contract. This section is not intended to impair those obligations.

iii. If membership in a group is terminated, the issuer shall:

(a) offer the certificate holder the conversion opportunities described in §510.A.1.e.ii; or

(b) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

iv. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the

policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

2. Minimum Benefit Standards

a. 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;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [\$100];

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1103 (June 1999).

§511. Reserved.

§512. Reserved.

§513. Reserved.

§514. Reserved.

§515. Benefit Standards for Policies or Certificates Issued or Delivered on or After July 20, 1992

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 20, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

1. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or

treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each Medicare supplement policy shall be guaranteed renewable.

i. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;

ii. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under §515. A.5.e.v, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

(a). provides for continuation of the benefits contained in the group policy; or

(b). provides for benefits that otherwise meet the requirements of this subsection.

iv. if an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(a). offer the certificate holder the conversion opportunity described in §515.A.1.e.iii; or

(b). at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

v. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

g.i. 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 twenty-four (24) months), or upon discovering thereof by the insurer 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 the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

ii. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

iii. Reinstitution of coverages:

(a). shall not provide for any waiting period with respect to treatment of preexisting conditions;

(b). shall provide for coverage which is substantially equivalent to coverage in effect before the date of suspension; and

(c). 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.

2. 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 of it.

a. 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;

b. 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;

c. 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;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount (or, in the case of hospital outpatient department services under a prospective payment system, the copayment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

3. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by §520 of this regulation.

Medicare Part A Deductible—coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

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 posthospital skilled nursing facility care eligible under Medicare Part A.

Medicare Part B Deductible—coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

Eighty Percent (80%) of the Medicare Part B Excess Charges—coverage for eighty percent (80%) 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.

One Hundred Percent (100%) 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.

Basic Outpatient Prescription Drug Benefit—coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

Extended Outpatient Prescription Drug Benefit—coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

Medically Necessary Emergency Care in a Foreign Country—coverage to the extent not covered by Medicare for eighty percent (80%) 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 sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$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.

Preventive Medical Care Benefit—coverage for the following preventive health services:

i. 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;

ii. any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(a). fecal occult blood test or digital rectal examination, or both;

(b). mammogram;

- (c). dipstick urinalysis for hematuria, bacteriuria and proteinuria;
- (d). pure tone (air only) hearing screening test, administered or ordered by a physician;
- (e). serum cholesterol screening (every five (5) years);
- (f). thyroid function test;
- (g). diabetes screening.
- iii. influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster (every ten (10) years);
- iv. any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) 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 one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

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.

i. For purposes of this benefit, the following definitions shall apply:

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.

Care Provider—means a duly qualified or licensed home health aide or 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.

Home—shall mean 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.

At-Home Recovery Visit—means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four-hour period of services provided by a care provider is one visit.

ii. Coverage Requirements and Limitations

(a). At-home recovery services provided must be primarily services which assist in activities of daily living.

(b). 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.

(c). 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 forty dollars (\$40) per visit;
- (iii). one thousand six hundred dollars (\$1,600) per calendar year;
- (iv). seven (7) 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 (8) weeks after the service date of the last Medicare approved home health care visit.

iii. Coverage is excluded for:

(a). home care visits paid for by Medicare or other government programs; and

(b). care provided by family members, unpaid volunteers, or providers who are not care providers.

New or Innovative 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. The 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.

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§516. Reserved.

§517. Reserved.

§518. Reserved.

§519. Reserved.

§520. 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 §515.A.2. 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 §515.A.3. *New and Innovative Benefits* and in §525 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 §503 of this regulation. Each benefit shall be structured in accordance with the format provided in §515.A.2. and §515.A.3 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 §515.A.2. of this regulation.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible as defined in §515.A.3. *Medicare Part A Deductible*.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: the core benefit as defined in §515.A.2 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 §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country*, respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: the core benefit as defined in §515.A.2. 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 §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country, and At-Home Recovery Benefit*, respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: the core benefit as defined in §515.A.2. 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 §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country, and Preventive Medical Care Benefit*, respectively.

6. Standardized Medicare supplement benefit plan "F" shall include only the following: the core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country*, respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare*

Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country, respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

8. Standardized Medicare supplement benefit plan "G" shall include only the following: the core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country*, respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country, as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Outpatient Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country*, respectively.

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Outpatient Prescription Drug Benefit, Medically Necessary Care in a Foreign Country and At-Home Recovery Benefit*, respectively.

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) 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 §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit*, respectively.

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit*, respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

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§521. Reserved.

§522. Reserved.

§523. Reserved.

§524. Reserved.

§525. 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:

Complaint—means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

Grievance—means 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.

Medicare Select Issuer—means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

Medicare Select Policy or *Medicare Select Certificate*—means respectively a Medicare supplement policy or certificate that contains restricted network provisions.

Network Provider—means 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.

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

Service Area—means 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. 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 twenty-four (24) hours per day and seven (7) 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 the 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 §525.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 the changes. Changes shall be considered approved by the Commissioner after thirty (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. The procedures shall be aimed at mutual agreement for settlement and may include arbitration 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 (6) 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 reauthorized 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 the 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1108 (June 1999).

§526. Reserved.

§527. Reserved.

§528. Reserved.

§529. Reserved.

§530. Open Enrollment

A. An issuer shall not 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 a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is 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.1. If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this Subsection.

C. Except as provided in Subsection B and §590, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

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§531. Reserved.

§532. Reserved.

§533. Reserved.

§534. Reserved.

§535. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue

1. Eligible persons are those individuals described in subsection B who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection B, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection C that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Person. An eligible person is an individual described in any of the following paragraphs.

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan;

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply:

a. The organization's or plan's certification [under this part] has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

b. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

c. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

i. the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

ii. the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

d. The individual meets such other exceptional conditions as the Secretary may provide.

3.a. The individual is enrolled with:

i. an eligible organization under a contract under Section 1876 (Medicare risk or cost);

ii. a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

iv. an organization under a Medicare Select policy; and

b. the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under §535.B.2.

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

a.i. of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

ii. of other involuntary termination of coverage or enrollment under the policy;

b. the issuer of the policy substantially violated a material provision of the policy; or

c. the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.a. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and

b. the subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. the individual, upon first becoming enrolled for benefits under Medicare part B, enrolls in a Medicare+Choice plan under part C of Medicare, and disenrolls from the plan by not later twelve (12) months after the effective date of enrollment.

C. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

1. §535.B.1.2.3 and 4 is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

2. §535.B.5 is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in §535.C.1.

3. §535.B.6 shall include any Medicare supplement policy available by any issuer.

D. Notification provisions

1. At the time of an event described in Subsection B of this Section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in Subsection B of this Section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under §535.A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1110 (June 1999).

§536. Reserved.

§537. Reserved.

§538. Reserved.

§539. Reserved.

§540. 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. No. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1111 (June 1999).

§541. Reserved.

§542. Reserved.

§543. Reserved.

§544. Reserved.

§545. **Loss Ratio Standards and Refund or Credit of Premium**

A. Loss Ratio Standards

1.a. 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:

i. at least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

ii. at least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

b. 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 the 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 §550.C.3. 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.

4. For policies issued prior to January 20, 1991, expected claims in relation to premiums shall meet:

a. the originally filed anticipated loss ratio when combined with the actual experience since inception;

b. the appropriate loss ratio requirement from §545.A.1.a.i. and ii. when combined with actual experience beginning with January 1, 1998 to date; and

c. the appropriate loss ratio requirement from §545.A.1.a.i. and ii. over the entire future period for which the rates are computed to provide coverage.

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 applicable 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. For the purposes of this Section, policies or certificates issued prior to January 20, 1991, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1998. The first report shall be due by May 31, 2000.

4. 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. The 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 thirteen-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. Filing of Rates and Rating Schedules. 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.

1. Each Medicare supplement policy or certificate form shall be accompanied, upon submission for approval, by an original and one copy of an actuarial memorandum. The memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the information listed in the following subparagraphs:

a. the form number that the actuarial memorandum addresses;

b. a brief description of benefits provided;

c. a schedule of rates to be used;

d. a certification that the anticipated lifetime loss ratio is at least 65% (for individual coverage) or at least 75% (for group coverage);

e. a table of anticipated loss ratio experience for each year from issue over a reasonable number of years;

f. a certification that the premiums are reasonable in relation to the benefits provided; and

g. the memorandum shall be filed in duplicate;

h. any additional information requested by the Commissioner.

2. Subsequent rate adjustments filings, except for those rates filed solely due to a change in the Part A calendar year deductible, shall also provide an original and one copy of an actuarial memorandum, prepared, signed and dated by a qualified actuary, in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the following:

a. the form number addressed by the actuarial memorandum;

b. a brief description of benefits provided;

c. a schedule of rates before and after the rate change;

d. a statement of the reason and basis for the rate change;

e. a demonstration and certification by the qualified actuary showing that the past plus future expected experience after the rate change will result in an aggregate loss ratio equal to, or greater than, the required minimum aggregate loss ratio;

i. this rate change and demonstration shall be based on the experience of the named form in Louisiana only, if that experience is credible.

ii. the rate change and demonstration shall be based on experience of the named form nationwide, if the named form is used nationwide and the Louisiana experience is not credible, but the nationwide experience is credible.

f. for policies or certificates in force less than three years, a demonstration shall be included to show that the third-year loss ratio is expected to be equal to, or greater than, the applicable percentage;

g. a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided;

h. the memorandum shall be filed in duplicate;

i. any additional information requested by the Commissioner.

3.a. 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 no later than December 31 its rates for the upcoming calendar year. Also, supporting documentation including ratios of incurred losses to earned premiums by policy duration shall be submitted for approval 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. The 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 (3) years.

b. The filing for purposes of this subsection shall contain all Medicare supplement plans issued by the issuer and shall not include rate adjustments. An actuarial memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the following:

i. the form number for each plan;

ii. plan type designation (for example: Plan A, Plan B, Pre-standardized);

iii. the rates for each plan;

iv. yearly loss ratios for each plan;

v. lifetime expected loss ratios for each plan;

vi. identify filing as "ANNUAL MEDICARE SUPPLEMENT FILING" on the face page of the memorandum.

vii. the memorandum shall be filed in duplicate;

viii. any additional information requested by the Commissioner.

4. 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:

a.i. appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

ii. an issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to 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 the 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.

iii. 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.

b. any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The 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 the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the Commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1112 (June 1999).

§546. Reserved.

§547. Reserved.

§548. Reserved.

§549. Reserved.

§550. 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 C.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 (4) 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 D.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 twelve (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 thirty (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 (5) 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 D.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 E.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 §545 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1113 (June 1999).

§551. Reserved.

§552. Reserved.

§553. Reserved.

§554. Reserved.

§555. 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 two hundred percent (200%) 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 (5) 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 non-pecuniary 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1114 (June 1999).

§556. Reserved.

§557. Reserved.

§558. Reserved.

§559. Reserved.

§560. Required Disclosure Provisions

A. General Rules

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The 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, the 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 preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting 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 thirty (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.a. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare 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 Guide shall be made whether or not the 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 Guide shall be made to the applicant at the time of application, and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

b. For the purposes of this Section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

1. As soon as practicable, but no later than thirty (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. The 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. The 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 the 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 the policy or certificate when it is delivered and contain the following statement, in no less than twelve (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.a. The outline of coverage provided to applicants pursuant to this Section consists of four parts:

- i. a cover page;
- ii. premium information;
- iii. disclosure pages, and
- iv. charts displaying the features of all benefit plans available by the issuer.

b. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-J shall be shown on the cover page, and each Medicare supplement policy and certificate currently available by an issuer shall be prominently identified. Premium information for plans that are available 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 available 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 plus two high deductible 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), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayment.

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	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	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	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
Part A Deductible	Part A Deductible	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%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
	At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery	
		Basic Drugs (\$1,250)	Basic Drugs (\$1,250)	Extended Drugs (3,000)		

		Limit	Limit	Limit
				Preventive Care

*Plan F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plan F and J after one has paid a calendar year [\$1500] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

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 §520.D 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 \$768	\$0	\$768 (Part A Deductible)
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after: --While using 60 lifetime reserve days	All but \$384/day	\$384/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.			

21st thru 100th day	All but \$96/day	\$0	Up to \$96/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	100%	\$0	\$0

SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES			
--	--	--	--

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 \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$384/day	\$384/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare	\$0

		Eligible Expenses	
--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 \$96/day	\$0	Up to \$96/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 \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after:			

While using 60 lifetime reserve days	All but \$384/day	\$384/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 \$96/day	Up to \$96/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 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	Generally, 80%	Generally, 20%	\$0

Amounts			
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

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 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 \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after;			
While using 60 lifetime reserve days	All but \$384/day	\$384/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 have 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 \$96/day	Up to \$96/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 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	\$0	\$0	All Costs

(Above Medicare Approved Amounts)			
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 \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$384/day	\$384/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 leave in the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th Daily	All but \$96/day	Up to \$96/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	All but very limited	\$0	Balance

your doctor certifies you are terminally ill and you elect to receive these services	coinsurance for out-patient drugs and inpatient respite care		
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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 TREATMENTS, 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	\$0	\$0	\$100 (Part B)

Amounts*			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

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F or HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same or offers the same benefits as plan F after one has paid a calendar year [\$1500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$1500 DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but	\$192/day	\$0

91st day and after:	\$192/day		
While using 60 lifetime reserve days	All but \$384/day	\$384/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 \$96/day	Up to \$96/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.

**This high deductible plan pays the same or offers the same benefits as plan F after one has paid a calendar year [\$1500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$1500 DEDUCTIBLE, ** 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 HEATH 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

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$1500 DEDUCTIBLE, ** YOU PAY
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
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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 \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$384/day	\$384/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 \$96/day	Up to \$96/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	80%	20%	\$0

Medicare Approved Amounts			
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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 \$768	\$768 (Part A Deductible)	\$0

61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$384 day	\$384/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 \$96/day	Up to \$96/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	
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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	\$0	\$0	All Costs

Charges (Above Medicare Approved Amounts)			
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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$384/day	\$384/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 the 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 \$96/day	Up to \$96/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
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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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	50%

		maximum benefit	
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN J or HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$1500 DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$768	\$768 (Part A Deductible)	\$0
61st thru 90th day	All but \$192/day	\$192/day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$384/day	\$384/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 \$96/day	Up to \$96/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 or HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

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	AFTER YOU PAY \$1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1500 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE (contd.) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your 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

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1500 DEDUCTIBLE,** YOU PAY
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 \$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

***Medicare benefits are subject to change. Please consult the latest *guide to health insurance for people with Medicare*.

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. §1395 et seq.), disability income policy; or other policy identified in §502.B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The 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. The notice shall be in no less than twelve (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 Guide to Health Insurance for People with Medicare available from the company."*

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D.1 shall disclose, using the

applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1114 (June 1999).

§561. Reserved.

§562. Reserved.

§563. Reserved.

§564. Reserved.

§565. 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.

B. An application for a Medicare supplement policy shall not be combined with an application for any other type of insurance coverage. The application may not make reference to or include questions regarding other types of insurance coverage except for those questions specifically required under this section.

1. [Statements]

a. You do not need more than one Medicare supplement policy.

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

c. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

d. The benefits and premiums under your Medicare supplement policy can be suspended, if requested, 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.

e. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

2. [Questions]

a. To the best of your knowledge,

i. Do you have another Medicare supplement policy or certificate in force?

(a). If so, with which company?

ii. Do you intend to replace your current Medicare supplement policy with this policy [certificate]?

iii. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(a). If so, with which company?

(b). What kind of policy?

iii. Are you covered for medical assistance through the state Medicaid program:

(a). As a Specified Low-Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c). For other Medicaid medical benefits?

C. 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 (5) years which are no longer in force.

D. 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.

E. 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.

F. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) 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 thirty (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. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not

duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (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 (preexisting 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 preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting 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.

G. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1130 (June 1999).

§566. Reserved.

§567. Reserved.

§568. Reserved.

§569. Reserved.

§570. Filing Requirements for Advertising

A. 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 and approval by the Commissioner to the extent permitted under the Insurance Code, particularly under R. S. 22:1215.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1131 (June 1999).

§571. Reserved.

§572. Reserved.

§573. Reserved.

§574. Reserved.

§575. 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. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1131 (June 1999).

§576. Reserved.

§577. Reserved.

§578. Reserved.

§579. Reserved.

§580. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§581. Reserved.

§582. Reserved.

§583. Reserved.

§584. Reserved.

§585. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§586. Reserved.

§587. Reserved.

§588. Reserved.

§589. Reserved.

§590. Prohibition Against Preexisting 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 preexisting 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 (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§591. Reserved.

§592. Reserved.

§593. Reserved.

§594. Reserved.

§595. Separability

A. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§596. Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM		
FOR CALENDAR YEAR _____		
Type ¹ _____	SMSBO ² _____	
For the State of _____		
Company Name _____		
NAIC Group Code _____	NAIC Company Code _____	
Address _____		
Person Completing This Exhibit _____		
Title _____	Telephone Number _____	
	(a)	(b)
	Earned	Incurred
	Premium ³	Claims ⁴
	_____	_____
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 1) _____

8 Experienced Ratio Since Inception

Total Actual Incurred Claims (line (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 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.	

- 1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- 2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
- 3 Includes Modal Loadings and Fees Charged
- 4 Excludes Active Life Reserves
- 5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

Type¹ _____ SMSBOP² _____

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 or credit against premiums to be used must be attached to this form.

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 _____**

Type¹ _____ SMSBP² _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio
1		2.770		0.507
2		4.175		0.567
3		4.175		0.567
4		4.175		0.567
5		4.175		0.567
6		4.175		0.567
7		4.175		0.567
8		4.175		0.567
9		4.175		0.567
10		4.175		0.567
11		4.175		0.567
12		4.175		0.567
13		4.175		0.567
14		4.175		0.567
15		4.175		0.567
Total:			(k):	

(f)	(g)	(h)	(i)	(j)	(o) ⁵
(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
	0.000		0.000		0.46
	0.000		0.000		0.63
	1.194		0.759		0.75
	2.245		0.771		0.77
	3.170		0.782		0.80
	3.998		0.792		0.82
	4.754		0.802		0.84
	5.445		0.811		0.87
	6.075		0.818		0.88
	6.650		0.824		0.88
	7.176		0.828		0.88
	7.655		0.831		0.88
	8.093		0.834		0.89
	8.493		0.837		0.89
	8.684		0.838		0.89
(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

³Year 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.)

⁴For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵These 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

**REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____**

Type¹ _____ SMSBP² _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

(g)	(h)	(i)	(j)	(o) ⁵
Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
0.000		0.000		0.40
0.000		0.000		0.55
1.194		0.659		0.65
2.245		0.669		0.67
3.170		0.678		0.69
3.998		0.686		0.71
4.754		0.695		0.73
5.445		0.702		0.75
6.075		0.708		0.76
6.650		0.713		0.76
7.176		0.717		0.76
7.655		0.720		0.77
8.093		0.723		0.77
8.493		0.725		0.77
8.684		0.725		0.77
	(m):		(n):	

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)
1		2.770		0.442	
2		4.175		0.493	
3		4.175		0.493	
4		4.175		0.493	
5		4.175		0.493	
6		4.175		0.493	
7		4.175		0.493	
8		4.175		0.493	
9		4.175		0.493	
10		4.175		0.493	
11		4.175		0.493	
12		4.175		0.493	
13		4.175		0.493	
14		4.175		0.493	
15		4.175		0.493	
Total:			(k):		(l):

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

³Year 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.)

⁴For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵These 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§597. 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
<div style="text-align: center; margin-bottom: 10px;"> _____ Signature </div> <div style="text-align: center; margin-bottom: 10px;"> _____ Name and Title (please type) </div> <div style="text-align: center;"> _____ Date </div>	

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State law and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not pre-empt state laws that are more stringent than the federal requirements.
8. The federal law does not pre-empt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1136 (June 1999).

598. Appendix C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for

Health Insurance Policies Sold to Medicare Beneficiaries

that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificates) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

hospitalization

physician services
other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

hospitalization
physician services
other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

hospitalization
physician services
hospice
other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items & services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.

- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization

physician services

hospice

other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1136 (June 1999).

§599. Effective Date

This regulation shall be effective on June 18, 1999

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1142 (June 1999).

James H. "Jim" Brown
Commissioner

9906#008

RULE

**Department of Labor
Office of Workforce Development**

Workforce Development Training Fund
(LAC 40:XVI.101-111)

The Louisiana Department of Labor, pursuant to authority vested in the Department by R.S. 23:1514 and in accordance with applicable provisions of the Administrative Procedure Act, has adopted rules governing the workforce development training account, LAC 40:XVI.101-111, to provide for eligibility and requirements for submission of applications.

Title 40

LABOR AND EMPLOYMENT

Chapter 1. Workforce Development Training Fund

§101. Definitions

Account—the Workforce Development Training Account.

Applicant—the business requesting training assistance from LDOL under this program.

Award—funding approved under this program for eligible training activities.

Awardee—an applicant (and/or company(ies)) receiving a training award under this program.

Contract—a legally enforceable agreement between LDOL, the awardee and a training provider governing the terms and conditions of the training award.

Contractee—the awardee and training provider that are party to a training award contract with LDOL under this program.

LDOL—the Louisiana Department of Labor.

Monitoring Entity—a public entity contracted to monitor the compliance of an awardee with the terms and conditions of a training award contract.

Secretary—the secretary of the Department of Labor.

Training Provider—the entity providing the customized training for the awardee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1142 (June 1999).

§103. Eligibility

A. An applicant shall be eligible for customized training if it is one of the following:

1. an individual employer that seeks to provide customized training for his present employees to prevent job loss caused by obsolete skills, technological change, or national or global competition;

2. an individual employer that seeks to provide customized training to create, update, or retain jobs in a labor demand occupation;

3. an individual employer that seeks to provide customized training to update or retain jobs in an occupation which is not a labor demand occupation, if the administrator determines that the services are necessary to prevent the likely loss of jobs;

4. a labor or community-based organization that seeks to provide customized training for a labor demand occupation;

5. a consortium made up of one or more educational institutions and one or more eligible individual employers, labor, or community-based organizations that seeks to provide customized training in labor demand occupations;

6. A local economic development entity and one or more eligible individual employers that seek to provide customized training in a labor demand occupation.

B. All applications by eligible applicants for customized training shall be submitted in conjunction with the entity selected by the applicant to provide the customized training. All disbursements of funds for the training shall be made to the entity actually providing the customized training. To be eligible, the training provider selected by the applicant must demonstrate a history of:

1. successful training through its placement, retention, and satisfaction rates;

2. collaboration with the targeted industry in the development of the training program curriculum;

3. use of a current industry standard as the basis for programs utilized to train students for employment in the targeted industry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1142 (June 1999).

§105. Criteria

A. Employer(s) must be in full compliance with Louisiana unemployment insurance laws.

B. During the first nine months of a fiscal year, not less than 25 percent of all funds available during a fiscal year shall be available for employers with 150 or fewer Louisiana-based employees. For the final three months of a fiscal year, the remaining available funds will be available to all eligible employers, without size restrictions.

C. No single employer shall receive training funds more than once in a 24-month time period. No single employer shall receive more than 5 percent of the total funds available to the program during a fiscal year.

D. Employers receiving awards must provide evidence satisfactory to LDOL of their long-range commitment to employee training and that funds shall be used to supplement and not supplant existing training efforts.

E. Applicants must request training for at least 15 employees.

F. Special emphasis shall be placed on entry-level/incumbent training programs.

G. Preference will be given to employers that have:

1. selected a public training institution as the training provider;

2. donated materials, equipment, or instructors to public training providers, secondary and postsecondary vocational-technical schools, or community colleges within the state;

3. hired former welfare recipients through participation in the Welfare to Work Partnership.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

§107. Application Procedure

LDOL will provide a standard form which applicants will use to apply for assistance. The application form will contain, but not be limited to, detailed descriptions of the following:

1. an overview of the company, its history, and the business climate in which it operates;

2. the company's overall training plan, including a summary of the types and amounts of training to be provided and a description of how the company determined its need for training;

3. the specific training programs for which LDOL assistance is requested, including descriptions of the methods, providers and costs of the proposed training; and

4. any additional information the secretary may require.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

§109. Submission and Review Procedure

A. Applicants must submit their completed application to LDOL. Submitted applications will be reviewed and evaluated by LDOL staff. Input may be required from the applicant, other divisions of the Department of Labor, and other state agencies as needed, in order to:

1. understand the labor market conditions the proposed training is seeking to mitigate;

2. evaluate the strategic importance of the proposed training to the economic well-being of the state and local communities;

3. determine whether the employer's specific needs are best met by training;

4. identify the availability of existing training programs which could be adapted to meet the employer's needs;

5. identify the resources the business can provide to support the training, including trainers, facilities, materials and equipment;

6. identify or develop appropriate curricula; and

7. determine the most cost effective approach to meet the employer's training needs.

B. Upon determination that an application meets the eligibility criteria for this program and is deemed to be beneficial to the well-being of the state, LDOL staff will then make a recommendation to the secretary of the Department of Labor. The application will then be reviewed and approved by the following entities in the following order:

1. the secretary of the Department of Labor;

2. the governor.

C. A copy of the application shall be sent to the executive director of the Louisiana Workforce Commission. No funds spent on the project prior to the secretary's approval will be considered eligible project costs.

D. The secretary will issue a Letter of Commitment to the applicant within five working days of the application approval by the governor.

E. If any application is rejected by any of the preceding entities, the application shall not be considered by the next succeeding entity unless first reconsidered and approved by the entity which initially rejected the application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

§111. General Award Provisions

A. Award Contract

1. A contract will be executed between LDOL, the awardee (and/or company(ies) receiving training) and the training provider. The contract will specify the performance objectives expected of the company(ies) and the compliance requirements to be enforced in exchange for state assistance, including, but not limited to, time lines for job training.

2. The monitoring entity will monitor the progress of the training.

3. LDOL will reimburse the training provider from invoices submitted by the training provider on a form approved by LDOL and disburse funds from invoices or certificates of work completed.

4. The cost associated with the contract between the monitoring entity and the awardee will be considered part of the total training award, but will not exceed 5 percent of the award amount or \$10,000, whichever is less.

5. Funds may be used for training programs extending up to two years in duration.

B. Use of Funds

1. The Louisiana Workforce Development Training Account offers financial assistance in the form of a grant for reimbursement of eligible training costs specified in the award agreement.

2. Eligible training costs may include, inter alia, the following:

a. instruction costs—wages for company trainers and training coordinators, Louisiana public and/or private school tuition, contracts for vendor trainers, training seminars;

b. travel costs (limited to 30 percent of the total training award)—travel for trainers and training coordinators (company and other), and travel for trainees; travel expenses reimbursable under this agreement will comply with State Travel Regulations, PPM 49;

c. materials and supplies costs—training texts and manuals, audio/visual materials, skills assessment (documents or services to determine training needs), raw materials (for manufacturing and new employee on-the-job training), Computer Based Training (CBT) software; and

d. other costs—facility rental, and fees or service costs incurred by the monitoring entity associated with the contract to monitor the training.

