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**V. POTPOURRI**

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# Executive Orders

## EXECUTIVE ORDER MJF 96-62

Bond Allocation—Jefferson  
Parish Mortgage Authority

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

WHEREAS: the Jefferson Home Mortgage Authority has requested an allocation from the 1996 Ceiling to be used in connection with a program of financing mortgage loans for first time home buyers throughout the Parish of Jefferson in accordance with the provisions of Section 143 of the Internal Revenue Code of 1986, as amended;

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

SECTION 1: The bond issue, as described in this Section, shall be and is hereby granted an allocation from the 1996 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$2,625,000	Jefferson Parish Mortgage Authority	Single Family Mortgage Revenue Bonds

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

SECTION 3: The granted allocation shall be valid and in full force and effect, provided that such bonds are delivered to the initial purchasers thereof on or before December 27, 1996.

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 7th day of November, 1996.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9612#018

## EXECUTIVE ORDER MJF 96-63

Bond Allocation—New Orleans  
Home Mortgage Authority

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

WHEREAS: the New Orleans Home Mortgage Authority has requested an allocation from the 1996 Ceiling to be used in connection with a program of financing mortgage loans for first time home buyers throughout the Parish of Orleans in accordance with the provisions of Section 143 of the Internal Revenue Code of 1986, as amended;

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

SECTION 1: The bond issue, as described in this Section, shall be and is hereby granted an allocation from the 1996 Ceiling as follows:

AMOUNT OF ALLOCATION	NAME OF ISSUER	NAME OF PROJECT
\$2,625,000	New Orleans Home Mortgage Authority	Single Family Mortgage Revenue Bonds

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

SECTION 3: The granted allocation shall be valid and in full force and effect, provided that such bonds are delivered

to the initial purchasers thereof on or before December 27, 1996.

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 7th day of November, 1996.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9612#033

#### EXECUTIVE ORDER MJF 96-64

##### Office of Business Advocacy

WHEREAS: Executive Order MJF 96-19, issued on July 1, 1996, created and established the Office of Business Advocacy, formerly known as the Office of Permits, within the Executive Department, Office of the Governor;

WHEREAS: it is the philosophy of this administration to eliminate the duplicative agencies of state government, to make government more efficient; and

WHEREAS: other agencies and divisions within state government perform duties and responsibilities similar to those being performed by the Office of Business Advocacy;

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: Executive Order MJF 96-19, which created and established the Office of Business Advocacy, is hereby terminated.

SECTION 2: The compilation of the list of nominees for one of the eight seats on the Tangipahoa River Task Force, formerly performed by the Office of Permits and/or the Office of Permits and /or the Office of Business Advocacy, shall be performed by a member of the executive staff, Office of the Governor.

SECTION 3: The provisions of the 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 the 8th day of November, 1996.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9612#016

#### EXECUTIVE ORDER MJF 96-65

##### Mississippi River Road Commission

WHEREAS: the widespread deterioration of the historic Mississippi River Road Corridor between Baton Rouge and New Orleans (hereafter "Corridor") is a grave concern to both the Department of Culture, Recreation and Tourism and the Department of Transportation and Development;

WHEREAS: the common goal of both Departments is for the Corridor to become a viable scenic and educational resource for the State of Louisiana;

WHEREAS: the Corridor is approximately 70 miles in length and is located on both sides of the Mississippi River between Baton Rouge and New Orleans; it encompasses the river, levees, adjacent lands, historical sites, and many historic and cultural resources of this state;

WHEREAS: in 1991, the National Trust for Historic Preservation designated the Corridor as one of the nation's 11 most endangered historic properties;

WHEREAS: the River Roads run the length of the Corridor, on both sides of the Mississippi River, and the citizens of the State of Louisiana have legitimate concerns regarding the status of the River Roads as a resource for tourism and as a scenic, historic, and cultural holding of the state;

WHEREAS: a vast majority of the historic homes which previously fronted the River Roads have been lost in recent years through neglect and deterioration;

WHEREAS: in response to this situation, the Department of Transportation and Development contracted with a consultant, the Mumphrey Group, Inc., for the preparation of a detailed study of the historic preservation problems facing the Corridor and for the preparation of a master plan which addresses those problems; and

WHEREAS: the State of Louisiana would benefit by having an advisory body to the consultant composed of individuals who have strong ties to the Corridor to serve as a resource regarding local concerns, interests, and information;

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 Mississippi River Road Commission (hereafter "Commission") is created within the Department of Culture, Recreation and Tourism, Office of the Lieutenant Governor.

SECTION 2: The Commission shall be composed of 25 members who shall be appointed by and serve at the pleasure of the Governor. The membership of the Commission shall be selected as follows:

A. four members of the Louisiana Legislature, who are elected from parishes which encompass portions of the Corridor;

B. the Commissioner of the Department of Culture, Recreation and Tourism, or the Commissioner's designee;

C. the Secretary of the Department of Transportation and Development, or the Secretary's designee;

D. the Secretary of the Department of Environmental Quality, or the Secretary's designee;

E. the President of the Louisiana Preservation Alliance, or the President's designee;

F. the Director of the Louisiana Chemical Association, or the Director's designee;

G. four Police Jurors or Parish Council members who are elected from parishes which encompass portions of the Corridor;

H. two representatives from tourist development boards who serve and/or work in parishes which encompass portions of the Corridor;

I. two representatives from economic development groups which are based in parishes which encompass portions of the Corridor;

J. one representative from a recreational organization with activities related to the River Road;

K. the President of the River Road Historical Society, or the President's designee;

L. the Chairman of the Louisiana Preservation Alliance River Road Task Force, or the Chairman's designee;

M. the Pilot-President of the Mississippi River Parkway Commission, or the Pilot-President's designee; and

N. four members to be appointed at large from parishes which encompass portions of the Corridor.

SECTION 3: The Chair of the Commission shall be selected by the Governor from its appointed membership.

SECTION 4: The Commission shall serve as an advisory body to the consultant, the Department of Culture Recreation and Tourism, the Department of Transportation and Development, the Department of Economic Development, and to all other state agencies involved in developing the Corridor into a viable resource for the state and in implementing the master plan. The Commission's duties shall include, but are not limited to, the following:

A. receiving progress reports from the consultant and attending the scheduled public meetings;

B. reviewing the consultant's master plan prior to its issuance and timely critiquing it in advance of its issuance in final form;

C. notifying the constituents who live in the Corridor of the progress of the consultants and the labors of the

Commission, and actively seeking the input of the constituents who live in the Corridor regarding the implementation of the master plan;

D. assisting state agencies in seeking and applying for federal funding to be used in implementing the master plan; and

E. assisting state agencies in obtaining the designation of the Corridor as a National Scenic By-way and as an All American Road.

SECTION 5: The Chairman of the Commission shall submit a report to Governor on January 5 of each year. The report shall detail the progress of the Commission and advise the Governor of any other actions which should be taken to preserve the Corridor and develop it into a viable scenic and educational resource of the state.

SECTION 6: The members of the Commission shall serve without compensation, or a per diem. Moreover, no member of the Commission shall be reimbursed for personal expenses.

SECTION 7: 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 8th day of November, 1996.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9612#035

#### EXECUTIVE ORDER MJF 96-66

##### Hazard Mitigation Team

WHEREAS: Executive Order No MJF 96-49, signed on October 17, 1996, re-establishes and continues the Hazard Mitigation Team within the Military Department, Office of Emergency Preparedness; and

WHEREAS: it is necessary to expand the membership of the Hazard Mitigation Team to include a representative from the Department of Agriculture and Forestry;

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

SECTION 1: Section 2 of Executive Order Number MJF 96-49, is amended to add Subsection K, which shall provide as follows:

K. Department of Agriculture and Forestry.

SECTION 2: All other Sections and Subsections of Executive Order Number MJF 96-49 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 8th day of November, 1996.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of state  
9612#034

#### EXECUTIVE ORDER MJF 96-67

##### Emergency Response Commission

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

WHEREAS: it is necessary to expand the membership of that Commission to include a representative from the Department of Agriculture and Forestry;

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

SECTION 1: Section 1 of Executive Order MJF 96-48, is amended to add Subsection J, which shall provide as follows:

J. The Secretary of the Department of Agriculture and Forestry, or the Secretary's designee.

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

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

IN WITNESS WHEREOF, I have set my hand officially, and caused to be affixed the Great Seal of the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 8th day of November, 1996.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9612#015

#### EXECUTIVE ORDER MJF 96-68

##### Series 1996 Bonds

WHEREAS: under the authority of Article XIV, Section 47 of the Louisiana Constitution of 1921, as amended, which

was continued as a statute by Article XIV, Section 16, of the Louisiana Constitution of 1974, the Louisiana Stadium and Exposition District (hereafter "LSED") was created as a body politic and corporate of the State of Louisiana for the purpose of planning, financing, developing, maintaining, and operating facilities to be located within the LSED, an area composed of all of the territory in the Parishes of Orleans and Jefferson, to accommodate the holding of sports events, athletic contests, and other events of public interest;

WHEREAS: pursuant to Act 541 of the 1976 Regular Session of the Louisiana Legislature, as amended by Act 499 of the 1978 Regular Session the Louisiana Legislature, Act 449 of the 1980 Regular Session of the Louisiana Legislature, Act 927 of the 1981 Regular Session of the Louisiana Legislature, Act 476 of the 1984 Regular Session of the Louisiana Legislature, Act 259 of the 1989 Regular Session of the Louisiana Legislature, and Act 640 of the 1993 Regular Session of the Louisiana Legislature (hereafter "the Act"), the LSED adopted a General Bond Resolution on January 31, 1994 (hereafter "General Bond Resolution"), authorizing the issuance from time to time of its Hotel Occupancy Tax Bonds in series to pay the costs of projects authorized by the Act;

WHEREAS: pursuant to the Act and the General Bond Resolution, as amended and supplemented by the First Supplemental Resolution of the LSED adopted on March 28, 1994, the Second Supplemental Resolution of the LSED adopted on April 21, 1995, and the Third Supplemental Resolution of the LSED adopted on November 10, 1995, the LSED adopted a resolution on June 28, 1996, approving the issuance of LSED Hotel Occupancy Tax Bonds, Series 1996 (hereafter "Series 1996 Bonds") in an aggregate principal amount of \$76,250,000 for the purpose of 1) paying the costs of construction of a multi-purpose arena in New Orleans; and 2) paying the costs of issuing the Series 1996 Bonds, including the purchase of a Reserve Fund Insurance Policy, paying the premium of the Bond Insurance Policy, and funding a deposit to the Reserve Fund;

WHEREAS: the resolution adopted by the LSED on June 28, 1996, demonstrates the LSED's intention to issue its Series 1996 Bonds on a parity with the outstanding Series 1994-A Bonds, the outstanding Series 1995-A Bonds, and the outstanding Series 1995-B Bonds it previously issued;

WHEREAS: the Series 1996 Bonds will not constitute an indebtedness, general or special, or a liability of the State of Louisiana or of the Parishes of Orleans and Jefferson, and is not and will not be considered a debt of the state or the parishes within the meaning of the Louisiana Constitution of 1974 or the laws of this state, and will not constitute a charge against the credit or taxing power of the state or the parishes, but will solely be an obligation of the LSED, which is obligated to pay the principal of, the premium, if any, and the interest on the Series 1996 bonds from the "Tax Revenues," as defined in the General Bond Resolution, as amended, which are derived from the collection of the "Hotel Occupancy Tax," as defined in the General Bond Resolution, as amended, and from other "Funds and Accounts" pledged pursuant to and defined in the General Bond Resolution, as amended; and

WHEREAS: Act 640 of the 1993 Regular Session of the Louisiana Legislature mandates that prior to the sale of LSED

Hotel Occupancy Tax Bonds issued pursuant to its terms, an Executive Order of the governor approving the issuance of the bonds shall be filed with the LSED and the State Bond Commission;

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: Pursuant to the provisions of the Act and in accordance with the terms of the Resolution that the LSED approved on June 28, 1996, and the General Bond Resolution, as amended through the Third Supplemental Resolution adopted on November 10, 1995, the LSED is authorized to issue Series 1996 Bonds in an amount not exceeding \$76,250,000.

SECTION 2: The General Bond Resolution shall be amended by an additional supplemental resolution which provides the details of the issuance and the terms of sale of the Series 1996 Bonds in an amount not exceeding \$76,250,000.

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 20th day of November, 1996.

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

ATTEST BY  
THE GOVERNOR  
Fox McKeithen  
Secretary of State  
9612#011

# Emergency Rules

## DECLARATION OF EMERGENCY

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

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

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

Due to recent publicity regarding the accuracy of scanning devices in commerce and the receipt of several citizen

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

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

The effective date of this Emergency Rule is December 4, 1996, and it shall be in effect for 120 days or until the final Rule takes effect through the normal promulgation process, whichever occurs first.

## Title 7

### AGRICULTURE AND ANIMALS

#### Part XXXV. Division of Weights and Measures

#### Chapter 175. Division of Weights and Measures

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

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

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

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

#### §17502. Definitions

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

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

\*\*\*

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

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

\*\*\*

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

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

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

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

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

**§17514. Bar Code Scanning Devices and Labels**

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

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

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

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

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

**§17522. Fee Schedule**

A. - D. ...

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

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

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

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

**§17523. Registration**

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

B. - C. ...

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

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

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

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

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

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

2. A compound weighing device that consists of one indicating element and more than one load receiving element shall for the purpose of registration be considered a separate device for each load receiving element.

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

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

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

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

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

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

N. Applications for annual renewal of registration shall be mailed by the Division of Weights and Measures of the Department of Agriculture and Forestry to all registrants, at the last address provided by the registrant, on or before November 15 and must be returned before January 1.

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

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

\* \* \*

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

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

Bob Odom  
Commissioner

9612#031

### DECLARATION OF EMERGENCY

Department of Agriculture and Forestry  
Office of Forestry  
Forestry Commission  
and  
Department of Revenue and Taxation  
Tax Commission

1997 Timber Stumpage Values  
(LAC 7:XXXIX.20101)

In accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, and R.S.

47:633, the Louisiana Forestry Commission and the Louisiana Tax Commission find that this Emergency Rule setting forth the determination by the two Commissions of the current average stumpage market value of trees, timber, and pulpwood for the purpose of predating severance tax for the 1997 tax year is required so that timber severance tax computation and collection can be accomplished beginning in January, 1997. By law, these values are set annually in a meeting of the Louisiana Forestry Commission and the Louisiana Tax Commission on the second Monday in December. Failure to adopt the values on or before January 1, 1997 and the resultant noncollection of severance tax will cause imminent peril to public health, safety, and welfare in that the monies generated from the severance tax go to state and parish governmental entities for such uses as fire protection, police and road maintenance and are necessary for maintaining essential governmental services.

The effective date of this Emergency Rule is January 1, 1997 and it shall be in effect for 120 days or until the final Rule takes effect through the normal promulgation process, whichever occurs first.

### Title 7

### AGRICULTURE AND ANIMALS

### Part XXXIX. Forestry

### Chapter 201. Timber Stumpage

### §20101. Stumpage Values

The Louisiana Forestry Commission, and the Louisiana Tax Commission, as required by R.S. 47:633, determined the following timber stumpage values based on current average stumpage market values to be used for severance tax computations for 1997:

1. Pine trees and timber	\$348.00/MBF	\$43.50/Ton
2. Hardwood trees and timber	\$188.58/MBF	\$19.85/Ton
3. Pine Chip and Saw	\$ 88.80/Cord	\$32.89/Ton
4. Pine pulpwood	\$ 23.95/Cord	\$ 8.87/Ton
5. Hardwood pulpwood	\$ 15.05/Cord	\$ 5.28/Ton

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

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Forestry, and the Louisiana Forestry Commission, LR 4:9 (January 1978), amended LR 5:7 (January 1979), LR 6:728 (December 1980), LR 7:627 (December 1981), LR 8:651 (December 1982), LR 9:848 (December 1983), LR 10:1038 (December 1984), LR 11:1178 (December 1985), amended by the Department of Agriculture and Forestry, Office of Forestry, and the Louisiana Forestry Commission, LR 12:819 (December 1986), LR 13:432 (August 1987), LR 14:9 (January 1988), LR 15:5 (January 1989), LR 16:16 (January 1990), LR 17:476 (May 1991), LR 18:6 (January 1992), LR 19:611 (May 1993), LR 20:408 (April 1994), LR 21:930 (September 1995), LR 21:1069 (October 1995), amended by the Louisiana Forestry Commission and Louisiana Tax Commission, LR 22:581 (July 1996), LR 23:

Billy Weaver, Chairman  
Forestry Commission

Malcolm Price, Chairman  
Tax Commission

9612#047



## DECLARATION OF EMERGENCY

### Department of Economic Development Boxing and Wrestling Commission

Deposits; Officials; Agents and Promotions  
(LAC 46:XI.Chapters 3 and 5)

In accordance with the emergency provisions of the Administrative Procedure Act, R.S. 49:953(B), the Boxing and Wrestling Commission determined a condition of emergency exists regarding the potential for lost tax revenues resulting from locations rebroadcasting television-related events and wrestling promoters/producers scheduling of events. Also, to improve the safety and welfare of Commission and ring officials, it became urgent to adopt these Rules on an emergency basis.