3. Training costs ineligible for reimbursement include:

a. trainee wages and fringe benefits;

b. nonconsumable tangible property (e.g., equipment, calculators, furniture, classroom fixtures, non-Computer Based Training (CBT) software), unless owned by a public training provider;

c. out-of-state, publicly supported schools;

d. employee handbooks;

e. scrap produced during training;

f. food, refreshments; and

g. awards.

C. Conditions for Disbursement of Funds

1. Funds will be available on a reimbursement basis following submission of approved invoices to LDOL. Only funds spent on the project after the secretary's approval will be considered eligible for reimbursement.

2. Invoices will be eligible for reimbursement at 90 percent until all contracted performance objectives have been met. After the company has achieved 100 percent of its contracted performance objectives, the remaining 10 percent of the grant award will be made available for reimbursement.

3. All disbursements of funds shall be made to the training provider actually providing the customized training.

D. Compliance Requirements

1. Training providers shall be required to complete quarterly reports describing progress toward the performance objectives specified in their contract with LDOL.

2. In the event the awardee fails to meet its performance objectives specified in its contract with LDOL, LDOL shall retain the rights to withhold award funds, modify the terms and conditions of the award, and to reclaim disbursed funds from the awardee in an amount commensurate with the scope of the unmet performance objectives and the foregone benefits to the state.

3. In the event the awardee or monitoring entity knowingly files a false statement in its application or in a progress report, the awardee or monitoring entity shall be guilty of the offense of filing false public records and shall be subject to the penalty provided for in La. R.S. 14:133.

4. LDOL shall retain the right to require and/or conduct financial and performance audits of a project,

including all relevant records and documents of the awardee and the monitoring entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

Garey Forster

Secretary

9906#023

RULE

Department of Social Services Office of Community Services

Reimbursement Rates for Residential Facilities (LAC 67:V.3503)

The Department of Social Services, Office of Community Services, has amended the rule entitled "Reimbursement Rates for Residential Facilities." The current rate setting methodology has been changed.

Title 67

SOCIAL SERVICES

Part V. Office of Community Services

Subpart 5. Foster Care

Chapter 35. Payments, Reimbursables and Expenditures

§3503. Reimbursement Rates for Residential Facilities

A.1. The rate setting methodology for residential facilities reimbursed by the Department of Social Services/Office of Community Services consists of four components:

a. administration;

b. basic care;

c. supervision; and

d. intervention.

2. Costs will be reimbursed through cost models with the models based on historical costs, reasonable costs and the level of services the Department wishes to purchase. Administrative costs will be reimbursed through models of reasonable administrative structures which are based on facility size and agency complexity. The costs of basic care will be based on the cost of raising a child as estimated by the United States Department of Agriculture. The model for the supervision component is based on the level of staffing needed to care for the level of care required for the children in the facility. Costs associated with supervision will continue to reflect the cost for direct care workers, and their immediate supervisors, when the supervisors are not included in the administration component. Costs associated with intervention will continue to reflect the cost of professional social workers, psychologists and psychiatrists and related costs. The salary levels in the Administrative, Intervention and Supervision cost models are based on the salaries for equivalent state workers. The rate will be the sum of the four components appropriate to the care being delivered to the client.

B. Facilities receiving reimbursement under this rate methodology will be required to submit audited cost reports to the Office of Community Services every second year,

starting with the first year of implementation. The audit must be conducted by a certified public accountant, must determine whether the cost report conforms to the requirements of the Department of Social Services, Rate Setting for Residential Services Manual, and must contain the opinion of a certified public accountant that the costs shown in the cost report are accurate and allowable. Facilities which submit costs reports after the date specified by the Office of Community Services are subject to progressive penalties including fiscal sanctions, suspension of eligibility for OCS placements and termination of the placement agreement with OCS.

C. Each year the Department will implement a percentage of the calculated rates as the approved budget allows.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:1084.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 14:542 (August 1988), amended LR 20:898 (August 1994), LR 25:1144 (June 1999).

Madlyn Bagneris
Secretary

9906#062

RULE

Department of Social Services Office of the Secretary

Drug Testing of Employees (LAC 67:I.101-121)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and in accordance with Executive Order MJF 98-38 and R.S. 49:1001 et seq., the Department of Social Services, Office of the Secretary has adopted rules regarding the implementation of a drug testing program for new and existing employees within the department.

Title 67

SOCIAL SERVICES

Part I. Office of the Secretary

Subpart 1. General Administration

Chapter 1. Drug Testing

§101. Introduction and Purpose

A. The employees of the State of Louisiana are among the state's most valuable resources, and the physical and mental well-being of these employees is necessary for them to properly carry out their responsibilities. Substance abuse causes serious adverse consequences to users, impacting on their productivity, health and safety, dependents and co-workers, as well as the general public. Substance abuse on the job can cause undue risk of harm to the public in general and the children and other clients directly served by and dependent on the services of the Department of Social Services (DSS).

B. The State of Louisiana has a long-standing commitment to working toward a drug-free workplace. In order to curb the use of illegal drugs by employees of the State of Louisiana, the Louisiana Legislature enacted laws

which provide for the creation and implementation of drug testing programs for state employees. Further, the Governor of the State of Louisiana issued Executive Order Number MJF 98-38 providing for the promulgation by executive agencies of written policies mandating drug testing of employees, appointees, prospective employees and prospective appointees, pursuant to R.S. 49:1001 et seq.

C. The Department of Social Services fully supports these efforts and is committed to a drug-free workplace.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1145 (June 1999).

§103. Applicability

This policy shall apply to all employees of DSS including appointees and all other persons having any employment relationship with this agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1145 (June 1999).

§105. Definitions

Controlled Substance—a drug, chemical substance or immediate precursor in Schedules I through V of R.S. 40:964 or Section 202 of the Controlled Substances Act (21 U.S.C. 812).

Designer (Synthetic) Drugs—those chemical substances that are made in clandestine laboratories where the molecular structure of both legal and illegal drugs is altered to create a drug that is not explicitly banned by federal law.

Employee—unclassified, classified, and student employees, student interns, both paid and unpaid, and any other person having any employment relationship with the agency, regardless of the appointment type (e.g. full-time, part-time, temporary, etc.).

Illegal Drug—any drug which is not legally obtainable or which has not been legally obtained, to include prescribed drugs not legally obtained and prescribed drugs not being used for prescribed purposes or being used by one other than the person for whom prescribed.

Public Vehicle—any motor vehicle, water craft, air craft or rail vehicle owned or controlled by the state.

Reasonable Suspicion—belief based upon reliable, objective and articulable facts derived from direct observation of specific physical, behavioral, odorous presence, or performance indicators and being of sufficient import and quantity to lead a prudent person to suspect that an employee is in violation of this policy.

Safety-Sensitive or *Security-Sensitive*—a position determined by the appointing authority to contain duties of such nature that the compelling state interest to keep the incumbent drug-free outweighs the employee's privacy interests. Executive Order Number MJF 98-38 sets forth the following non-exclusive list of examples of safety-sensitive and/or security-sensitive positions in state government:

1. positions with duties that may require or authorize the safety inspection of a structure;
2. positions with duties that may require or authorize access to a prison or an incarcerated individual;

3. positions with duties that may require or authorize carrying a firearm;

4. positions with duties that may allow access to controlled substances (drugs);

5. positions with duties that may require or authorized inspecting, handling, or transporting hazardous waste as defined in R.S. 30:2173(2) or hazardous materials as defined in R.S. 32:1502(5);

6. positions with duties that may require or authorize any responsibility over power plant equipment;

7. positions with duties that may require instructing or supervising any person to operate or maintain, or that may require or authorize the operating or maintaining, any heavy equipment or machinery;

8. positions with duties that may require or authorize the operation or maintenance of a public vehicle, or the supervision of such an employee.

Under the Influence—for the purposes of this policy, a drug, chemical substance, or the combination of a drug, chemical substance that affects an employee in any detectable manner. The symptoms or influence are not confined to that consistent with misbehavior, nor to obvious impairment of physical or mental ability, such as slurred speech or difficulty in maintaining balance. A determination of influence can be established by a professional opinion or a scientifically valid test.

Workplace—any location on agency property including all property, offices, facilities, vehicles and equipment, whether owned, leased or otherwise used by the agency or by an employee on behalf of the agency in the conduct of its business, in addition to any location from which an individual conducts agency business while such business is being conducted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1145 (June 1999).

§107. DSS Drug-free Workplace Policy

A. It shall be the policy of DSS to maintain a drug-free workplace and a workforce free of substance abuse (see DSS Policy 8050-89). Employees are prohibited from reporting for work, performing work, or otherwise being on any duty status for DSS with the presence in their bodies of illegal drugs, controlled substances, or designer (synthetic) drugs at or above the initial testing levels and confirmatory testing levels as established in the contract between the State of Louisiana and the official provider of drug testing services. Employees are further prohibited from illegal use, possession, dispensation, distribution, manufacture, or sale of controlled substances, designer (synthetic) drugs, and illegal drugs at the work site and while on official state business, on duty or on call for duty.

B. To assure maintenance of a drug-free workforce, it shall be the policy of DSS to implement a program of drug testing in accordance with Executive Order Number MJF 98-38, R.S. 49:1001 et seq., and all other applicable federal and state laws, as set forth below.

C. DSS will begin drug testing after the Division of Administration (DOA) awards the request for proposal to a drug testing service and provides procedures to the department regarding the use of the drug testing service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1146 (June 1999).

§109. Conditions Requiring Drug Tests

A. DSS shall require drug testing under the following conditions.

1. Reasonable Suspicion. Any employee shall be required to submit to a drug test if there is a reasonable suspicion (as defined in this policy) that the employee is using illegal drugs. At least two supervisors/managers must concur there is reasonable suspicion before an employee is required to submit to a drug test.

2. Post-Accident. Each employee involved in an accident that occurs during the course and scope of employment shall be required to submit to a drug test if the accident:

a. involves circumstances leading to a reasonable suspicion of the employee's drug use;

b. results in a fatality; or

c. results in or causes the release of hazardous waste as defined in R.S. 30:2173(2) or hazardous materials as defined in R.S. 32:1502(5).

3. Rehabilitation Monitoring. Any employee who is participating in a substance abuse after-treatment program or who has a rehabilitation agreement with the agency shall be required to submit to random drug testing.

4. Pre-Employment. Each prospective employee shall be required to submit to drug screening at the time and place designated by the appointing authority or designee following a job offer contingent upon a negative drug-testing result. Pursuant to R.S. 49:1008, a prospective employee who tests positive for the presence of drugs in the initial screening or who fails to cooperate in the testing shall be eliminated from consideration for employment.

5. Safety-Sensitive and Security-Sensitive Positions—Appointments and Promotions. Each employee who is offered a safety-sensitive or security sensitive position (as defined in this policy) shall be required to pass a drug test before being placed in such position, whether through appointment or promotion. (See §119 listing of these positions.)

6. Safety-Sensitive and Security-Sensitive Positions—Random Testing. Every employee in a safety-sensitive or security-sensitive position shall be required to submit to drug testing as required by the appointing authority, who shall periodically call for a sample of such employees, selected at random by a computer-generated random selection process, and require them to report for testing. All such testing shall, if practicable, occur during the selected employee's work schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1146 (June 1999).

§111. Procedure

A. Drug testing pursuant to this policy shall be conducted for the presence of any illegal drugs including, but not limited to, cannabinoids (marijuana metabolites), cocaine metabolites, opiate metabolites, phencyclidine, and amphetamines in accordance with the provisions of R.S. 49:1001 et seq. DSS reserves the right to test employees for

the presence of any other illegal drugs or controlled substance when there is a reasonable suspicion to do so.

B. The human resource director of each Office shall be involved in any determination that one of the above-named conditions requiring drug-testing exists. Upon such determination, the appointing authority or designee for each Office shall notify the supervisor of the employee to be tested, who shall immediately notify the employee where and when to report for the testing.

C. Testing services shall be performed by a provider chosen by the Office of State Purchasing, Division of Administration, pursuant to applicable bid laws. At a minimum, the testing service shall assure the following.

1. All specimen collections will be performed in accordance with applicable federal and state regulations and guidelines to ensure the integrity of the specimens and the privacy of the donors. The appointing authority or designee for each Office shall review and concur in advance with any decision by a collection site person to obtain a specimen under direct observation. All direct observation shall be conducted by a collection site person of the same gender.

2. Chain of custody forms must be provided to ensure the integrity of each urine specimen by tracking its handling and storage from point of collection to final disposition.

3. Testing shall be performed by a SAMSHA-certified (Substance Abuse Mental Services Health Administration) laboratory.

4. The laboratory shall use a cut-off of 50 ng/ml for a positive finding in testing for cannabinoids.

5. All positives reported by the laboratory must be confirmed by gas/chromatography/mass spectrometry.

6. All initial positive results of drug-testing shall be reported by the laboratory to a qualified medical review officer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1146 (June 1999).

§113. Confidentiality

All information, interviews, reports, statements, memoranda, and/or test results received by DSS through its drug testing program are confidential communications, pursuant to R.S. 49:1012, and may not be used or received in evidence, obtained in discovery, or disclosed in any public or private proceedings, except in an administrative or disciplinary proceeding or hearing, or civil litigation where drug use by the tested individual is relevant. These records will be kept in a locked confidential file just as any other medical records are retained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1147 (June 1999).

§115. Responsibilities

A. The Secretary of DSS is responsible for the overall compliance with this policy and shall submit to the Office of the Governor, through the Commissioner of Administration, a report on this policy and drug testing program; describing the process, the number of employees affected, the categories of testing being conducted, the associated costs of testing, and the effectiveness of the program by November 1 of each year.

B. The appointing authority or designee is responsible for administering the drug testing program; determining when drug testing is appropriate; receiving, acting on, and holding confidential all information received from the testing services provider and from the medical review officer; and collecting appropriate information necessary to agency defense in the event of legal challenge.

C. All supervisory personnel are responsible for assuring that each employee under their supervision receives a copy of this policy, signs a receipt form, and understands or is given the opportunity to understand and have questions answered about its contents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1147 (June 1999).

§117. Violation of the Policy

A. Positive Test Result. Any employee reported with a confirmed positive test will be subject to the following disciplinary action, up to and including termination at the Secretary's discretion. Post-accident or return to duty tests which are positive will result in the employee's termination. At a minimum the following actions will be taken in the instance of a first positive test.

1. The safety-sensitive employee will be suspended without pay for a period of time determined by the appointing authority but not less than one week.

2. The employee must meet with an approved chemical abuse counselor for a substance abuse evaluation. The employee must release the substance abuse evaluation prior to returning to duty. The evaluation will become part of the follow-up plan for that employee to continue employment with the department.

3. The employee shall be screened on a random basis for not less than 12 months nor more than 60 months. Follow-up testing, return to duty testing, counseling and any other recommended treatment will be at the cost of the employee and not the department.

B. Refusal to Test. Any employee refusing to submit to a drug test will be subject to the consequences of a positive test. A refusal is defined as a verbal refusal, abusive language to the supervisor or personnel performing the test, or tampering of any sample, container, equipment or documentation of the sampling process. If a test is determined to be invalid, it is not considered a refusal and no disciplinary action will be taken. Inability to perform the testing procedures must be documented by a medical physician and recorded in the employee's personnel file.

C. Challenging Test Results. All initial screening tests must be confirmed by a second more accurate test with the results reviewed by a medical review officer. If a current or prospective employee receives a confirmed positive test result, he/she may challenge the test results within 72 hours of actual notification, with the understanding that he/she might be placed on suspension pending investigation, until the challenge is resolved. A written explanation of the reason for the positive test result may be submitted to the medical review officer. Employees who are on legally prescribed and obtained medication for a documented illness, injury or ailment will be eligible for continued employment upon receiving clearance from the medical review officer.

D. Other Violations. Each violation and alleged violation of this policy will be handled on an individual basis, taking into account all data, including the risk to self, fellow employees, clients, and the general public.

E. Failure to comply with provision of the policy, including but not limited to, the following, will be grounds for disciplinary action:

1. possession of controlled substances without a prescription or sale of controlled substances will be cause for immediate discharge;

2. refusal or failure to report to an approved counseling or rehabilitation program after voluntarily requesting help for drug addiction;

3. refusal or failure to report to an approved counseling or rehabilitation program, if advised by the department to do so, after a confirmed positive test for any substance prohibited by this policy;

4. leaving a treatment program prior to completion and not being properly released to return to work.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1147 (June 1999).

§119. Attachment A—Safety-Sensitive and Security-Sensitive Positions Within DSS

A candidate for one of the following positions will be required to pass a drug test before being placed in such a position, whether through appointment or promotion:

Louisiana Rehabilitation Services	Registered Nurse Licensed Practical Nurse Psychiatric Aide Supervisor Psychiatric Aide Rehabilitation Facility Supervisor Rehabilitation Aide Maintenance Repairer Maintenance Repairer Master Administrative Specialist 3 (Position 060871)
Office of Family Support	Support Enforcement Specialist I Support Enforcement Regional Administrator Support Enforcement District Manager Support Enforcement Specialist II Support Enforcement Supervisor
Office of Community Services	Social Service Counselor I Social Service Counselor II Social Service Counselor Supervisor Social Service Counselor/Adoption Social Service Specialist Intern Social Service Specialist I Social Service Specialist II Social Service Specialist III Social Service Supervisor Client Service Worker
Office of the Secretary/Office of Management and Finance	Licensing Specialist External Auditor Mailroom Courier

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1148 (June 1999).

§121. Attachment B—Procedures for Scheduling Drug Testing

A. On a yearly basis a percentage of all DSS employees in safety-sensitive or security-sensitive positions will be randomly drug-tested. One-twelfth of that number will be scheduled each month.

1. Information services will set up a computerized system which will randomly select a designated number of employees by social security numbers.

2. Each month the appropriate managers will be notified by human resources of the names of employees in their office location randomly selected to be drug-tested. The names of employees to be tested must be kept confidential at all times.

3. Based on each individual employee's schedule, at the earliest possible date within the designated month, the appropriate manager will notify the employee in writing first thing in the morning that they must report to a designated lab for testing. Human resources must be notified if an employee is on extended leave.

4. Each employee must go to the designated lab within 24 hours of being notified.

5. The office human resources personnel will be notified of the results of the tests. All test results must be kept confidential and retained in a locked file cabinet.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1148 (June 1999).

Madlyn B. Bagneris
Secretary

9906#061

Notices of Intent

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 741—Minutes Requirement
for 1/2 Carnegie Unit of Credit (LAC 28:I.901)

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 approved for advertisement, an amendment to Bulletin 741, referenced in LAC 28:I.901.A, promulgated by the Board of Elementary and Secondary Education in LR 1:483 (November, 1975). The content of the procedural block clarifies the number of minutes required for a one-half (1/2) Carnegie unit of credit: the minimum length of any high school class in which one-half (1/2) Carnegie unit of credit is earned shall be no less than one-half (1/2) of the total minutes required for one (1) full Carnegie unit of credit.

Title 28 EDUCATION

Part I. Board of Elementary and Secondary Education Chapter 9. Bulletins, Regulations, and State Plans Subchapter A. Bulletins and Regulations

§901. School Approval Standards and Regulations

A. Bulletin 741

* * *

Standard 2.037.11:

The minimum length of any high school class in which one-half (1/2) Carnegie unit of credit is earned shall be no less than one-half (1/2) of the total minutes required for one (1) full Carnegie unit of credit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3761-3764.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education in LR 1:483 (November, 1975) amended by the Board of Elementary and Secondary Education LR 25:

Interested persons may submit written comments until 4:30 p.m., August 10, 1999, to Jeannie Stokes, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Weegie Peabody
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Bulletin 741 Minutes Requirement for 1/2 Carnegie Unit of Credit

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

BESE's estimated cost for printing this policy change and first page of the fiscal and economic impact statement in the *Louisiana Register* is approximately \$60.

The implementation of changes requires no further cost or savings to state or local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is 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)

There are no effects on costs or economic benefits to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There are no effects on competition and employment.

Marlyn Langley
Deputy Superintendent
9906#032

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Student Financial Assistance Commission Office of Student Financial Assistance

Loan Guarantee Fee

The Louisiana Student Financial Assistance Commission (LASFAC) announces its intention to amend its fee schedule for loans guaranteed on or after May 5, 1999, as follows:

Loans Guaranteed before May 5, 1999	1% of loan principal
Loans Guaranteed on or after May 5, 1999	No Fee

Interested persons may submit written comments on the proposed changes until 4:30 p.m., July 20, 1999, to Jack L. Guinn, Executive Director, Office of Student Financial Assistance, Box 91202, Baton Rouge, LA 70821-9202.

Jack L. Guinn
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Loan Guarantee Fee

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The implementation cost associated with publishing these rule revisions in the *Louisiana Register* as declaration of emergency, notice, and rule is approximately \$120. Currently, under federal regulations, the 1% guarantee fee is deposited in the Federal Fund, which is the property of the U.S. Department of Education.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on state revenues collected by this agency. The 1998 Reauthorization of the Higher Education Act requires the agency to maintain a reserve ratio in the Federal Fund (the ratio between the original principal of loans

outstanding and the monies in the agency's Federal Fund) of .25%. Currently, the agency's reserve ratio is .94%, or about \$7.6 million more than the minimum currently required for operations to continue. If other assumptions remain equal, by eliminating the guarantee fee the Reserve Fund ratio will be maintained at above the .25% requirement.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Postsecondary education borrowers will benefit from the elimination of the guarantee fee by retaining the dollars for their school expenses.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The state guarantor's operation, in competition with national guarantors who also operate in the state, benefits Louisiana citizens and students who rely on the programs administered and the training and information provided by the state agency.

Jack L. Guinn
Executive Director
9906#017

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Tuition Trust Authority
Office of Student Financial Assistance**

Student Tuition and Revenue Trust (START Saving)
Program (LAC 28:VI.107, 301, 307)

The Louisiana Tuition Trust Authority (LATTA) announces its intention to amend rules of the Student Tuition and Revenue Trust (START Savings) Program (R.S. 3091-3099.2). The full text of these proposed rules may be viewed in the emergency rule section of this issue of the *Louisiana Register*.

Interested persons may submit written comments on the proposed changes until 4:30 p.m., July 20, 1999, to Jack L. Guinn, Executive Director, Office of Student Financial Assistance, Box 91202, Baton Rouge, LA 70821-9202.

Jack L. Guinn
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Student Tuition and Revenue Trust
(START Saving) Program**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The implementation cost associated with publishing revisions to the START Program rules is approximately \$100. These program revisions are not expected to impact program costs.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

No impact on revenue collections is anticipated to result from the expanded program enrollment period. Data are not available to assess the cost of the expanded use of tuition assistance grant (TAG) monies to out-of-state educational institutions. The lost revenue to in-state institutions would be

directly related to the dollar amount of TAGs that would be transported to out-of-state educational institutions.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

These changes will make the START saving program more attractive to its participants, provide for use of a generic contract which can be used continually, save on development and printing costs, and assist in reaching the participation goals projected for the program.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

No impact on competition and employment is anticipated to result from this rule.

Jack L. Guinn
Executive Director
9906#024

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Student Financial Assistance Commission
Office of Student Financial Assistance**

Tuition Opportunity Program for Students
(TOPS) (LAC 28:IV.301, 703, 803, 2115)

The Louisiana Student Financial Assistance Commission (LASFAC) advertises its intention to revise the provisions of the Tuition Opportunity Program for Students (TOPS).

The full text of these proposed rules may be viewed in the emergency rule section of this issue of the *Louisiana Register*.

Interested persons may submit written comments on the proposed changes until 4:30 p.m., July 20, 1999, to Jack L. Guinn, Executive Director, Office of the Student Financial Assistance, Box 91202, Baton Rouge, LA 70821-9202.

Jack L. Guinn
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Tuition Opportunity Program for
Students (TOPS)**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The implementation cost associated with publishing these rule revisions in the *Louisiana Register* as emergency, notice and rule is approximately \$100. Costs for funding for TOPS awards are not anticipated to increase as a result of this rule change.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

No impact on revenue collections is anticipated to result from this rule change.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

TOPS applicants who are disabled or exceptional may be provided a waiver of the core curriculum requirements as a result of this rule change.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)

No impact on competition and employment is anticipated to result from this rule.

Jack L. Guinn
Executive Director
9906#016

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

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

Emissions (LAC 33:III.5116, 5122, and 5311)(AQ193*)

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 rulemaking procedures have been initiated to amend the Air Quality Division regulations, LAC 33:III.5116, 5122, and 5311 (Log #AQ193*).

This proposed rule is identical to a federal regulation found in 40 CFR Parts 61 and 63, July 1, 1998, which is applicable in Louisiana. For more information regarding the federal requirement, contact the Investigations and Regulation Development Division at the address or phone number given below. 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 incorporates by reference, additional federal regulations in 40 CFR Parts 61 and 63, National Emission Standards for Hazardous Air Pollutants (NESHAP). These changes will expedite both the EPA approval process and the state implementation of delegation of authority for the NESHAP program. The NESHAP program and the authority for EPA to delegate authority of that program to the state is established in the Clean Air Act Amendments of 1990, Section 112. The State of Louisiana has received delegation of authority from the EPA to implement NESHAP by "straight" delegation (incorporation into the LAC rules as promulgated by EPA without change). Louisiana incorporated certain NESHAP regulations by reference on July 20, 1998. In agreement with the revised delegated authority mechanism and with EPA grant objectives, the department is now incorporating additional NESHAP regulations by reference. The basis and rationale for this rule is to mirror the federal regulations. If the rule is not adopted, it would be a hindrance to Louisiana's authority to implement the NESHAP program. Louisiana would also fail to meet its 1998/99 EPA grant objectives related to this rulemaking and to delegation revisions.

This proposed rule meets an exception 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 51. Comprehensive Toxic Air Pollutant
Emission Control Program**

**Subchapter B. Incorporation by Reference of 40 CFR
Part 61 (National Emission Standards for
Hazardous Air Pollutants)**

**§5116. Incorporation by Reference of 40 CFR Part 61
(National Emission Standards for Hazardous Air
Pollutants)**

A. Except as modified in this Section and specified below, National Emission Standards for Hazardous Air Pollutants published in the *Code of Federal Regulations* at 40 CFR part 61, revised as of July 1, 1998, and specifically listed in the following table are hereby incorporated by reference as they apply to sources in the State of Louisiana.

40 CFR 61	Subpart/Appendix Heading

[See Prior Text in Subpart A-Appendix C]	

[See Prior Text in B-C]

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 23:61 (January 1997), amended LR 23:1658 (December 1997), LR 24:1278 (July 1998), LR 25:

**Subchapter C. Incorporation by Reference of 40 CFR
Part 63 (National Standards for
Hazardous Air Pollutants for Source
Categories) as it Applies to Major Sources**

**§5122. Incorporation by Reference of 40 CFR Part 63
(National Standards for Hazardous Air
Pollutants for Source Categories) as it Applies to
Major Sources**

A. Except as modified in this Section and specified below, National Emission Standards for Hazardous Air Pollutants for Source Categories published in the *Code of Federal Regulations* at 40 CFR part 63, revised as of July 1, 1998, and specifically listed in the following table are hereby incorporated by reference as they apply to major sources in the State of Louisiana.

40 CFR 63	Subpart/Appendix Heading

[See Prior Text in Subpart A-R]	
Subpart S	National Emission Standards for Hazardous Air Pollutants from the Pulp and Paper Industry

[See Prior Text in Subpart T]	
Subpart U	National Emission Standards for Hazardous Air Pollutant Emissions: Group 1 Polymers and Resins

[See Prior Text in Subpart W-KK]	
Subpart LL	National Emission Standards for Hazardous Air Pollutants for Primary Aluminum Reduction Plants

[See Prior Text in Subpart OO-QQ]	

40 CFR 63	Subpart/Appendix Heading
Subpart RR	National Emission Standards for Individual Drain Systems * * *
[See Prior Text in Subpart VV]	
Subpart EEE	National Emission Standards for Hazardous Air Pollutants from Hazardous Waste Combustors
Subpart JJJ	National Emission Standards for Hazardous Air Pollutant Emissions: Group IV Polymers and Resins * * *
[See Prior Text in Appendix A-D]	

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 23:61 (January 1997), amended LR 23:1659 (December 1997), LR 24:1278 (July 1998), LR 24:2240 (December 1998), LR 25:

Chapter 53. Area Sources of Toxic Air Pollutants
Subchapter B. Incorporation by Reference of 40 CFR Part 63 (National Emission Standards for Hazardous Air Pollutants for Source Categories) as it Applies to Area Sources
§5311. Incorporation by Reference of 40 CFR Part 63 (National Emission Standards for Hazardous Air Pollutants for Source Categories) as it Applies to Area Sources

Except as modified in this Section and specified below, National Emission Standards for Hazardous Air Pollutants for Source Categories published in the *Code of Federal Regulations* at 40 CFR part 63, revised as of July 1, 1998, and specifically listed in the following table are hereby incorporated by reference as they apply to area sources in the State of Louisiana.

40 CFR 63	Subpart/Appendix Heading
* * *	
[See Prior Text in Subpart A-Subpart X]	

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 23:63 (January 1997), amended LR 23:1660 (December 1997), LR 24:1279 (July 1998), LR 25:

A public hearing will be held on July 26, 1999, 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 (225) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by AQ193*. Such comments must be received no later than July 26, 1999, at 4:30 p.m., and should be sent to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884 or to fax (225) 765-0486.

The comment period for this rule ends on the same date as the public hearing. Copies of this proposed regulation can be purchased at the above referenced address. Contact the Investigations and Regulation Development Division at (225) 765-0399 for pricing information. Check or money order is required in advance for each copy of AQ193*.

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; 104 Lococo Drive, Raceland, LA 70394 or on the Internet at <http://www.deq.state.la.us/olae/irdd/olaereg.htm>.

Gus Von Bodungen, P.E.
Assistant Secretary

9906#051

NOTICE OF INTENT

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

Graphic Arts (Printing) by Rotogravure and Flexographic Processes (LAC 33:III.2143)(AQ192)

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 rulemaking procedures have been initiated to amend the Air Quality Division regulations, LAC 33:III.2143.A.1 and B (Log #AQ192).

This proposed rule will make a grammatical correction and will clarify the applicability exemption in the regulations regarding the control of volatile organic compounds for the rotogravure and flexographic processes. The basis and rationale for this proposed rule are to make a grammatical clarification and clarification of applicability.

This proposed rule meets an exception 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 21. Control of Emission of Organic Compounds

Subchapter H. Graphic Arts

§2143. Graphic Arts (Printing) by Rotogravure and Flexographic Processes

* * *

[See Prior Text in A]

1. The solvent fraction of ink, as it is applied to the substrate, less water and exempt solvent, contains 25 volume percent or less of organic solvent and 75 volume percent or more of water. Also acceptable as an alternative limit is ink

containing no more than 0.5 pounds of volatile organic compounds per pound of solids.

* * *

[See Prior Text in A.2-5]

B. Applicability Exemption. A rotogravure or flexographic printing facility that has the potential to emit at full production (8760 hours per year basis) a combined weight of volatile organic compounds of less than 50 TPY (in nonattainment areas) or 100 TPY (in attainment areas), calculated from historical records of actual consumption of ink, is exempt from the provisions of Subsections A and C of this Section and need only comply with Subsection D of this Section.

* * *

[See Prior Text in C-D.3]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 16:959 (November 1990), LR 18:1123 (October 1992), LR 22:1212 (December 1996), LR 24:25 (January 1998), LR 25:

A public hearing will be held on July 26, 1999, 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 (225) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by AQ192. Such comments must be received no later than August 2, 1999, at 4:30 p.m., and should be sent to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884 or to fax (225) 765-0486. Copies of this proposed regulation can be purchased at the above referenced address. Contact the Investigations and Regulation Development Division at (225) 765-0399 for pricing information. Check or money order is required in advance for each copy of AQ192.

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; 104 Lococo Drive, Raceland, LA 70394 or on the Internet at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>.

Gus Von Bodungen, P.E.
Assistant Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Graphic Arts (Printing) by Rotogravure
and Flexographic Processes**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
There will be no costs or savings to state or local governmental units for this proposal.
- 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 as a result of this rule.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
The rule makes technical changes which will neither exempt additional facilities from existing standards and requirements nor will preclude the use of such exemptions by these facilities.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This proposal will have no effect on competition or employment.

Gus Von Bodungen
Assistant Secretary
9906#047

Robert E. Hosse
General Government Section Director
Legislative Fiscal Office

**NOTICE OF INTENT
Department of Environmental Quality
Office of the Secretary**

Louisiana Environmental Regulatory Innovations Program
(LERIP)(LAC 33:I.3701-3715)(OS032)

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 rulemaking procedures have been initiated to adopt the Office of the Secretary regulations, LAC 33:I.Chapter 37 (Log No. OS032).

The proposed rule will establish the procedures for participation in the Louisiana Environmental Regulatory Innovations Program (LERIP), as well as an Excellence and Leadership Program. The proposed rule contains application requirements, department review conditions, a priority system for ranking demonstration projects, project amendment and renewal procedures, and project termination. Facility owners and operators, in conjunction with stakeholders, are encouraged to develop and implement effective pollution prevention and/or pollution reduction strategies to achieve levels below required regulation levels. R.S. 30:2566 requires the department to promulgate regulations for the administration of the Louisiana Environmental Regulatory Innovations Programs, including the Excellence and Leadership Program. The basis and

rationale for this proposed rule are to promulgate regulations to consider regulatory flexibility as an incentive to superior environmental performance.

This proposed rule meets an exception 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 I. Office of the Secretary

Subpart 1. Departmental Administrative Procedures

Chapter 37. Regulatory Innovations Programs

§3701. Purpose

This Chapter establishes procedures for voluntary participation in the Louisiana Environmental Regulatory Innovations Programs (LERIP) as provided by R.S. 30:2561 et seq. Its purpose is to provide regulatory flexibility consistent with federal guidelines in exchange for superior environmental performance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

§3703. Definitions

Administrative Authority—the secretary of the Department of Environmental Quality or the secretary's designee.

Demonstration Project (DP)—a project containing all the elements required in LAC 33:I.3705, which shall be implemented in exchange for regulatory flexibility.

Final Project Agreement (FPA)—the final document agreed upon between the administrative authority and a program participant that specifically states the terms and duration of the proposed project. The final project agreement is an enforceable document.

Regulatory Flexibility—exemption by the administrative authority from regulations promulgated by the department, consistent with federal law and regulation.

Stakeholders—citizens in the communities near the project site, facility workers, government representatives, industry representatives, environmental groups, or other public interest groups with representatives in Louisiana and Louisiana citizens.

Superior Environmental Performance—

1. a significant decrease of pollution to levels lower than the levels currently being achieved by the subject facility under applicable law or regulation, where these lower levels are better than required by the applicable law and regulation; or

2. improved social or economic benefits to the state, as determined by the administrative authority, while achieving protection to the environment as required by applicable law and regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

§3705. Application for a Demonstration Project

A. An application for a demonstration project (DP) shall be submitted to the administrative authority. The application shall, at a minimum, include:

1. a narrative summary of the DP, including the specific statutes or rules for which an exemption is being sought;

2. a detailed explanation including a demonstration that the DP:

a. is at least as protective of the environment and the public health as the method or standard prescribed by the statute or rule that would otherwise apply;

b. will provide superior environmental performance;

c. will not transfer pollution impacts into a product;

d. will identify, if applicable, any proposed transfer of pollutants between media;

e. will include verifiable measures of success for project goals;

f. will not increase or shift risk to citizens or communities;

g. is consistent with federal law and regulation, including any requirement for a federally approved or authorized program; and

h. reduces the time and money spent at the facility on paperwork and other administrative tasks that do not directly benefit the environment;

3. an implementation schedule that includes a proposal for monitoring, recordkeeping, and/or reporting, where appropriate, of environmental performance and compliance under the DP;

4. a plan to identify and contact stakeholders, to advise stakeholders of the facts and nature of the project, and to request stakeholder participation and review. Stakeholder participation and review shall occur during the development, consideration, and implementation stages of the DP. The plan shall also include notice to the employees of the facility to be covered by the proposed project and a description of efforts made or proposed to achieve local community support;

5. the time period for which the exemption is sought; and

6. any other information requested from the applicant by the administrative authority during the application period.

B. The application shall be signed by the applicant or its duly authorized agent and shall certify that all information is true, accurate, and complete to the best of that person's knowledge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

§3707. Demonstration Project Priority System

A. Priority will be given to projects after considering whether the technology:

1. will result in significant pollution prevention or source reduction, particularly in low income areas already burdened with pollution;

2. will reduce air emissions in a nonattainment area;

3. will maintain or improve coastal wetland environments;

4. will be transferable to other members of the regulated community; and

5. will allow the department, the applicant, and other state and local agencies to spend less time and resources over the long term to monitor and administer the project.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

§3709. Review of Application for Demonstration Project

A. Within 180 days after submittal of an application for a DP, the department will conduct a review and notify the applicant of the acceptability of the proposed project.

B. The department will consider, among other factors, the applicant's compliance history and efforts made to involve the stakeholders and to achieve local community support.

C. If the department determines the DP to be unacceptable, it will provide written reasons for the determination.

D. If the department determines the DP to be acceptable:

1. a public hearing will be held at a location near the proposed project to receive comments;

2. public comments will be received for 30 days after the hearing;

3. a response summary addressing the major issues raised during the comment period will be prepared by the department;

4. an applicant may be required to supplement or modify the application;

5. a recommendation will be made to the administrative authority to approve or deny the project; and

6. a FPA will be executed or a denial issued.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

§3711. Public Notice

A. An applicant whose DP has been approved shall publish notice of the FPA in the official journal of the parish governing authority where the project will be implemented. Notice under this Section shall, at a minimum, include:

1. a brief description of the FPA and of the business conducted at the facility;

2. the name and address of the applicant and, if different, the location of the facility for which regulatory flexibility is sought; and

3. the name, address, and telephone number of a department contact person from whom interested persons may obtain further information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

§3713. Amendment or Renewal

A. An application for amendment or renewal of a FPA shall be filed in the same manner as an original application under this Chapter.

B. If amendment or renewal procedures have been initiated at least 120 days prior to the FPA expiration date, the existing FPA will remain in effect and will not expire until the administrative authority has made a final decision on the amendment or renewal.

C. The administrative authority shall determine whether a public hearing will be held.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

§3715. Termination

A. By the Recipient

1. A party to a FPA may terminate the FPA at any time by sending notice of termination to the administrative authority by certified mail.

2. The party terminating must be in compliance with all existing statutes or regulations at the time of termination.

B. By the Department

1. Noncompliance with the terms and conditions of a FPA or any provision of this Chapter may result in the FPA being voided, except that the recipient shall be given written notice of the noncompliance and provided an opportunity, not less than 30 days from the date the notice was mailed, to show cause why the FPA should not be voided. Procedures for requesting a show cause hearing before the Division of Administrative Law shall be included in the written notice.

2. In the event a FPA becomes void, the administrative authority may specify an appropriate and reasonable transition period to allow the recipient to come into full compliance with all existing statutory and regulatory requirements, including time to apply for any necessary agency permits, authorizations, or certifications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2561 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Legal Affairs and Enforcement, Legal Division, LR 25:

A public hearing will be held on July 26, 1999, 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 (225) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by OS032. Such comments must be received no later than August 2, 1999, at 4:30 p.m., and should be sent to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884 or to fax (225) 765-0486. Copies of this proposed regulation can be purchased at the above referenced address. Contact the Investigations and Regulation Development Division at (225) 765-0399 for pricing information. Check or money order is required in advance for each copy of OS032.

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; 104 Lococo Drive, Raceland, LA 70394 or on the Internet at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>.

Dale Givens
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Louisiana Environmental Regulatory
Innovations Program (LERIP)**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
No implementation cost or savings to state or local governmental units are expected as a result of this rule. However, departmental staff time may be saved through reduction of paperwork or other administrative tasks that do not benefit the environment.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
No effect on revenue collections of state or local governmental units is anticipated.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
The regulated community may receive some economic benefit by implementation of pollution prevention or reduction strategies that employ cheaper, more efficient or innovative technologies.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
No effect on competition and employment is expected as a result of this rule.

J. Dale Givens
Secretary
9906#050

Robert E. Hosse
General Government Section Director
Legislative Fiscal Office

**NOTICE OF INTENT
Department of Environmental Quality
Office of Waste Services
Hazardous Waste Division**

90-Day Tank Rule (LAC 33:V.1909)(HW067)

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 rulemaking procedures have been initiated to amend the Hazardous Waste Division regulations, LAC 33:V.1909.D (Log #HW067).

This rule seeks to make Louisiana's hazardous waste regulations on 90-day tanks clearer and to lessen the risk of accidental releases of hazardous waste due to having to physically open and inspect the tanks every 90 days. The basis and rationale for this proposed rule are to clarify the existing rule and allow it to be more consistent with EPA and neighboring state regulations.

This proposed rule meets an exception 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 V. Hazardous Waste and Hazardous Materials
Subpart 1. Department of Environmental
Quality Hazardous Waste
Chapter 19. Tanks
§1909. General Operating Requirements**

* * *

[See Prior Text in A-C]

D. Owners or operators must provide documentation, maintained on-site, that tanks subject to the accumulation time exclusion of LAC 33:V.1109.E have been emptied and cleaned of all residues and/or sludges at least once in each 90-day period.

1. A tank is deemed emptied and cleaned for the purposes of this Subsection if it has been emptied to the maximum extent practicable and:

a. for tanks used to store similar wastes (compatible), cleaning/rinsing or removal of hazardous waste to a level that is no more than 2.5 centimeters (one inch) of waste on the bottom of the tank or three percent by volume of the total tank capacity remains in the tank; or

b. for tanks that may be used to store dissimilar (incompatible) wastes, cleaning/rinsing by method(s) necessary to remove all hazardous wastes to a level which precludes any incompatibility reactions and is sufficient to allow visible inspection of all tank interior surfaces is required.

2. Notwithstanding the provisions of Subsection D.1 of this Section, except to the extent otherwise approved by the administrative authority, tanks subject to the exclusion of LAC 33:V.1109.E must be completely emptied and cleaned once per year to a level sufficient to allow visual inspection of all tank interior surfaces.

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 13:651 (November 1987), LR 16:614 (July 1990), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

A public hearing will be held on July 26, 1999, 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 (225) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by HW067. Such comments must be received no later than August 2, 1999, at 4:30 p.m., and should be sent to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884 or to fax (225) 765-0486. Copies of this proposed regulation can be purchased at the

above referenced address. Contact the Investigations and Regulation Development Division at (225) 765-0399 for pricing information. Check or money order is required in advance for each copy of HW067.

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; 104 Lococo Drive, Raceland, LA 70394 or on the Internet at <http://www.deq.state.la.us/olae/irdd/olaeregs.htm>.

James H. Brent, Ph.D.
Assistant Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: 90-Day Tank Rule (HW067)

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
No significant costs to state or local governments are anticipated as a result of the implementation of this rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There should be no significant effect on revenue collections of state or local governments as a result of the implementation of this rule.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
The regulated community will be relieved of the requirement to shut down the tank, drain, clean, and inspect it every 90 days. This would only be required once a year.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
Competition and employment are not expected to be significantly affected as a result of the implementation of this rule.

James H. Brent, Ph.D.
Assistant Secretary
9906#053

Robert E. Hosse
General Government Section Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Environmental Quality Office of Waste Services Hazardous Waste Division

EPA Authorization Package—RCRA VII, VIII, and IX
(LAC 33:V.517, 519, 1109, 3001, and 4301)(HW069*)

(Editor's Note: A portion of the following proposed rule, which appeared on pages 919 through 921 of the May 20, 1999 *Louisiana Register* is being republished to correct typographical errors.)

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 rulemaking procedures have been initiated to amend the Hazardous Waste Division regulations, LAC 33:V.517, 519, 1109, 3001, and 4301 (Log #HW069).

This proposed rule adds the requirement for a registered professional engineer who certifies specific technical data to be a Louisiana registered professional engineer. The universal wastes, lamps and antifreeze, were adopted in a previous regulatory package, but an omission of these wastes was made in LAC 33:V.4301. This rule is correcting the omission. LAC 33:V.3001 is being amended to exclude "conditionally exempt" from conditionally exempt small quantity generators, because Louisiana does not recognize conditionally exempt small quantity generators. The basis and rationale for this proposed rule are to clarify and correct specific requirements within Louisiana's 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 V. Hazardous Waste and Hazardous Materials

Subpart 1. Department of Environmental

Quality Hazardous Waste

Chapter 5. Permit Application Contents

Subchapter D. Part II General Permit Information Requirements

§517. Part II Information Requirements (the Formal Permit Application)

The formal permit application information requirements presented in this Section reflect the standards promulgated in LAC 33:V.Subpart 1. These information requirements are necessary in order to determine compliance with all standards. Responses and exhibits shall be numbered sequentially according to the technical standards. The permit application must describe how the facility will comply with each of the sections of LAC 33:V.Chapters 15-37 and 41. Information required in the formal permit application shall be submitted to the administrative authority and signed in accordance with requirements in LAC 33:V.509. The description must include appropriate design information (calculations, drawings, specifications, data, etc.) and administrative details (plans, flow charts, decision trees, manpower projections, operating instructions, etc.) to permit the administrative authority to determine the adequacy of the hazardous waste permit application. Certain technical data, such as design drawings, specifications, and engineering studies, shall be certified by a Louisiana registered professional engineer. If a section does not apply, the permit application must state it does not apply and why it does not apply. This information is to be submitted using the same numbering system and in the same order used in these regulations:

[See Prior Text in A - W]

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 10:280 (April 1984), LR 13:433 (August 1987), LR 14:790 (November 1988), LR 15:181 (March 1989), LR 15:378 (May 1989), LR 16:220 (March 1990), LR 16:399 (May 1990), LR 16:614 (July 1990), LR 16:683 (August 1990), LR 17:658 (July 1991), LR 18:1256 (November 1992), LR 21:266 (March 1995), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:657 (April 1998), LR 24:1691 (September 1998), LR 25:436 (March 1999), LR 25:

James H. Brent, Ph.D.
Assistant Secretary

9906#074

NOTICE OF INTENT

Department of Environmental Quality Office of Waste Services Hazardous Waste Division

Land Disposal of Prohibited Waste by Deep Well Injection
(LAC 33:V.517, 1529, 2201-2269, 2273, 4357 and 5120)
(HW062)

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 rulemaking procedures have been initiated to amend the Hazardous Waste Division regulations, LAC 33:V.517, 1529, 2201-2269, 2273, 4357, and 5120 (Log #HW062).

The proposed rule states that if land disposal by deep well injection has been exempted by the US EPA from the land disposal prohibitions; a permit has been issued for the injection well by the Louisiana Office of Conservation; and the secretary of the Department of Environmental Quality has made a determination that there are no economically reasonable and environmentally sound alternatives to the injection of such hazardous waste, then the land disposal restrictions do not apply to the disposal of the hazardous waste by injection well. The US EPA currently reviews and renders a decision on all petitions for exemption from the land disposal restrictions for hazardous waste disposal by injections wells. The Louisiana Office of Conservation is authorized to review and render a decision on applications for permits for all types of injection wells, including hazardous waste injection wells. This rule change will eliminate the department's duplication of work done by the US EPA and the Louisiana Office of Conservation. However, the department does retain the authority to grant or deny the use of injection wells for the disposal of hazardous waste based on the availability of economically reasonable and environmentally sound alternative methods of disposal. The basis and rationale for this rule is to bring the regulations in line with R.S. 30:2193.

This proposed rule meets an exception 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 V. Hazardous Waste and Hazardous Materials

Subpart 1. Department of Environmental

Quality Hazardous Waste

Chapter 5. Permit Application Contents

Subchapter D. Part II General Permit Information

Requirements

§517. Part II Information Requirements (the Formal Permit Application)

The formal permit application information requirements presented in this Section reflect the standards promulgated in LAC 33:V.Subpart 1. These information requirements are necessary in order to determine compliance with all standards. Responses and exhibits shall be numbered sequentially according to the technical standards. The permit application must describe how the facility will comply with each of the sections of LAC 33:V.Chapters 15-37 and 41. Information required in the formal permit application shall be submitted to the administrative authority and signed in accordance with requirements in LAC 33:V.509. The description must include appropriate design information (calculations, drawings, specifications, data, etc.) and administrative details (plans, flow charts, decision trees, manpower projections, operating instructions, etc.) to permit the administrative authority to determine the adequacy of the hazardous waste permit application. Certain technical data, such as design drawings, specifications, and engineering studies, shall be certified by a registered professional engineer. If a section does not apply, the permit application must state it does not apply and why it does not apply. This information is to be submitted using the same numbering system and in the same order used in these regulations:

* * *

[See Prior Text in A-U]

V. for land disposal facilities, if an approval has been granted under LAC 33:V.2239, a petition has been approved under LAC 33:V.2241 or 2271, or a determination made under LAC 33:V.2273, a copy of the notice of approval or a determination is required; and

* * *

[See Prior Text in W]

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 10:280 (April 1984), LR 13:433 (August 1987), LR 14:790 (November 1988), LR 15:181 (March 1989), LR 15:378 (May 1989), LR 16:220 (March 1990), LR 16:399 (May 1990), LR 16:614 (July 1990), LR 16:683 (August 1990), LR 17:658 (July 1991), LR 18:1256 (November 1992), LR 21:266 (March 1995), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:657 (April 1998), LR 24:1691 (September 1998), LR 25:436 (March 1999), LR 25:

Chapter 15. Treatment, Storage, and Disposal Facilities

§1529. Operating Record and Reporting Requirements

* * *

[See Prior Text in A-B.11]

12. Records of the quantities (and date of placement) for each shipment of hazardous waste placed in land disposal units under an extension to the effective date of any land disposal prohibition granted in accordance with LAC 33:V.2239, a petition approved in accordance with LAC 33:V.2241 or 2271, a determination made under LAC 33:V.2273, or a certification under LAC 33:V.2235 and the applicable notice required by a generator under LAC 33:V.2245.

* * *

[See Prior Text in B.13-E.3]

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 15:378 (May 1989), LR 16:220 (March 1990), LR 16:399 (May 1990), LR 17:658 (July 1991), LR 18:1256 (November 1992), LR 20:1000 (September 1994), LR 21:266 (March 1995), LR 22:832 (September 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:1695 (September 1998), LR 25:437 (March 1999), LR 25:

Chapter 22. Prohibitions on Land Disposal
Subchapter A. Land Disposal Restrictions

§2201. Purpose, Scope, and Applicability

* * *

[See Prior Text A-G.1]

2. where persons have been granted an approval from a prohibition in accordance with a petition under LAC 33:V.2241 or 2271, or a determination made in accordance with LAC 33:V.2273, with respect to those wastes and units covered by the petition;

* * *

[See Prior Text G.3-I.5.e]

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 15:378 (May 1989), amended LR 16:398 (May 1990), LR 16:1057 (December 1990), LR 17:658 (July 1991), LR 18:723 (July 1992), LR 21:266 (March 1995), LR 22:22 (January 1996), LR 23:568 (May 1997), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:300 (February 1998), LR 24:666 (April 1998), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:1107 (June 1998), LR 24:1759 (September 1998), LR 24:1724 (September 1998), LR 25:

§2205. Storage of Prohibited Wastes

* * *

[See Prior Text in A-C]

D. The prohibition in Subsection A of this Section does not apply to hazardous wastes that are the subject of an approval under LAC 33:V.2241 or 2271, or a determination under LAC 33:V.2273, a case-by-case extension of time under LAC 33:V.2239, or a national capacity variance.

* * *

[See Prior Text in E-G]

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 15:378 (May 1989), amended LR 16:220 (March 1990), LR 17:658 (July 1991), LR 21:266 (March 1995), LR 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:1724 (September 1998), LR 25:

§2209. Waste-Specific Prohibitions Wood Preserving Wastes

* * *

[See Prior Text in A-C]

D. The requirements of Subsections A and B of this Section do not apply if:

1. an exemption or an approval has been granted in accordance with a petition under LAC 33:V.2241 or 2271, or a determination made under LAC 33:V.2273, with respect to those wastes and units covered by the petition;

* * *

[See Prior Text in D.2-E]

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 15:378 (May 1989), amended LR 17:658 (July 1991), LR 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:1725 (September 1998), LR 25:

§2211. Waste-Specific Prohibitions Dioxin-Containing Wastes

* * *

[See Prior Text in A-B.1]

2. the wastes are disposed of at a facility that has been granted an approval from a prohibition in accordance with a petition under LAC 33:V.2241 or 2271, or a determination made under LAC 33:V.2273, with respect to those wastes covered by the exemption or approval or determination; or

* * *

[See Prior Text in B.3-C]

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 15:378 (May 1989), amended LR 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:1725 (September 1998), LR 25:

§2243. Administrative Procedures for Exemptions under LAC 33:V.2241 and 2271, No-Alternative Determinations under LAC 33:V.2273, and Case-by-Case Extensions of an Effective Date under LAC 33:V.2239

Before making a final decision on the exemption, determination, or extension request, the administrative authority will provide the person requesting the exemption, determination, or extension and the public, through a newspaper notice in the official state journal and the local newspaper in the affected area, the cost of which will be charged to the person requesting the exemption, determination, or extension, the opportunity to submit written comments on the request on the conditions of the exemption, determination, or extension, allowing a 45-day comment period. The notices referred to in this Section will be provided in the local newspaper in three separate issues; however, the comment or notice period shall begin with the

notice in the official state journal. The administrative authority will also, in response to a request or at his or her own discretion, hold a public hearing whenever such a hearing might clarify one or more issues concerning the exemption, determination, or extension request. The administrative authority will give public notice of the hearing at least 30 days before it occurs. (Public notice of the hearing may be given at the same time as notice of the opportunity for the public to submit written comments.)