Furthermore, the operation of law has effectively repealed §§523 and 525; therefore, these Sections are being repealed. The booking and promoting of wrestling events are inhibited as a result of uninformed agents and promoters reading and following Rules which are not in effect, and the Commission needs to insure that its published Rules accurately and correctly reflect the purpose and intent of the Commission as adopted.

This Emergency Rule is effective November 14, 1996 and is to remain in effect for a period of 120 days or until the final Rule takes effect through the normal promulgation process, whichever occurs first.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XI. Boxing and Wrestling

#### Chapter 3. Professional Boxing

#### §304. Deposits: Closed Circuit and Pay-Per-View Television Rebroadcasting

All locations rebroadcasting television related events may be required to deposit a maximum of \$1,000, in advance, for expenses and taxes. Location in this particular Rule means any casino, public auditorium, hotel or civic center. Money, less taxes and expenses, will be refunded by the Commission to producer if taxes collected do not equal amount deposited. If taxes exceed the deposit, then the Commission will proceed with collecting taxes as outlined in R.S. 4:67. Sports bars with a 250-person capacity or less will be required to purchase a permit for \$100; sports bars with a 400-person capacity or less will be required to purchase a permit for \$200; over 400-person capacity requires a promoters license. If sports bars are part of a location, as defined in this Rule, then the same Rule will apply as a location. Five percent taxes will apply as indicated in R.S. 4:67. Complimentary passes or tickets are taxable if ticket prices are outlined in the television contract or advertised and sold at a specified price. The capacity of a location will be determined by the state/local Fire Marshal's Office. Locations are required to obtain a promoters license from the Commission; sports bars with a capacity of less than 400 are exempt from purchasing a promoters license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:61(D), R.S. 4:64 and R.S. 4:67.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Boxing and Wrestling Commission, LR 23:  
**§314. Prohibited Ring Official Assignments**

A ring official domiciled in the State of Louisiana shall not accept an assignment in the United States or its possessions that is not sponsored, sanctioned, approved or supervised by the Commission, another official state commission, or a member of the Association of Boxing Commissions. *Official State Commission*, in this Rule, means a commission domiciled and coming under the jurisdiction and regulatory powers of their state or United States' possession.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:61(D) and R.S. 4:64.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Boxing and Wrestling Commission, LR 23:  
**§316. Hold Harmless and Indemnity Agreement**

All individuals, except the members of the Commission, acting in any official capacity for any event(s) sanctioned by the Commission shall be required to execute the Hold Harmless and Indemnity Agreement of the Commission, prior to receiving any assignment from the Commission. This shall be in addition to the agreement as set forth in the license application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:61(D), R.S. 4:64 and R.S. 4:79.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Boxing and Wrestling Commission, LR 23:  
**§335. Compensation of Officials**

All officials, including ring doctors, that participate in an event sanctioned by the Commission, shall be compensated by the promoters/producers. The amount compensated will be predetermined, prior to the event, between the Commission and the promoter/producer. Officials, in this Rule, do not include the Commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:61(D), R.S. 4:64 and R.S. 4:67.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Boxing and Wrestling Commission, LR 23:  
**§353. Penalties and Sanctions**

Anyone licensed and/or subject to the authority of the Commission who violates any of the rules and regulations of the Commission as set forth in Title, Parts and Chapters, shall be subject to such sanctions as imposed by the Commission which may result in fines, suspensions and revocations of licenses to be determined by the Commission pursuant to the laws of the State of Louisiana and the authority of the Commission vested to the Commission by those laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:61(D), R.S. 4:64 and R.S. 4:82.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Boxing and Wrestling Commission, LR 23:  
**§522. Wrestling Event Deposits**

Wrestling promoters/producers will be required to deposit, in advance with the Commission, \$250 to secure a date for their scheduled event. This amount will be applied to taxes and deputy expenses. Any cancellation of the advanced booking will result in the loss of the deposit and will be deposited in the Commission's treasury. If taxes and expenses do not exceed the \$250 deposit, the Commission will refund the excess to the promoter/producer. If expenses and taxes



exceed the \$250 deposit, the Commission will then collect taxes as outlined in R.S. 4:67.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:61(D), R.S. 4:64 and R.S. 4:67.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Boxing and Wrestling Commission, LR 23: §523. Wrestling Booking Agent

Repealed (Reserved).

AUTHORITY NOTE: Adopted in accordance with R.S. 4:61(D) and R.S. 4:64.

HISTORICAL NOTE: Adopted by the Department of Commerce, Boxing and Wrestling Commission, 1967, amended 1974, repealed by the Department of Economic Development, Boxing and Wrestling Commission, LR 23:

§525. Wrestling Promoters

Repealed (Reserved).

AUTHORITY NOTE: Adopted in accordance with R.S. 4:61(D) and R.S. 4:64.

HISTORICAL NOTE: Adopted by the Department of Commerce, Boxing and Wrestling Commission, 1967, amended 1974, repealed by the Department of Economic Development, Boxing and Wrestling Commission, LR 23:

Mike Cusimano  
Chairman

9612#017

**DECLARATION OF EMERGENCY**

**Department of Economic Development  
Office of Financial Institutions**

**Debt Collection Agencies (LAC 10:XV.503)**

Under the authority of the Administrative Procedure Act, R.S. 49:950 et seq., and particularly R.S. 49:953(B)(1) relating to emergency rulemaking, and in accordance with the provisions of R.S. 9:3576.16(C) contained within the Collection Agency Regulation Act, R.S. 9:3576.1 et seq., the Commissioner of the Office of Financial Institutions hereby determines that adoption of the following Emergency Rule, which provides for the procedure this Office and all affected constituents are to follow upon the forfeiture of the posted security of a licensed debt collection agency and the resolution of competing claims to these monies, is necessary and that failure to do so would pose an imminent peril to the public health, safety and welfare.

The Office of Financial Institutions ("Office") is presently faced with competing claims by former clients of now-defunct collection agencies to the monies represented by surety bonds or other security posted by these companies and assigned to this Office in accordance with the provisions of R.S. 9:3576.15. This Office must now promulgate a procedure for the disbursement of the underlying funds of such posted security as required by R.S. 9:3576.16(C) to assure that such monies are fairly, equitably and expeditiously distributed among all proper claimants.

Therefore, in accordance with R.S. 49:953(B), the Office hereby adopts this Emergency Rule, the effective date of

which is December 10, 1996, and such Emergency Rule shall be in effect for a period of 120 days or until promulgation of a final Rule, whichever occurs first.

**Title 10**

**FINANCIAL INSTITUTIONS, CONSUMER CREDIT,  
INVESTMENT SECURITIES AND UCC**

**Part XV. Other Regulated Entities**

**Chapter 5. Debt Collection Agencies**

**§501. Reserved**

**§503. Procedure to Resolve Competing Claims on  
Posted Security Monies**

A. Background. LSA-R.S. 9:3576.15(A) requires entities licensed as debt collection agencies under the Collection Agency Regulation Act, LSA-R.S. 9:3576.1 et seq., to post a surety bond in the favor of the Office of Financial Institutions ("Office") in the amount of \$10,000. LSA-R.S. 9:3576(B) permits a licensee to deposit cash or other securities with the Office in lieu of such bond. LSA-R.S. 9:3576.16 permits clients or customers of the licensee to bring suit against such bond or other security when such parties allege damages through the failure of the licensee to properly remit due and owing funds in accordance with LSA-R.S. 9:3576.18.

**B. Office Action**

1. When the Office is made aware of the filing of any action(s) against the posted security of a licensee through personal or mail service of such petition(s), and the amount of the claims exceed the value of the posted security, the Office shall, on behalf of the Commissioner and as expeditiously as possible and reasonable, file a motion for concursus proceeding in the appropriate State Judicial District Court.

2. This action shall conform to the procedure for concursus proceedings set forth under the Louisiana Code of Civil Procedure, Title X, Articles 4651-4662 ("LSA-C.C.P. art. 4651-4662"). A summary, but not exclusive, list of required steps follows.

a. In accordance with LSA-C.C.P. art. 4654, the Office's petition shall comply with the requirements of LSA-C.C.P. art. 891 by alleging the nature of the competing claims and praying that all proper claimants be required to assert such claims.

b. The Office's petition shall be filed in the Nineteenth Judicial District Court of East Baton Rouge Parish unless the provisions of LSA-C.C.P. art. 42 require otherwise.

c. In accordance with LSA-C.C.P. art. 4655, the Office will serve each known claimant with citation and a copy of the petition in the same manner and form as in an ordinary proceeding. For the purposes of this Subparagraph, *Known Claimant* shall mean those parties which the Office has knowledge of either through the service of an action filed against the bond or which are identified in records of the Office as having a claim against the posted security. This information may also be gathered pursuant to the record-keeping requirement of LSA-R.S. 9:3576.16(B).

d. As soon as practicable after filing of the petition, the Office shall ask the Court to accept the funds in dispute into its registry pursuant to LSA-C.C.P. art. 4658.

3. Notwithstanding the aforementioned Paragraphs, if the circumstances of the particular situation warrant, the Commissioner of the Office may prescribe another procedure

to resolve competing claims to the posted security of a licensed or defunct debt collection agency.

AUTHORITY NOTE: Promulgated in accordance with LSA-R.S. 9:3576.16 C.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 23:

Larry L. Murray  
Commissioner

9612#053

## DECLARATION OF EMERGENCY

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

Community Care Program—Physician Management Fee

The Department of Health and Hospitals, Office of the Secretary, 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 and as directed by the 1996-97 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law". This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing currently provides reimbursement to primary care physicians who are enrolled as physician managers in the Community Care Waiver Program to insure that the recipients under their care receive the appropriate hospital and specialty care as well as primary care. These physicians were being reimbursed a \$5 management fee per month per Medicaid recipient enrolled in the Community Care Program.

The Bureau adopted an Emergency Rule to reduce the physician management fee to \$2 per month per enrolled Medicaid recipient effective July 1, 1996 (*Louisiana Register*, Volume 22, Number 7). The Bureau determined it was necessary to amend the July 1, 1996, Emergency Rule to increase the physician management fee. An Emergency Rule was adopted to increase the physician management fee under the Community Care Waiver Program from \$2 to \$3 per month per enrolled Medicaid recipient, effective September 5, 1996 (*Louisiana Register*, Volume 22, Number 9, page 796). The following Emergency Rule is necessary to assure continued access to primary medical care and physician case management services for recipients who reside in designated Community Care Program parishes, and to maintain the cost

savings initiated through the September 1996 Emergency Rule.

## Emergency Rule

Effective for dates of service January 3, 1996, and thereafter, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing increases the physician management fee in the Community Care Waiver Program to \$3 per enrolled recipient per month.

Bobby P. Jindal  
Secretary

9612#044

## DECLARATION OF EMERGENCY

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

Eligibility—Application Centers

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:953(B), and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the Rule, whichever occurs first. Adoption of this Rule on an emergency basis is necessary to avoid sanctions or penalties from the United States resulting from failure to timely determine eligibility of potential recipients.

Reimbursement procedures for Certified Medicaid Enrollment Centers were published in the *Louisiana Register* May 20, 1993 (Volume 19, Number 5). Reimbursement was set at a uniform, flat-fee rate on a per-application basis, with provision for sanction if a performance audit indicated above-average denial rates. Further instructions for submitting applications to the appropriate Medicaid Office were included in the procedural manual provided to enrollment centers. Reimbursement has not been contingent on the accuracy or timeliness of activities undertaken by the enrollment center.

Maximum standards for timeliness in processing applications for Medicaid are found at 42 CFR 435.911(a), which states, "These standards may not exceed 90 days for applicants who apply for Medicaid on the basis of disability; and 45 days for all other applicants." The Louisiana Medicaid Enrollment Center Program was established in July, 1992 to provide outstation sites for the purpose of interviewing the applicant for potential Medicaid benefits. It has been determined that delays occur at the Enrollment Center site because of applications that are incomplete (and thus require further clarification by Medicaid staff) are sent to a Medicaid Office other than the one responsible for the eligibility determination for that or are forwarded later than required time frames. Delays in the application process result in failure to complete certification activities timely, which is reflected in the state error rate used to determine whether federal

penalties will be levied. It is, therefore, necessary to prevent such delays whenever possible. This Emergency Rule specifies conditions under which payment for applications will be withheld and incidentally changes the designation from Medicaid Enrollment Center Program to Medicaid Application Center Program.

#### **Emergency Rule**

Effective January 1, 1997 and thereafter, the Medicaid Enrollment Center Program is renamed the Medicaid Application Center Program. Reimbursement for applications taken by Medicaid Application Centers is available only when the applications are:

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

Bobby P. Jindal  
Secretary

9612#057

### **DECLARATION OF EMERGENCY**

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

#### **Pharmacy Program—Maximum Allowable Overhead Cost**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act and as directed by the 1996-97 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:953(B) 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 Services Financing provides a pharmacy dispensing fee in the Pharmacy Program in accordance with the methodology approved in the State Plan for the Maximum Allowable Overhead Cost which includes a \$0.10 provider fee collected on all prescriptions dispensed to Louisiana residents by pharmacists. This dispensing fee is called the Louisiana Maximum Allowable Overhead Cost and is determined by updating the base rate through the application of certain economic indices to appropriate cost categories to assure recognition of costs which are incurred by efficiently and economically operated providers. During state fiscal year

1995-96 the bureau maintained the Louisiana Maximum Allowable Overhead Cost at the state fiscal year 1994-1995 level. An Emergency Rule was adopted to continue the Louisiana Maximum Allowable Overhead Cost at the state fiscal year 1994-1995 level (*Louisiana Register*, Volume 22, Number 8). The following Emergency Rule is necessary to maintain the cost savings initiated through emergency rulemaking.

#### **Emergency Rule**

Effective for dates of service December 6, 1996 and thereafter, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following provisions applicable to the Maximum Overhead Cost under the Pharmacy Program.

#### **Maximum Allowable Overhead Cost**

1. For state fiscal year 1996-97, the Maximum Allowable Overhead Cost will remain at the level established for state fiscal year 1994-95. This Maximum Allowable Overhead Cost was established by applying the 1993 indices to appropriate cost categories for a one-year period.
2. No inflation indices or any interim adjustments will be applied to the Maximum Allowable Overhead Costs for the time period July 1, 1996 through June 30, 1997.

Bobby P. Jindal  
Secretary

9612#060

### **DECLARATION OF EMERGENCY**

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

#### **Rescission of Pharmacy—Five Prescription Limit**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing published an Emergency Rule establishing a limit of five prescriptions per month in the Pharmacy Program effective for dates of service January 1, 1997 and thereafter (*Louisiana Register*, Volume 22, Number 11). The Department has now determined that it is necessary to rescind this Emergency Rule and notification is provided to interested persons through this medium.

Bobby P. Jindal  
Secretary

9612#084

### **DECLARATION OF EMERGENCY**

**Department of Insurance  
Commissioner of Insurance**

**Medicare Supplement Insurance  
Minimum Standards—Regulation 33B**

In accordance with the provisions of R.S. 49:953(B) of the Administrative Procedure Act, the Department of Insurance has by emergency procedures revised Regulation 33 and has

adopted provisions allowing the marketing of Medicare Select policies in this state as authorized by recent revisions to federal legislation (OBRA, 1990) governing the marketing of Medicare Supplement policies.

This emergency regulation is effective December 20, 1996 and will remain in effect for 120 days.