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 15:378 (May 1989), amended LR 16:1057 (December 1990), LR 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

Subchapter B. Hazardous Waste Injection Restrictions
§2249. Purpose, Scope, and Applicability

* * *

[See Prior Text in A-C.1]

2. if an approval has been granted in response to a petition filed under LAC 33:V.2271, or a determination has been made under LAC 33:V.2273, to allow injection of prohibited wastes with respect to those wastes and wells covered by the petition; or

* * *

[See Prior Text in C.3-D.2]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2255. Waste Analysis

Generators of hazardous wastes that are disposed into Class I injection wells, under LAC 33:V.2271, must comply with the applicable requirements of LAC 33:V.2245. Owners or operators of Class I hazardous waste injection wells must comply with the applicable requirements of LAC 33:V.2247.

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2257. Waste-Specific Prohibitions Solvent Wastes

* * *

[See Prior Text in A-D.1]

2. an approval has been granted in response to a petition under LAC 33:V.2271, or a determination made under LAC:V.2273; or

* * *

[See Prior Text in D.3-Table B]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2259. Waste-Specific Prohibitions Dioxin-Containing Wastes

* * *

[See Prior Text in A-B.1]

2. an approval has been granted in response to a petition under LAC 33:V.2271, or a determination made under LAC 33:V.2273; or

* * *

[See Prior Text in B.3]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2261. Waste-Specific Prohibitions California List Wastes

* * *

[See Prior Text in A-C.1]

2. an approval has been granted in response to a petition under LAC 33:V.2271, or a determination made under LAC 33:V.2273; or

* * *

[See Prior Text in C.3]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2263. Waste-Specific Prohibitions First Third Wastes

* * *

[See Prior Text in A-F.1]

2. an approval has been granted in response to a petition under LAC 33:V.2271, or a determination made under LAC 33:V. 2273; or

* * *

[See Prior Text in F.3]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2265. Waste-Specific Prohibitions Second Third Wastes

* * *

[See Prior Text in A-C.1]

2. an approval has been granted in response to a petition under LAC 33:V.2271, or a determination made under LAC 33:V.2273; or

* * *

[See Prior Text in C.3]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2267. Waste-Specific Prohibitions Third Third Wastes

* * *

[See Prior Text in A-D.1]

2. an approval has been granted in response to a petition under LAC 33:V.2271, or a determination made under LAC 33:V.2273; or

* * *

[See Prior Text in D.3]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2269. Waste-Specific Prohibitions Newly Listed Wastes

* * *

[See Prior Text in A-C.1]

2. an exemption or an approval has been granted in response to a petition under LAC 33:V.2271, or a determination made under LAC 33:V.2273; or

* * *

[See Prior Text in C.3]

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 22:22 (January 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

§2273. Petition for Determinations Concerning No Alternatives to Land Disposal of a Prohibited Waste by Deep Well Injection

A. To the extent that the administrative authority has previously determined, through the issuance of an exemption under LAC 33:V.2271 or otherwise under LAC 33:V.Chapter 22, that no economically and environmentally reasonable alternatives to injection exist to the land disposal of a particular hazardous waste by injection well(s), such determination shall satisfy the requirement of and be deemed the determination by the administrative authority for purposes of R.S. 30:2193(G)(3). A formal petition in accordance with Subsection C of this Section may, but need not, be filed by the owner or operator of the injection well. The land disposal of the hazardous waste subject to the exemption shall be deemed to be excluded from the requirements of R.S. 30:2193(A)-(F), LAC 33:V.2205-2271, and any conditions of such exemption. The provisions set forth in Subsections C-L of this Section shall be applicable to such determination.

B. This Section is intended to provide the requirements to implement the exclusion provision set forth in R.S. 30:2193(G)(1)-(3). The implementation of this exclusion requires a determination from the administrative authority that there are no economically reasonable and environmentally sound alternatives to the land disposal of a hazardous waste by injection well. The requirements of R. S. 30:2193(A)-(F) and LAC 33:V.2205-2271 shall not apply to the land disposal of a hazardous waste by injection well excluded under R.S. 30:2193(G)(1)-(3).

C. Any person seeking a determination of no alternatives must submit a petition to the administrative authority that does the following:

1. the petition must show that such land disposal has been exempted by the United States Environmental Protection Agency (EPA) from land disposal prohibitions contained in the Resource Conservation and Recovery Act, 42 U.S.C. 6901 et seq.;

2. the petition must show that a permit has been issued for such injection well or wells by the Louisiana Department of Natural Resources, Office of Conservation, in accordance with Title 30. Subtitle I. Chapter 1 of the Louisiana Revised

Statutes of 1950 and the Safe Drinking Water Act, 42 U.S.C. 300(f) et seq.;

3. the petition must show that for the injected hazardous waste there are no economically reasonable and environmentally sound alternatives to disposal into an injection well. The petition submitted in accordance with this Subsection must include:

a. an analysis of alternatives considered for technical feasibility;

b. an analysis of technically feasible alternatives, if any, showing whether any are economically reasonable;

c. an assessment of the impact of those economically reasonable alternatives considered, if any, on other environmental programs and permits of the facility, including impacts on air and water discharges; and

d. where applicable and appropriate, a description of the available capacity of economically reasonable and environmentally sound alternative technologies; and

4. the petition must include:

a. a waste characterization that describes the chemical and physical characteristics of the wastes being or to be injected;

b. a copy of the decision by the EPA exempting the land disposal from the prohibitions contained in the Resource Conservation and Recovery Act, 42 U.S.C. 6901 et seq., if issued;

c. a copy of the permit issued for such injection well or wells by the Louisiana Department of Natural Resources, Office of Conservation, in accordance with Title 30. Subtitle I. Chapter 1 of the Louisiana Revised Statutes of 1950 and the Safe Drinking Water Act, 42 U.S.C. 300(f), et seq., if issued;

d. such additional information as is required by the administrative authority to support the petition under this Section; and

e. this statement signed by a duly authorized representative:

"I certify under penalty of law that I have personally examined and am familiar with the information submitted for this petition and all attached documents, and that based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fines and imprisonment."

D. Following a determination under this Section, the owner or operator of the injection well must submit a report to the administrative authority, by March 1 of each calendar year during the term of the determination, describing in detail the efforts undertaken during the preceding calendar year to identify any economically reasonable and environmentally sound alternatives to disposal into an injection well for any hazardous waste injected on site.

E. Except as otherwise provided in this Section, if a hazardous waste not subject to an existing determination is to be injected, a petition that addresses such hazardous waste must be submitted and a determination of no alternatives be made prior to this waste being injected. The provisions contained in Subsection I of this Section, shall apply with respect to such hazardous waste.

1. If such hazardous waste is substantially similar in potential alternative technologies to a hazardous waste subject to an existing determination under this Section issued to the same owner or operator, a new petition is not necessary, and such hazardous waste shall be included within that determination upon the owner or operator providing notice to the administrative authority. The notice must include a brief showing that the alternatives determination for the existing hazardous waste is applicable to such hazardous waste.

2. If the administrative authority determines that the condition of Subsection E.1 of this Section is not satisfied, the administrative authority shall require the owner or operator of the injection well to submit a petition under Subsection C of this Section that addresses such hazardous waste. In this circumstance such hazardous waste may be injected pending a final decision by the administrative authority on the petition.

F. If a new injection well(s) is to be used to inject a hazardous waste subject to an existing approved determination under this Section, a new petition is not necessary, provided the owner or operator submits a notice to the administrative authority. The notice shall include a copy of the EPA exemption approval for the new well(s) and a copy of the permit issued by the Louisiana Department of Natural Resources, Office of Conservation for the new well(s).

G. The administrative authority shall provide public notice and an opportunity for public comment, in accordance with the procedures in LAC 33:V.2243, of the intent to approve or deny a petition for no-alternatives determination. The administrative authority shall provide public notice of the final decision on such a petition.

H. Whenever the administrative authority determines that the basis for a determination may no longer be valid, the administrative authority may require a new petition in accordance with this Section.

I. Termination of a No-Alternatives Determination

1. The administrative authority may terminate a determination granted under this Section for any of the following causes:

- a. noncompliance by the facility with any condition of the determination;
- b. the facility's failure in the petition or during the review and determination to disclose fully all relevant facts or the facility's misrepresentation of any relevant facts at any time;
- c. a determination that new information shows the basis for a determination of the petition is no longer valid;
- d. upon the denial or termination of a Louisiana Department of Natural Resources, Office of Conservation final permit; or
- e. upon the denial or termination of an EPA exemption for injection.

2. Should a determination be terminated because an economically reasonable and environmentally sound alternative exists, the administrative authority shall issue a compliance schedule authorizing continued injection for the amount of time reasonably necessary to construct and/or implement such alternative.

3. If during the review and determination of the petition, the facility willfully withholds facts directly and

materially relevant to the decision, the administrative authority may terminate the determination.

4. The administrative authority shall follow the procedures in LAC 33:V.323 in terminating any determination under this Section.

J. If a petition has been submitted in accordance with this Section and the EPA and the Louisiana Department of Natural Resources, Office of Conservation have approved the land disposal of prohibited waste by injection well, the land disposal of the waste by injection well may continue until the administrative authority makes a decision on the petition.

K. If a no-alternatives determination is vacated and/or remanded, the land disposal of the waste by injection well may continue until final action on the remand is taken by the administrative authority and all subsequent administrative and/or judicial appeal processes have been completed.

L. Term of the No-Alternatives Determination

1. The term of a determination granted under this Section shall be a maximum of 10 years from the date of the determination.

2. The petitioner shall submit a petition for reissuance of a determination at least 180 days prior to the end of the term. If the petitioner submits a timely and technically complete petition and the administrative authority, through no fault of the petitioner, fails to act on the petition for reissuance on or before the expiration date of the existing determination, the petitioner may, with the written approval of the administrative authority, continue to operate under the terms and conditions of the existing determination, which shall remain in effect until final action on the petition is taken by the administrative authority and all subsequent administrative and/or judicial appeal processes have been completed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2180 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Waste Services, Hazardous Waste Division, LR 25:

Chapter 43. Interim Status
§4357. Operating Record

* * *

[See Prior Text in A-B.9]

10. records of the quantities (and date of placement) for each shipment of hazardous waste placed in land disposal units under an extension to the effective date of any land disposal prohibition granted in accordance with LAC 33:V.2239, monitoring data required in accordance with an exemption under LAC 33:V.2241 or 2271 or a certification under LAC 33:V.2235, and the applicable notice required of a generator under LAC 33:V.2245;

* * *

[See Prior Text in B.11-16]

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 15:378 (May 1989), LR 16:220 (March 1990), LR 17:658 (July 1991), LR 18:723 (July 1992), LR 20:1000 (September 1994), LR 21:266 (March 1995), LR 22:837 (September 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:1744 (September 1998), LR 25:484 (March 1999), LR:25:

Chapter 51. Fee Schedules

§5120. Land Disposal Prohibition Petition Fees

Petitions submitted in accordance with R.S. 30:2193(E)(2) and/or LAC 33:V.Chapter 22 are subject to additional fees as noted below for each petition submitted. These fees must be submitted at the time a petition is submitted.

Variance	\$ 10,000
Exemption	45,000
Extension	5,000
No-Alternatives Determinations	10,000
Original Petition	10,000
Renewal Petition/Request	1,000
Request for determination for	
addition of a hazardous	
waste(s) not covered by	
existing determination	

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2014 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Hazardous Waste Division, LR 15:378 (May 1989), amended LR 17:658 (July 1991), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

A public hearing will be held on July 26, 1999, 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 (225) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by HW062. Such comments must be received no later than August 2, 1999, at 4:30 p.m., and should be sent to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884 or to fax (225) 765-0486. Copies of this proposed regulation can be purchased at the above referenced address. Contact the Investigations and Regulation Development Division at (225) 765-0399 for pricing information. Check or money order is required in advance for each copy of HW062.

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; 104 Lococo Drive, Raceland, LA 70394 or on the Internet at <http://www.deq.state.la.us/olae/irdd/olae.rgs.htm>.

James H. Brent, Ph.D.
Assistant Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Land Disposal of Prohibited Waste by
Deep Well Injection**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
No significant cost (savings) to state or local governments are anticipated as a result of the implementation of this rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
The revenue collections of the state will be increased \$70,000 during the first fiscal year as a result of establishing a new alternative review fee for an injection well exemption petition. In 10 years when alternate submittals are made, there will be a reduction of \$245,000 in revenue collected. There should be no effect on revenue collections of local governments as a result of the implementation of this rule.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
The regulated community is currently required to submit a full petition for an injection well exemption to both the USEPA and the LDEQ. Under the proposed action, facilities will still be required to submit the full petition to the USEPA, but will have the option to submit only the alternative Section to the LDEQ. The regulated community will incur an additional expenditure of \$70,000 in FY 99-2000 as a result of paying the \$10,000 fee for an alternate submittal. There will be a savings in petition preparation cost and a \$245,000 reduction in review fees paid in ten years when only the Alternatives Section of the petition is submitted to the LDEQ.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There should be no effect on competition and employment as a result of the implementation of this rule.

James H. Brent, Ph.D.	Robert E. Hosse
Assistant Secretary	General Government Section Director
9906#054	Legislative Fiscal Office

NOTICE OF INTENT

**Department of Environmental Quality
Office of Waste Services
Hazardous Waste Division**

Requirements for Commercial Hazardous Waste
Incinerators (LAC 33:V.529)(HW070)

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 rulemaking procedures have been initiated to amend the Hazardous Waste Division regulations, LAC 33:V.529 (Log #HW070).

The proposed regulation requires that applications for new permits and substantial modifications of existing permits for commercial hazardous waste incinerators comply with certain existing provisions of the Hazardous Waste Regulations (LAC 33:Part V), Air Quality Regulations (LAC 33:Part III), and Water Quality Regulations (LAC 33:Part IX). The basis and rationale for the proposed rule are to respond to a petition for rulemaking requesting that rules be adopted to comply with R.S. 30:2011(D)(24). This rule clarifies which DEQ regulations apply to commercial hazardous waste incinerators.

This proposed rule meets an exception 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 V. Hazardous Waste and Hazardous Materials

Subpart 1. Department of Environmental Quality Hazardous Waste

Chapter 5. Permit Application Contents

Subchapter E. Specific Information Requirements

§529. Specific Part II Information Requirements for Incinerators

Except as LAC 33:V.Chapter 31 provides otherwise, owners and operators of facilities that incinerate hazardous waste must fulfill the requirements of Subsection A, B or C of this Section.

* * *

[See Prior Text in A. - D.2]

E. Commercial Hazardous Waste Incinerators. The administrative authority shall issue no new permit or substantial permit modification, as defined in LAC 33:I.1503, that authorizes the construction or operation of any commercial hazardous waste incineration facility, of any type, until the permit applicant complies with:

1. all applicable hazardous waste regulations in LAC 33:V, particularly as they pertain to:
 - a. design as required in LAC 33:V.Chapters 5 and 31;
 - b. siting as required in LAC 33:V.Chapters 5, 7, and 15;
 - c. construction as required in LAC 33:V.Chapters 7 and 31;
 - d. operation as required in LAC 33:V.Chapters 3, 5, 7, and 31;
 - e. emission limitations as required in LAC 33:V.Chapters 5 and 31; and
 - f. disposal methods as required in LAC 33:V.Chapters 22, 31, and 35;
2. all applicable air quality regulations in LAC 33:III; and
3. all applicable water quality regulations in LAC 33:IX.

AUTHORITY NOTE: Promulgated in accordance with R.S. 2180 and 30:2011D.24(a).

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

10:280 (April 1984), LR 22:817 (September 1996), amended by the Office of Waste Services, Hazardous Waste Division, LR 25:

A public hearing will be held on July 26, 1999, 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 (225) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by HW070. Such comments must be received no later than August 2, 1999, at 4:30 p.m., and should be sent to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884 or to fax (225) 765-0486. Copies of this proposed regulation can be purchased at the above referenced address. Contact the Investigations and Regulation Development Division at (225) 765-0399 for pricing information. Check or money order is required in advance for each copy of HW070.

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; 104 Lococo Drive, Raceland, LA 70394 or on the Internet at <http://www.deq.state.la.us/olae/irdd/olaereg.htm>.

James H. Brent, Ph.D.
Assistant Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Requirements for Commercial Hazardous Waste Incinerators

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

No significant effect of this proposed rule on state or local governmental expenditures is anticipated. This proposed rule will merely identify and clarify which of the existing departmental regulations apply to commercial hazardous waste incinerators.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

No significant effect of this proposed rule on state or local governmental revenue collections is anticipated.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

No significant costs and/or economic benefits to directly affected persons or non-governmental groups is anticipated. The regulated community is already required to abide by the existing departmental regulations identified and clarified in this proposed rule.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)

No significant effect of this proposed amendment on competition and employment is anticipated.

James H. Brent, Ph.D.
Assistant Secretary
9906#052

Robert E. Hosse
General Government Section Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Environmental Quality
Office of Water Resources
Water Pollution Control Division**

Louisiana Pollutant Discharge Elimination System (LPDES)
Program (LAC 33:IX.2301, 2531, 2533)(WP032*)

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 rulemaking procedures have been initiated to amend the Water Quality regulations, LAC 33:IX.2301, 2531, and 2533 (Log #WP032*).

This proposed rule is identical to federal regulations found in all 40 CFR sections referenced in LAC 33:IX.Chapter 23; 40 CFR 136; 40 CFR 401, 402, and 404-471, which are applicable in Louisiana. For more information regarding the federal requirement, contact the Investigations and Regulation Development Division at the address or phone number given below. 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 rule will update the incorporation by reference of federal regulations to refer to those regulations published in the July 1998 *Code of Federal Regulations*, unless otherwise noted. The basis and rationale for this proposed rule are to clarify which edition of the federal regulations to consult when LAC 33:IX.Chapter 23 references the federal regulations. This will assure consistent application of state and federal requirements.

This proposed rule meets an exception 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 IX. Water Quality Regulations
Chapter 23. The Louisiana Pollutant Discharge
Elimination System (LPDES) Program
Subchapter A. Definitions and General Program
Requirements
§2301. General Conditions**

* * *

[See Prior Text in A - E]

F. All references to the *Code of Federal Regulations* (CFR) contained in this Chapter (e.g., 40 CFR 122.29) shall refer to those regulations published in the July 1998 *Code of Federal Regulations*, unless otherwise noted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 23:199 (February 1997), LR 23:722 (June 1997), LR 25:

Subchapter N. Adoption by Reference

**The Louisiana Department of Environmental Quality
adopts by reference the following federal requirements.
§2531. 40 CFR Part 136**

Title 40 (Protection of the Environment) *Code of Federal Regulations* (CFR) part 136, Guidelines Establishing Test Procedures for the Analysis of Pollutants, revised July 1, 1998, in its entirety.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 23:958 (August 1997), LR 25:

§2533. 40 CFR Subchapter N

Title 40 (Protection of the Environment) CFR, chapter 1, subchapter N (Effluent Guidelines and Standards), revised July 1, 1998, parts 401 and 402, and parts 404 - 471 in their entirety. (Note: General Pretreatment Regulations for Existing and New Sources of Pollution found in part 403 of Subchapter N have been included in these regulations as Subchapter T.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 23:958 (August 1997), LR 25:

A public hearing will be held on July 26, 1999, 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 (225) 765-0399.

All interested persons are invited to submit written comments on the proposed regulations. Commentors should reference this proposed regulation by WP032*. Such comments must be received no later than July 26, 1999, at 4:30 p.m., and should be sent to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70884 or to fax (225) 765-0486. The comment period for this rule ends on the same date as the public hearing. Copies of this proposed regulation can be purchased at the above referenced address. Contact the Investigations and Regulation Development Division at (225) 765-0399 for pricing information. Check or money order is required in advance for each copy of WP032*.

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; 104

Linda Korn Levy
Assistant Secretary

9906#049

NOTICE OF INTENT
Office of the Governor
Board of Trustees of the State Employees
Group Benefits Program

EPO Plan Document

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board hereby gives Notice of Intent to adopt an entire new Plan Document for the State Employees Group Benefits Program, designating it as the EPO Plan Document. The EPO Plan Document sets forth the terms and conditions pursuant to which eligibility and benefit determinations are made with regard to the self-insured health and accident benefits plan, designated as the EPO Plan, provided for state employees and their dependents pursuant to R.S. 42:851 et seq., as follows:

The text of this notice of intent may be viewed in its entirety at the office of the Board of Trustees for State Employees Group Benefits Program, 5825 Florida Boulevard, Second Floor, Baton Rouge, Louisiana, and the Office of the State Register, 1051 North Third Street, Baton Rouge, Louisiana.

Interested persons may present their views, in writing, to Jack W. Walker, Ph.D., Chief Executive Officer, State Employees Group Benefits Program, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Friday, July 23, 1999.

Jack W. Walker, Ph.D.
Chief Executive Officer

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: EPO Plan Document

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is estimated the implementation of the benefit changes included in the EPO Plan Document of the State Employees Group Benefits Program will save approximately \$30.6 million in claim cost during the period of July 1, 1999 through June 30, 2002. These savings are broken down as follows: FY

1999/2000 – \$5.6 million; FY 2000/2001 – \$10.0 million; FY 2001/2002 – \$15.0 million. These savings will be primarily due to revisions in the current fee schedule, renegotiation of hospital contracts with mandatory pre-certification and lower per diem payments, and higher discounts among medical providers due to increased utilization.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of state or local governmental units will not be affected. This cost saving measure should result in less need for further rate increases the may have been necessary.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Those persons or groups that will be directly affected will be the medical providers that become a part of the SEGBP Exclusive Provider Organization. They will be accepting payment from SEGBP that are somewhat lower than they have been in the past based on these agreements. In addition, state employees choosing this option will have benefits subject to co-lower out-of-pocket expenses with the removal of an annual deductible and implementation of a co-payment design.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected.

Jack W. Walker
Chief Executive Officer
9906#067

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT
Office of the Governor
Board of Trustees of the State Employees
Group Benefits Program

PPO Plan Document

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board hereby gives Notice of Intent to amend and readopt the entire Plan Document for the State Employees Group Benefits Program, designating it as the PPO Plan Document. The PPO Plan Document sets forth the terms and conditions pursuant to which eligibility and benefit determinations are made with regard to the self-insured health and accident benefits plan, designated as the PPO Plan, provided for state employees and their dependents pursuant to R.S. 42:851 et seq.

The text of this notice of intent may be viewed in its entirety at the office of the Board of Trustees for State Employees Group Benefits Program, 5825 Florida Boulevard, Second Floor, Baton Rouge, Louisiana, and the

Office of the State Register, 1051 North Third Street, Baton Rouge, Louisiana.

Interested persons may present their views, in writing, to Jack W. Walker, Ph.D., Chief Executive Officer, State Employees Group Benefits Program, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Friday, July 23, 1999.

Jack W. Walker, Ph.D.
Chief Executive Officer

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: PPO Plan Document

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is estimated the implementation of the benefit changes included in the PPO Plan Document of the State Employees Group Benefits Program will save approximately \$59.2 million in claim cost during the period of July 1, 1999 through June 30, 2002. These savings are broken down as follows: FY 1999/2000 - \$13.0 million; FY 2000/2001 - \$19.4 million; FY 2001/2002 - \$26.8 million. These savings will be primarily due to revisions in the current fee schedule and renegotiation of hospital contracts with mandatory pre-certification and lower per diem payments.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of state or local governmental units will not be affected. This cost saving measure should result in less need for further rate increases that may have been necessary.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Those persons or groups that will be directly affected will be the medical providers that become a part of the SEGBP Preferred Provider Organization. They will be accepting payments from SEGBP that are somewhat lower than they have been in the past based on these agreements. Plan members will no longer be responsible for an annual deductible on prescription drugs and an increase lifetime maximum benefit of \$1,000,000.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected.

Jack W. Walker
Chief Executive Officer
9906#066

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Board of Veterinary Medicine

Disciplinary Procedures
(LAC 46:LXXXV.101, 105, 106, 815, 816,
1001, 1215, 1216, and 1401-1425)

The Louisiana Board of Veterinary Medicine proposes to amend LAC 46:LXXXV.101, 105, 106, 815, 1001, and 1215 and adopt 46:LXXXV.816, 1216, and 1401-1425. These proposed changes pertain to disciplinary procedures and are

offered in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and the Louisiana Veterinary Practice Act, La. R.S. 37:1518 et seq. No preamble has been prepared.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXXXV. Veterinarians

Chapter 1. Operations of the Board of Veterinary Medicine

§101. Information, Agency Office, Request for Rules or Action

A. - D. ...

E. Reports to Licensees. The board shall provide a regular report, which shall include, but not be limited to, notices of changes in policy, procedure, regulations, and/or statutes by the board or other governmental entities and dispositions of disciplinary cases. Other information deemed by the board to be pertinent in its mission of protecting the public health, safety, and welfare in the practice of veterinary medicine shall be printed and mailed to all licensees and other interested parties who have requested in writing to receive this report. The report shall be published not less than one time per fiscal year and may be published more frequently as the president of the board shall order.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 8:66 (February 1982), amended LR 19:1328 (October 1993), LR 23:966 (August 1997), LR 25:

§105. Appeals and Review

A. ...

B. Persons Aggrieved by a Decision of the Board

1. Any person aggrieved by a decision of the board may, within 30 days of notification of the board's action or decision, petition the board for a review of the board's actions.

2. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 8:66 (February 1982), amended LR 19:345 (March 1993), LR 23:966 (August 1997), LR 23:1529 (November 1997), LR 25:

§106. Disciplinary Proceedings

Any person against whom disciplinary proceedings have been instituted and against whom disciplinary action has been taken by the board pursuant to R.S. 37:1526 and/or 37:1531 and/or the board's rules, shall have rights of review and/or rehearing and/or appeal in accordance with the terms and provisions of the Administrative Procedure Act and §1401 et seq. of the board's rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 19:345 (March 1993), amended LR 23:967 (August 1997), LR 24:940 (May 1998), LR 25:

Chapter 8. Registered Veterinary Technicians

§815. Appeals and Review

A. ...

B. Persons Aggrieved by a Decision of the Board

1. Any person aggrieved by a decision of the board, other than a holder of certificate of approval against whom disciplinary proceedings have been brought pursuant to R.S. 37:1544-1548, may, within 30 days of notification of the board's action or decision, petition the board for a review of the board's actions.