The revision to Regulation 33 consists of the relocation of the current provisions of Section 10 relative to premium payment to Section 19. Revised Section 10 adopts new provisions regulating the marketing of Medicare Select policies in accordance with federally prescribed standards. Regulation 33 as revised establishes the minimum standards which must be complied with by insurers seeking to market Medicare Select policies in Louisiana. A Medicare Select policy is a Medicare Supplement policy which utilizes a restricted provider network. Use of a restricted provider network reduces costs thus making such policies more affordable for the elderly many of whom are facing a financial crisis due to the escalating costs of medical care. Medicare does not cover the cost of prescriptions which is one of the largest health care expenses for the elderly. An affordable supplemental policy is a life saving necessity for many senior citizens. The authority for implementation of this regulation is found in R.S. 22:224 and in 42 U.S.C. 1395 et seq. (OBRA'90).

The revised regulation sets forth the minimum standards for policy conditions and benefits that must be followed by insurers providing Medicare select insurance plans. It also sets forth the requirements for coverage and standards for payment for services and fees. Issuers of such policies are required to The regulation includes charts which detail the types of coverage and costs covered under the various plans. It also sets standards for the payment of claims, the payment of premiums, the filing and approval of policies including mandatory policy provisions and the approval of premium rates. And it also requires insurers to submit the plan of operation with evidence that it has an adequate number of providers in the network and that they are accessible.

### Emergency Rule

#### Section 1. Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

#### Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner under R.S. 49:950 et seq., the Administrative Procedure Act, and R.S. 22:224 of the Insurance Code.

#### Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 12, 13 and 21, this regulation shall apply to:

(1) all Medicare supplement policies delivered or issued for delivery in this State on or after the effective date hereof, and

(2) all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this State.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

#### Section 4. Definitions

For purpose of this regulation:

##### A. Applicant—

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy, the proposed certificate holder.

B. *Certificate*—any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

C. *Certificate Form*—the form on which the certificate is delivered or issued for delivery by the issuer.

D. *Issuer*—includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

E. *Medicare*—the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

F. *Medicare Supplement Policy*—a group or individual policy of health insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 or Section 1833 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

G. *Policy Form*—the form on which the policy is delivered or issued for delivery by the issuer.

#### Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this Section.

A. *Accident, Accidental Injury, or Accidental Means*—shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words or description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. *Benefit Period or Medicare Benefit Period*—shall not be defined more restrictively than as defined in the Medicare program.

C. *Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility*—shall not be defined more restrictively than as defined in the Medicare program.

D. *Health Care Expenses*—expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include:

- (1) home office and overhead costs;
- (2) advertising costs;
- (3) commissions and other acquisition costs;
- (4) taxes;
- (5) capital costs;
- (6) administrative costs; and
- (7) claims processing costs.

E. *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.

F. *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 the Public Law 89-97, as Enacted by the 89th 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.

G. *Medicare Eligible Expenses*—expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

H. *Physician*—shall not be defined more restrictively than as defined in the Medicare program.

I. *Sickness*—shall not be defined to be more restrictive than the following:

*Sickness*—illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

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.

#### Section 6. Policy Provisions

A. Except for permitted pre-existing condition clauses as described in Section 7A(1) and Section 8A(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 such 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 pre-existing 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.

#### Section 7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 20, 1992

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.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a pre-existing condition. The policy or certificate shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) 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.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) 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

(b) be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)(a) 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.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8B of this regulation.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificate holder such conversion opportunities as are described in Subparagraph (b); or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer 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 pre-existing conditions that would have been covered under the group policy being replaced.

(6) 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.

#### B. Minimum Benefit Standards

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) 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];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in

accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

#### Section 8. Benefit Standards for Policies or Certificates Issued or Delivered on or After July 20, 1992

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.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a pre-existing condition. The policy or certificate may not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) 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.

(4) 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.

(5) Each Medicare supplement policy shall be guaranteed renewable and:

(a) the issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(b) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;

(c) if the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for such benefits as otherwise meets the requirements of this Subsection.

(d) if an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificate holder the conversion opportunity described in Section 8A(5)(c); or

(ii) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.



(e) if a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer 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 pre-existing conditions that would have been covered under the group policy being replaced.

(6) 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.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(b) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(c) Reinstitution of such coverages:

(i) shall not provide for any waiting period with respect to treatment of pre-existing conditions;

(ii) shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. Standards for Basic ("Core") Benefits Common to All Benefit Plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation:

(1) Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One-hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit. Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar-year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(7) Extended Outpatient Prescription Drug Benefit. Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(8) Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible

expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, *Emergency Care* shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit. Coverage for the following preventive health services:

(a) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures.

(b) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(1) fecal occult blood test and/or digital rectal examination;

(2) mammogram;

(3) dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(4) pure tone (air only) hearing screening test, administered or ordered by a physician;

(5) serum cholesterol screening (every five years);

(6) thyroid function test;

(7) diabetes screening.

(c) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every 10 years).

(d) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) *Activities of Daily Living*—include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) *Care Provider*—a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) *Home*—any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare.

A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) *At-home Recovery Visit*—the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(III) \$1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this Section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

(11) New or Innovated Benefits. An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

### Section 9. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be



permitted in Section 8C(11) and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this Subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C and list the benefits in the order shown in this Subsection. For purposes of this Section, *Structure*, *Language*, and *Format* means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-up of Benefit Plans

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

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

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

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

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

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

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

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

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

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

**Section 10. Medicare Select Policies and Certificates**

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

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

B. For the purposes of this Section:

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

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

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

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

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

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

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

C. The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act

(OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.

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

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

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

(a) such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

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

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

(ii) to make appropriate referrals;

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

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

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

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

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

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

(a) the formal organizational structure;

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

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

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

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

(7) any other information requested by the Commissioner.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to

implementing such changes. Such changes shall be considered approved by the Commissioner after 30 days unless specifically disapproved.

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

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

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

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

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

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

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

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

(b) other Medicare Select policies or certificates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

M.(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(2) For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be re-authorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs,

coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

#### **Section 11. Open Enrollment**

A. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six-month period beginning with the first month in which an individual (who is 65 years of age or older) first enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this Subsection without regard to age.

B. Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a pre-existing condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before it became effective.

#### **Section 12. Standards for Claims Payment**

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. Number 100-203) by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

#### **Section 13. Loss Ratio Standards and Refund or Credit of Premium**

##### **A. Loss Ratio Standards**

(1) A Medicare Supplement policy form or certificate shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide

coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(a) at least 75 percent of the aggregate amount of premiums earned in the case of group policies; or

(b) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this Section and Subsection C(3) of Section 14 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

#### B. Refund or Credit Calculation

(1) An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-Week Treasury Notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

#### C. Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued before or after the effective date of Regulation 33 (Revised, 1992) in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner. The supporting

documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this State shall file with the Commissioner, in accordance with the applicable filing procedures of this State:

(1)(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The Commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of Regulation 33 as revised July 20, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the Commissioner.

#### Section 14. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.

C.(1) Except as provided in Paragraph (2) of this Subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the Commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

- (a) the inclusion of new or innovative benefits;
- (b) the addition of either direct response or agent marketing methods;
- (c) the addition of either guaranteed issue or underwritten coverage;
- (d) the offering of coverage to individuals eligible for Medicare by reason of disability.

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

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

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

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

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

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

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

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

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

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

#### **Section 15. Permitted Compensation Arrangements**

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

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

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

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

#### **Section 16. Required Disclosure Provisions**

##### **A. General Rules**

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

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

coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

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

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

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

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

**B. Notice Requirements**

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

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

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

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

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

**C. Outline of Coverage Requirements for Medicare Supplement Policies**

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

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

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

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

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

[COMPANY NAME]

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

**BASIC BENEFITS:** Included in All Plans.

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

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

**Blood:** First three pints of blood each year.

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



				Preventive Care

F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible				Part B Deductible
Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
	At-Home Recovery		At-Home Recovery	At-Home Recovery
		Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (3,000 Limit)
				Preventive Care

**PREMIUM INFORMATION [Boldface Type]**

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**DISCLOSURES [Boldface Type]**

Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY [Boldface Type]**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**RIGHT TO RETURN POLICY [Boldface Type]**

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

**POLICY REPLACEMENT [Boldface Type]**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

**NOTICE [Boldface Type]**

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this Paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.]

**PLAN A**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$0	\$760(Part A Deductible)
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	\$0	Up to \$95/day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:	All but \$380/day	\$380/day	\$0
--While using 60 lifetime reserve days			
--Once lifetime reserve days are used:	\$0	100% of Medicare Eligible Expenses	\$0
--Additional 365 days			
--Beyond the Additional 365 days	\$0	\$0	All Costs

SKILLED NURSING FACILITY CARE\*

You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital

First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	\$0	Up to \$95/day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES*</b> 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	\$0	All Costs
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A and B

<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
--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

<b>FOREIGN TRAVEL--NOT COVERED BY MEDICARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 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
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
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

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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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 respire care	\$0	Balance

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
--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
<b>AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

PLAN 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
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A and B

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

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
<b>PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE</b>			
Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

PLAN F

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

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

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A and B

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

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All Approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES*</b> 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%
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
--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
<b>AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

PLAN H

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

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

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

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A and B

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

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
<b>BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$760	\$760(Part A Deductible)	\$0
61st thru 90th day	All but \$190/day	\$190/day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$380/day	\$380/day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$95/day	Up to \$95/day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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 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
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
--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
<b>AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE</b> 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

<b>FOREIGN TRAVEL--NOT COVERED BY MEDICARE</b> 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
<b>BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE</b>			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%--\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN J

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

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

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

PLAN J

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES*</b> 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
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A and B

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE(cont'd)</b> <b>AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE</b> Home care certified by our doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50%--\$3,000 calendar year maximum benefit	50%
Over \$6,000 each calendar year	\$0	\$0	All Costs
<b>PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE</b> Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other

policy identified in Section 3.B of this regulation, issued for delivery in this State to persons eligible for Medicare by reason of age shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. Such notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

### Section 17. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

#### [Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(3) The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

(4) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

#### [Questions]

To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

(a) If so, with which company?

(2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

(a) If so, with which company?

(b) What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?

(4) Are you covered by Medicaid?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than 10-point type:

#### NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE [Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits.  
 No change in benefit, but lower premiums.  
 Fewer benefits and lower premiums.  
 Other. (please specify)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this Paragraph need not appear.]



Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative)\*  
[Typed Name and Address of Issuer, Agent or Broker]

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to pre-existing conditions) may be deleted by an issuer if the replacement does not involve application of a new pre-existing condition limitation.

#### **Section 18. Filing Requirements for Advertising**

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the Commissioner of Insurance of this State for review or approval by the Commissioner to the extent it may be required under state law.

#### **Section 19. Standards for Marketing**

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Louisiana Revised Statutes 22:1211 et seq. the following acts and practices are prohibited:

(1) **Twisting.** Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) **High Pressure Tactics.** Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) **Cold Lead Advertising.** Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall

not be used unless the policy is issued in compliance with this regulation.

D. No insurer providing Medicare supplement insurance in this state shall allow its agent to accept premiums except by check, money order, or bank draft made payable to the insurer. If payment in cash is made, the agent must leave the insurer's official receipt with the insured or the person paying the premium on behalf of the insured. This receipt shall bind the insurer for the monies received by the agent.

Under this Section, the agent is prohibited from accepting checks, money orders and/or bank drafts payable to the agent or his agency. The agent is not to leave any receipt other than the insurer's for premium paid in cash.

#### **Section 20. Appropriateness of Recommended Purchase and Excessive Insurance**

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

#### **Section 21. Reporting of Multiple Policies**

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this State for which the issuer has in force more than one Medicare supplement policy or certificate:

- (1) policy and certificate number, and
- (2) date of issuance.

B. The items set forth above must be grouped by individual policyholder.

#### **Section 22. Prohibition Against Pre-existing Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates**

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods.

#### **Section 23. Separability**

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

#### **Section 24. Effective Date**

The revisions to this regulation shall become effective on January 1, 1997.

**Appendix A**

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

Type \_\_\_\_\_ SMSBP(W) \_\_\_\_\_  
 For the State of \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

	(a)	(b)
	Earned Premium (x)	Incurred Claims (y)
	_____	_____

line \_\_\_\_\_

- 1 Current Year's Experience
  - a. Total (all policy years)
  - b. Current year's issues (z)
  - c. Net (for reporting purposes = 1a - 1b)
- 2 Past Years' Experience (All Policy Years)
- 3 Total Experience (Net Current Year + Past Years' Experience)
- 4 Refunds last year (Excluding Interest)
- 5 Previous Since Inception (Excluding Interest)
- 6 Refunds Since Inception (Excluding Interest)
- 7 Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)
- 8 Experienced Ratio Since Inception

Total Actual Incurred Claims (line 3, col b) = Ratio 2

---

Tot. Earned Prem. (line 3, col a) - Refunds Since Inception (line 6)

9 Life Years Exposed Since Inception \_\_\_\_\_

If the Experience Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) \_\_\_\_\_

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

Type \_\_\_\_\_ SMSBP(W) \_\_\_\_\_  
 For the State of \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

11 Adjustment to Incurred Claims for Credibility  
 Ratio 3 = Ratio 2 + Tolerance  
 If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the benchmark ratio, then proceed.  
 12 Adjusted Incurred Claims =  
 [Tot. Earned Premiums (line 3, col a) - Refunds Since Inception (line 6)] X Ratio 3 (line 11)

13 Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6)

Adjusted Incurred Claims (line 12)  
 -----  
 Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table	
Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

Type \_\_\_\_\_ SMSBP(W) \_\_\_\_\_  
For the State of \_\_\_\_\_  
Company Name \_\_\_\_\_  
NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
Address \_\_\_\_\_  
Person Completing This Exhibit \_\_\_\_\_  
Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

- (w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
- (x) Includes modal loadings and fees charged.
- (y) Excludes Active Life Reserves.
- (z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Signature  
\_\_\_\_\_  
Name - Please Type  
\_\_\_\_\_  
Title  
\_\_\_\_\_  
Date

REPORTING FORM FOR THE CALCULATION OF  
BENCHMARK RATIO SINCE INCEPTION  
FOR GROUP POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

Type \_\_\_\_\_ SMSBP(p) \_\_\_\_\_  
For the State of \_\_\_\_\_  
Company Name \_\_\_\_\_  
NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
Address \_\_\_\_\_  
Person Completing This Exhibit \_\_\_\_\_  
Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)
1		2.770		0.507		0.000		0.000	
2		4.175		0.567		1.194		0.000	
3		4.175		0.567		2.245		0.759	
4		4.175		0.567		3.170		0.771	
5		4.175		0.567		3.998		0.782	
6		4.175		0.567		4.754		0.792	
7		4.175		0.567		5.445		0.802	
8		4.175		0.567		6.075		0.811	
9		4.175		0.567		6.650		0.818	
10		4.175		0.567		7.176		0.824	
11		4.175		0.567		7.655		0.828	
12		4.175		0.567		8.093		0.831	
13		4.175		0.567		8.493		0.834	
14		4.175		0.567		8.684		0.837	
15		4.175		0.567				0.838	
Total		(k):	-----	(l):	-----	(m):	-----	(n):	-----

enchmark Ratio Since Inception:  $(l + n) / (k + m)$ :

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

REPORTING FORM FOR THE CALCULATION OF  
BENCHMARK RATIO SINCE INCEPTION  
FOR INDIVIDUAL POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

Type \_\_\_\_\_ SMSBP(p) \_\_\_\_\_  
 For the State of \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)
1		2.770		0.442		0.000		0.000	
2		4.175		0.493		0.000		0.000	
3		4.175		0.493		1.194		0.659	
4		4.175		0.493		2.245		0.669	
5		4.175		0.493		3.170		0.678	
6		4.175		0.493		3.998		0.686	
7		4.175		0.493		4.754		0.695	
8		4.175		0.493		5.445		0.702	
9		4.175		0.493		6.075		0.708	
10		4.175		0.493		6.650		0.713	
11		4.175		0.493		7.176		0.717	
12		4.175		0.493		7.655		0.720	
13		4.175		0.493		8.093		0.723	
14		4.175		0.493		8.493		0.725	
15		4.175		0.493		8.684		0.725	
				0.493					
<b>Total</b>		(k):	-----	(l):	-----	(m):	-----	(n):	-----

Benchmark Ratio Since Inception:  $(1 + n) / (k + m)$ :

(a): Year 1 is the current calendar year - 1  
 Year 2 is the current calendar year - 2  
 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990;  
 Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(c): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p) "SMSBP" = Standardized Medicare Supplement Benefit Plan

**Appendix B**  
FORM FOR REPORTING  
MEDICARE SUPPLEMENT POLICIES

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

\_\_\_\_\_  
Signature  
 \_\_\_\_\_  
Name and Title (please type)  
 \_\_\_\_\_  
Date

James H. "Jim" Brown  
Commissioner

9612#063

## DECLARATION OF EMERGENCY

### Department of Public Safety and Corrections Liquefied Petroleum Gas Commission

#### Permit Fees (LAC 55:IX.107 and 113)

The Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission has exercised the emergency provision of the Administrative Procedure Act, R.S. 49:953(B) to adopt an Emergency Rule, effective December 29, 1996, for 120 days or until a final Rule takes effect through the normal promulgation process, whichever occurs first. Emergency rule action is necessary to meet the requirements as prescribed by the 1996-97 budget.