2. A petition shall be in the form of a letter, signed by the person aggrieved, and mailed to the board at its principal office located in Baton Rouge, Louisiana.

3. Upon receipt of such petition, the board then may proceed to take such action as it deems expedient or hold such hearings as may be necessary, and may review such testimony and/or documents and/or records as it deems necessary to dispose of the matter, but the board shall not, in any event, be required to conduct any hearings or investigations, or consider any offerings, testimony, or evidence unless so required by statute or other rules or regulations of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:26 (March 1990), amended LR 25:

§816. Disciplinary Proceedings

Any registered veterinary technician against whom disciplinary proceedings have been instituted and against whom disciplinary action has been taken by the board pursuant to R.S. 37:1544-1548 and/or the board's rules, shall have rights of review and/or rehearing and/or appeal in accordance with the terms and provisions of the Administrative Procedure Act and §1401 et seq. of the board's rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

Chapter 10. Rules of Professional Conduct

§1001. Purpose and Scope

A. The Rules of Professional Conduct shall govern the professional conduct of the members of the veterinary profession in the state of Louisiana. These rules of professional conduct shall be cumulative of all laws of the state of Louisiana relating to the professional conduct of veterinarians and to the practice of veterinary medicine in this state, and shall include the American Veterinary Medical Association's Principles of Veterinary Medical Ethics, Policy Statements and Guidelines. In the event the Principles of Veterinary Medical Ethics, Policy Statements and Guidelines contradict the Louisiana Veterinary Practice Act and/or the board's rules, the latter shall govern.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:228 (March 1990), amended LR 25:

Chapter 12. Certified Animal Euthanasia Technicians

§1215. Appeals and Review

A. ...

B. Persons Aggrieved by a Decision of the Board

1. Any certified animal euthanasia technician aggrieved by a decision of the board, other than a holder of a certificate of approval against whom disciplinary proceedings have been brought pursuant to R.S. 37:1551 et

seq. may, within 30 days of notification of the board's action or decision, petition the board for a review of the board's actions.

2. A petition shall be in the form of a letter, signed by the person aggrieved, and mailed to the board at its principal office.

3. Upon receipt of such petition, the board may proceed to take such action as it deems expedient or hold such hearings as may be necessary, and may review such testimony and/or documents and/or records as it deems necessary to dispose of the matter, but the board shall not, in any event, be required to conduct any hearings or investigations, or consider any offerings, testimony, or evidence unless so required by statute or other rules or regulations of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 19:1424 (November 1993), amended LR 25:

§1216. Disciplinary Proceedings

Any CAET against whom disciplinary proceedings have been instituted and against whom disciplinary action has been taken by the board pursuant to R.S. 37:1551 et seq. and/or the board's rules, shall have rights of review and/or rehearing and/or appeal in accordance with the terms and provisions of the Administrative Procedure Act and §1401 et seq. of the board's rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

Chapter 14. Disciplinary Procedures

§1401. Causes for Administrative Action

The board, after due notice and hearing as set forth herein and the Louisiana Administrative Procedure Act, LSA R.S. 49:950 et seq., may deny, revoke or suspend any license, temporary permit, or certification issued or applied for or otherwise discipline a licensed veterinarian, registered veterinary technician or certified animal euthanasia technician on a finding that the person has violated the Louisiana Veterinary Practice Act, any of the rules and regulations promulgated by the board, the Principles of Veterinary Medical Ethics, Policy Statements and Guidelines of the American Veterinary Medical Association, or prior final decisions and/or consent orders involving the licensed veterinarian, registered veterinary technician or certified animal euthanasia technician or applicant. Sometimes hereinafter in this Chapter, where the context allows, a licensed veterinarian, registered veterinary technician or certified animal euthanasia technician or applicant may be referred to as "person."

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1403. Disciplinary Process and Procedures

A. The purpose of the following rules and regulations is to supplement and effectuate the applicable provisions of the Louisiana Administrative Procedure Act, LSA R.S. 49:950 et seq., regarding the disciplinary process and procedures incident thereto. These rules and regulations are not intended to amend or repeal the provisions of the Louisiana

Administrative Procedure Act, and to the extent any of these rules and regulations are in conflict therewith, the provisions of the Louisiana Administrative Procedure Act shall govern.

B. A disciplinary proceeding, including the formal hearing, is less formal than a judicial proceeding. It is not subject to strict rules and technicalities, but must be conducted in accordance with considerations of fair play and constitutional requirements of due process.

C. The purpose of a disciplinary proceeding is to determine contested issues of law and fact; whether the person did certain acts or omissions and, if he did, whether those acts or omissions violated the Louisiana Veterinary Practice Act, the rules and regulations of the board, the Principles of Veterinary Medical Ethics, Policy Statements and Guidelines of the American Veterinary Medical Association, or prior Final Decisions and/or Consent Orders involving the veterinarian, registered veterinary technician or certified animal euthanasia technician or applicant and to determine the appropriate disciplinary action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1405. Initiation of Complaints

A. Complaints may be initiated by any person or by the board on its own initiative.

B. All complaints shall be addressed confidential and shall be sent to the board office. The investigating board member, with benefit of counsel, shall decide to investigate the charges or deny the charges. If the charges are denied, a letter of denial is prepared and forwarded to the complainant and the person accused of wrongdoing. If the investigating board member decides to investigate, the person shall be notified that allegations have been made that he may have committed a breach of statute, rule and regulation, the American Veterinary Medical Association's Principles of Veterinary Medical Ethics, Policy Statements and Guidelines, and/or prior final decisions or consent orders and that he must respond in writing to the board within a specified time period. The response is to be made to the board office address. The complaint letter of alleged violations shall not be given initially to the person. However, sufficiently specific allegations shall be conveyed to the person for his response. Once the person has answered the complaint, and other pertinent information, if available, is reviewed, a determination by the investigating board member, with benefit of counsel, will be made if a disciplinary proceeding is required.

C. Pursuant to its authority to regulate the industry, the board through its investigating board member, may issue subpoenas to secure evidence of alleged violations of the Louisiana Veterinary Practice Act, any of the rules and regulations promulgated by the board, the American Veterinary Medical Association's Principles of Veterinarian Medical Ethics, Policy Statements and Guidelines, or prior final decisions and/or consent orders involving the licensed veterinarian, registered veterinary technician or certified animal euthanasia technician or applicant.

D. "Counsel" referenced in this Chapter shall mean the board's General Counsel who will be assisting in the investigation and prosecution of an administrative action. Said counsel shall not provide any legal advices or act as legal counsel to the board or its members, other than the

investigating board member, regarding a pending administrative action during the investigation, prosecution and resolution of such disciplinary action by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1407. Informal Disposition of Complaints

A. Some complaints may be settled informally by the board and the person accused of a violation without a formal hearing. The following types of informal dispositions may be utilized.

1. Disposition by Correspondence. For complaints less serious, the investigating board member may write to the person explaining the nature of the complaint received. The person's subsequent response may satisfactorily explain the situation, and the matter may be closed. If the situation is not satisfactorily explained, it shall be pursued through an informal conference or formal hearing.

2. Informal Conference

a. The investigating board member may hold a conference with the person in lieu of, or in addition to, correspondence in cases of less serious complaints. If the situation is satisfactorily explained in conference, a formal hearing is not scheduled.

b. The person shall be given adequate notice of the conference, of the issues to be discussed, and of the fact that information brought out at the conference may later be used in a formal hearing. Board members, other than the investigating board member, may not be involved in informal conferences.

3. Settlement. An Agreement worked out between the person making the complaint and the person accused of a violation does not preclude disciplinary action by the board. The nature of the offense alleged and the evidence before the board must be considered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1409. Formal Hearing

A. The board has the authority, granted by LSA R.S. 37:1511 et seq., to bring administrative proceedings against persons to whom it has issued a license, temporary permit or certification or any applicant requesting a license, temporary permit or certification. The person has the right to appear and be heard, either in person or by counsel; the right of notice; a statement of what accusations have been made; the right to present evidence and to cross-examine; and the right to have witnesses subpoenaed.

B. If the person does not appear, either in person or through counsel, after proper notice has been given, the person may be considered to have waived these rights and the board may proceed with the hearing without the presence of the person.

C. The process of administrative action shall include certain steps and may include other steps as follows.

1. The board receives a complaint alleging that a person has acted in violation of the Louisiana Veterinary Practice Act, the rules and regulations of the Board, or the Principles of Veterinary Medical Ethics, Policy Statements and Guidelines of the American Veterinary Medical Association. Communications from the complaining party

shall not be revealed to any person until and unless a formal complaint is filed except those documents being subpoenaed by a court.

2.a. The complaint is investigated by the investigating board member or board attorney to determine if there is sufficient evidence to warrant disciplinary proceedings. No board member, other than the investigating board member, may communicate with any party to a proceeding or his representative concerning any issue of fact or law involved in that proceeding.

b. A decision to initiate a formal complaint or charge is made if one or more of the following conditions exists:

- i. the complaint is sufficiently serious;
- ii. the person fails to respond to the board's correspondence concerning the complaint;
- iii. the person's response to the board's letter or investigation demand is not convincing that no action is necessary; or
- iv. an informal approach is used, but fails to resolve all of the issues.

3. A sworn complaint is filed, charging the violation of one or more of the provisions of the Louisiana Veterinary Practice Act, the rules and regulations promulgated thereto, the American Veterinary Medical Association's Principles of Veterinary Medical Ethics, Policy Statements and Guidelines, or prior final decisions and/or consent orders involving the person.

4. A time and place for a hearing is fixed by the chairman or an agent of the board.

5.a. At least twenty days prior to the date set for the hearing, a copy of the charges and a notice of the time and place of the hearing are sent by certified mail to the last known address of the person accused. If the mailing is not returned to the board, it is assumed to have been received. It is the person's obligation to keep the board informed of his whereabouts.

b. The content of the charges limits the scope of the hearing and the evidence which may be introduced. The charges may be amended at any time up to ten days prior to the date set for the hearing.

c. If the board is unable to describe the matters involved in detail at the time the sworn complaint is filed, this complaint may be limited to a general statement of the issues involved. Thereafter, upon the person's request, the board shall supply a more definite and detailed statement to the person.

6. Except for extreme emergencies, motions requesting a continuance of a hearing shall be filed at least five days prior to the time set for the hearing. The motion shall contain the reason for the request, which reason must have relevance to due process.

7.a. The chairman, or an authorized agent of the board, issues subpoenas for the board for disciplinary proceedings, and when requested to do so, may issue subpoenas for the other party. Subpoenas include:

- i. a subpoena requiring a person to appear and give testimony; and
- ii. a subpoena duces tecum, which requires that a person produce books, records, correspondence, or other materials over which he has custody.

b. A motion to limit or quash a subpoena may be filed with the Board, but not less than seventy-two hours prior to the hearing.

8.a. The hearing is held, at which time the board's primary role is to hear evidence and argument, and to reach a decision. Any board member who, because of bias or interest, is unable to assure a fair hearing, shall be recused from the particular proceeding. The reasons for the recusal are made part of the record. Should the majority of the board members be recused for a particular proceeding, the governor shall be requested to appoint a sufficient number of pro tem members to obtain a quorum for the proceeding;

b. The board is represented by its agent who conducted the investigation and presents evidence that disciplinary action should be taken against the person and/or by the board's attorney. The person may present evidence personally or through an attorney, and witnesses may testify on behalf of the person;

c. Evidence includes the following:

i. oral testimony given by witnesses at the hearing, except that, for good cause, testimony may be taken by deposition (cost of the deposition is borne by requesting party);

ii. documentary evidence, i.e., written or printed materials including public, business, institutional records, books and reports;

iii. visual, physical and illustrative evidence;

iv. admissions, which are written or oral statements of a party made either before or during the hearing;

v. facts officially noted into the record, usually readily determined facts making proof of such unnecessary; and/or

vi. other items or things allowed into evidence by the Louisiana Evidence Code or applicable statutory law or jurisprudence.

d. All testimony is given under oath. If the witness objects to swearing, the word "affirm" may be substituted.

9. The chairman of the board presides and the customary order of proceedings at a hearing is as follows:

a. the board's representative makes an opening statement of what he intends to prove, and what action, he wants the board to take;

b. the person, or his attorney, makes an opening statement, explaining why he believes that the charges against him are not legally founded;

c. the board's representative presents the case against the person;

d. the person, or his attorney, cross-examines;

e. the person presents evidence;

f. the board's representative cross-examines;

g. the board's representative rebuts the person's evidence;

h. both parties make closing statements. The board's representative makes the initial closing statement and the final statement.

10. Motions may be made before, during, or after a hearing. All motions shall be made at an appropriate time according to the nature of the request. Motions made before or after the hearing shall be in writing. Those made during

the course of the hearing may be made orally since they become part of the record of the proceeding.

11.a. The record of the hearing shall include:

- i. all papers filed and served in the proceeding;
- ii. all documents and/or other materials accepted as evidence at the hearing;
- iii. statements of matters officially noticed;
- iv. notices required by the statutes or rules; including notice of the hearing;
- v. affidavits of service or receipts for mailing or process or other evidence of service;
- vi. stipulations, settlement agreements or consent orders, if any;
- vii. records of matters agreed upon at a prehearing conference;
- viii. reports filed by the hearing officer, if one is used;
- ix. orders of the board and its final decision;
- x. actions taken subsequent to the decision, including requests for reconsideration and rehearing;
- xi. a transcript of the proceedings, if one has been made, or a tape recording or stenographic record.

b. The record of the proceeding shall be retained until the time for any appeal has expired, or until the appeal has been concluded. The record is not transcribed unless a party to the proceeding so requests, and the requesting party pays for the cost of the transcript.

12.a. The decision of the board shall be reached according to the following process:

- i. determine the facts at issue on the basis of the evidence submitted at the hearing;
- ii. determine whether the facts in the case support the charges brought against the person; and
- iii. determine whether charges brought are in violation of the Louisiana Veterinary Practice Act, rules and regulations of the board, and/or the American Veterinary Medical Association's Principles of Veterinary Medical Ethics, Policy Statements and Guidelines.

b. Deliberation

- i. The board will deliberate in closed session.
- ii. The board will vote on each charge as to whether the charge has been supported by the evidence. The standard will be "preponderance of the evidence."
- iii. After considering each charge, the board will vote on a resolution to dismiss the charges, deny, revoke or suspend any license, temporary permit or certification issued or applied for or otherwise discipline a person or applicant. An affirmative vote of a majority of the quorum of the board shall be needed to deny, revoke, or suspend any license, temporary permit or certification issued or applied for in accordance with the provisions of this Chapter or otherwise discipline a person or applicant. The investigating board member shall not be involved in or present during deliberation, nor shall he be included in the quorum or allowed to vote on the outcome of the proceeding.

c. Sanctions against the person who is party to the proceeding are based upon findings of fact and conclusions of law determined as a result of the hearing, and will be issued by the board in accordance with applicable statutory authority. The party is notified by mail of the final decision of the Board.

d. In addition to the disciplinary action or fines assessed by the board against a licensed veterinarian or temporary permittee, the board may assess all costs incurred in connection with the proceedings, including but not limited to investigators', stenographers', attorney's fees and court costs.

e. With regards to a registered veterinary technician or a certified animal euthanasia technician, the board may, as a probationary condition or as a condition of the reinstatement of any certification suspended or revoked hereunder, require the holder to pay all costs of the Board proceedings, including investigators', stenographers', secretaries', attorney's fees and court costs.

13. Every order of the board shall take effect immediately on its being rendered unless the board in such order fixes a stay of execution of a sanction for a period of time against an applicant or licensee, temporary permittee or holder of a certificate. Such order, without a stay of execution, shall continue in effect until expiration of any specified time period or termination by a court of competent jurisdiction. The board shall notify all licensees, temporary permittees or holders of certificates of any action taken against him and may make public its orders and judgment in such manner and form as allowed by law.

14.a. The board may reconsider a matter which it has decided. This may involve rehearing the case, or it may involve reconsidering the case on the basis of the record. Such reconsideration may occur when a party who is dissatisfied with a decision of the board files a motion requesting that the decision be reconsidered by the board.

b. The board shall reconsider a matter when ordered to do so by a higher administrative authority or when the case is remanded for reconsideration or rehearing by a court to which the board's decision has been appealed.

c. A motion by a party for reconsideration or rehearing must be in proper form and filed within ten days after notification of the Board's decision. The motion shall set forth the grounds for the rehearing, which include one or more of the following:

- i. the board's decision is clearly contrary to the law and evidence;
- ii. there is newly discovered evidence by the party since the hearing which is important to the issues and which the party could not have discovered with due diligence before or during the hearing;
- iii. there is a showing that issues not previously considered ought to be examined in order to dispose of the case properly; or
- iv. it would be in the public interest to further consider the issues and the evidence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1411. Consent Order

An order involving a type of disciplinary action may be made to the board by the investigating board member with the consent of the person. To be accepted, a consent order requires formal consent of a majority of the quorum of the board. Such quorum does not include the investigating board member. It is not the result of the board's deliberation; it is

the board's acceptance of an agreement reached between the board and the person. A proposed consent order may be rejected by the board in which event a formal hearing will occur. The consent order, if accepted by the board, is issued by the board to carry out the parties' agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1413. Withdrawal of a Complaint

If the complainant wishes to withdraw the complaint, the inquiry is terminated, except in cases where the investigating board member judges the issues to be of such importance as to warrant completing the investigation in its own right and in the interest of public welfare.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1415. Refusal to Respond or Cooperate with the Board

A. If the person does not respond to the original inquiry within a reasonable period of time as requested by the board, a follow-up letter shall be sent to the person by certified mail, return receipt requested.

B. If the person refuses to reply to the board's inquiry or otherwise cooperate with the board, the board shall continue its investigation. The board shall record the circumstances of the person's failure to cooperate and shall inform the person that the lack of cooperation may result in action which could eventually lead to the denial, revocation or suspension of his license, temporary permit or certification, or application for licensure, temporary permit or certification, or otherwise issue appropriate disciplinary sanction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1417. Judicial Review of Adjudication

Any person whose license, temporary permit or certification, or application for licensure, temporary permit or certification, has been denied, revoked or suspended or otherwise disciplined by the board shall have the right to have the proceedings of the board reviewed by the state district court for the parish of East Baton Rouge, provided that such petition for judicial review is made within thirty days after the notice of the decision of the board. If judicial review is granted, the board's decision is enforceable in the interim unless the court orders a stay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1419. Appeal

A person aggrieved by any final judgment rendered by the state district court may obtain a review of said final judgment by appeal to the appropriate circuit court of appeal. Pursuant to the applicable section of the Louisiana Administrative Procedure Act, LSA R.S. 49:950 et seq., this appeal shall be taken as in any other civil case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1421. Reinstatement of Suspended or Revoked License

Any person whose license is suspended or revoked may, at the discretion of the board, be relicensed or reinstated at any time without an examination by majority vote of the board on written application made to the board showing cause justifying relicensing or reinstatement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1423. Declaratory Statements

The Board may issue a declaratory statement in response to a request for clarification of the effect of the provisions contained in the Louisiana Veterinary Practice Act, LSA R.S. 37:1511 et seq., the rules and regulations promulgated by the board and/or the Principles of Veterinary Medical Ethics, Policy Statements and Guidelines of the American Veterinary Medical Association.

A. A request for declaratory statement is made in the form of a petition to the board. The petition should include at least:

1. the name and address of the petitioner;
2. specific reference to the statute, rule and regulation, or the American Veterinary Medical Association's Principles of Veterinary Medical Ethics, Policy Statements and Guidelines to which the petitioner relates; and
3. a concise statement of the manner in which the petitioner is aggrieved by the statute, rules and regulations, or provision of the American Veterinary Medical Association's Principles of Veterinary Medical Ethics, Policy Statements and Guidelines by its potential application to him in which he is uncertain of its effect.

B. The petition shall be considered by the board within a reasonable period of time taking into consideration the nature of the matter and the circumstances involved.

C. The declaratory statement of the board in response to the petition shall be in writing and mailed to the petitioner at the last address furnished to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

§1425. Injunction

A. The board or any citizen of this state may bring an action to enjoin any person from practicing veterinary medicine without a currently valid license or temporary permit.

B. If the court finds that the person is violating, or is threatening to violate, this Chapter it shall enter an injunction restraining him from such unlawful acts.

C. The successful maintenance of an action based on any one of the remedies set forth in this rule shall in no way prejudice the prosecution of an action based on any other of the remedies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 25:

Interested parties may submit written comments to Charles B. Mann, executive director, Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge, LA 70801. Comments will be accepted through the close of business on July 30, 1999. If it becomes necessary

to convene a public hearing to receive comments in accordance with the Administrative Procedure Act, the hearing will be held on July 30, 1999, at 9:00 a.m. at the office of the Louisiana Board of Veterinary Medicine, 263 Third St., Suite 104, Baton Rouge, LA.

Charles B. Mann
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Disciplinary Procedures**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
There will be no costs or savings to state or local governmental units, except for those associated with publishing the amendment (estimated \$1,600). The veterinary profession will be informed of this rule change via the board's regular newsletter or other direct mailings, which are 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 the amendment.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There are no anticipated costs and/or economic benefits to directly affected persons or non-governmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
No impact on competition and employment is anticipated as a result of the proposed rule change.

Charles B. Mann
Executive Director
9906#009

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Board of Veterinary Medicine**

Licensure and Examinations
(LAC 46:LXXXV.301 and 303)

The Louisiana Board of Veterinary Medicine proposes to amend LAC 46:LXXXV.301 and 303 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and the Louisiana Veterinary Practice Act, La. R.S. 37:1518 et seq. No preamble has been prepared.

**Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part LXXXV. Veterinarians

Chapter 3. Licensure Procedures

§301. Applications for Licensure

- A. ...
B. In addition to the above requirements, the board may also require that any applicant furnish the following information:

1. ...
2. a copy of the applicant's diploma from a veterinary medical school or college accredited or approved by the American Veterinary Medical Association;

3. - 8. ...

C. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 8:66 (February 1982), amended LR 10:464 (June 1984), LR 16:224 (March 1990), LR 19:343 (March 1993); LR 23:964 (August 1997), LR 25:

§303. Examinations

A. ...

1. - 3. ...

4. A candidate for examination must be:

a. a graduate of a school or college of veterinary medicine accredited or approved by the American Veterinary Medical Association; or

b. - c. ...

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 8:66 (February 1982), amended LR 19:344 (March 1993), LR 19:1327 (October 1993), LR 23:964 (August 1997), LR 25:

Interested parties may submit written comments to Charles B. Mann, executive director, Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge, LA 70801. Comments will be accepted through the close of business on July 30, 1999. If it becomes necessary to convene a public hearing to receive comments in accordance with the Administrative Procedure Act, the hearing will be held on July 30, 1999, at 9:00 a.m. at the office of the Louisiana Board of Veterinary Medicine, 263 Third St., Suite 104, Baton Rouge, LA.

Charles B. Mann
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Licensure and Examinations**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
There will be no costs or savings to state or local governmental units, except for those associated with publishing the amendment (estimated \$160). The veterinary profession will be informed of this rule change via the board's regular newsletter or other direct mailings, which are 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 the amendment.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There are no anticipated costs and/or economic benefits to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)

No impact on competition and employment is anticipated as a result of the proposed rule change. The Board would anticipate that the number of graduates from approved schools who apply for licensure in this state to be minimal.

Charles B. Mann
Executive Director
9906#010

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**

**Medicaid—Gifts to Children with Life-Threatening
Conditions**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to adopt the following proposed rule in the Medical Assistance Program 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 provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Bureau of Health Services Financing adopted a rule promulgating the Medicaid Eligibility Manual in its entirety by reference in July of 1996 (*Louisiana Register*, Volume 22, No. 7). Section I of the Medicaid Eligibility Manual explains the eligibility factors used to determine Medicaid eligibility, including countable income and resources.

The Non-Citizen Benefit Clarification and Other Technical Amendments Act of 1998 (Public Law 105-306) was recently enacted amending section 1612 (b) income disregard, and section 1613(a) resource disregard of the Social Security Act (42 U.S.C.1382a.(b) and 1382b(a)). These amendments require the Medicaid Program to provide for gift exclusions for children who are under age 18 and have a life-threatening condition. The gift must be from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 as exempt from taxation. The Bureau proposes to amend section I of the Medicaid Eligibility Manual governing countable income and resources by adopting the provisions of P. L. 105-306, which retroactively excludes any gifts made to, or for the benefit of, children who are under age 18 and have a life-threatening condition, from consideration in the determination of Medicaid eligibility.

Proposed Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends section I of the Medicaid Eligibility Manual governing countable income and resources by adopting the provisions of P.L. 105-306 which exclude from consideration as countable income and resources, any gifts made to, or for the benefit of, children who are under age 18 and have a life-threatening condition, if the gifts are from an organization described in section 501(c)(3) of the Internal Revenue Code

of 1986 as exempt from taxation. This amendment is applicable to gifts made on or after October 28, 1996.

A. Income Determinations. Gifts are excluded from the income determination of Medicaid eligibility under the following circumstances:

1. in the case of an in-kind gift, it is not considered income if the gift is not converted to cash;
2. if an in-kind gift is converted to cash, the cash is counted as income in the month it is converted;
3. in the case of a cash gift, it is excluded as income only to the extent that the total amount excluded from the income under this provision does not exceed \$2,000 in any calendar year;
4. cash in excess of \$2,000 received in a calendar year is subject to regular income determination policy.

B. Resource Determination. Gifts will be excluded from the resource determination of Medicaid eligibility under the following circumstances:

1. in the case of an in-kind gift, it is not considered as income if the gift is not converted to cash;
2. if an in-kind gift is converted to cash, any cash remaining in the month following the month that it is converted is a resource;
3. in the case of a cash gift, it is considered as a resource only to the extent that the cash excluded does not exceed \$2,000 in any calendar year;
4. retained cash in excess of \$2,000 received in a calendar year is subject to regular resource determination policy.

C. A gift to a parent whose income and resources are subject to deeming is excluded (subject to the aforementioned limits) if the gift is for the benefit of a child under age 18 with a life-threatening condition.

Interested persons may submit written comments to the following address: Thomas D. Collins, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this proposed rule. A public hearing on this proposed rule is scheduled for Friday, July 27, 1999 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. 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 next business day following the public hearing.