#### Title 55

#### PUBLIC SAFETY

#### PART IX. Liquefied Petroleum Gas

#### Chapter 1. General Requirements

#### Subchapter A. New Dealers

#### §107. Requirements

##### A.1. - 5.b. ...

6. Must have paid permit fee in the amount of \$75 to the Liquefied Petroleum Gas Commission of the State of Louisiana. For all succeeding years the permit fee shall be as described in R.S. 40:1849(A) with a minimum of \$75.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Liquefied Petroleum Gas Commission, November 1972, amended December 1974, LR 1:315 (July 1975), LR 4:86 (March 1978), LR 7:633 (December 1981), amended by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 11:557 (May 1985), LR 15:854 (October 1989), LR 16:1063 (December 1990), LR 20:1400 (December 1994), LR 23:

#### §113. Classes of Permits

##### A.1.a. - f. ...

g. Must pay permit for first year's operations in the amount of \$75 to the Liquefied Petroleum Gas Commission of the State of Louisiana. For all succeeding years the permit fee shall be as described in R.S. 40:1849(A) with a minimum of \$75.

##### g.i. - 4.c.ii. ...

d. Must pay permit for first year's operations in the amount of \$75 to the Liquefied Petroleum Gas Commission of the State of Louisiana. For all succeeding years the permit fee shall be as described in R.S. 40:1849(A) with a minimum of \$75.

##### 4.d.i. - 6.d. ...

e. Must pay permit for first year's operations in the amount of \$75 to the Liquefied Petroleum Gas Commission of the State of Louisiana. For all succeeding years the permit fee shall be as described in R.S. 40:1849(A) with a minimum of \$75.

##### 6.e.i. - 7.c.ii. ...

7.d. Must pay permit for first year's operations in the amount of \$75 to the Liquefied Petroleum Gas Commission of

the State of Louisiana. For all succeeding years the permit fee shall be as described in R.S. 40:1849(A) with a minimum of \$75.

##### 7.d.i. - 10.b. ...

10.c. Must pay permit for first year's operations in the amount of \$75 to the Liquefied Petroleum Gas Commission of the State of Louisiana. For all succeeding years the permit fee shall be as described in R.S. 40:1849(A) with a minimum of \$75.

##### 10.c.i. - 11.j. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Liquefied Petroleum Gas Commission, November 1972, amended December 1974, LR 3:315 (July 1977), LR 7:633 (December 1981), LR 8:53 (January 1982), amended by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 11:557 (May 1985), LR 12:841 (December 1986), LR 15:855 (October 1989), LR 16:1063 (December 1990), LR 19:904 (July 1993), LR 20:1400 (December 1994), LR 21:704 (July 1995), LR 23:

G. L. "Mike" Manuel, Jr.  
Director

9612#007

## DECLARATION OF EMERGENCY

### Department of Social Services Office of Family Support

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

The Department of Social Services, Office of Family Support, has exercised the emergency provision of the Administrative Procedure Act, R.S. 49:953(B) to adopt the following Emergency Rule in the Aid to Families with Dependent Children (AFDC) Program, effective December 10, 1996. This Emergency Rule shall remain in effect for a period of 120 days.

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

**Title 67**  
**SOCIAL SERVICES**

**Part III. Office of Family Support**

**Subpart 2. Aid to Families with Dependent Children**

**Chapter 11. Application, Eligibility, and Furnishing Assistance**

**Subchapter B. Coverage and Conditions of Eligibility**

**§1141. Eligibility Requirements for Aliens**

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

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

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

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

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

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

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

**§1143. Income and Resources of Alien Sponsors**

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

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

1. achieves United States citizenship through naturalization; or
2. has worked 40 qualifying SSA quarters of coverage or can be credited with such qualifying quarters, and in the case of any such qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any Federal means-tested public benefit during any such period. In determining the number of qualifying quarters of coverage an alien shall be credited with:
  - a. all of the qualifying quarters of coverage worked by a parent of such alien while the alien was under age 19; and
  - b. all of the qualifying quarters worked by a spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased.

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

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

Madlyn B. Bagneris  
Secretary

9612#037

**DECLARATION OF EMERGENCY**

**Department of Social Services**  
**Office of Family Support**

**AFDC Eligibility—State Plan**  
**JOBS State Plan (LAC 67:III.Chapters 9-29)**

The Department of Social Services, Office of Family Support, has exercised the emergency provision of the Administrative Procedure Act, R.S. 49:953(B) to adopt the following Emergency Rule in the Aid to Families with Dependent Children Program (AFDC) and the JOBS Program known as Project Independence, effective January 1, 1997. This Emergency Rule shall remain in effect for a period of 120 days.

Pursuant to Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, changes are being made in the AFDC Program regarding denial of assistance for failure to cooperate in establishing paternity or obtaining child support; denial of cash assistance to fleeing felons and probation/parole violators; permanent disqualification for cash assistance to an individual convicted of a felony involving a controlled substance; establishment of a 60 month life-time limit for cash assistance; denial of cash assistance to minor children who are absent from the home for a significant period; and denial of

cash assistance to a person who fraudulently misrepresented residence in two or more states. The state is adopting the Title IV-A, IV-F, and IV-A/F state plans as they existed on October 1, 1996 to the extent that their provisions are not in conflict with any emergency or normal rules adopted or implemented on or after October 1, 1996. An Emergency Rule is necessary to effect these mandated regulations and to avoid sanctions or penalties which could be imposed by delaying implementation and to seek enhanced funding.

**Title 67**  
**SOCIAL SERVICES**

**Part III. Office of Family Support**

**Subpart 2. Aid to Families with Dependent Children  
(AFDC)**

**Chapter 9. Administration**

**§902. State Plan**

A. The Title IV-A State Plan as it existed on October 1, 1996 is hereby adopted to the extent that its provisions are not in conflict with any emergency or normal rules adopted or implemented on or after October 1, 1996.

B. The Office of the State Register has determined that publication of the plan would be unduly cumbersome and had exercised its privilege to omit it from the *Louisiana Register*, as per R.S. 49:954.1(C).

C. Copies of the plan may be obtained from the Office of Family Support, Planning Section, P.O. Box 94065, Baton Rouge, Louisiana 70804.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:474, R.S. 46:233 and P.L. 104-193.

HISTORICAL NOTE; Promulgated by the Department of Social Services, Office of Family Support, LR 23:

**Chapter 11. Application, Eligibility and Furnishing Assistance**

**Subchapter B. Coverage and Conditions of Eligibility**

**§1113. Eligibility Requirements**

A - B. ...

C. Cooperation. Each applicant for, or recipient of, AFDC is required to cooperate in identifying and locating the parent of a child with respect to whom aid is claimed, establishing the paternity of a child born out of wedlock with respect to whom aid is claimed, obtaining support payments for such applicant or recipient and for a child with respect to whom aid is claimed, and obtaining any other payment or property due such applicant or recipient of such child. Effective January 1, 1997, failure to cooperate in establishing paternity or obtaining child support will result in denial or termination of cash assistance benefits.

D - F. ...

G. Living in the Home. A child must reside with a qualified relative who is responsible for the day-to-day care of the child. Benefits will not be denied when the qualified relative or the child is temporarily out of the home. Good cause must be established for a temporary absence of more than 45 days.

AUTHORITY NOTE: Promulgated in accordance with 45 CFR 232, P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Louisiana Health and Human Resources Administration, Division of Family Services, LR

1:494 (November 1975), amended by the Department of Social Services, Office of Family Support, LR 23:

**§1116. Fleeing Felons and Probation/Parole Violators**

A. No cash assistance shall be provided to a person fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the state from which the individual flees. This does not apply with respect to the conduct of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct.

B. No cash assistance shall be provided to a person violating a condition of probation or parole imposed under federal or state law. This does not apply with respect to the conduct of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:

**§1118. Individuals Convicted Of A Felony Involving A Controlled Substance**

An individual convicted under federal or state law of any offense which is classified as a felony by the law of the jurisdiction involved and which has as an element the possession, use, or distribution of a controlled substance (as defined in Section 102(6) of the Controlled Substances Act [21 U.S.C. 802(6)]) shall be permanently disqualified from receiving cash assistance. This shall not apply to convictions occurring on or before August 22, 1996.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:

**Chapter 13. Special Conditions of Eligibility**

**Subchapter A. Family Independence Project (FIP)**

**§1301. Terms and Conditions**

A - E. ...

F. Life-Time Limit. Eligibility for cash assistance is limited to a life-time limit of 60 months. No cash assistance will be provided to a family that includes an adult who has received assistance for 60 months (whether or not consecutive).

1. Any month for which such assistance was provided will be disregarded with respect to the individual, if the individual was:

a. a minor child; and

b. not the head of a household or married to the head of a household.

G. All individuals determined ineligible under any of these provisions shall retain the same Medicaid eligibility that they would have had in the absence of the project.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:447.3, 46:460, 46:474, 46:477, 46:239, 46:459, Public Law 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:



## Chapter 15. General Program Administration

### Subchapter A. Fraud

#### §1501. Fraud Control Program

A. - B.2. ...

3. Cash assistance shall be denied to an individual for 10 years from the date that individual is convicted in federal or state court of having made a fraudulent statement or representation with respect to his place of residence in order to receive assistance simultaneously from two or more states. This does not apply with respect to a conviction of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct which was the subject of the conviction.

AUTHORITY NOTE: Promulgated in accordance with P.L. 100-203 and CFR 235, P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, LR 14:439 (July 1988), amended by the Department of Social Services, Office of Family Support, LR 20:1019 (September 1994), LR 23:

### Subchapter B. Recovery

#### §1506. Special Considerations In Determining Recovery Amounts

If the payee fails to report a child's absence of more than a 45-day duration by the end of the five day period that begins with the date that it became clear to the payee that the child would be absent for a 45-day period, and good cause for the absence is not established, the needs of the payee as well as the needs of the child will be excluded when determining the recovery amount.

AUTHORITY NOTE: Promulgated in accordance with PL 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:

#### Subpart 5. Job Opportunities and Basic Skills Training (JOBS) Program

### Chapter 29. Organization

#### Subchapter A. Designation and Authority of State Agency

#### §2902. State Plan

A. The Title IV-F and IV-A/F State Plan as it existed on October 1, 1996 is hereby adopted to the extent that its provisions are not in conflict with any emergency or normal rules adopted or implemented on or after October 1, 1996.

B. The Office of the State Register has determined that publication of the plan would be unduly cumbersome and had exercised its privilege to omit it from the *Louisiana Register*, as per R.S. 49:954.1(C).

C. Copies of the plan may be obtained from the Office of Family Support, Planning Section, P.O. Box 94065, Baton Rouge, Louisiana 70804.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:474, R.S. 46:233 and P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:

Madlyn B. Bagneris  
Secretary

9612#046

## DECLARATION OF EMERGENCY

### Department of Treasury Board of Trustees of the State Employees Group Benefits Program

#### Plan Document—Catastrophic Illness Endorsement

Pursuant to the authority granted by R.S. 42:871(C) and 874(A)(2), vesting the Board of Trustees with the sole 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 R.S. 49:953(B) to adopt amendments to the Plan Document of Benefits.

The Board finds that it is necessary to amend the Plan Document to implement changes to the Catastrophic Illness Endorsement to provide a more meaningful benefit to members who purchase the endorsement, as well as to facilitate adjudication of claims for benefits under the endorsement. Failure to adopt these amendments on an emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents which are crucial to the delivery of vital services to the citizens of the state. Accordingly, the Plan Document of Benefits for the State Employees Group Benefits Program is hereby amended in the following particulars:

**Amendment Number 1** -- Amend the Catastrophic Illness Endorsement provision in the *Schedule of Benefits* by deleting therefrom all references to 70 percent payment for inpatient hospital expenses and 30 percent payment for outpatient and professional expenses, such that the provision will read as follows:

#### CATASTROPHIC ILLNESS ENDORSEMENT (Optional)

All eligible expenses are payable at 100 percent following diagnosis of any covered disease.

Maximums for any one disease or combination thereof per lifetime:

Option 1 -- \$10,000 Maximum

Option 2 -- \$5,000 Maximum

**Amendment Number 2** -- Delete Article 3, Section VI, in its entirety, and insert a new Article 3, Section VI to read as follows:

#### VI. Catastrophic Illness Endorsement

A. Optional at the Election of the Employee. Upon enrollment and payment of an additional monthly premium, Catastrophic Illness Endorsement (CIE) benefits are available to persons, except dependent parents as defined in Article 1, Section I (1) (4), covered under the Comprehensive Medical Plan as set forth in Article 3, Section I.

A new Employee may enroll together with any eligible Dependents in the CIE benefit within 30 days of the Employee's date of employment without a pre-existing condition exclusion or evidence of good health. The Employee must elect and maintain coverage under the CIE in order for the dependent to be eligible to enroll in the CIE.

Any request for coverage after 30 days of employment will be subject to the terms of Article 1, Section II (D).

B. Diseases Included. Benefits will be payable under this provision for services rendered on or after the Covered Person's effective date, for treatment of one or more of the following diseases:

1. Cancer, including Leukemia
2. Poliomyelitis (polio)
3. Diphtheria
4. Smallpox
5. Scarlet fever
6. Tetanus (lockjaw)
7. Spinal Meningitis
8. Encephalitis (sleeping sickness)
9. Tularemia
10. Hydrophobia (rabies)
11. Sickle Cell Anemia

C. Lifetime Maximum Benefit. The lifetime maximum benefit payable under Article 3, Section VI for Eligible Expenses incurred by any one Covered Person with respect to all diseases listed above is indicated in the Schedule of Benefits.

D. Benefits Payable. Catastrophic Illness Endorsement benefits are paid prior to benefits available under all other provisions of this contract, up to the Catastrophic Illness Endorsement lifetime maximum benefit, and shall be subject to the limitations of the Fee Schedule.

In the event a Covered Person has received the maximum amount payable under the Catastrophic Illness Endorsement, such person shall be eligible for benefits under the Comprehensive Medical Benefits provisions of the Plan, to the extent such benefits remain unpaid.

E. Eligible Expenses. Eligible Expenses under the Catastrophic Illness Endorsement are any expenses for which benefits are payable under Article 3, including services authorized under Article 3, Section IV. The difference between the allowable expense under Article 3, Section I, and the billed charges shall be considered an Eligible Expense under the Catastrophic Illness Endorsement, up to the Catastrophic Illness Endorsement lifetime maximum benefit, provided that billed charges in excess of the Fee Schedule shall not be considered an Eligible Expense.

F. Ineligible Expense. Expenses not eligible for reimbursement under the Catastrophic Illness Endorsement are:

1. any expense not eligible under Article 3, Section 1, except as noted above in Article 3, Section VI (E);
2. any expense incurred for outpatient prescription drugs; and
3. any expense incurred for mental health and/or substance abuse treatment.

This Emergency Rule shall become effective on January 1, 1997, and shall remain effective for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

James R. Plaisance  
Executive Director

9612#008

## DECLARATION OF EMERGENCY

### Department of Treasury Board of Trustees of the State Employees Group Benefits Program

#### Plan Document—Emergency Room Facility Charges at Non-PPO Hospitals

Pursuant to the authority granted by R.S. 42:871(C) and 874(A)(2), vesting the Board of Trustees with the sole 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 R.S. 49:953(B) to adopt amendments to the Plan Document of Benefits.