David W. Hood
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Medicaid Gifts to Children with Life-
Threatening Conditions**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENT UNITS (Summary)

Estimated costs to the state cannot be determined at this time, as no cases are currently affected by implementation of this rule. However, it is anticipated that costs, once determined, shall be minimal. In SFY 1999, \$205 will be incurred for the state's administrative expense of promulgating this proposed

rule, the final rule and the Medicaid Eligibility Manual revisions.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The estimated effect on revenue collections cannot be determined at this time, as no cases are currently affected. However, it is anticipated that revenue collections, once determined, shall be minimal. In SFY 1999, \$205 will be incurred for the federal share of promulgating this proposed rule, the final rule and the Medicaid Eligibility Manual revisions.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Children who are under age 18, have a life-threatening condition, and receive gifts from organizations described in section 501(c)(3) of the Internal Revenue Code of 1986 as exempt from taxation, may have exclusions applied in considering countable income and resources during Medicaid eligibility determination. State programmatic costs cannot be determined at this time as current cases are not affected by implementation 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
9906#044

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**

Medicaid—Louisiana Children's Health
Insurance Program (LaCHIP)

The Department of Health and Hospitals, Bureau of Health Services Financing, proposes to adopt the following rule as authorized by LA. R.S. 46:153. This proposed rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Section 4901 of the Balanced Budget Act of 1997 amended the Social Security Act to create the Children's Health Insurance Program under Title XXI to assist State efforts to initiate and expand child health assistance to uninsured, low-income children (BBA, Public Law 105-33). Under this program, child health assistance is to be provided by obtaining health benefits coverage through 1) providing coverage that meets requirements specified in the law under section 2103 of the Act; or 2) expanding coverage under the State's Medicaid Plan under Title XIX of the Act; or 3) a combination of both. The Department of Health and Hospitals, Bureau of Health Services Financing adopted a rule effective November 1, 1998 to implement the first phase of the Louisiana Children's Health Insurance Program (LaCHIP) for uninsured children, birth through age nineteen, whose family income does not exceed 133 percent of the federal poverty level by expanding coverage to these children under the Medicaid Program (*Louisiana Register*, Volume 24, No. 10).

In accordance with the recommendation of the Governor's LaCHIP Task Force and Senate Bill No. 256 of the 1999 Regular Session of the Louisiana Legislature, the Department is amending the October 20, 1998 rule in order to implement the second phase of LaCHIP which increases the family income limits for LaCHIP eligibility from 133 percent to 150 percent of the federal poverty level. All other requirements for LaCHIP eligibility will remain the same.

Proposed Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing implements the second phase of the Louisiana Children's Health Insurance Program (LaCHIP) effective October 1, 1999 by expanding coverage under the Medicaid Program to uninsured children, birth through age nineteen, whose family income is between 133 percent and 150 percent of the federal poverty level (FPL). This expansion is in compliance with section 4901 of the Balanced Budget Act of 1997 which enacted Title XXI of the Social Security Act, Act 128 of the First Extraordinary Session of the 1998 Louisiana Legislature which enacted the LaCHIP Program, and Senate Bill No. 256 and the General Appropriation Act of the 1999 Regular Session of the Louisiana Legislature which authorizes the funding for the expansion. All other requirements for LaCHIP eligibility will remain the same.

Interested persons may submit written comments to the following address: Thomas D. Collins, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030. He is the person responsible for responding to inquiries regarding this proposed rule. A public hearing on this proposed rule is scheduled for Tuesday, July 27, 1999 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. 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 next business day following the public hearing.

David W. Hood
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Medicaid Louisiana Children's Health
Insurance Program (LaCHIP)**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Implementation of the second phase of the LaCHIP will result in additional costs of approximately \$2,005,107 for SFY 1999-00, \$2,532,757 for SFY 2000-01, and \$2,634,067 for SFY 2001-02. Included in SFY 1999 is \$80 for the state's administrative expense of promulgating this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The estimated effect on revenue collection is approximately \$7,542,803 for SFY 1999-00, \$9,527,990 for SFY 2000-01, and \$9,909,110 for SFY 2001-02. Included in SFY 1999 is \$80 for the federal share of promulgating this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Uninsured children whose family income is between 133 percent and 150 percent of the federal poverty level and who meet the other eligibility requirements will be able to obtain Medicaid coverage under LaCHIP. In addition, the expansion of coverage under LaCHIP will increase reimbursement to providers by approximately \$8,697,814 for SFY 1999-00, \$11,210,651 for SFY 2000-01, and \$11,659,077 for SFY 2001-02. Costs reflected are for services and do not include administrative expenditures.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins
Director
9906#045

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**

Medicaid—Presumptive Eligibility Certification Period

The Department of Health and Hospitals, 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 proposed rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Federal regulations authorizing presumptive Medicaid eligibility for pregnant women were originally adopted by §9407(b) of the Omnibus Budget Reconciliation Act of 1986 and subsequently amended by §411(k)(16) of the Medicare Catastrophic Coverage Act of 1988, §608(d)(26)(L) of the Family Support Act of 1988, and §4605 of the Omnibus Budget Reconciliation Act of 1990. A rule was adopted in the Louisiana Medicaid Program effective January 1, 1988 (*Louisiana Register*, Volume 14, Number 12) which adopted presumptive eligibility as an optional provision of the Louisiana Medicaid Program. Presumptive eligibility is defined as temporary determination of Medicaid eligibility for a pregnant woman made by a qualified provider based on preliminary information concerning her gross family income. Under the original rule, which reflected federal requirements at that time, if a standard application for Medicaid eligibility was not filed by the pregnant woman within 45 days of the date the presumptive eligibility decision was made, presumptive eligibility expired. If an application was filed within the 45 day timeframe, the presumptive eligibility certification continued until a decision was made on the application.

The Bureau proposes to adopt the following rule concerning the length of time that presumptive eligibility determinations are effective in order to conform to amended federal guidelines.

Proposed Rule

The Department of Health and Hospitals, Bureau of Health Services Financing amends the length of the presumptive eligibility period when the pregnant woman does not file a standard Medicaid application after being determined presumptively eligible. If a presumptively eligible pregnant woman does not file an application for Medicaid by the last day of the month following the month in which she is determined presumptively eligible, her presumptive eligibility ends on that last day. If she files an application timely, her presumptive eligibility certification stays open until a decision is made.

Interested persons may submit written comments to: Thomas D. Collins, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this proposed rule.

A public hearing on this proposed rule is scheduled for Tuesday, July 27, 1999 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. At that time all interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

David W. Hood
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Medicaid Presumptive Eligibility
Certification Period**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There is no estimated costs or savings to the state as a result of implementation of this proposed rule, however, \$80 will be incurred in SFY 1999-2000 for the state's administrative expense of promulgating this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no estimated effect on federal revenue collections. However, the federal share of promulgating this proposed rule and the final rule is \$80.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The average length of time that a presumptively eligible pregnant woman who does not file an application for regular Medicaid eligibility is eligible will vary from thirty (30) to sixty (60) days, but will average 45 days. Therefore, some women will be eligible up to 15 days less, and others will be eligible up to 15 days more. There is no change in the average length of certification.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins
Director
9906#046

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

Physician Assistant Supervision

The Department of Health and Hospitals, 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 proposed rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Physician assistants are allied health personnel considered to be useful in combating the growing shortage and geographic maldistribution of health care services. They are widely used in clinic settings to provide certain functions in an effective and productive manner in order to more appropriately utilize traditional health care personnel. Federal regulations regarding rural health clinics require that midlevel practitioners (which include physician assistants) be employed at least 50 percent of the time that the practice is open. Federally qualified health centers allow, but do not require, the employment of physician assistants.

Louisiana statutory law authorizing licensure of physician assistants was first established by Act 753 of the 1977 Louisiana Legislature, which added a new Part V of Chapter 15 of Title 37 of the Louisiana Revised Statutes of 1950 containing R.S. 37:1360.21 through 37:1360.27. Among other things, Part V provided for the authorization, regulation, and certification of physician's trained assistants, including the regulation and approval of education and training programs, and the regulation and approval of physicians employing and supervising trained assistants. Subsequently, Act 662 of the 1993 Louisiana legislature amended and reenacted this Part to contain R.S. 37:1360.21 through 37:1360.38, and Act 879 of the 1995 Louisiana Legislature further amended statutory law.

The Department of Health and Hospitals, Board of Medical Examiners, pursuant to the authority vested in that agency by the Legislature, published LAC 46:XLV, Chapters 15 and 45 which contains standards for the licensing and certification and practice of physician assistants (*Louisiana Register*, Volume 22, No. 3). In particular, the rule requires that the physician who supervises a physician assistant be approved by and registered with the Board of Medical Examiners. In addition, the rule states that the supervising physician may supervise no more than two physician assistants at the same time, or a maximum of four when approved to act as a supervising physician on a *locum tenens* basis for physician assistants in addition to those for whom he or she is the primary supervising physician. According to the Board of Medical Examiners' rule, physician supervision must be conducted either on site where the physician assistant is providing services or within close proximity when there is the capability to be in contact with each other by telephone or other telecommunication device. The only exceptions are in emergencies or disasters, or when the physician assistant is volunteering unpaid services while in

the presence of and under the supervision of another physician. The supervising physician is responsible for the supervision, control, and direction of the physician assistant and retains responsibility to the patient for the competence and performance of the physician assistant.

The Louisiana Medicaid Program does not enroll or reimburse physician assistants for services rendered to Medicaid recipients. However, the supervising physician may bill for the services performed by the physician assistants under his supervision if the services are provided in accordance with the provisions of Board of Examiners' rule. The Bureau proposes to adopt the following rule governing physician supervision of physician assistants.

Proposed Rule

The Department of Health and Hospitals, Bureau of Health Services Financing adopts the following provisions governing Medicaid reimbursement to a physician who supervises a physician assistant.

1. The supervising physician and the physician assistant must comply with the regulations promulgated under the Administrative Procedure Act by the Board of Medical Examiners.

2. Medicaid payment for services provided by a physician assistant is available only when the supervising physician is at the site where the service is provided or within reasonable geographic distance sufficient to ensure that appropriate intervention can be provided in case of an emergency. Under no circumstances will reimbursement be made for services provided by a physician assistant when the supervising physician is outside the continental United States.

3. Supervising physicians are to arrange for substitute supervision as defined by the Board of Medical Examiners to act on a *locum tenens* basis when the supervising physician is not within close proximity.

Interested persons may submit written comments to: Thomas D. Collins, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this proposed rule.

A public hearing on this proposed rule is scheduled for Tuesday, July 27, 1999 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. At that time all interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

David W. Hood
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Physician Assistant Supervision

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There is no estimated costs or savings to the state as a result of implementation of this proposed rule. However, \$80 will be incurred in SFY 1999 for the state's administrative expense of promulgating this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no estimated effect on revenue collections. However, \$80 will be incurred in SFY 1999 for the federal share of promulgating this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Some supervising physicians will be required to make arrangements to have physician assistants supervised on a *locum tenens* basis rather than providing supervision from distant geographic locations. Medicaid recipients whose care is provided by a physician assistant will be assured that the supervising physician is within reasonable geographic distance in case of emergency.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins
Director
9906#048

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Insurance Office of the Commissioner

Regulation 68—Patient Rights Under Health Insurance Coverage in Louisiana (LAC 37:XIII.Chapter 91)

In accordance with the provisions of LSA-R.S. 49:953 of the Administrative Procedure Act, LSA-R.S. 22:3, R.S. 22:2014, and R.S. 22:2021(C), the Department of Insurance is proposing to adopt the following regulation regarding the rights of patients with health insurance coverage in Louisiana. This regulation is necessary to establish reasonable requirements for health insurance coverage that assures compliance with state statutory requirements under Title 22 of the Louisiana Revised Statutes of 1950. More specifically, this regulation is necessary to implement and enforce the following provisions: LSA-R.S. 22:2(G), 22:4, 22:215.9, 22:215.11, 22:215.13, 22:215.17 22:215.18, 22:215.19 22:2004, 22:2005, 22:2013, 22:2016 22:2018, 22:2020, 22:2021 and 22:2022.

Title 37

INSURANCE

Part XIII. Regulations

Chapter 91. Regulation 68 Patient Rights Under Health Insurance Coverage in Louisiana

§9101. Purpose

A. The purpose of this regulation is to clarify the rights of insureds and requirements for health insurance coverage approved under Title 22 of the Louisiana Revised Statutes of 1950. Title 22 of the Louisiana Revised Statutes of 1950 establishes the statutory requirements that health insurance coverage must meet to be issued for delivery in Louisiana. The statutory requirements also establish the intent of the legislature to afford patients with health insurance coverage, basic rights to access covered benefits without undue delays or denials based on arbitrary determinations of medical necessity. The statutory requirements also establish the

legislative intent to prohibit the use of a health insurance coverage requirement or procedure that impinges on the ability of the insured patient to receive appropriate medical advice and/or treatment from a health care provider.

B. To carry out the intent of the legislature and assure full compliance with the provisions of applicable statutory requirements, this regulation sets forth the patient rights under health insurance coverage policies or plans issued for delivery in this state.

AUTHORITY NOTE: Promulgated in accordance with LSA-R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:

§9103. Definitions

Emergency Medical Condition—means the sudden and, unexpected onset of a health condition that requires immediate medical attention, where failure to provide such medical attention could reasonably be expected to result in death, permanent disability, serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or could place the person's health in serious jeopardy.

Formal Managed Care Plan—basic health coverage provided by a Health Maintenance Organization licensed to operate in Louisiana. The term does not include health insurance coverage that does not meet the same quality standards that are applied to Health Maintenance Organizations. The term does not apply to any health insurance coverage or employer benefit plan that advertises or markets coverage as "managed care" but is not required to comply with the statutory consumer protections required of formal managed care plans operated by Health Maintenance Organizations in Louisiana.

Geographic Area—a Parish.

Health Care Professional—a physician duly licensed to practice medicine by the Louisiana State Board of Medical Examiners, or other health care professional duly licensed, certified, or registered as appropriate in Louisiana, or an acute care hospital licensed to provide medical care in this state.

Health Insurance Coverage—means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract. This term shall not mean limited benefit insurance as defined in LSA-R.S. 22:6(2)(b)(i) or any short term health insurance exempt from guaranteed renewal by PL 102-191, the Health Insurance Portability and Accountability Act of 1996.

Incentive Arrangement—any payment or contractual obligation included in a general payment plan, capitation contract, shared risk arrangement, or other agreement between a managed care organization and a health care provider that is tied to utilization of covered benefits.

Managed Care Plan—has the same meaning as set forth under LSA-R.S. 22:215.18A(3) and (4). This includes health insurance policies and health maintenance organization coverage. The term does not include supplemental insurance or limited benefit coverage for out of pocket expenses that is exempt from being classified as creditable coverage under Part of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

Service Area—the geographic area or areas of the state served by a managed care plan.

AUTHORITY NOTE: Promulgated in accordance with LSA-R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:

§9105. Applicability and Scope

Except as otherwise specifically provided, the requirements of this regulation apply to all health insurance coverage issued for delivery in the state of Louisiana that is otherwise subject to the statutory requirements of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

AUTHORITY NOTE: Promulgated in accordance with LSA-R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:

§9107. Patient Rights Under Policies or Plans of Health Insurance Coverage

A. Prohibition on the Use of Gag Clauses—Applies to HMO Coverage. Patients have a right to talk freely with health care professionals about their health, medical conditions, and any treatment options that are available, including those not covered by their health plan. LSA-R.S. 22:215.18(B) prohibits a managed care plan from adopting any requirement that interferes with the ability of a health care professional to communicate with a patient regarding his or her health care. This statutory protection also includes communications regarding treatment options and medical alternatives, or other coverage arrangements. The managed care plan is only allowed to prohibit a health care professional from soliciting alternative coverage arrangements for the purpose of securing financial gain by the health care professional.

B. Prohibition on Incentives to Restrict, Delay or Deny Medically Necessary Care—Applies to HMO and Major Medical Insurance Coverage. Patients have a right to receive medically necessary and appropriate services covered under a managed care plan. LSA-R.S. 22:215.19 prohibits managed care plans from offering any financial incentives to health care professionals to deny, reduce, limit, or delay specific, medically necessary, and appropriate services.

C. Holding Managed Care Plans Liable for their Actions, Omissions, or Activities—Applies to HMO and Major Medical Insurance Coverage. Managed care plans are responsible for their actions, activities or omissions that result in harm to the patient. LSA-R.S. 22:215.18(G) prohibits managed care plans from transferring their liability related to activities, actions or omissions of the plan to a health care professional treating the insured. This right does not relieve health care professionals of their responsibilities to appropriately practice within the scope of license, certification, or registration.

D. Guaranteed Direct Access to Obstetricians/Gynecologists—Applies to HMO and Major Medical Insurance Coverage. Women have a right to see an Obstetrician or Gynecologist for routine care. LSA-R.S. 22:215.17 requires health insurance coverage to include direct access to these health care professionals without prior authorization. In addition, health insurance coverage is required to include up to two annual routine visits and follow up treatment within sixty days of either visit if a related condition is diagnosed or treated during the visits.

This requirement also applies to pregnancy related care if covered by the policy or plan.

E. Requirement for Appropriate Access to Covered Medical Services—Applies to HMO Coverage

1. Formal managed care plans operated by health maintenance organizations are required to maintain an adequate number of health care professionals to serve plan participants. Covered services must be provided within a reasonable period of time once ordered or prescribed. LSA-R.S. 22:2004, 2005, 2013, 2016, and 2021 establish requirements for HMO plans to document that their networks of primary care physicians and specialists are adequate. HMOs are allowed to use point of service options to expand networks and assure access to plan participants.

2. Other health insurance coverage is only allowed to offer managed care as a coverage option. These plans must offer traditional payment of medical claims based on the terms of the policy for deductibles and co-insurance.

F. Confidentiality of Medical Records—Applies to HMO Coverage

1. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or potential enrollee obtained from such persons or from any provider by any formal managed care plan shall be held in confidence and shall not be disclosed to any person except:

a. to the extent that it may be necessary to carry out the purposes of operating a formal managed care plan as permitted by law;

b. upon the express consent of the enrollee or potential enrollee;

c. pursuant to statute or court order for the production of evidence or the discovery thereof;

d. in the event of a claim or litigation between such person and the formal managed care plan wherein such data or information is pertinent.

2. A formal managed care plan shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the formal managed care plan is entitled.

G. Prohibit Unreasonable Denial of Emergency Care—Applies to HMO and Major Medical Insurance Coverage

1. Any managed care plan that includes emergency medical services shall provide coverage and shall subsequently pay health care professionals for emergency medical services provided to a covered patient who presents himself/herself with an emergency medical condition.

2. No health insurance plan shall retrospectively deny or reduce payment to health care professionals for emergency medical services of a covered patient even if it is determined that the emergency medical condition initially presented is later identified through screening not to be an actual emergency, except in the following cases:

a. material misrepresentation, fraud, omission, or clerical error;

b. any payment reductions due to applicable co-payments, co-insurance, or deductibles that may be the responsibility of the covered patient;

c. cases in which the covered patient does not meet the emergency medical condition definition, unless the covered patient has been referred to the emergency

department by the insured's primary care physician or other agent acting on behalf of the health insurance plan;

H. Appeal/Grievance Procedures for Denials of Coverage—Applies to HMO and Major Medical Insurance Coverage

1. Formal managed care plans operated by health maintenance organizations are required to have an administrative appeal or grievance process for patients. LSA-R.S. 22:2022 requires these plans to submit their appeal/grievance procedures to the Department of Insurance to verify the process or procedures used are reasonable and meet the intent of the statute.

2. In addition, where any insured patient is denied benefits under a health insurance coverage plan, a request can be made to the Department of Insurance for investigation of the denial. Where the denial is valid, the insured is so notified. Where the denial is erroneous, the health insurance coverage plan is required to institute corrective action and may be subject to fines and penalties if a statutory violation has occurred.

I. Guaranteed Continuation Of Group Insurance—Applies To HMO and Major Medical Insurance Coverage

1. LSA-R.S. 22:215.13 guarantees Louisiana residents who lose their eligibility for coverage under a group health insurance policy or plan, the right to maintain such coverage in force for up to 12 months. This guaranteed continuation of group health insurance does not include accident only coverage, specific disease coverage, limited benefit coverage for dental, vision care or any benefits provided in addition to the basic hospital, surgical, or major medical benefits of the policy. This means that additional or optional insurance coverage purchased is not guaranteed to be provided during this 12-month continuation period. This continuation of group coverage right is guaranteed for up to one year so long as the following conditions are met:

- a. the individual is not eligible for any other group health coverage plan or government sponsored health plan, such as Medicare and Medicaid;
- b. the individual timely pays the full monthly premium to keep coverage in force;
- c. the individual was not terminated from coverage for fraud or failure to pay any required contribution for the group insurance, and continues to meet the group policy's terms and conditions other than membership in that original group;
- d. all dependents covered under the group policy or plan continue to be covered;
- e. the group policy has not been terminated or the employer has withdrawn participation in a multiple employer group policy; and
- f. the individual continues to reside within the service area of the plan in the event that such group coverage is provided by a Health Maintenance Organization.

2. This right is not automatic and requires the employee or member who is losing coverage to make a written election of continuation on a form furnished by the group policyholder and pay for the first month's coverage prior to the date that coverage is being terminated. Written notification of termination must be provided to the individual in advance to allow election of this right.

3. Special continuation rights are provided to a surviving spouse of an individual who was covered by a group health insurance policy or plan at the time of death and is age 55 or older. Under Louisiana law the surviving spouse is guaranteed the right to continue such group coverage in effect until eligible for any other group coverage. The surviving spouse is also allowed to provide coverage to all dependents that were covered under the deceased spouse's policy or plan at the time of death so long as they remain eligible under the policy.

J. Guaranteed Renewal of Health Insurance Coverage—Applies to HMO and Major Medical Insurance Coverage

1. Under Louisiana law, once health insurance coverage has been purchased, the insurer cannot cancel the coverage unless one of the following conditions exists:

- a. failure to pay premiums or contributions in accordance with the terms of the policy;
- b. failure to comply with a material plan provision relating to employer contribution or group participation rules;
- c. performance of an act or practice that constitutes fraud or the intentional misrepresentation of a material fact under the terms of coverage;
- d. the policyholder no longer resides, lives, or works in the service area in the event the coverage is provided under a formal managed care plan operated by a Health Maintenance Organization;
- e. the policyholder's coverage is purchased through a bona-fide association plan and the policyholder is no longer eligible to participate in such association;
- f. the insurance company is no longer offering the type of coverage purchased and offers to replace the policy with any other type of similar coverage being marketed within 90 days of renewal; or
- g. the insurance company is leaving the market and will no longer be selling any group and/or individual health insurance products in Louisiana for a period of at least five years. In such instances the insurer must give each policyholder 180 days advance notice in writing before the policy is terminated. All termination notices must be filed and approved by the Department of Insurance prior to issuance.

K. Limits on Preexisting Medical Condition Exclusions from Coverage—Applies To HMO and Major Medical Insurance Coverage. Under Louisiana law, a health insurance plan is allowed to exclude certain medical conditions from coverage for a limited period of time. All policies now being sold are prohibited from excluding coverage for specific preexisting medical conditions for more than 12 months. Regardless of the type of coverage (group or individual), health plans are not allowed to apply an exclusion of coverage based on a preexisting medical condition for more than 12 months.

1. Group Coverage. The medical conditions that can be excluded from coverage are limited to those that were diagnosed or treated during the six month period prior to the day coverage begins under the policy. Any condition that was not being treated during the prior six months cannot be excluded from coverage.

2. Individual Coverage. The medical conditions that can be excluded from coverage are limited to those that were diagnosed, treated or reasonably should have been treated during the twelve month period prior to the day coverage begins under the policy. Any condition that was not diagnosed, treated, or reasonably should have been treated during the prior twelve months cannot be excluded from coverage.

L. Guaranteed Portability Protections—Applies to HMO and Major Medical Insurance Coverage

1. Individuals who are moving their health coverage from one employment situation to another or from one group plan to another are guaranteed the following rights provided they have enrolled in the new plan within 63 days of termination from the prior plan:

a. if the new plan imposes a 12-month preexisting exclusionary period, the individual must be given one month's credit for each month of continuous coverage under the prior plan. If the individual had 12 or more months of continuous coverage under the prior plan, the preexisting exclusionary period has been satisfied. If the individual had 6 months of continuous coverage under the prior plan, the preexisting exclusionary period is reduced by 6 months;

b. if the new employer imposes an exclusionary or waiting period for employees before coverage can begin, such periods do not count as a break in coverage for applying portability rights;

c. during any exclusionary or waiting period, no premiums can be charged to the individual;

d. during any exclusionary or waiting period the individual may maintain their prior coverage if eligible under state continuation of coverage rights, federal COBRA rights, or through purchase of an individual policy;

e. individuals, who had at least 18 months of prior coverage under a group plan, have exhausted or are not eligible for state continuation rights or COBRA rights, are guaranteed access to individual health insurance coverage through the Louisiana Health Insurance Association.

2. Any Louisiana resident who has individual health insurance coverage is guaranteed credit for prior individual coverage when replacing coverage if the insurance plan is applying the prior insurance policy's lifetime benefit usage against the replacement policy. Residents can waive credit for prior coverage to avoid any reduction in the lifetime benefit limit of the replacement coverage. However, state law no longer allows the sale of any policy of insurance that excludes coverage in excess of 12 months.

M. Prohibiting Discrimination Against Individuals Based on Health Status—Applies to HMO and Major Medical Insurance Coverage

1. State and federal law prohibit any group health coverage plan from discriminating against individuals based on their health status. This means that an individual's medical status cannot be used to determine eligibility to join a group health plan with certain exceptions. Plans are specifically prohibited from adopting any rules for eligibility or continued eligibility based on any of the following health status related factors:

- a. health status;
- b. medical condition, including both physical and mental illness;
- c. claims experience;
- d. receipt of health care;
- e. medical history;
- f. genetic information;
- g. evidence of insurability, including conditions arising out of acts of domestic violence; and
- h. disability.

2. A plan's rules for eligibility to enroll under a plan also include rules defining any applicable waiting periods for such enrollment. This means that the plan may only apply exclusionary or waiting period uniformly based on date of hire for all eligible employees. No exclusionary or waiting periods are allowed after coverage begins and premiums are being collected from the insured.

N. Prohibition on Use of Prenatal and Genetic Tests by Health Insurance Plans—Applies to HMO and Major Medical Insurance Coverage. State law prohibits health insurance plans from requiring any individual to take genetic tests or prenatal tests prior to being offered coverage. Plans are also prohibited from requesting release of any genetic or prenatal test results or using such information in the determination of benefits or rates for an insured.