The Board finds that it is necessary to amend the Plan Document to implement a higher benefit for those cases in which emergency treatment is received at an emergency room in a hospital which is outside the Group Benefits preferred provider network. Failure to adopt these amendments on an emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents which are crucial to the delivery of vital services to the citizens of the state. Accordingly, the Plan Document of Benefits for the State Employees Group Benefits Program is hereby amended in the following particulars:

**Amendment Number 1** -- Amend the footnote indicated by "\*\*\*" SCHEDULE OF BENEFITS by adding a new Paragraph c to read as follows:

c. A Non-PPO Hospital will be paid, after applicable deductibles, at 80 percent of Eligible Expenses for Emergency Room Services provided at the Hospital Emergency Room and billed by that Hospital.

**Amendment Number 2** -- Amend Article 1, Section I, by adding a new Subsection OO to read as follows:

OO. The term 'Emergency Room Services' as used herein shall mean Hospital services eligible for reimbursement, provided at a Hospital Emergency Room and billed by a Hospital, and provided on an expeditious basis for treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could reasonably result in physical impairment or loss of life.

**Amendment Number 3** -- Amend Article 3, Section X, Subsection B, by adding a new Paragraph 3 to read as follows:

3. A Non-PPO Hospital will be paid, after applicable deductibles, 80 percent of Eligible Expenses for Emergency Room Services provided at the Hospital Emergency Room and billed by that Hospital. The Plan Member has the responsibility for establishing that such treatment services were Emergency Room Services, as defined by the Program.

This amendment shall become effective on November 13, 1996, and shall remain effective for a maximum of 120 days or until promulgation of the final Rule, whichever occurs first.

James R. Plaisance  
Executive Director

9612#009

# Rules

## RULE

### Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences Seed Commission

#### Sweet Potatoes (LAC 7:XIII.8789)

In accordance with provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Agriculture and Forestry, Seed Commission, hereby amends regulations regarding seed sweet potatoes and sweet potato plant certification.

The Department published its Notice of Intent proposing to amend LAC 7:XIII.8789 in the August 20, 1996 issue of the *Louisiana Register*, LR 22:717 (August 1996). The effective date of this Rule amendment is December 20, 1996.

#### Title 7

### AGRICULTURE AND ANIMALS

#### Part XIII. Seeds

#### Chapter 87. Louisiana Seed

#### Subchapter C. Requirements for Certification of Specific Crops/Varieties

#### §8789. Seed Sweet Potatoes and Sweet Potato Plant Certification

A. - E. ...

#### F. Tagging and Certificate Tape

1. Each container of seed sweet potatoes and all certified sweet potato plants shall be tagged as follows:

- a. foundation (white tag);
- b. registered (purple tag); and
- c. certified (blue tag).

2. Each tag shall contain the following:

- a. kind and variety;
- b. year in which grown; and
- c. grower's name and address.

3. Sweet potato plants shall be tied in bundles of approximately 100 each with official tape issued by the Department of Agriculture and Forestry.

G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Seed Commission, LR 8:579 (November 1982), amended LR 9:202 (April 1983), repealed and

readopted LR 12:825 (December 1986), amended LR 22:1210 (December 1996).

Bob Odom  
Commissioner

9612#052

## RULE

### Department of Agriculture and Forestry Office of Forestry Forestry Commission

#### Forest Tree Seedling Prices (LAC 7:XXXIX.20301)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Department of Agriculture and Forestry, Office of Forestry, and the Louisiana Forestry Commission hereby amend LAC 7:XXXIX.20301, Seedling Prices. The Rule increases the prices for Improved Pine Seedlings, Advanced Generation Pine Seedlings, and Special Pine Seedlings. These price changes are designed to allow the Office of Forestry to recover production costs for these seedlings.

The Department published its Notice of Intent to amend LAC 7:XXXIX.20301 in the July 20, 1996, issue of the *Louisiana Register*, LR 22:586 (July 1996). The effective date of this Rule amendment is December 20, 1996.

#### Title 7

### AGRICULTURE AND ANIMALS

#### Part XXXIX. Forestry

#### Chapter 203. Tree Seedlings

#### §20301. Seedling Prices

A. The Louisiana Forestry Commission adopts the following prices for forest tree seedlings:

1. Improved Pine Seedlings	\$ 32 per thousand
2. Advanced Generation Pine Seedlings	\$ 42 per thousand
3. Special Pine Seedlings	\$ 52 per thousand
4. Hardwood Seedlings	\$175 per thousand
5. Baldcypress Seedlings	\$175 per thousand

B.1. Volume discounts for bulk loblolly/slash pine seedling orders and contracts shall be as follows:

Order/Sale Volume (Number Seedlings)	Proposed Discounted Prices
-1000000	\$ 32.00/M
1,000,001 - 2,000,000	\$ 31.50/M
2,000,001 - 3,000,000	\$ 31.00/M
3,000,001 - 4,000,000	\$ 30.50/M
4,000,001 - 5,000,000	\$ 30.00/M
5,000,001 - 6,000,000	\$ 29.50/M
6,000,001 -	\$ 29.00/M

The Office of Forestry seed costs shall be deducted from these prices when seedlings are produced from seed supplied by the customer.

B.2. - B.3. ...

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 56:1503, redesignated R.S. 3:4303.

**HISTORICAL NOTE:** Promulgated by the Department of Natural Resources, Office of Forestry, and the Louisiana Forestry Commission, LR 8:285 (June 1982), amended LR 10:458 (June 1984), amended by the Department of Agriculture and Forestry, Office of Forestry, and the Louisiana Forestry Commission, LR 13:432 (August 1987), LR 19:610 (May, 1993), LR 21:671 (July 1995), LR 22:1210 (December 1996).

Bob Odom  
Commissioner

9612#051

## RULE

### Department of Economic Development Board of Examiners of Certified Shorthand Reporters

#### Transcript Format Guidelines (LAC 46:XXI.1101)

Under authority of R.S. 37:2551 and with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Board of Examiners of Certified Shorthand Reporters is amending Part XXI of the *Louisiana Administrative Code*. This Rule amends the established transcript format guidelines.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XXI. Certified Shorthand Reporters

#### Chapter 11. Court Reporting Procedures

#### §1101. Transcript Format Guidelines (Freelance Reporters)

A. Every freelance certified reporter shall use the following transcript format rules on every deposition transcript prepared by that reporter:

1. Transcripts shall contain no fewer than 25 typed lines on standard 8½ x 11 paper exclusive of page numbers and footers.
2. Transcripts shall contain no fewer than eight characters to the typed inch.
3. The distance between the left and right margins shall be no less than 6% inches.
4. Each question and answer shall begin on a separate line.
5. Either of the following may be used:
  - a. Each question and answer shall begin no more than five spaces from the left-hand margin. The text shall begin no more than five spaces following the question and answer. Carryover question and answer lines shall begin at the left-hand margins.

b. Block Version. Each question and answer shall begin at the left-hand margin. The text shall begin no more than five spaces following the question and answer. Carryover question and answer lines shall begin no more than six spaces from the left-hand margin.

6. Either of the following may be used:

a. Colloquy material shall begin no more than 15 spaces from the left-hand margin, with carryover lines commencing no more than 10 spaces from the left-hand margin.

b. Colloquy material shall begin with the speaker ID on a separate line no more than 10 spaces from the left-hand margin. The actual text shall begin on the next line 15 spaces from the left-hand margin, with carryover lines no more than 12 spaces from the left-hand margin.

7. Quoted material shall be treated in the same manner as either question and answer (Paragraphs 5.a or 5.b) or colloquy material (Paragraphs 6.a or 6.b). Quoted material shall be single spaced or double spaced.

8. Parentheticals and exhibit markings shall begin no more than 15 spaces from the left-hand margin with carryover lines commencing no more than 15 spaces from the left-hand margin.

9. There shall be no numbered lines that are blank on a transcript page, excluding the last page of a transcript, title page, contents page, appearance page, stipulation page and certificate pages.

B. The Board recognizes that technological advances in the court reporting profession may from time to time require the Board to render advisory interpretations of the foregoing transcript format guidelines or may require modification of them in response to innovations and the evolving technology in court reporting. Technological advances are desirable and should be encouraged. The Board needs a mechanism to accommodate technological changes while also maintaining enforceable standards to protect the profession from abuses in court reporting. The Board hereby acknowledges its authority to issue advisory opinions on a case-by-case basis in response to petitions for declaratory orders and rulings in order to take account of technological innovation, customary practices, and unanticipated questions or ambiguities in the application of the foregoing transcript format guideline. Any interested person may petition the Board for a declaratory order or ruling in writing no less than 30 days prior to a board meeting. If timely filed, the matter will be placed on the agenda for discussion at the board's next meeting and will be finally disposed of by the Board within 90 days after the meeting. Further review of such final disposition by the Board may be sought in the same manner as review of agency decisions or orders in adjudicated cases, as provided in R.S. 49:962.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:2551.

**HISTORICAL NOTE:** Promulgated by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 21:548 (June 1995), amended LR 22:1211 (December 1996).

Gay M. Pilié  
Executive Director

9612#036

**RULE**

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

**Chemical Accident Prevention Program  
(LAC 33:III.5901) (AQ126F)**

*(Editor's Note: A portion of the following Rule, appearing on pages 1124-1125 of the November, 1996 Louisiana Register is being republished to correct typographical errors.)*

**Title 33**

**ENVIRONMENTAL QUALITY**

**Part III. Air**

**Chapter 59. Chemical Accident Prevention Program**

**§5901. Incorporation by Reference of Federal Regulations**

A. Except as provided in Subsection C of this Section, the Department incorporates by reference 40 CFR Part 68 (July 1, 1995), as amended in 61 FR 31668-31730 (June 20, 1996) and in 61 FR 31730-31732 (June 20, 1996).

B. - C.5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054 and R.S. 30:2063.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:421 (April 1994), amended LR 22:1124 (November 1996), repromulgated LR 22:1212 (December 1996).

Gus Von Bodungen  
Assistant Secretary

9612#010

**RULE**

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

**Incorporation by Reference (LAC 33:III.Chapters 1, 15, 21, 25, 29, 30, 31, 60, 61 and 64) (AQ145)**

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Secretary has amended the Air Quality Division regulations, LAC 33:III.Chapters 1, 15, 21, 25, 29, 30, 31, 60, 61 and 64 (AQ145).

This Rule repeals LAC 33:III.Chapters 31, 60 (except §6099 which is moved and renumbered as LAC 33:III:2901.G), 61 (except Subchapter A which is moved and renumbered as Subchapter N in Chapter 21), and 64 from LAC 33:III and incorporates by reference into Chapter 30 federal regulations in 40 CFR Part 60 - Standards of Performance for New Stationary Sources. Revisions are also made in LAC 33:III.Chapters 1, 15, 21, 25 and 29, so that referenced LAC cites agree with changes per this rulemaking, and to add 40 CFR references. These changes will expedite

both the EPA approval process, and state implementation of delegation of authority for the NSPS program. The NSPS 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 111. This rulemaking is applicable to stationary sources statewide.

The full text of this Rule may be obtained from the Office of the State Register, 1051 North Third Street, Baton Rouge, LA 70802.

Gus Von Bodungen  
Assistant Secretary

9612#054

**RULE**

**Department of Environmental Quality  
Office of the Secretary**

**Emergency Response (LAC 33:I.6915) (OS18A)**

*(Editor's Note: A portion of the Rule which appeared on pages 976-979 of the October 20, 1996, Louisiana Register is being republished to correct a Louisiana Administrative Code citation in §6915.A.)*

**Title 33**

**ENVIRONMENTAL QUALITY**

**Part I. Office of the Secretary**

**Subpart 4. Emergency Response Regulations**

**Chapter 69. Emergency Response Regulations**

**§6915. Transportation, Receipt, and Storage of Material from the Cleanup and/or Abatement of an Off-site Emergency Condition**

A. Transportation, receipt, and storage of any material generated as a result of the cleanup and/or abatement of any off-site emergency condition, and not specifically authorized by the Louisiana Administrative Code, Title 33, Part V, Subpart I, may be authorized by the administrative authority.

B. These regulations supplement and do not replace requirements of 49 CFR parts 100-177 that remain fully applicable to the transportation of hazardous materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011(D)(1),(14), and (15).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of the Secretary, LR 22:979 (October 1996), repromulgated LR 22:1212 (December 1996).

Herman Robinson  
Assistant Secretary

9612#062

**RULE**

**Department of Environmental Quality  
Office of Solid and Hazardous Waste  
Solid Waste Division**

**Waste Tire (LAC 33:VII.Chapter 105)(SW021)**

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the

provisions of the Administrative Procedure Act, R.S. 49:950, et seq., the Secretary has amended the Solid Waste Division regulations, LAC 33:VII.Chapter 105 (SW021).

The Rule makes modifications to the Waste Tire Management Fund Prioritization System providing more equity in cleanups and makes the Emergency Rule in effect permanent. The Rule also provides for grammatical cleanup of the waste tire regulations.

**Title 33**  
**ENVIRONMENTAL QUALITY**  
**Part VII. Solid Waste**  
**Subpart 2. Recycling**

**Chapter 105. Waste Tires**

**§10505. Definitions**

The following words, terms, and phrases, when used in conjunction with the Solid Waste Rules and Regulations, shall have the meanings ascribed to them in this Section, except where the context clearly indicates a different meaning:

\* \* \*

[See Prior Text]

*Major Highway*—all asphaltic concrete and concrete interstate and intrastate highways and roads maintained by the United States government or Louisiana state government, or both, or any agencies or departments thereof.

\* \* \*

[See Prior Text]

*Marketing*—the selling and transferring of waste tires or waste tire material for recycling and/or beneficial use or reuse.

\* \* \*

[See Prior Text]

*Promiscuous Tire Pile*—an unauthorized waste tire pile that has resulted from storage or disposal activities by anyone other than the landowner without the landowner's knowledge.

\* \* \*

[See Prior Text]

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 30:2411-2422.

**HISTORICAL NOTE:** Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Solid Waste Division, LR 18:37 (January 1992), amended LR 20:1001 (September 1994), LR 22:1213 (December 1996).

**§10525. Standards and Responsibilities of Waste Tire Processors**

\* \* \*

[See Prior Text in A-E.10]

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 30:2411-2422.

**HISTORICAL NOTE:** Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Solid Waste Division, LR 18:41 (January 1992), amended LR 20:1001 (September 1994), amended LR 22:1213 (December 1996).

**§10535. Fees and Fund Disbursement**

\* \* \*

[See Prior Text in A-D.10]

11. After January 1, 1998, a payment of \$1 per 20 pounds of shredded waste tire material or an equivalent amount for waste tire material produced by other processes shall be made when it is documented to the administrative authority that this material has been marketed and delivered for beneficial use.

\* \* \*

[See Prior Text in D.12-D.13]

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 30:2411 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Solid Waste Division, LR 20:1001 (September 1994), amended LR 22:1213 (December 1996).

**§10536. Cleanup of Promiscuous/Unauthorized Tire Piles**

A. Upon promulgation of these regulations, the administrative authority may issue agreements for cleanup of promiscuous/unauthorized tire piles. The number of agreements issued each year shall be determined based on the availability of funds in the Waste Tire Management Fund that are designated for promiscuous/unauthorized tire pile cleanup. Any such agreements will designate specific eligible sites and the Department will monitor the cleanup activities, which shall be made in accordance with the standards and responsibilities outlined in the solid waste regulations, LAC 33:VII. Any such agreements shall stipulate a maximum amount of total allowable costs that shall be paid from the Waste Tire Management Fund. These monies shall not be applied to indirect costs and other unallowable costs, which include but are not limited to, administrative costs, consulting fees, or legal fees. Furthermore, they shall not be applied to reclamation efforts or cleanup costs associated with other types of contaminants, which may be detected during the remediation process. Rather, these funds shall be applied to direct costs such as labor, transportation, processing, and disposal costs of the waste tires.

B. In order to apply for and receive funding for promiscuous/unauthorized tire site cleanup, local governments must provide the administrative authority with promiscuous/unauthorized tire site information. This information includes, but is not limited to, accurate site location, number of tires on site, visual report on site with photographs and proximity to residences, schools, hospitals and/or nursing homes, and major highways. Such information will be submitted using forms available from the administrative authority.

C. Promiscuous/unauthorized tire piles shall be chosen for cleanup based on their placement on the waste tire priority cleanup list. Point values will be assigned in accordance with the Waste Tire Management Fund Prioritization System located in Appendix B. These ranking criteria were developed in consideration of threat to human health, threat of damage to surrounding property, and adverse impact on the environment.

\* \* \*

[See Prior Text in D]

E. Waste tires may not be removed from promiscuous/unauthorized waste tire piles without prior approval of the administrative authority.

F. The administrative authority will seek reimbursement from all responsible parties for any waste tire cleanup costs incurred by the state by any method allowed by law, provided same is practicable and cost effective.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 30:2411 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Solid Waste Division, LR 20:1001 (September 1994), amended LR 22:1213 (December 1996).

**Appendix A. Louisiana Department of Environmental Quality Financial Assurance Documents for Waste Tire Facilities (August 4, 1994)**

The following documents are to be used to demonstrate financial responsibility for the closure of waste tire facilities. The wording of the documents shall be identical to the wording that follows, except that the instructions in brackets are to be replaced with the relevant information and the brackets deleted.

\* \* \*

[See Prior Text in Sample Document 1]

**SAMPLE DOCUMENT 2:**

**WASTE TIRE FACILITY PERFORMANCE BOND**

Date bond was executed: [date bond executed]  
Effective date: [effective date of bond]  
Principal: [legal name and business address of permit holder or applicant]  
Type of organization: [insert "individual," "joint venture," "partnership," or "corporation"]  
State of incorporation:  
Surety: [name(s) and business address(es)]  
[Site identification number, site name, facility name, facility address, and closure amount(s) for each facility guaranteed by this bond]  
Total penal sum of bond: \$  
Surety's bond number:

Know All Persons By These Presents, That we, the Principal and Surety hereto, are firmly bound to the Louisiana Department of Environmental Quality, Waste Tire Management Fund, in the above penal sum for the payment of which we bind ourselves, our heirs, executors, administrators, successors, and assigns jointly and severally; provided that, where Sureties are corporations acting as cosureties, we, the sureties, bind ourselves in such sum "jointly and severally" only for the purpose of allowing a joint action or actions against any or all of us, and for all other purposes each Surety binds itself, jointly and severally with the Principal, for the payment of such sum only as is set forth opposite the name of such Surety, but if no limit of liability is indicated, the limit of liability shall be the full amount of the penal sum.

WHEREAS, said Principal is required, under the Resource Conservation and Recovery Act as amended (RCRA) and the Louisiana Environmental Quality Act, R.S. 30:2001, et seq., to have a permit in order to own or operate the waste tire facility identified above; and

WHEREAS, the Principal is required by law to provide financial assurance for closure care, as a condition of the permit;

THEREFORE, the conditions of this obligation are such that if the Principal shall faithfully perform closure, whenever required to do so, of the facility for which this bond guarantees closure, in accordance with the closure plan and other requirements of the permit as such plan and permit may be amended, pursuant to all applicable laws, statutes, rules, and regulations, as such laws, statutes, rules, and regulations may be amended;

OR, if the Principal shall provide financial assurance as specified in LAC 33.VII.10525.D.26-28 and obtain written approval of the administrative authority of such assurance, within 90 days after the date of notice of cancellation is received by both the Principal and the administrative authority, then this obligation shall be null and void; otherwise it is to remain in full force and effect.

The surety shall become liable on this bond obligation only when the Principal has failed to fulfill the conditions described hereinabove.

Upon notification by the administrative authority that the Principal has been found in violation of the closure requirements of the Louisiana Administrative Code, Title 33, Part VII, or of its permit, for the facility for which this bond guarantees performances of closure, the Surety shall either perform closure, in accordance with the closure plan and other permit requirements, or place the closure amount guaranteed for the facility into the Waste Tire Management Fund as directed by the administrative authority.

Upon notification by the administrative authority that the Principal has failed to provide alternate financial assurance as specified in LAC 33.VII.10525.D.26-28 and obtain written approval of such assurance from the administrative authority during the 90 days following receipt by both the Principal and the administrative authority of a notice of cancellation of the bond, the surety shall place funds in the amount guaranteed for the facility into the Waste Tire Management Fund as directed by the administrative authority.

The Surety hereby waives notification of amendments to closure plans, permits, applicable laws, statutes, rules, and regulations, and agrees that no such amendment shall in any way alleviate its obligation on this bond.

The liability of the Surety(ies) shall not be discharged by any payment or succession of payments hereunder, unless and until such payment or payments shall amount in the aggregate to the penal sum of the bond, but in no event shall the obligation of the Surety hereunder exceed the amount of the penal sum.

The Surety may cancel the bond by sending notice of cancellation by certified mail to the Principal and to the administrative authority. Cancellation shall not occur before 120 days have elapsed beginning on the date that both the Principal and the administrative authority received the notice of cancellation, as evidenced by the return receipts.

The Principal may terminate this bond by sending written notice to the Surety and to the administrative authority, provided, however, that no such notice shall become effective until the Surety receives written authorization for termination of the bond by the administrative authority.

The Principal and Surety hereby agree that no portion of the penal sum may be expended without prior written approval of the administrative authority.

IN WITNESS WHEREOF, the Principal and the Surety have executed this PERFORMANCE BOND and have affixed their seals on the date set forth above.

Those persons whose signatures appear below hereby certify that they are authorized to execute this surety bond on behalf of the Principal and Surety, that each Surety hereto is authorized to do business in the state of Louisiana and that the wording of this surety bond is identical to the wording specified by the Louisiana Department of Environmental Quality's Financial Assurance Documents dated August 4, 1993, effective on the date this bond was executed.

**PRINCIPAL**

[Signature(s)]  
[Name(s)]  
[Title(s)]  
[Corporate Seal]

**CORPORATE SURETY**

[Name and Address]  
State of incorporation:  
Liability limit:  
[Signature(s)]  
[Name(s) and title(s)]  
[Corporate seal]  
[For every cosurety, provide signature(s), corporate seal, and other information in the same manner as for Surety above.]  
Bond Premium: \$

\* \* \*

[See Prior Text in Sample Document 3]

**Appendix B. Waste Tire Management Fund Prioritization System**

Each waste tire site for which cleanup funds are solicited will be ranked according to the point system described below. The total number of points possible for any one site is 145 points. The points shall be allocated according to the following criteria:

I. Approximate Number of Tires in the Pile. This figure shall be an estimate by the Department.



Number of Tires in Pile	Point Value
>1,000,000	50
250,001 - 1,000,000	40
100,001 - 250,000	30
50,001 - 100,000	20
<50,000	10

II. Proximity to Nearest Schools. If a school is located within the radius described below then the corresponding point value is assigned. Only one category may be chosen such that the maximum value allowed is 25.

Proximity to Nearest School	Point Value
School within 2 mile radius	25
School within 4 mile radius	17
School within 6 mile radius	9

III. Proximity to Residences. If 50 or more residences are located within the radius described below then the corresponding point value is assigned. Only one category may be chosen such that the maximum value allowed is 25.

Proximity to 50+ Residences	Point Value
50 or more within 2 mile radius	25
50 or more within 4 mile radius	17
50 or more within 6 mile radius	9

IV. Proximity to Hospitals and/or Nursing Homes. If a hospital and/or nursing home is located within the radius described below then the corresponding value is assigned. Only one category may be chosen such that the maximum value is 25.

Proximity to Hospital and/or Nursing Home	Point Value
Hospital and/or nursing home within 2 mile radius	25
Hospital and/or nursing home within 4 mile radius	17
Hospital and/or nursing home within 6 mile radius	9

V. Proximity to Major Highways. If a major highway is located within the radius described below then the corresponding value is assigned. Only one category may be chosen such that the maximum value is 20.

Proximity to Major Highway	Point Value
Major highway within ¼ mile radius	20
Major highway within ½ mile radius	10

Mike Strong  
Assistant Secretary

9612#055

## RULE

### Department of Health and Hospitals Board of Dentistry

#### Advertising; Records on Prescriptions (LAC 46:XXXIII.301 and 303)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760(8), the Department of Health and Hospitals, Board of Dentistry hereby amends LAC 46:XXXIII.301, Advertising and Soliciting by Dentists, and repeals LAC 46:XXXIII.303, Maintenance of Records on Prescriptions Pursuant to R.S. 37:1204.

The Board is amending the definition of pediatric dentistry to conform with the recently adopted definition of the American Dental Association.

LAC 46:XXXIII.303 is being repealed as it conflicts with R.S. 37:794 which was adopted by the Legislature in 1995.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XXXIII. Dental Health Professions

#### Chapter 1. General Provisions

#### §301. Advertising and Soliciting by Dentists

A. - C. ...

D. Definitions

*Pediatric Dentistry*—an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.

E. - K. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Adopted by the Department of Health and Human Resources, Board of Dentistry, December 1970, amended 1971, amended and promulgated LR 13:179 (March 1987), amended by the Department of Health and Hospitals, Board of Dentistry, LR 15:966 (November 1989), LR 18:739 (July 1992), LR 20:657 (June 1994), LR 21:567 (June 1995), LR 22:23 (January 1996), LR 22:1215 (December 1996).

#### §303. Maintenance of Records on Prescriptions Pursuant to R.S. 37:1204

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Dentistry, LR 13:179 (March 1987), repealed by the Department of Health and Hospitals, Board of Dentistry, LR 22:1215 (December 1996).

C. Barry Ogden  
Executive Director

9612#001

**RULE**

**Department of Health and Hospitals  
Board of Dentistry**

**Conscious Sedation with Parenteral Drugs  
(LAC 46:XXXIII.1505 and 1509)**

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760(8), the Department of Health and Hospitals, Board of Dentistry hereby amends LAC 46:XXXIII.1505, Conscious Sedation with Parenteral Drugs, and LAC46:XXXIII.1509, Minimal Education Requirements for the Granting of Permits to Administer Nitrous Oxide Inhalation Analgesia, Conscious Sedation with Parenteral Drugs, and General Anesthesia/Deep Sedation.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part XXXIII. Dental Health Professions**

**Chapter 15. Anesthesia/Analgesia Administration  
§1505. Conscious Sedation with Parenteral Drugs**

A. The Board shall issue two types of conscious sedation with parenteral drugs permits.

1. A "limited" permit will be issued to those dentists who qualify for such permit by meeting the minimal educational requirements specified in §1509. This permit will be limited to the administration of parenteral drugs via intramuscular (IM), submucosal (SM), intranasal (IN), and subcutaneous (SC) routes only.

2. A "full" permit will be issued to those dentists who qualify for such permit by meeting all minimal educational requirements specified in §1509.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 20:659 (June 1994), amended LR 22:1216 (December 1996).

**§1509. Minimal Education Requirements for the  
Granting of Permits to Administer Nitrous Oxide  
Inhalation Analgesia, Conscious Sedation with  
Parenteral Drugs, and General Anesthesia/Deep  
Sedation**

A. ...

B. Conscious Sedation with Parenteral Drugs

1. To be granted a "limited" permit, the applicant must submit verification of formal post-doctoral training in the use of parenteral drugs via the intramuscular (IM), submucosal

(SM), intranasal (IN), and subcutaneous (SC) routes of administration and competency to handle all emergencies relating to parenteral sedation providing such program consists of a minimum of 60 hours of instruction and 100 hours of clinical experience which includes at least 10 documented cases of parenteral sedation.

2. To be granted a "full" permit, the applicant must submit verification of formal post-doctoral training in the use of parenteral drugs via the intramuscular (IM), submucosal (SM), intranasal (IN), subcutaneous (SC), and conscious IV sedation routes administration and competency to handle all emergencies relating to parenteral sedation providing such program consists of a minimum of 60 hours of instruction and 100 hours of clinical experience which includes at least 20 documented cases of parenteral sedation.

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 20:659 (June 1994), amended LR 22:1216 (December 1996).

C. Barry Ogden  
Executive Director

9612#006

**RULE**

**Department of Health and Hospitals  
Board of Dentistry**

**Continuing Education (LAC 46:XXXIII.1611 and 1613)**

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760(8) and (13), the Department of Health and Hospitals, Board of Dentistry hereby amends LAC 46:XXXIII.1611, Continuing Education Requirements for Relicensure of Dentists, and LAC 46:XXXIII.1613, Continuing Education Requirements for Relicensure of Dental Hygienists.

These Rule changes clarify how to obtain the required clinical continuing education requirements for dentists and dental hygienists.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part XXXIII. Dental Health Professions**

**Chapter 16. Continuing Education Requirements  
§1611. Continuing Education Requirements for  
Relicensure of Dentists**

A. ...

B. At least one-half of the minimum credit hours (10) must be attained by personally attending clinical courses pertaining to the actual delivery of dental services to patients.

C. - J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8) and (13).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 20:661 (June 1994), amended

LR 21:569 (June 1995), LR 22:24 (January 1996), LR 22:1216 (December 1996).

**§1613. Continuing Education Requirements for Relicensure of Dental Hygienists**

- A. ...
- B. At least one-half of the minimum credit hours (6) must be attained by personally attending clinical courses pertaining to the actual delivery of dental services to patients.

C. - J. ...  
 AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8) and (13).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 20:661 (June 1994), amended LR 21:570 (June 1995), LR 22:24 (January 1996), LR 22:1217 (December 1996).

C. Barry Ogden  
 Executive Director

9612#002

**RULE**

**Department of Health and Hospitals  
Board of Dentistry**

Dental Assistants (LAC 46:XXXIII.502)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760(8), the Department of Health and Hospitals, Board of Dentistry hereby amends LAC 46:XXXIII.502, Authorized Duties of Expanded Duty Dental Assistants.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part XXXIII. Dental Health Professions**

**Chapter 5. Dental Assistants**

**§502. Authorized Duties of Expanded Duty Dental Assistants**

- 1. - 8. ...
- 9. Prepare the teeth and the tray for indirect orthodontic bonding procedures and then seat the prepared tray provided the dentist has personally adjusted the brackets on the casts or the brackets have been placed according to a written prescription by the dentist for final positioning of the brackets. A duplicate of the written prescription should be maintained in the patient's chart if the prescription is filled by an outside laboratory.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 19:205 (February 1993), amended LR 21:569 (June 1995), LR 22:1217 (December 1996).

C. Barry Ogden  
 Executive Director

9612#003

**RULE**

**Department of Health and Hospitals  
Board of Dentistry**

Dental Hygienists—Authorized Duties  
(LAC 46:XXXIII.701)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760(8), the Department of Health and Hospitals, Board of Dentistry hereby amends LAC 46:XXXIII.701, Authorized Duties.

This Rule authorizes dental hygienists to prepare teeth for and to place fissure sealants on teeth.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part XXXIII. Dental Health Professions**

**Chapter 7. Dental Hygienists**

**§701. Authorized Duties**

A. - B.12. ...

13. Preparation of teeth for and placement of fissure sealants.

14. - 15. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 14:791 (November 1988), amended LR 15:965 (November 1989), LR 19:206 (February 1993), LR 22:22 (January 1996), LR 22:1217 (December 1996).

C. Barry Ogden  
 Executive Director

9612#004

**RULE**

**Department of Health and Hospitals  
Board of Dentistry**

Emergency Suspension of Licenses  
(LAC 46:XXXIII.903)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Dental Practice Act, R.S. 37:751 et seq., and particularly R.S. 37:760(8), the Department of Health and Hospitals, Board of Dentistry hereby amends LAC 46:XXXIII.903, Initiation of Proceedings.

This Rule clarifies the Board's authority to issue an emergency suspension of a license when the public's health, safety, or welfare is at risk in accordance with the Administrative Procedure Act.

**Title 46**  
**PROFESSIONAL AND OCCUPATIONAL**  
**STANDARDS**

**Part XXXIII. Dental Health Professions**

**Chapter 9. Formal Adjudication**

**§903. Initiation of Proceedings**

A. - B. ...

C. If the public health, safety, and/or welfare imperatively requires emergency action, the Board, through its President, may order an interim suspension of a dental or dental hygiene license pending formal disciplinary proceedings, as provided in R.S. 49:961(C). The President shall appoint one or more board members to hear the evidence in support of an immediate interim suspension and to make recommendations to the Board President, who shall thereafter issue whatever order of interim suspension pending formal adjudication as is warranted by the circumstances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:760 (4), (8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Dentistry, LR 19:1317 (October 1993), amended LR 22:1218 (December 1996).