AUTHORITY NOTE: Promulgated in accordance with LSA-R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:

§9109. Patient Responsibilities

Under Louisiana law, formal managed care plans operated by health maintenance organizations are held to a higher standard than other health insurance coverage plans that include managed care options. All materials provided by a health insurance coverage plan should be carefully reviewed prior to making a purchasing decision. Managed care requirements under each health insurance coverage plan may vary significantly. For this reason, all patient requirements should be carefully reviewed to assure there is no misunderstanding regarding how medical coverage will be provided.

AUTHORITY NOTE: Promulgated in accordance with LSA-R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:

A public hearing on the proposed regulation will be held on March 31, 1999 in the Plaza Hearing room of the Louisiana Department of Insurance located at 950 North Fifth Street, Baton Rouge, LA, at 9:00 a.m. All interested persons will be afforded an opportunity to make comments.

Interested persons may submit oral or written comments to Claire Lemoine, Senior Attorney, Division of Health, Department of Insurance, Box 94214, Baton Rouge, LA 70804-9214, telephone (225) 219-4771. Comments will be accepted through the close of business at 4:30 p.m., June 17, 1999.

James H. "Jim" Brown
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Regulation 68 Patient Rights Under
Health Insurance Coverage In Louisiana**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
It is not anticipated that Regulation 68 would result in any implementation costs or savings to local or state governmental units. The rights set forth in the regulation have already been established statutorily.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There should be no impact on revenue collections of state or local governmental units as a result of Regulation 68. All rights set forth in the regulation have already been established statutorily.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There are no anticipated benefits or costs to directly affected groups or persons, as a result of Regulation 68. The rights set forth in the regulation have already been established statutorily.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
Regulation 68 is not expected to have any impact on competition and employment.

Craig S. Johnson
Deputy Commissioner
Management and Finance
9906#002

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Social Services
Office of Community Services**

Child Protection Investigation Report Acceptance
(LAC 67:V.1301)

The Department of Social Services, Office of Community Services, proposes to amend the Rule entitled Child Protection Investigation Report Acceptance published in the Louisiana Register Vol. 19, No. 4, April 20, 1993, page 503.

This proposed rule regards the acceptance of reports of child abuse and/or neglect for investigation by the Office of Community Services. The Office of Community Services will now accept for investigation all reports of suspected child abuse/neglect related deaths regardless of whether there are surviving children in the child victim's home.

Title 67

SOCIAL SERVICES

**Part V. Office of Community Services
Subpart 3. Child Protective Services**

Chapter 13. Intake

**§1301. Child Protection Investigation Report
Acceptance**

- A. - F. ...
- G.2.a. Repealed
- b. - m. ...

AUTHORITY NOTE: Promulgated in accordance with the Louisiana Children's Code, Article 612.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 17:387 (April 1991), amended LR 18:1246 (November 1992), repromulgated LR 19:165 (February 1993), LR 19:503 (April 1993), amended LR 25:

Interested persons may submit written comments for forty days from the date of this publication to the following address: Shirley Goodwin, Assistant Secretary, P. O. Box 3318, Baton Rouge, LA 70821. She is the person responsible for responding to inquiries.

Madlyn Bagneris
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Child Protection Investigation
Report Acceptance**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
The only cost in FY 99/2000 will be \$500 to print manual material. It is estimated that the acceptance of these child fatality reports will result in approximately twenty-five additional investigations per year statewide. Currently OCS conducts approximately 25,000 investigations. These additional 25 investigations will not result in a need for additional staff.
There will be no saving as a result of the revision to agency policy.
- 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.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There will not be any costs nor economic benefits to directly affected persons or non-governmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There will be no effect on revenue competition and employment.

Robert J. Hand
Director
9906#036

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Transportation and Development
Office of the Secretary
Crescent City Connection Division**

Bridge Toll—Crescent City Connection-Transit Lanes
(LAC 70:I.515)

The Department of Transportation and Development, Crescent City Connection Division, in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., gives notice that rulemaking procedures have been instituted to amend LAC 70:I.515 to allow access to the transit lanes on the Crescent City Connection Bridge No. 2, New Orleans,

Louisiana, by motorcycles and inherently low emission vehicles.

The proposed Rule Amendment is necessary in part to implement recent changes in federal law.

Title 70

TRANSPORTATION AND DEVELOPMENT

Part I. Office of the General Counsel

Chapter 5. Tolls

§515. Crescent City Connection Transit Lanes

A. Intent. It is the intent of this Rule to efficiently maximize the use of the vehicular traffic lanes of the Crescent City Connection for the increased mobility of individuals and goods across the Mississippi River at New Orleans, to encourage and promote mass transit and transportation such as the use of carpools and other high occupancy vehicle (HOV) use, while minimizing transportation related fuel consumption and air pollution, and to provide for one-way reversible traffic flow on the transit lanes of the Crescent City Connection Bridge No. 2, and the establishment of the requirements for vehicles operating on the transit lanes.

B. Hours of Operation

1. The transit lanes of the Crescent City Connection Bridge No. 2 will be open for use by eligible vehicles in accordance with the control signals posted by the Crescent City Connection Division through the Crescent City Connection Police.

2. Generally, the transit lanes of the Crescent City Connection Bridge No. 2 will be open for use by eligible vehicles with the traffic proceeding to the Eastbank in the morning and with the traffic proceeding to the Westbank in the afternoon.

3. However, the directional traffic flow of the transit lanes may be reconfigured by the Crescent City Connection Division in its sole discretion at such times and in such directions in order to protect the public safety during emergencies and to accommodate the public interest during special events.

C. Ineligible Vehicles. The objective of the transit lanes is to provide a free flowing facility for mass transit, high occupancy vehicles, and other eligible vehicles. Accordingly, the following vehicles are prohibited from using the transit lanes during the hours of operation even though they may satisfy the vehicle occupancy requirements:

1. trucks with more than two axles or having a gross weight capacity of one ton or more;
2. vehicles towing trailers;
3. parades;
4. funeral processions;
5. pedestrians;
6. bicycles; and
7. non-motorized vehicles.

D. Eligible Vehicles. The following vehicles are eligible to use the transit lanes during the hours of operation:

1. all public mass transit vehicles, including Regional Transit Authority buses and Jefferson Transit System buses;
2. school buses;
3. commercial passenger vehicles manufactured to carry seven (7) or more passengers and pre-qualified to use the transit lanes ("HOV-7");

4. other motor vehicles carrying more than a specified number of persons and properly displaying a valid toll tag issued by the Crescent City Connection Division ("HOV-2");

5. motorcycles properly displaying a valid toll tag issued by the Crescent City Connection Division ("Authorized Motorcycles"); and

6. any vehicle certified as an Inherently Low-Emission Vehicle pursuant to title 40, Code of Federal Regulations, and labeled in accordance with, section 88.312-93(c) of such title, and properly displaying a valid toll tag issued by the Crescent City Connection Division ("ILEV").

E. Vehicle Occupancy Requirements. The minimum occupancy requirement for vehicles designated as HOV-2 shall be two or more persons during all hours of operation. The minimum occupancy requirement for vehicles designated as HOV-7 shall continue to be seven or more persons during all hours of operation. There are no minimum occupancy requirements for vehicles designated as Authorized Motorcycles or for vehicles designated as ILEV during all hours of operation.

F. Qualifications

1. Eligible vehicles must be prequalified to use the transit lanes as follows.

a. Public Mass Transit Vehicles. All public mass transit vehicles shall continue to be pre-qualified to access the transit lanes toll-free during the hours of operation.

b. School Buses. All school buses shall continue to be authorized to access the transit lanes toll-free during the hours of operation upon compliance with the school buses exemption provided for under LAC 70:I.509(E).

c. HOV-7+. Eligible vehicles meeting the minimum occupancy requirement of seven or more persons must register with the Crescent City Connection Division by providing proof of:

- i. current vehicle registration with the State of Louisiana or other jurisdiction;
- ii. current and valid Driver's License; and
- iii. current and fully-paid liability insurance coverage.

d. HOV-2+. Eligible vehicles meeting the minimum occupancy requirement of two or more persons and displaying a valid toll tag issued by the Crescent City Connection Division.

e. Authorized Motorcycles. Motorcycles displaying a valid toll tag issued by the Crescent City Connection Division.

f. ILEV. Any vehicle certified as an Inherently Low-Emission Vehicle pursuant to title 40, Code of Federal Regulations, and labeled in accordance with, section 88.312-93(c) of such title, and properly displaying a valid toll tag issued by the Crescent City Connection Division.

2. Toll tags on HOV-2 vehicles, Authorized Motorcycles, and ILEV's must be conspicuously displayed in accordance with the instructions of the Crescent City Connection Division at all times while operating on the transit lanes.

G. Enforcement. During all hours of operation, the Crescent Connection Police shall supervise and actively control access to the transit lanes, and enforce vehicle eligibility, minimum occupancy requirements and permit emblem display.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:25 et seq., and R.S. 48:1101.2.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of the Secretary, Crescent City Connection Division, LR 24:960 (May 1998), amended LR 25:

Interested persons may comment on this proposed Rule amendment to Mr. Alan LeVasseur, P.O. Box 6297, New Orleans, Louisiana 70174.

Alan LeVasseur
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Bridge Toll Crescent City-Transit
Lanes**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There will not be any implementation costs to the State as a result of this Rule Amendment. L.R.S. 47:820.5 and L.R.S. 48:1101.2 currently allow for use of discounted toll tags for bridge crossings and for access to the transit lanes by eligible vehicles. It is not anticipated that the proposed amended Rule's expansion of eligible vehicles for transit lane access will result in a material increase in toll tag issuances.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that there will be no adverse effect on revenue collections by the Crescent City Connection Division. The Crescent City Connection currently allows for the use of regular bridge traffic by means of a discounted toll tag, as well as for the use of the transit lanes by eligible vehicles displaying a discounted toll tag. It is not anticipated that the proposed Rule Amendment will materially increase the number of toll tag issuances.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The expanded eligibility requirements for transit lane access could result in cost savings to motorcycles and inherently low emission vehicles which do not currently subscribe to discounted toll tags.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition or employment.

Kenneth E. Pickering General Counsel Crescent City Connection 9906#001	Robert E. Hosse General Government Section Director Legislative Fiscal Office
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NOTICE OF INTENT

**Department of the Treasury
Board of Trustees of the Teachers'
Retirement System of Louisiana**

Management of DROP Accounts
(LAC 58:III.503)

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

Trustees of Teachers' Retirement System of Louisiana approved an amendment to policies governing the Management of DROP Accounts, LAC 58:III.503 as follows.

**Title 58
RETIREMENT**

**Part III. Teachers' Retirement System
Chapter 5. Deferred Retirement Option Plan
§503. Management of DROP Accounts**

A. - B.2. ...

3. Interest earnings will begin accruing the day after termination of DROP participation and will be compounded daily. Interest will be deposited to DROP accounts once a year when the actuarially realized rate of return is approved by the Public Retirement Systems' Actuarial Committee. Interest deposits will reflect the interest earned on the account during the previous fiscal year and will be entered on quarterly statements issued after this approval is obtained. No interest will accrue on the DROP account after the date the account has been liquidated. No interest is paid on an interest only balance. Liquidated means all funds have been withdrawn from the DROP account except for the possible final interest earnings due but not yet posted.

B.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:739 and R.S. 11:786 - 791.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 18:621 (June 1992), amended LR 18:1419 (December 1992), LR 19:1601 (December 1993), LR 20:1020 (September 1994), LR 21:1267 (November 1995), LR 23:85 (January 1997), repromulgated LR 24:500 (March 1998), amended LR 25:

Interested persons may comment on the proposed rule in writing until 4:30 p.m., August 27, 1999, to Graig A. Luscombe, Assistant Director, Teachers' Retirement System of Louisiana, P. O. Box 94123, Baton Rouge, LA 70808-9123.

James P. Hadley, Jr.
Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Management of DROP Accounts**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no implementation costs to state or local government units. This amended rule explains how interest is currently calculated and added to DROP accounts.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no effect on revenue collection of state or local government units. No revenue is currently being collected and none will ever be collected in the future because of this amended rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Interest is currently being paid to eligible former DROP participants of Teachers' Retirement System of Louisiana

(TRSL). No changes are being made in how this interest is calculated or paid.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition or employment because no changes are being made in the compensation or fringe benefits being paid to DROP participants/retirees.

James P. Hadley, Jr.
Director
9906#034

H. Gordon Monk
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Wildlife and Fisheries
Office of Fisheries**

Tilapia (LAC 76:VII.903)

(Editor's Note: The following notice, which appeared on page 899 of the May 20, 1999 Louisiana Register, is being republished in its entirety to correct a typographical error in the department name.)

The Secretary of the Department of Wildlife and Fisheries does hereby give notice of its intent to amend the rule governing importation, culture, possession, disposal and sale of tilapia in Louisiana.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 9. Aquaculture Exotic Species

§903. Tilapia

A. Rules and Regulations on Importation, Culture, Possession, Disposal and Sale of Tilapia in Louisiana. The following terms shall have the following meanings in this Section.

Culture—all activities associated with the propagation and nurturing of tilapia.

Culture Permittee—the individual or organization that possesses a valid Louisiana tilapia culture permit.

Culture System—shall be an approved indoor system designed such that all water containing, or that at any time might contain, tilapia (adult fish, juvenile fish, fry, or fish eggs) is filtered, screened and/or sterilized in such a manner as the department deems adequate to prevent any possibility of escape from the system.

Department—the Louisiana Department of Wildlife and Fisheries or an authorized employee of the Department.

Disposal—the business of processing, selling, or purposely removing tilapia from the culture system.

Live Holding Permittee—the individual or organization that possesses a valid Louisiana tilapia live holding permit.

Live Holding System—an approved indoor holding or display system designed such that all water containing, or at any time might contain, tilapia (adult fish, juvenile fish, fry or fish eggs) is filtered, screened and/or sterilized prior to release in such manner as the department deems adequate to prevent any possibility of escape.

Process—the act of chill killing whole tilapia in an ice slurry for a period of not less than 60 minutes, or removal of tilapia intestines followed by immersion in an ice slurry for a period of not less than two minutes or removal and proper

disposal of tilapia heads in such manner as the department deems necessary to prevent any possibility of accidental release of fry or fertilized eggs.

Secretary—the Secretary of the Department of Wildlife and Fisheries.

Tilapia—eggs, fish, or body parts belonging to the genera *Tilapia*, *Sarotherdon*, or *Oreochromis* and their hybrids.

Tilapia Culture Permit—official document pertaining to culture that identifies the terms of, and allows for the importation, exportation, transport, culture, possession, disposal, transfer and sale of tilapia in Louisiana as approved by the secretary or his designee.

Tilapia Live Holding Permit—official document pertaining to live holding for retail sale that identifies the terms of, and allows for the possession and sale of tilapia in Louisiana as approved by the secretary or his designee.

B. Tilapia Permit Request Procedures

1. Individuals or organizations wishing to import, export, transport, culture, possess, dispose, transfer or sell live tilapia in Louisiana must first request a tilapia culture or live holding permit from the secretary or his designee of the Department of Wildlife and Fisheries. The following procedures will be necessary.

a. Applications for permits can be obtained by contacting the Administrator, Inland Fisheries Division, Department of Wildlife and Fisheries, P. O. Box 98000, Baton Rouge, LA 70898-9000.

b. The completed applications should be returned to the same address whereby Inland Fisheries Division personnel will review the application. Department personnel or a department approved contractor, at the applicant's expense, will then make an on-site inspection of the property and culture or live holding system.

c. After the on-site inspection has been completed, department personnel will make a final determination as to whether the applicant is in full compliance with all rules for a tilapia culture or live holding permit. Department personnel will then recommend to the secretary or his designee if the applicant's request should be approved or disapproved.

C. Rules on Transport of Live Tilapia

1. The department shall be notified in writing at least 24 hours prior to shipments of live tilapia from one Louisiana culture permit holder to another Louisiana culture permit holder or live holders within the state or shipments out-of-state on a form provided by the department. Notification shall include Louisiana tilapia culture permit number, route, date and time(s) of transport, destination, owner of transport vehicle, total number of each species, permit number of resident tilapia culturer or live holder, and a copy or reference to electrophoretic certification of shipped stock by species. Anyone possessing live tilapia within the State must have a tilapia culture or live holding permit. Live tilapia showing signs of diseases shall not be transported into or within the State of Louisiana.

2. For each occurrence of tilapia being imported into Louisiana from out of state to a permitted resident culturer or live holder, the permittee must obtain, in writing, approval from the department. Procedures and necessary information for obtaining approval are:

a. requests shall be made to: Administrator, Inland Fisheries Division, Louisiana Department of Wildlife and Fisheries, P. O. Box 98000, Baton Rouge, Louisiana 70898-9000;

b. requests shall include:

- i. Louisiana tilapia permit number, or a copy of the permit;
- ii. route of transport;
- iii. date of transport;
- iv. time(s) of transport;
- v. destination;
- vi. owner of transport vehicle;
- vii. electrophoretic certification made within the past thirty days identifying shipped stock(s) to species.
- viii. total number of each species;
- ix. identification of seller and buyer.

3. A bill of lading must accompany the live tilapia during import, export, transport, transfer or sale and shall include:

- a. copy of the permittee's written approval as described in LAC 76:VII.903.C.2. above;
- b. date and approximate time of shipment;
- c. route of shipment;
- d. source of tilapia (culture facility);
- e. name, address and phone number of seller;
- f. name, address and phone number of buyer;
- g. identification and certification as to species;
- h. total number of each species;
- i. destination;
- j. letter from source stating that tilapia are not showing signs of diseases;

k. display the word "TILAPIA" prominently on at least two sides of the vehicle or hauling tank with letters that are no less than six inches high.

D. Rules for Security of Tilapia Culture or Live Holding Facility

4. It shall be the responsibility of the permittee to immediately notify the secretary or his designee of any tilapia that leave the facility for any reason other than those specifically identified and allowed for under their current permit, including but not limited to accidental releases, theft, etc.

E. Rules of Tilapia Culture and Live Holding Site

2. The applicant must agree to allow department officials or a department approved contractor, at the applicant's expense, to conduct unannounced random inspections of the transport vehicle, property, culture system or live holding system, and fish. Department officials may request other officials to accompany them during these inspections. Additionally, those individuals performing these inspections may remove or take fish samples for analysis and/or inspection.

4. The department will require a live holding contingency plan for disposal of live tilapia in the event of impending flooding or other natural disasters.

F. Rules for the Tilapia Culture and Live Holding System

1. Applicant must provide a detailed narrative description, including scale drawings, of the tilapia culture or live holding system.

2. The tilapia culture or live holding system shall be an approved indoor system designed such that tilapia eggs, larvae, juveniles or adults cannot escape.

3. All water utilized in the culture or live holding of tilapia shall be accounted for and shall be filtered, screened, and/or sterilized prior to leaving the culture or live holding system and the permittee's property in such a manner as the department deems adequate to prevent any possibility of escape from the system.

4. All aspects of the tilapia culture or live holding system and processing shall be completely enclosed so that predation from birds, mammals, amphibians, and reptiles is precluded.

5. A means to dispose of tilapia through chlorination, desiccation, or other appropriate methods, in the event of an emergency must be included as a component of any department-approved live-holding system.

6. One or more persons responsible for the operation of the live holding system must demonstrate to the department's satisfaction a basic knowledge and understanding of the culture, biology, and potential local ecological impacts of tilapia.

G. Rules for the Processing of Tilapia

1. All tilapia and tilapia parts other than live tilapia specifically permitted by the department must be properly processed and killed prior to leaving the tilapia culture or live holding facility.

3. Records shall be kept of all tilapia processed at a culture or live holding facility and shall include the following information:

- a. source of fish;
- b. processed pounds;
- c. date processed.

4. A copy of this information shall be sent to the Department's Baton Rouge office at the end of each year, or at anytime upon the request of Department officials.

H. General Rules for Tilapia

1. The cost of a Tilapia Culture or Live Holding Permit shall be \$50, plus the actual cost of the on-site inspection. Qualified universities conducting research approved by the department shall be exempt from the fee charge.

2. In order for the permit to be valid, the following license is required as a prerequisite:

- a. a Fish Farming License for tilapia culturers;
- b. a Retail Dealers License for live holders.

5. Live tilapia, may be sold within the state only to a holder of a valid tilapia culture or live holding permit. A tilapia culture permit shall be required for the possession or transport of tilapia eggs, fry or juveniles.

9. Tilapia culturers shall be required to submit an annual report to the secretary or his designee on a form provided by the department.

11. The department shall be overseer of all escape incidents and may implement or require to be implemented whatever measures deemed necessary to contain, kill or recapture fish. The permittee shall agree to reimburse Wildlife and Fisheries for all department costs including, but not limited to, man hours and materials utilized during these corrective actions. In order to assure the secretary that the permittee will fulfill their financial obligations, the tilapia culturer shall, at the option of the department, post a \$25,000 performance bond, or present a letter of credit from a financial institution stating that the \$25,000 is available to the department on a certificate of deposit. Tilapia live holder permittees will be required to post a \$10,000 performance bond, or present a letter of credit from a financial institution stating that the \$10,000 is available to the department on a certificate of deposit.

12. If a permittee terminates tilapia production or live holding, the permittee shall notify the secretary or his designee immediately and dispose of the tilapia according to methods approved by the department.

13. In addition to all other legal remedies, including provisions of R.S. 56:319.E, failure to comply with any of the provisions herein shall be just cause to immediately suspend and/or revoke the permittee's permit. All tilapia shall be destroyed at permittee's expense under the department's supervision within 30 days of permit revocation.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:318 and R.S. 56:319.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Office of Fisheries, LR 17:804 (August 1991), amended LR 20:1022 (September 1994), LR 21:594 (June 1995), LR 25:

Interested persons may submit written comments on the proposed rule to Mr. Bennie Fontenot, Jr., Administrator, Inland Fisheries Division, Department of Wildlife and Fisheries, Box 98000, Baton Rouge, LA 70898-9000, no later than 4:30 P.M., Wednesday, August 4, 1999.

James H. Jenkins, Jr.
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Tilapia

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no anticipated implementation costs or savings to state or local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Sale of tilapia from live holding facilities may increase revenue collections of state or local governmental units through increased sales and subsequent tax revenues, but the increase, although inestimable, is anticipated to be minimal at best.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Persons who sell tilapia as live holders are subject to a permit fee and a performance bond. Live holders will be subject to providing records of sales, similar to that now maintained by tilapia culturers. Benefits to sellers would accrue from an anticipated increase of seafood sales. Seafood buyers

would benefit from having an additional, fresh seafood item available to them.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Effects on competition and employment can not be anticipated at this time. Employment is not expected to increase as a result of the proposed rule, since existing sales personnel will probably be utilized in the live holding and sale of tilapia.

James L. Patton
Undersecretary
9906#018

Robert E. Hosse
General Government Section Director
Legislative Fiscal Office

NOTICE OF INTENT

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

Black Bass Regulations—Lake
Fausse Point/Lake Dauterive
(LAC 76:VII.189)

The Wildlife and Fisheries Commission hereby advertises its intent to establish the following rule on black bass (*Micropterus spp.*) on the Lake Fausse Point/Lake Dauterive complex located west of the West Atchafalaya Basin Protection Levee in Iberia and Upper St. Martin Parishes, Louisiana.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 1. Freshwater Sports and Commercial Fishing

§189. Black Bass Regulations, Lake Fausse Point/Lake Dauterive Complex

A. The harvest regulations for black bass (*Micropterus spp.*) on the Lake Fausse Point/Lake Dauterive complex located west of the West Atchafalaya Basin Protection Levee in Iberia and St. Martin Parishes, Louisiana are as follows.

1. Size limit: It shall be unlawful to take or possess, while on the water or while fishing in the water, black bass less than 14 inches total length.

2. Daily take: No more than 10 fish.

B. These regulations apply to all areas west of the West Atchafalaya Basin Protection Levee from Highway 3083 to the U.S. Army Corps of Engineers locks at the Charenton Drainage and Navigation Canal, north of and including the Charenton Drainage and Navigation Canal from the Corps of Engineers locks to Highway 87, north and east of Highway 87 from the Charenton Drainage and Navigation Canal to Highway 320, east of Highway 320 from Highway 87 to Highway 86, south and east of Highway 86 from Highway 320 to Highway 345, east of Highway 345 from Highway 86 to Highway 679, east of Highway 679 from Highway 345 to Highway 3083 and south of Highway 3083 from Highway 679 to the West Atchafalaya Basin Protection Levee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6 (25)(a), R.S. 56:325(C) and R.S. 56:326.3.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 25:

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 statements, the filing of the notice of intent and final rule and the preparation of reports and correspondence to other agencies of government.

Interested persons may submit written comments on the proposed rule to Mr. Mike Walker, Biologist Supervisor, Inland Fisheries Division, Department of Wildlife and Fisheries, 2415 Darnall Rd., New Iberia, LA 70560 no later than 4:30 p.m., Wednesday, August 6, 1999.

Bill A. Busbice, Jr.
Chairman

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Black Bass Regulations Lake Fausse
Point/Lake Dauterive**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENT 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 and local governmental units.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO
DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL
GROUPS (Summary)**

Sport fishermen who fish in the Lake Fausse Point and Lake Dauterive complex will be affected by the proposed action, since they will have to release black bass less than 14 inches in length. The implementation of a 14 inch minimum should result in an increase in black bass below or just above 14 inches and aid in sustaining the population in these waters. The proposed rule will have no effect on costs and/or economic benefits to sport fishermen at the Lake Fausse Point and Lake Dauterive complex.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

The proposed rule should have no impact on competition and employment in the public and private sectors.

James L. Patton
Undersecretary
9906#030

H. Gordon Monk
Staff Director
Legislative Fiscal Office

Potpourri

POTPOURRI

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

1998 State Implementation Plan (SIP)
General Revisions

The Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division will conduct a public hearing to receive comments regarding revisions to the State Implementation Plan (SIP). The revisions include amendments to various rules in LAC 33:III.Chapters 5, 6, 11, 15, 21, 23, and 25 that were previously promulgated in 1998.

The hearing will be held on July 26, 1999, at 1:30 p.m. on the third floor of the Maynard Ketcham Building, Room 326, 7290 Bluebonnet Boulevard, Baton Rouge, LA. All interested persons are invited to attend and submit oral comments on the SIP revisions. Written comments may be submitted no later than 4:30 p.m. on August 2, 1999, to Patricia Vidrine, Air Quality Division, Box 82135, Baton Rouge, LA 70884-2135 or to 7290 Bluebonnet Boulevard, Second Floor, Baton Rouge, LA 70810.

A copy of the SIP changes may be viewed Monday through Friday, from 8:00 a.m. to 4:30 p.m., at the following DEQ locations: 5222 Summa Court, Baton Rouge, LA; 7290 Bluebonnet, 2nd Floor, Baton Rouge, LA; 100 Asma Blvd., Suite 151, Lafayette, LA; 804 31st Street, Suite D, Monroe, LA; 104 Lococo Drive, Raceland, LA; 1525 Fairfield, Rm. 11, Shreveport, LA; 402 Rainbow Drive, Pineville, LA; 3501 Chateau Blvd., W. Wing, Kenner, LA; and 3519 Patrick St., Rm. 265A, Lake Charles, LA.

The SIP is also distributed to the State Library of Louisiana, Louisiana Section, 760 North Third Street, Baton Rouge, LA.

If there are any questions or other comments, please direct them to Patricia Vidrine at (225) 765-0917.

Gustave A. Von Bodungen, P.E.
Assistant Secretary

9906#068

POTPOURRI

Office of the Governor Division of Administration Office of Community Development

Fiscal Year 2000-2004 Consolidated Plan
and Fiscal Year 2000 Annual Action Plan

As set forth in 24CFR Part 91, the U.S. Department of Housing and Urban Development (HUD) requires state agencies which administer certain HUD programs to

incorporate their planning and application requirements into one master plan called the Consolidated Plan. In Louisiana, the four state agencies participating in this consolidated planning process and the HUD funded program administered by each agency include the Division of Administration/Office of Community Development (Small Cities Community Development Block Grant Program), the Louisiana Housing Finance Agency (HOME Investment Partnerships Program), the Department of Social Services/Office of Community Services (Emergency Shelter Grants Program), and the Department of Health and Hospitals/HIV/AIDS Program (Housing Opportunities for Persons with AIDS Program).

A consolidated plan is being prepared which outlines the State's overall housing and community development needs and a strategy for meeting those needs for federal fiscal years 2000-2004 and includes a one year action plan for the distribution of FY 2000 federal funds received for the four aforementioned HUD programs. An annual update or action plan for the distribution of funds will be prepared and publicized for each of the subsequent four program years.

The proposed Consolidated Plan for FY 2000-FY 2004, including the proposed FY 2000 Annual Action Plan which identifies the proposed method of distribution of FY 2000 funds under the four HUD programs, will be prepared and will be available for review beginning July 6, 1999, at the Office of Community Development, State Capitol Annex, 1051 North Third Street, Room 168, Baton Rouge, LA. Copies of the proposed annual action plan will also be available for review at the Louisiana Housing Finance Agency at 200 Lafayette Street, Suite 300 in Baton Rouge, and the Department of Social Services/Office of Community Services at 333 Laurel Street, Room 606, in Baton Rouge, and the Department of Health and Hospitals/HIV/AIDS Program at 234 Loyola Avenue, Fifth Floor, in New Orleans.

A limited number of the proposed plans will be available for distribution and may be requested in writing or by telephone from any of the four agencies participating in the consolidated planning process. The proposed plan will also be available for viewing and copying on the internet (www.state.la.us/cdbg/cdbg.htm).

The following presents a summary of the FY 2000 Annual Action Plan.

The State's anticipated federal allocation for the FY 2000 Louisiana Community Development Block Grant (LCDBG) Program is approximately \$36,643,000 (subject to federal allocation). The Office of Community Development is proposing to establish the following five program areas for the distribution of these funds.

(1) Housing. \$2.4 million will be set aside to provide safe and sanitary living conditions through housing rehabilitation or replacement housing for low/moderate income persons.

(2) Public Facilities. Approximately \$24 million will be allocated for water and sewer systems, streets, and multi-purpose community centers.

(3) Economic Development. Approximately \$6 million will be allocated to provide loans to businesses for job creation or retention projects and/or to provide grants to local governing bodies for infrastructure improvements which will facilitate the location of a particular business.

(4) Demonstrated Needs. \$2.7 million will be set aside to alleviate critical/urgent needs involving improvements to existing water, sewer, and gas systems.

(5) LaStep. \$600,000 will be set aside to fund one or more water and/or sewer projects which may utilize LCDBG funds for materials, engineering, and administrative costs in conjunction with local resources (human, material, and/or financial). The remainder of the LCDBG funds will be utilized for the State's cost of providing program administration and technical assistance services.

The Louisiana Housing Finance Agency, as the administrator of the State's HOME Program, expects to receive an estimated allocation of \$14,719,000 in FY 2000 funds. These funds are intended for use in support of the following affordable housing categories:

(1) Approximately \$2 million (or fifteen percent of the HOME project allocation) will be set aside for the exclusive use of state designated community housing development organizations in developing home ownership and rental projects.

(2) Approximately \$3.5 million will be reserved to provide mortgage financing, down payment and closing cost assistance for first time home buyers. These funds are to be used in combination with state mortgage revenue bonds which provide below market rates mortgage financing.

(3) Approximately \$3 million will be available for primary or secondary financing to for-profit and non-profit developers of multi-family rental housing in Home nonentitlement areas.

(4) Approximately \$3 million will be available for funding the SHARE Grant Program to provide monies for the rehabilitation of substandard housing owned and occupied by very low income families. The balance of the grant is to be used by the agency in support of the administration of the various HOME supported programs.

The State's estimated federal allocation for the FY 2000 Emergency Shelter Grants Program (ESGP) is \$1,580,000. ESGP funding is dedicated for the rehabilitation, renovation, or conversion of buildings for use as emergency shelters for the homeless, for payment of certain operating costs and social services expenses in connection with emergency shelter for the homeless and for homeless prevention services. The Louisiana Department of Social Services, administrative agency for the Emergency Shelter Grants Program, proposes to distribute the State's funding allocation to eligible units of general local government which may make all or part of the grant amounts available to private non-profit organizations for use in eligible activities. Eligible applicants are defined as governmental bodies for all parish jurisdictions and those city jurisdictions with a minimum population of 10,000. The Department of Social Services shall continue use of a geographic allocation formula (based on factors for low income population) to ensure that each

region of the State is allotted a specified minimum of Emergency Shelter Grant assistance. Within each region, grant distribution will be conducted through a competitive grant award process. Among other evaluation criteria, this selection process will consider the extent to which proposed activities will address local needs to "complete the development of a comprehensive system of services which will provide a continuum of care to assist homeless persons to achieve independent living."

The Louisiana Department of Health and Hospitals, Office of Public Health, HIV/AIDS Program proposes to allocate the FY 2000 Housing Opportunities for Persons with AIDS grant funds (approximately \$1,063,000) through a 50/50 percent funding split. Through HOPWA the State receives housing assistance funds which are disbursed in Regions II through IX. Funding for Region I, the greater New Orleans area, is administered through a separate grant provided directly to the City of New Orleans. Currently there are residential facilities located in each of the State's eight funded regions; they will be allocated fifty percent of the HOPWA grant funds, with the exception of Region IX. These funds will be allocated through a competitive statewide HIV/AIDS Residential Facilities Solicitation of Application process. These HOPWA funds are for new construction, renovation, rehabilitation, acquisition, conversion, lease and repair of facilities or purchase of capital equipment. The other source of assistance available through HOPWA is short-term emergency rental assistance, which provides low income persons with HIV/AIDS with funding to aid in paying their housing expenses, such as rent, mortgage, and utility assistance for a maximum of five months. This remaining fifty percent will be allocated through a Request for Proposal through the Ryan White Title II Regional Consortia. As mentioned before, grant funds will be disbursed to Regions II through IX.

Written comments on the proposed consolidated and annual action plans may be submitted beginning July 6, 1999, and must be received no later than August 5, 1999. Comments should be submitted to the Office of Community Development, Post Office Box 94095, Baton Rouge, LA 70804-9095.

Mark C. Drennen
Commissioner

9906#035

POTPOURRI

Office of the Governor Oil Spill Coordinator's Office

Damage Assessment and Restoration
Plan—Vermilion Parish

Description of the Incident

On June 21, 1997, Apache Corporation notified the Louisiana Department of Environmental Quality of an unauthorized discharge of crude oil from a subsurface pipeline in the Vermilion Block 16 pipeline located approximately 3 miles west of Freshwater City, Vermilion

Parish, LA. Approximately 6 acres of marsh were oiled by the discharge that was burned as a response action on July 3, 1997. Original estimates of the discharge based on the surface area of impact indicated a minimal discharge. However, following repair of the pipeline and further monitoring of the site, it was determined that the release probably resulted from a slow leak that occurred over time. U.S. Coast Guard records indicate that 2000 barrels of oil may have been released at the site.

Affected Environment

The area is predominately brackish coastal marsh and is characterized by *Spartina alteriflora*, *Spartina patens*, *Eleocharis fallax*, and *Scirpus olneyi*. Water levels in the area impacted by the spill and burn are controlled by the landowner.

Natural Resource Trustees and Authorities

Pursuant to 33 U.S.C. §§2702 and 2706(c), the Louisiana Oil Spill Coordinator's Office and the Natural Resource Trustees of the State of Louisiana, to wit, the Louisiana Department of Natural Resources, the Louisiana Department of Wildlife and Fisheries and the Louisiana Department of Environmental Quality, have authority to pursue damages resulting from the incident. Trusteeship authority is designated according to Section 2706(b) of the Oil Pollution Act of 1990 (OPA) and Subpart G of the National Oil and Hazardous Substances Pollution Contingency Plan. State Natural Resources Trustees are designated by the Governor of the State of Louisiana. Under Article IX of the 1974 Constitution, the control and supervision of the wildlife of the state, including all aquatic life, is vested in the Louisiana Wildlife and Fisheries Commission. The Louisiana Department of Natural Resources/Office of Coastal Restoration and Management, under L.R.S. 49:213.1 et seq., is mandated to protect, develop, and restore or enhance the resources of the state's Coastal Zone. Under Louisiana Title 36, the Department of Wildlife and Fisheries and the Department of Environmental Quality are mandated to protect wildlife and fishery resources, and air and water quality, respectively. The Louisiana Oil Spill Prevention and Response Act (LOSPRA) (L.R.S. 30:2451 et seq.) created the Oil Spill Coordinator's Office within the Office of the Governor, and charged that office with the authority to assess natural resources damages. These agencies are jointly responsible for assessing injuries to natural resources resulting from unauthorized discharges of oil, and ensuring that the public is made whole for the losses of natural resources and services through the restoration, replacement, or acquisition of the equivalent of the injured resources.

Injury Assessment and Restoration Planning

Injury assessment techniques used for the three categories of natural resource injury are discussed individually, as are the restoration alternatives and evaluations. Selection criteria used by the Trustees to evaluate restoration alternatives include the following: results of response actions, relationship to assessed injury, relationship to natural recovery, likelihood of success, site requirements, potential for additional natural resource injury, multiple benefits, sustainability of a given restoration action, consistency with policies and compliance with the law, and cost effectiveness.

Brackish Marsh

Approximately 6 acres of marsh were impacted by the crude oil pipeline leak as of June 21, 1997. At the time of notification, the vegetation was heavily and completely coated with oil. An *in-situ* burn was conducted on July 3, 1997 as a response action. Because the perimeter of the impacted site was less heavily oiled, it did not burn. A sampling and monitoring plan was cooperatively developed by the State Natural Resource Trustees and Apache to document the natural resource injury and recovery and to coincide with the state protocol for the monitoring of *in-situ* burns as oil spill response. The sampling and monitoring plan addressed vegetation and sediments.

Joint trustee-Apache teams conducted sampling events on March 31, 1998 and October 7, 1998. During the sampling event in March 1998, approximately 4" to 6" of water covered the marsh surface and oil sheen was observed throughout the area of impact when the soil surface was disturbed. Although there was some revegetation occurring along the fringe of the impacted area, 4 acres of marsh remained unvegetated. The sampling event in October 1998 found conditions similar to that of March 1998. The impacted area appeared largely unvegetated, although some stands of taller vegetation were visible along the unburned fringe. A rainbow sheen was observed when the soil surface was disturbed.

Primary Restoration of Brackish Marsh

The trustees considered the following alternatives for primary restoration:

a. Natural Recovery. Because oil remained on the marsh over a period of time, root mass of coastal marsh vegetation died. Some natural recovery has occurred through encroachment of plants on the perimeter of the spill area, and it is expected that this process will continue.

b. Replanting of Impacted Area. Because oil remains in the sediments and other unfavorable conditions for planting, it was decided that this was not the favored option.

Compensatory Restoration

Compensatory Restoration will consist of planting approximately 2 acres of shallow water broken marsh habitat with California Bullrush or Bullwhip (*Scirpus californicus*) near Pecan Island, Vermilion Parish, Louisiana. The vegetation will enhance marsh building processes in this area of broken marsh.

Wildlife and Fishery Resources

Animals using this area had high probability of some contamination from the oil through contact with the product coating the vegetation. In addition, animals depending on food sources in this area had high probability of contamination of food materials. Although animals were seen throughout the area during the spill clean up and the period of monitoring, mortality was not observed. The Trustees believe that the habitat enhancement provided by replanting will provide sufficient compensation for any injury potentially suffered by these resources.

Lost Human Use

The area in the vicinity of the pipeline rupture is privately owned and managed, and is currently used to graze cattle. The Natural Resource Trustees and LOSCO considered that this component of possible loss of services was negligible.

Proposed Primary and Compensatory Restoration Projects

Trustees evaluated damages to the brackish coastal marsh and the wildlife and fishery resources as part of the natural resource assessment. No significant wildlife and fishery mortality was observed after the spill. Subtle decreases in the fitness of these resources can be compensated through improvement of habitat resources on the area.

It is expected that primary restoration will occur through natural recovery by encroachment of plants from the perimeter of the impacted area. This is expected to occur over a period of 5-8 years. The Trustees have opted for compensatory restoration to replace the services lost by the unauthorized discharge of crude oil as of June 21, 1997.

Project Design

The project design will be appended to this document and will be available for viewing by the public at the office of the Louisiana Oil Spill Coordinator. Office of the Governor, 625 N. Fourth Street, Suite 800, Baton Rouge, LA 70802. Arrangements should be made in advance by contacting Warren P. Lorentz at the listed address or calling him at (225) 219-5800.

Monitoring Requirements

The standard performance criterion for restoration projects is 80% vegetative cover after one complete growing season (March through October). The 80% coverage will be determined using aerial photographs or other appropriate methods.

Public Involvement

Pursuant to 15 C.F.R. §990.14(d) and L.R.S. 30:2480, the Natural Resource Trustees and LOSCO seek public involvement in restoration planning for this spill through public review of and comment on the documents contained in the administrative record, as well as on the draft and final Restoration Plans. Comments are solicited for a 10 working day period following publication in accordance with the provision in L.R.S. 30:2480. Comments should be sent to Roland Guidry, Louisiana Oil Spill Coordinator, Office of the Governor, 625 North Fourth Street, Suite 800, Baton Rouge, LA 70802.

Roland J. Guidry
Oil Spill Coordinator

9906#026

POTPOURRI

Office of the Governor Oil Spill Coordinator's Office

Restoration Planning—Vernon Parish Sonat Goins Oil Spill

The Louisiana Oil Spill Coordinator's Office (LOSICO) as the trustee coordinator for the State of Louisiana, in consultation and agreement with the State Natural Resource Trustees, namely the Louisiana Department of Environmental Quality (LDEQ), the Louisiana Department of Wildlife and Fisheries (LDWF); and the Federal Natural Resource Trustees, namely the U.S.D.A. Forest Service (USFS), have determined that the impacts on or about

August 8, 1997 from the discharge of oil associated with the Goins #7 well blow out, operated by Sonat Exploration Co. warrants conducting a natural resource damage assessment that will include restoration planning.

On or about August 8, 1997, a Sonat Exploration Co. well blew out, discharging an unknown quantity of oil, salt water, drilling mud and tailings, and natural gas, 1.25 miles north of Cravens, Louisiana in Section 7, T1S, R6W, Vernon Parish including portions of Compartment 24 of the Vernon Unit of the Calcasieu Ranger District. The nature of the discharge (uncontrolled well blow out) makes accurate determinations of release volumes difficult to estimate since the oil and salt water was released onto the area in both overland flow and in the form of an aerially deposited light mist. Approximately 120.81 acres of forest, surface waters, and other habitats and, potentially, the fauna inhabiting this area may have been exposed to oil as a result of this discharge. Sonat Exploration Co. has accepted responsibility for this incident, and will be hereafter referred to as the Responsible Party (RP).

The Trustees are designated pursuant to 33 U.S.C. §2706(e), Executive order 12777, and the National Contingency Plan, 40 C.F.R. Part 300.600 and 300.605. Pursuant to L.R.S. 30:2460, the State of Louisiana Oil Spill Contingency Plan, September 1995, describes that the state trust resources, including the following: vegetated wetlands, surface waters, ground waters, air, soil, wildlife, aquatic life, and the appropriate habitats on which they depend. The DOI, through the involvement of the USFWS is trustee for natural resources described within the National Contingency Plan, 40 C.F.R. §300.600(b)(2) and (3), include the following and their supporting ecosystems: migratory birds, anadromous fish, endangered species and marine mammals federally owned minerals, certain federally managed water resources, and natural resources located on, over, or under land administered by the DOI. In the case at hand, the trust resources that may be of concern are migratory birds and threatened and endangered species, which are managed by the USFWS, which represents DOI in this matter. USFS's trust resources include, but are not limited to: timber, recreation, wildlife, fish and rare plant habitat, soil, water, and air. The Calcasieu Ranger District, Kisatchie National Forest, USFS, will be preparing a draft Restoration Plan and Environmental Assessment (RP/EA) which will pertain only to injuries and planned restoration activities on National Forest System land. The USFS RP/EA will become part of the overall Restoration Plan which will be issued by the LOSCO and will reference all injuries to natural resources resulting from the incident.

Following the notice of the discharge, the Natural Resource Trustees have made the following determinations required by 15 C.F.R. §990.41(a):

The Natural Resource Trustees have jurisdiction to pursue restoration pursuant to the Oil Pollution Act.

The discharge of oil onto the area on August 8, 1997 was an incident as defined in 15 C.F.R. §990.30.

This unauthorized discharge is not permitted under state, federal or local law from a public vessel; or from an onshore facility subject to the Trans-Alaska Pipeline Authority Act.

Natural resources under the trusteeship of the Natural Resource Trustees listed above may have been injured as a result of the incident. The oil discharged contains components that may be toxic to aquatic organisms, birds, wildlife and vegetation when high exposure levels occur. Vegetation, birds, and or aquatic organisms may have been exposed to the oil from this discharge, and mortalities to some flora and fauna and lost ecological services may have resulted from this incident.

Since the conditions of 15 C.F.R. §990.41(a) were met, as described above, the trustees made the further determination pursuant to 15 C.F.R. §990.42(b) to proceed with preassessment. The RP at the invitation of the Trustees, agreed to participate in the preassessment, pursuant to 15 C.F.R. §990.14(c).

For the reasons discussed below, the Natural Resource Trustees have made the following determinations required by the 15 C.F.R. §990.42(a) and are providing notice pursuant to 15 C.F.R. §990.44 that they intend to conduct restoration planning in order to develop restoration alternatives that will restore, replace, rehabilitate, or acquire the equivalent of natural resources injured and/or natural resource services lost as a result of this incident.

Injuries have resulted from this incident, the extent of which have not been fully determined at this time. The Trustees base this determination upon data which was collected and analyzed pursuant to 15 C.F.R. §990.43 and which demonstrates that resources and services have been injured from this incident. Natural resources injured as a result of the discharge and the response may include, but are not limited to: riparian, upland longleaf pine forest habitats, streamside and aquatic habitats, and resident fauna. In addition, response actions have not adequately addressed the injuries resulting from this incident. Finally, assessment procedures are available to evaluate the injuries and define the appropriate type and scale of restoration for the injured natural resources and services. Models, comparisons to observations of injury resulting from similar releases or other methodologies are available for evaluating injuries to fauna. Various restoration activities are also possible including site preparation and planting of trees, both pines and bottomland hardwoods, and salvaging dead and injured trees.

Pursuant to 15 C.F.R. §990.44(c), the Trustees seek public involvement in restoration planning for this petroleum discharge, through public review of the comment on the documents contained in the administrative record, which is maintained in the Louisiana Oil Spill Coordinator's Office, as well as on the Draft and Final Restoration Plans when they have been prepared.

For more information, contact the Louisiana Oil Spill Coordinator's Office, Office of the Governor, 625 N. Fourth Street, Suite 800, Baton Rouge, LA 70802; phone (225) 219-5800 (Attn: Warren P. Lorentz). Comments on the Restoration Plan within the Vernon Unit should be sent to: Calcasieu Ranger District, 9912 Highway 28 West, Boyce LA 71409; phone (318) 793-9427 (Attn: James Burton).

The Louisiana Oil Spill Coordinator, as the Lead Administrative Trustee, and on behalf of the Natural Resource Trustees of the State of Louisiana, the

DOI/USFWS and USFS, pursuant to the determinations made above and in accordance with 15 C.F.R. §990.44(d), hereby provides the RP this notice of intent to conduct restoration planning and invites their participation with the Natural Resource Trustees in restoration planning.

Roland J. Guidry
Oil Spill Coordinator

9906#025

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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, La. R.S. 30:80 et seq., and as such are being declared Orphaned Oilfield Sites.

Operator	Field	Well Name	Well No.	Serial No.
Woster Anderson	Lake End	Woster Anderson	001	173111
Barron Utilities, Inc.	Little Creek	Elliott SWD	004	188248
Barron Utilities, Inc.	Little Creek	Elliott	003	187313
Barron Utilities, Inc.	Little Creek	Carroll	002	191293
Barron Utilities, Inc.	Little Creek	Carroll	001	212511
Barron Utilities, Inc.	Little Creek	Elliott	001	212512
Barron Utilities, Inc.	Little Creek	Elliott	002	212513
Barron Utilities, Inc.	Little Creek	Carroll	003	212907
Robert Bowles Oil Co.	Leeville	Armant Crosby	003	017320
Cardinal Exploration, Inc.	Red River-Bull Bayou	JEN A RA SUB; Dill	001	201075
Cardinal Exploration, Inc.	Red River-Bull Bayou	JEN A RB SUA; Dill	003	201978
Cardinal Exploration, Inc.	Red River-Bull Bayou	LAF RC SUA; Dill	002	201900
Cardinal Exploration, Inc.	Red River-Bull Bayou	JEN A RB SUA; Bundrick	001	202347
Milton Galoob	Tullos Urania	Cockerham	004	173570
Hercules Petroleum Co. Inc.	Wildcat	Hercules Petroleum Co Inc	005	990422
Hercules Petroleum Co. Inc.	Wildcat	Hercules Petroleum Co Inc	006	990423
Hercules Petroleum Co. Inc.	Wildcat	Hercules Petroleum Co Inc	007	990424
Hercules Petroleum Co. Inc.	Wildcat	Hercules Petroleum Co Inc	008	990425

Hochendel Consultants	Leeville	Community Lease 1	002	017312
Hochendel Consultants	Leeville	Allen Land C	006	017623
Hochendel Consultants	Leeville	Louis Bernard	007	017178
Hochendel Consultants	Leeville	Louis Bernard	006	017052
L. I. Mistrot d/b/a Latex Gulf Oil Co.	Leeville	T Cenac	003	017186
Prince Oil Co., Inc.	Leeville	Derame-Nicol	002	016913
Prince Oil Co., Inc.	Leeville	Theophile Cenac	002	016940
Town of Urania	Tullos Urania	Town of Urania	001	990421
Dewey E. White	Richland	Yarbrough	001	129305
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	002	111917
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	003	112096
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	004	112448
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4545	002	112615
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	006	112774
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	009	112776
Wood Energy Corporation	Chandeleur Sound Block 25	Lake Eugenie Ld & Dev Inc	001	113142
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4545	004	113373
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	010	113423
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	015	113763
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	017	114068
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	018	114069
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	019	114070
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4545	020	114071
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB 2 RA SU; SL 4541	001	116113
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB 2 RA SU; Land Inv. Co	001	118197
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	021	130963
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	022	130964
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	023	130965

Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	026	141326
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	027	141327
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	028	148200
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	029	148201
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	030	149680
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	034	149681
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	033	150005
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	035	150290
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;LD Inv. Co	004	184026
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	036	184027
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	037	184552
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	038	184585
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	040	184629
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	039	184732
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	042	187434
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	043	187435
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	044	187437
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	045	187438
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	046	187439
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	047	187440
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	049	192165
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	051	192167
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	052	192168
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	053	192169
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	055	192171

Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB 1 RA SU;SL 11834	001	200843
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	057	200844
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	058	200845
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	062	200847
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU; Lake Eugenie	005	201270
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	059	201272
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	061	201273
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	063	210274
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4545	005	201275
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	064	204364
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	065	204365
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	066	204366
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	067	204367
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	068	204368
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	069	204369
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	070	204370
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB 1 RS SU; Land Inv. Co	B-1	204851
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	65-D	204915
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB 1 RA SU; Land Inv. Co	B-2	205345
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB RA SU; Lake Eugenie	007	205436
Wood Energy Cooperation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	071	205437
Wood Energy Cooperation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	073	205439
Wood Energy Cooperation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	074	205440
Wood Energy Cooperation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	075	205441
Wood Energy Cooperation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4542	077	205443

Wood Energy Cooperation	Chandeleur Sound Block 25	CSB25 BB RA SU;SL 4545	006	205445
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	37-D	205909
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 4800 RA SU;SL 4542	71-D	205910
Wood Energy Corporation	Chandeleur Sound Block 25	CSB25 BB 1 RA SU;SL 11834	002	206145
Worth Exploration Company	Bayou Perot	Laura Paillet	004	108403

Philip N. Asproditis
Commissioner

9906#070

POTPOURRI

**Department of Social Services
Office of Community Services**

**2000 Low-Income Home Energy Assistance Program
(LIHEAP) Public Hearing**

The Department of Social Services, Office of Community Services will hold a public hearing concerning the use and distribution of federal fiscal year 2000 LIHEAP block grant funds in accordance with the Louisiana State Plan for 2000.

The Low-Income Home Energy Assistance Program provides services to low-income households, and in particular, households in which elderly, handicapped and/or children reside. The purposes of LIHEAP activities are:

- a) to reduce the burden of home heating and cooling expenses of low income households through direct payments to home energy suppliers;
- b) to conserve energy and reduce energy costs through the weatherization of dwelling units of low-income residents; and
- c) to provide for energy crisis intervention in instances of weather related and supply-shortage emergencies.

The public hearing is scheduled for Thursday, July 8, 1999, at 1:30 P.M. in Baton Rouge, LA, at 333 Laurel Street, Room 652. Louisiana's grant for the 2000 program year is estimated to be \$9,415,140.00. Any additional Department of Health and Human Services funds which may become available during the 2000 program year will be expended according to the approved State Plan.

Copies of the plan can be obtained prior to the hearing by contacting the Department of Social Services, Office of Community Services at (504) 342-2288 or by writing to P.O. Box 3318, Baton Rouge, LA 70821. Written comments will be accepted through July 15, 1999.

Madlyn B. Bagneris
Secretary

9906#064

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