C. Barry Ogden  
Executive Director

9612#005

**RULE**

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

**Respiratory Therapy; Continuing Education**  
**(LAC 46:XLV.2541-2569)**

The Louisiana State Board of Medical Examiners (Board), pursuant to the authority vested in the Board by the Louisiana Respiratory Therapy Practice Act, R.S. 37:3351-3361, and the provisions of the Administrative Procedure Act, has amended its Rules governing the licensure of respiratory therapists and respiratory therapy technicians, LAC 46:XLV, Subpart 2, Chapter 25, §§2501-2551, to implement the requirements for continuing education as a condition of renewal of licensure as prescribed and authorized by R.S. 37:3357(D) (Acts 1995, Number 802). The Rules were proposed for adoption by Notice of Intent published in the *Louisiana Register*, Volume 22, Pages 745-749 (August 1996). In the absence of objection or other comment, the amendments were adopted by the Board as then proposed. The text of the final amendments is set forth below.

**Title 46**  
**PROFESSIONS AND OCCUPATIONS**  
**Part XLV. Medical Professions**

**Subpart 2. Licensure and Certification**

**Chapter 25. Respiratory Therapists and Respiratory Therapy Technicians**

**Subchapter E. Licensure, Issuance Termination, Renewal, Temporary Issuance and Reinstatement**

**§2541. Expiration of License**

A. Every license issued by the Board under this Chapter shall expire, and thereby become null, void and to no effect, on the thirty-first day of December next following the date on which the license was issued.

B. The timely submission of an application for renewal of a license as provided by §2543 hereof shall operate to continue the expiring license in force and effect pending the Board's issuance, or denial of issuance, of the renewal license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:3351-3361.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 12:767 (November 1986), amended LR 22:1218 (December 1996).

**§2543. Renewal of License**

A. Every license issued by the Board under this Subchapter shall be renewed annually on or before the date of its expiration by submitting to the Board an application or renewal, upon forms supplied by the Board, together with the applicable renewal fee prescribed in Chapter 81 of these Rules and documentation of satisfaction of the continuing professional education requirements prescribed by Subchapter G of these Rules.

B. An application for renewal of license shall be mailed by the Board to each person holding a license issued under this Chapter on or before the first day of November of each year. Such form shall be mailed to the most recent address of each licensed respiratory therapist or licensed respiratory therapy technician as reflected in the official records of the Board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:3351-3361.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 12:767 (November 1986), amended LR 22:1218 (December 1996).

**§2545. Reinstatement of License**

A. A license which has expired without renewal may be reinstated by the Board if application for reinstatement is made not more than two years from the date of expiration and subject to the conditions and procedures hereinafter provided.

B. An application for reinstatement shall be made upon forms supplied by the Board and accompanied by two letters of recommendation from responsible officers of the applicant's last employment as a licensed respiratory therapist or as a licensed respiratory therapy technician, together with the applicable renewal fee, plus a penalty equal to twice the renewal fee.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), R.S. 37:3351-3361.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 12:767 (November 1986), amended LR 22:1218 (December 1996).

#### **Subchapter F. Advisory Committee on Respiratory Care**

##### **2551. Delegation of Authority**

A. Authority is hereby delegated to the Advisory Committee on Respiratory Care to:

1. survey, by site visit or otherwise, each hospital or other institution located in this state which is affiliated with and at which is conducted a nontraditional respiratory care education and training program for the purpose of reporting to the Board as provided by Subsection B hereof;

2. assist the Board in the review of applicant's satisfaction of continuing education requirements for renewal of licensure under this Chapter as provided in Subsection D hereof.

B. The Committee shall annually report to the Board, in writing, on each such nontraditional respiratory care education and training program conducted in this state and, with respect to each such program, advise the Board with respect to:

1. such program's compliance with the provisions of these Rules relating to the conduct of such programs;

2. the number of students enrolled and participating in such program during the preceding year;

3. the number of graduates of such program having taken the National Board of Respiratory Care entry-level examination and the number of such graduates having successfully passed such examination; and

4. any recommendations the Committee may have with respect to the future conduct of such program and regulation of the same by the Board.

C. In discharging the responsibilities provided for by this Section, the Committee shall have authority to:

1. periodically request and obtain necessary and appropriate information from hospitals or other institutions located in this state which are affiliated with and at which are conducted a nontraditional respiratory care education and training programs, from the coordinators of such program, and from students enrolled in such programs; and

2. periodically conduct visits of the hospitals or other institutions at which such programs are conducted in this state.

D. To carry out its duties of Subsection A.2, the Advisory Committee is authorized by the Board to advise and assist the Board in the review and approval of continuing professional education programs and licensee satisfaction of continuing professional education requirements for renewal of licensure,

as prescribed by Subchapter G of these Rules, including the authority and responsibility to:

1. evaluate organizations and entities providing or offering to provide continuing professional education programs for respiratory therapists and respiratory therapy technicians and provide recommendations to the Board with respect to the Board's recognition and approval of such organizations and entities as sponsors of qualifying continuing professional education programs and activities pursuant to §2559 of these Rules; and

2. review documentation of continuing professional education by respiratory therapists and respiratory therapy technicians, verify the accuracy of such documentation, and evaluation of and make recommendations to the Board with respect to whether programs and activities evidenced by applicants for renewal of licensure comply with and satisfy the standards for such programs and activities prescribed by these Rules; and

3. request and obtain from applicants for renewal of licensure such additional information as the Advisory Committee may deem necessary or appropriate to enable it to make the evaluations and provide the recommendations for which the Committee is responsible.

E. In discharging the functions authorized under this Section the Advisory Committee and the individual members thereof shall, when acting within the scope of such authority, be deemed agents of the Board. All information obtained by the Advisory Committee members pursuant to §2551.A.2 and D shall be considered confidential. Advisory Committee members are prohibited from communicating, disclosing or in any way releasing to anyone, other than the Board, any information or documents obtained when acting as agents of the Board without first obtaining written authorization from the Board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3351-3361, R.S. 37:1270(B)(6), R.S. 37:3357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 19:747 (June 1993), amended LR 22:1219 (December 1996).

#### **Subchapter G. Continuing Professional Education**

##### **§2553. Scope of Subchapter**

The Rules of this Subchapter provide standards for the continuing professional education requisite to the annual renewal of licensure as a respiratory therapist or respiratory therapy technician, as required by §2543 and §2555 of these Rules, and prescribe the procedures applicable to satisfaction and documentation of continuing professional education in connection with application for renewal of licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1219 (December 1996).

##### **§2555. Continuing Professional Educational Requirement**

A. Subject to the exceptions specified in §2569 of this Subchapter, to be eligible for renewal of licensure for 1998 and thereafter, a respiratory therapist or respiratory therapy technician shall, within each year during which he holds licensure, evidence and document, upon forms supplied by the

Board, successful completion of not less than 10 hours, or 1.0 continuing education unit (CEU) of continuing education courses sanctioned by the American Association of Respiratory Care, the Respiratory Care Advisory Committee to the Board, or their successors. Not less than six of the required hours shall be related to cardiopulmonary care.

B. One Continuing Education Unit (CEU) constitutes and is equivalent to 10 hours of participation in organized continuing professional education programs approved by the Board and meeting the standards prescribed in this Subchapter. One hour of continuing education credit is equivalent to 50 minutes of instruction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1219 (December 1996).

#### **§2557. Qualifying Continuing Professional Education Programs**

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

1. have significant and substantial intellectual or practical content dealing principally with matters germane and relevant to the practice of respiratory therapy;

2. have pre-established written goals and objectives, with its primary objective being to maintain or increase the participant's competence in the practice of respiratory therapy;

3. be presented by persons whose knowledge and/or professional experience is appropriate and sufficient to the subject matter of the presentation;

4. provide a system or method for verification of attendance or course completion; and

5. be a minimum of 50 continuous minutes in length.

B. Other approved continuing education activities include:

1. earning a grade of "C" or better in a course related to health care in an academic setting, or grade of "pass" in a pass/fail course. One credited semester hour will be deemed to equal 15 contact hours.

2. programs on advanced cardiac life support (ACLS), pediatric advanced life support (PALS) or neonatal advanced life support (NALS), each of which will equal 10 contact hours;

3. successfully completing a recertification examination for the highest credential held by the respiratory therapist or respiratory therapy technician including certified respiratory therapy technician (CRTT), registered respiratory therapist (RRT), certified pulmonary function technologist (CPFT), registered pulmonary function technologist (RPFT), registered cardiovascular technologist (RCVT), and certified cardiovascular technologist (CCVT), with each such recertification examination equal to 10 contact hours;

4. initial certification as a CPFT, RPFT Perinatal/Pediatric Specialist, RCVT or CCVT and each such certification will equal 10 hours;

5. any accredited home study/correspondence program issued by an approved organization as set out in §2559.A. Credit will be issued in the same manner as earning a grade of

C or better in a course related to health care in an academic setting within that one semester hour will equal 15 contact hours;

6. any instructor course taken in preparation for teaching a course.

C. None of the following programs, seminars or activities shall be deemed to qualify as acceptable CPE programs under these Rules:

1. any program not meeting the standards prescribed by Subsection A of this Section;

2. independent study not approved or sponsored by one of the organizations identified as a program sponsor in §2559.A;

3. in-service education provided by a sales representative;

4. teaching, training or supervisory activities not specifically included in Subsection B of this Section;

5. holding office in professional or governmental organizations, agencies or committees;

6. participation in case conferences, informal presentations, or in service activities;

7. giving or authorizing verbal or written presentations, seminars or articles or grant applications; or

8. passing basic cardiac life support (BCLS).

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1220 (December 1996).

#### **§2559. Approval of Program Sponsors**

A. Any program, course, seminar, workshop or other activity meeting the standards prescribed by §2557 shall be deemed approved for purposes of satisfying continuing education requirements under this Subchapter, if sponsored or offered by the American Association for Respiratory Care (AARC), any AARC-chartered affiliate, the Louisiana Hospital Association, the Louisiana Nurses Association, the American Lung Association, the American Heart Association, the American College of Chest Physicians, the American Thoracic Society, the American Nursing Association, the American Society of Cardiovascular Professionals, the American Medical Association, the American College of Cardiology, the Louisiana Association for Home Care, the Louisiana Association of Cardiovascular and Pulmonary Rehabilitation, the Louisiana State Medical Society, any hospital or agency belonging to the Louisiana Hospital Association, any hospital or agency accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO), and Cardiovascular Credentialing International.

B. Upon the recommendation of the Advisory Committee, the Board may designate additional organizations and entities whose programs, courses, seminars, workshops, or other activities shall be deemed approved by the Board for purposes of qualifying as an approved continuing professional education program under §2557.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1220 (December 1996).

### **§2561. Approval of Program**

A. A continuing professional education program or activity sponsored by an organization or entity not deemed approved by the Board pursuant to §2559.A may be pre-approved by the Board as a program qualifying and acceptable for satisfying continuing professional education requirements under the Subchapter upon written request to the Board therefore, upon a form supplied by the Board, providing a complete description of the nature, location, date, content and purpose of such program and such other information as the Board or Advisory Committee may request to establish the compliance of such program with the standards prescribed by §2557. Any such requests for pre-approval respecting a program which makes and collects a charge for attendance shall be accompanied by a nonrefundable processing fee of \$30.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1221 (December 1996).

### **§2563. Documentation Procedure**

A. A form for annual documentation and certification of satisfaction of the continuing professional education requirements prescribed by these Rules shall be mailed by the Board to each respiratory therapist or respiratory therapy technician subject to such requirements with the application for renewal of licensure form mailed by the Board pursuant to §2543 of these Rules. Such form shall be completed and delivered to the Board with the licensee's renewal application.

B. A respiratory therapist or respiratory therapy technician shall maintain a record or certificate of attendance for at least four years from the date of completion of the continuing education program.

C. The Board or Advisory Committee shall randomly select for audit no fewer than three percent of the licensees each year for an audit of continuing education activities. In addition, the Board or Advisory Committee has the right to audit any questionable documentation of activities. Verification shall be submitted within 30 days of the notification of audit. A licensee's failure to notify the Board of a change of mailing address will not absolve the licensee from the audit requirement.

D. Any certification of continuing professional education not presumptively approved by the Board pursuant to these

Rules, or pre-approved by the Board in writing, shall be referred to the Advisory Committee for its evaluation and recommendations pursuant to §2551.D.1. The Board's decision with respect to approval and recognition of any such program or activity shall be final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1221 (December 1996).

### **§2565. Failure to Satisfy Continuing Professional Education Requirements**

A. An applicant for renewal of licensure who fails to evidence satisfaction of the continuing professional education requirements prescribed by these Rules shall be given written notice of such failure by the Board. The license of the applicant shall remain in full force and effect for a period of 90 days following the mailing of such notice, following which it shall be deemed expired, unexpired and subject to revocation without further notice, unless the applicant shall have, within 90 days, furnished the Board satisfactory evidence, by affidavit, that:

1. the applicant has satisfied the applicable continuing professional education requirements;
2. the applicant is exempt from such requirements pursuant to these Rules; or
3. the applicant's failure to satisfy the continuing professional education requirements was occasioned by disability, illness or other good cause as may be determined by the Board.

B. The license of a respiratory therapist or respiratory therapy technician whose license has expired by nonrenewal or has been revoked for failure to satisfy the continuing professional education requirements of these Rules may be reinstated by the Board upon written application to the Board made not more than two years from the date of expiration or revocation, accompanied by payment of a reinstatement fee, in addition to all other applicable fees and costs of \$50, together with documentation and certification that:

1. the applicant has, for each calendar since the date on which the applicant's license lapsed, expired or was revoked, completed eight hours (0.8 CEU) of qualifying continuing professional education, and if the application for reinstatement is made more than one year following the date on which such license lapsed, expired or was revoked, the applicant shall evidence completion of an additional four hours of qualifying continuing professional education since the date on which the applicant's license lapsed, expired or was revoked; or
2. the applicant has, within one year prior to making application of reinstatement taken and successfully passed the Recertification Examination of the National Board for Respiratory Care.

C. Any licensee who falsely certifies attendance and/or completion of the required continuing education requirement will be subject to disciplinary action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1221 (December 1996).



## §2567. Waiver of Requirements

The Board may, in its discretion upon the recommendation of the Advisory Committee, waive all or part of the continuing professional education required by these Rules in favor of a respiratory therapist or respiratory therapy technician who makes written requests for such waiver to the Board and evidences to the satisfaction of the Board a permanent physical disability, illness, financial hardship or other similar extenuating circumstances precluding the individual's satisfaction of continuing professional education requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1222 (December 1996).

## §2569. Exceptions to the Continuing Professional Education Requirements

The continuing professional education requirements prescribed by this Subchapter as requisite to renewal of licensure shall not be applicable to:

1. a respiratory therapist or respiratory therapy technician employed exclusively by, or at an institution operated by, any department or agency of the United States; or

2. a respiratory therapist or respiratory therapy technician who has held an initial Louisiana license on the basis of examination for less than one year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3357(D) and R.S. 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 22:1222 (December 1996).

Delmar Rorison  
Executive Director

9612#022

## RULE

### Department of Health and Hospitals Office of Public Health

#### Sanitary Code—Commercial Seafood Inspection Program (Chapters XXII, XXIII, and XXIII-A)

The Department of Health and Hospitals, Office of Public Health hereby amends Chapters XXII, XXIII, and XXIII-A of the State Sanitary Code. The changes reflect new and emerging technologies that have been developed in an effort to make raw molluscan shellfish consumption safe for certain high risk consumers. Eating establishments and retail markets serving raw shellfish that have undergone an approved treatment process shall be exempt from displaying a consumer information advisory.

New Sections to these Chapters are adopted as follows:

## Chapter XXII

### Retail Food Establishments: Markets

**22:018-4** Exemption. Establishments that exclusively serve raw molluscan shellfish that have been subjected to a process recognized by the State Health Officer as being effective in reducing the bacteria *Vibrio vulnificus* to nondetectable levels may apply for an exemption from the mandatory consumer information notification requirement. Establishments interested in obtaining an exemption shall certify in writing to the State Health Officer, that it shall use exclusively for raw consumption only molluscan shellfish that have been subjected to the approved process. Upon receipt of that communication, the State Health Officer shall confirm the establishment as being exempt from the requirement of displaying the consumer information message. The establishment's certification must be sent to the State Health Officer at the following address: Louisiana Office of Public Health, P. O. Box 60630, New Orleans, Louisiana 70160.

## Chapter XXIII

### Eating and Drinking Establishments

**23:006-6** Exemption. Establishments that exclusively serve raw molluscan shellfish that have been subjected to a process recognized by the State Health Officer as being effective in reducing the bacteria *Vibrio vulnificus* to nondetectable levels may apply for an exemption from the mandatory consumer information notification requirement. Establishments interested in obtaining an exemption shall certify in writing to the state health Office, that it shall use exclusively for raw consumption only molluscan shellfish that have been subjected to the approved process. Upon receipt of that communication, the State Health Officer shall confirm the establishment as being exempt from the requirement of displaying the consumer information message. The establishment's certification must be sent to the State Health Officer at the following address: Louisiana Office of Public Health, P. O. Box 60630, New Orleans, Louisiana 70160.

## Chapter XXIII-A

### Temporary Food Service

**23A:005-6** Exemption. Establishments that exclusively serve raw molluscan shellfish that have been subjected to a process recognized by the State Health Officer as being effective in reducing the bacteria *Vibrio vulnificus* to nondetectable levels may apply for an exemption from the mandatory consumer information notification requirement. Establishments interested in obtaining an exemption shall certify in writing to the State Health Officer, that it shall use exclusively for raw consumption only molluscan shellfish that have been subjected to the approved process. Upon receipt of that communication, the State Health Officer shall confirm the establishment as being exempt from the requirement of displaying the consumer information message. The establishment's certification must be sent to the State Health Officer at the following address: Louisiana Office of Public Health, P. O. Box 60630, New Orleans, Louisiana 70160.

Bobby P. Jindal  
Secretary

9612#049

## RULE

### Department of Health and Hospitals Office of Public Health

#### Sanitary Code—Reportable Diseases (Chapter II)

Under the authority of R.S. 40:5 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Health and Hospitals, Office of Public Health hereby amends Chapter II of the Louisiana Sanitary Code. This revised list of reportable diseases provides for the deletion of some diseases (anthrax, aseptic meningitis, brucellosis, erythema infectiosum [Fifth Disease], foodborne illness, genital warts, granuloma inguinale, herpes genitalis, leprosy, leptospirosis, ophthalmia neonatorum, plague, poliomyelitis, psittacosis, trichinosis, tularemia, typhus, yellow fever); the addition of other diseases (cryptosporidiosis, enterococcus infection resistant to vancomycin, staphylococcus aureus infection resistant to methicillin/oxacillin or vancomycin, streptococcus pneumoniae invasive infection resistant to penicillin, varicella [chickenpox]), and the further clarification of some diseases already on the reportable disease list (Haemophilus influenzae invasive infection, Neisseria meningitidis invasive infection, meningitis, other bacterial or fungal).

This action is necessary as a result of the recognition of new and emerging diseases of public health importance and the need to simplify the list so that medical providers can focus on diseases that are actively tracked epidemiologically and diseases for which there is an active prevention program. Diseases removed from the list are those for which diagnostic criteria are not well defined (such as "foodborne illness"), diseases which may represent chronic or recurrent condition with uncertain onset dates (such as herpes genitalis), and extremely rare communicable diseases in Louisiana (such as plague). Additionally, this last group of diseases will still be reported under the requirement listed above which states "... all cases of rare or exotic communicable diseases and all outbreaks shall be reported."

#### Chapter II

##### The Control of Disease

2:003 The following diseases are hereby declared reportable:

- Acquired Immune Deficiency Syndrome (AIDS)
- Amebiasis
- Arthropod-borne encephalitis (Specify type)
- Blastomycosis
- Botulism\*
- Campylobacteriosis
- Chancroid\*\*
- Chlamydial infection\*\*
- Cholera\*
- Cryptosporidiosis
- Diphtheria
- Enterococcus infection; resistant to vancomycin)
- Escherichia coli 0157:H7
- Gonorrhea\*\*

- Haemophilus influenzae (invasive infection)
- Hemolytic-Uremic Syndrome
- Hepatitis, Acute (A,B,C, Other)
- Human Immunodeficiency Virus (HIV) infection\*\*\*\*
- Legionellosis
- Lyme disease
- Lymphogranuloma venereum\*\*
- Malaria
- Measles (rubeola)\*
- Meningitis, other bacterial or fungal
- Mumps
- Mycobacteriosis, atypical\*\*\*
- Neisseria meningitidis (invasive infection)
- Pertussis
- Rabies (animal and man)
- Rocky Mountain Spotted Fever (RMSF)
- Rubella (congenital syndrome)
- Salmonellosis
- Shigellosis
- Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)
- Streptococcus pneumoniae (invasive infection; resistant to penicillin)
- Syphilis\*\*
- Tetanus
- Tuberculosis\*\*\*
- Typhoid fever
- Varicella (chickenpox)
- Vibrio infections (excluding cholera)

Report cases on green EPI-2430 card unless indicated otherwise below.

\*Report suspected cases immediately by telephone. In addition, report all cases of rare or exotic communicable diseases and all outbreaks.

\*\*Report on STD-43 form. Report syphilis cases with active lesions by telephone.

\*\*\*Report on CDC 72.5 (f5.2431) card

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions followed by asterisks should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, Louisiana 70160, telephone 1-800-256-2748 or FAX (504) 568-3206.

#### Other Reportable Conditions

- Cancer
- Complications of abortion
- Congenital hypothyroidism\*\*\*\*\*
- Galactosemia\*\*\*\*\*
- Hemophilia\*\*\*\*\*
- Lead poisoning
- Phenylketonuria\*\*\*\*\*
- Severe traumatic head injury\*\*\*\*
- Severe traumatic head injury\*\*\*\*
- Severe undernutrition (severe anemia, failure to thrive)
- Sickle cell disease (newborns)\*\*\*\*\*
- Spinal cord injury\*\*\*\*
- Sudden infant death syndrome (SIDS)

Report cases on an EPI-2430 card unless indicated otherwise below:

\*\*\*\*Report on DDP3 form; preliminary telephone report from emergency room encouraged (504) 568-2509.

\*\*\*\*\*Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.

Bobby P. Jindal  
Secretary

9612#050

**RULE**

**Department of Health and Hospitals  
Office of Public Health**

**Sanitary Code—Tattooing (Chapter XXIII)**

In accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Secretary of the Department of Health and Hospitals amends Chapter XXIII of the State Sanitary Code to protect patrons and employees at eating and drinking establishments from possible contamination with bloodborne pathogens by prohibiting the practice of "tattooing" at these establishments.

**Chapter XXIII**

**Eating and Drinking Establishments**

\*\*\*

Add 23:116 Prohibitive Acts:

Change 23:116 to 23:116-1

Add 23:116-2 Tattooing: No employee or any other person shall engage in the practice of "tattooing" within the premises of any food service establishment as defined in this Chapter.

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Bobby P. Jindal  
Secretary

9612#048

**RULE**

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

**Federally Qualified Health Centers  
Reimbursement Methodology**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This 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 limits reimbursement to federally qualified health centers by applying the Medicare payment limit to core services. A core service is defined as a face-to-face encounter with a physician, physician assistant, nurse practitioner, clinical psychologist or clinical social worker.

Bobby P. Jindal  
Secretary

9612#058

**RULE**

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

**Pharmacy Program—Maximum Allowable Overhead Cost**

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

**Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following provisions applicable to the Maximum Overhead Cost under the Pharmacy Program.

**Maximum Allowable Overhead Cost**

1. For state fiscal year 1996-97, the Maximum Allowable Overhead Cost will remain at the level established for state fiscal year 1994-95. This Maximum Allowable Overhead Cost was established by applying the 1993 indices to appropriate cost categories for a one year period.

2. No inflation indices or any interim adjustments will be applied to the Maximum Allowable Overhead Costs for the time period July 1, 1996 through June 30, 1997.

Bobby P. Jindal  
Secretary

9612#059

**RULE**

**Department of Insurance  
Commissioner of Insurance**

**Regulation 60—Advertising of Life Insurance**

**Section 1. Purpose**

The purpose of this regulation is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant

information in the advertising of life insurance policies and annuity contracts.

## Section 2. Authority

This regulation is promulgated by the Department of Insurance under the authority granted by R.S. Title 22, Section 3, and the Administrative Procedure Act, R.S. 49:950 et seq.

## Section 3. Definitions

For the purpose of these Rules:

A. *Advertisement*—shall be material designed to create public interest in life insurance or annuities or in an insurer, or in an insurance producer; or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy including:

(1) printed and published material, audiovisual material, and descriptive literature of an insurer or insurance producer used in direct mail, newspapers, magazines, radio and television scripts, billboards and similar displays;

(2) descriptive literature and sales aids of all kinds, authored by the insurer, its insurance producers, or third parties, issued, distributed or used by such insurer or insurance producer; including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters;

(3) material used for the recruitment, training, and education of an insurer's insurance producers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy;

(4) prepared sales talks, presentations and material for use by insurance producers.

B. *Advertisement*—for the purpose of these Rules shall NOT include:

(1) communications or materials used within an insurer's own organization and not intended for dissemination to the public;

(2) communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy;

(3) a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

C. *Department* or *Department of Insurance*—the Louisiana Department of Insurance.

D. *Insurance Producer*—a person [as defined in R.S. 1212(D)] who solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance for risks residing, located, or intended for issuance in this State.

E. *Insurer*—includes any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an *insurer* in the Louisiana Insurance Code or issues life insurance or annuities in this State and is engaged in the advertisement of a policy.

F. *Policy*—includes any policy, plan, certificate, including a fraternal benefit certificate, contract, agreement, statement

of coverage, rider or endorsement which provides for life insurance or annuity benefits.

G. *Nonguaranteed Policy Elements*—the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

H. *Preneed Funeral Contract or Prearrangement*—an agreement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

## Section 4. Applicability

A. These Rules shall apply to any life insurance or annuity advertisement intended for dissemination in this State.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer, provided the insurer shall not be responsible for advertisements that are published in violation of written procedures or guidelines of the insurer.

## Section 5. Form and Content of Advertisements

A. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive.

Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Department of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

B. No advertisement shall use the terms *investment*, *investment plan*, *founder's plan*, *charter plan*, *deposit*, *expansion plan*, *profit*, *profits*, *profit sharing*, *interest plan*, *savings*, *savings plan*, or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

## Section 6. Disclosure Requirements

A. The information required to be disclosed by these Rules shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

B. No advertisement shall omit material information or use words, phrases, statements, references or illustrations if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

C. In the event an advertisement uses *Non-Medical, No Medical Examination Required*, or similar terms where issue is not guaranteed, such items shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions set forth in the application.

D. An advertisement shall not use as the name or title of a life insurance policy any phrase which does not include the words *life insurance* unless accompanied by other language clearly indicating it is life insurance.

E. An advertisement shall prominently describe the type of policy advertised.

F. An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no insurance producer or commission involved there will be a cost saving to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the Department of Insurance prior to use.

G. An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed. An advertisement of or for a life insurance policy under which the death benefit varies with the length of time the policy has been in force shall accurately describe and clearly call attention to the amount of minimum death benefit under the policy.

H. An advertisement for the types of policies described in F. and G. of this Section shall not use the words *inexpensive, low cost*, or other phrase or words of similar import when such policies are being marketed to persons who are 50 years of age or older, where the policy is guaranteed issue.

#### I. Premiums

(1) An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

(2) An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.

(3) An advertisement shall not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

(4) An advertisement which represents a pure endowment benefit as a *profit* or *return* on the premium paid rather than as a policy benefit for which a specific premium is paid is deemed to be deceptive and misleading and is prohibited.

J. Analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments must be complete and accurate.

K. An advertisement shall not state or imply in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable, or in any manner an incorrect or improper practice.

L. If nonforfeiture values are shown in any advertisement, the values must be shown either for the entire amount of the basic life policy death benefit or for each \$1,000 of initial death benefit.

M. The words *free, no cost, without cost, no additional cost, at no extra cost*, or words of similar import shall not be used with respect to any benefit or service being made available with a policy unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

N. No insurance producer may use terms such as *financial planner, investment advisor, financial consultant, or financial counseling* in such a way as to imply that he or she is generally engaged in an advisory business in which compensation is unrelated to sales unless such actually is the case.

#### O. Nonguaranteed Policy Elements

(1) An advertisement shall not utilize or describe nonguaranteed policy elements in a manner which is misleading or has the capacity or tendency to mislead.

(2) An advertisement shall not state or imply that the payment or amount of nonguaranteed policy elements is guaranteed. If nonguaranteed policy elements are illustrated, they must be based on the insurer's current scale and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

(3) An advertisement that includes any illustrations or statements containing or based upon nonguaranteed elements shall set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.

(4) If an advertisement refers to any nonguaranteed policy element, it shall indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way; such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience, the advertisement may indicate any such limitation on the insurer's right.

(5) An advertisement shall not refer to dividends as *Tax Free* or use words of similar import, unless the tax treatment of dividends is fully explained and the nature of the dividend as a return of premium is indicated clearly.

P. An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

#### Q. Testimonials, Appraisals, Analysis, or Endorsements by Third Parties

(1) Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion

of the author; be applicable to the policy advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective insureds as to the nature or scope of the testimonial, appraisal, analysis or endorsement. In using testimonials, appraisals or analysis; the insurer or insurance producer makes as its own all of the statements contained therein, and such statements are subject to all the provisions of these Rules.

(2) If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, such fact shall be prominently disclosed in the advertisement.

(3) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the insurer, or receives any payment or other consideration from the insurer for making such endorsement or testimonial, such fact shall be disclosed in the advertisement.

R. An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

#### S. Policies Sold to Students

(1) The envelope in which insurance solicitation material is contained may be addressed to the parents of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student unless such is a correct and truthful statement.

(2) All advertisements including but not limited to informational flyers used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities must be clearly identified as such.

(3) The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with university, college, school or other educational or training institution, unless true.

#### T. Introductory, Initial or Special Offers and Enrollment Periods

(1) An advertisement of an individual policy or combination of such policies shall not state or imply that such policy or combination of such policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar

words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

(2) An advertisement shall not state or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(3) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised.

(4) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application which shall be not less than 10 days and not more than 40 days from the date on which such enrollment period is advertised for the first time. This Rule applies to all advertising media, e.g., mail, newspapers, radio, television, magazines and periodicals - by any one insurer or insurance producer. The phrase *Any One Insurer* includes all the affiliated companies of a group of insurance companies under common management or control. This Rule does not apply to the use of an termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his request. It is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specified provisions of the Louisiana Insurance Code for group, blanket or franchise insurance. In cases where an insurance product is marketed on a direct mail basis to prospective insureds by reason of some common relationship with a sponsoring organization, this Rule shall be applied separately to each sponsoring organization.

U. An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group, or quasi-group and as such enjoy special rates, dividends or underwriting privileges, unless such is the fact.

V. An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not disparage other insurers, insurance producers, policies, services or methods of marketing.

W. For individual deferred annuity products or deposit funds, the following shall apply:

(1) Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates shall likewise set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. Such higher interest rates shall not be greater than those currently being credited by the company unless such higher rates have been publicly declared by the company with an effective date for new issues not more than three months subsequent to the date of declaration.

(2) If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it shall also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.

(3) If any contract does not provide a cash surrender benefit prior to commencement of payment of any annuity benefits, any illustrations or statements concerning such contract shall prominently state that cash surrender benefits are not provided.

X. An advertisement of a life insurance product and an annuity as a single policy or life insurance policy with an annuity rider shall include the following disclosure or substantially similar statement at the point of sale before the application is taken; provided, however, if the policy contains an unconditional refund provision of at least 10 days, then the disclosure statement shall be delivered with or prior to the delivery of the policy, or upon the applicant's request, whichever occurs sooner. The disclosure shall include the first five policy years, the tenth and twentieth policy years, at least one age from 60 to 70, and the scheduled commencement of annuity payments:

YEAR	GROSS ANNUAL LIFE %	PREMIUM ANNUITY %	GUARANTEED CASH VALUE OF ANNUITY
1	%	%	\$
2	%	%	\$
3	%	%	\$
4	%	%	\$
5	%	%	\$
10	%	%	\$
20	%	%	\$
etc.	%	%	\$

Information in the disclosure statement shall be based on gross premium. The life and annuity percentages of the total gross premium shall equal 100 percent for each required duration. The guaranteed cash value of the annuity shall be the value at the end of the contract year. A copy of the disclosure statement shall be provided to the applicant.

Y. An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement as defined in Section 3.H above which is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

- (1) the fact that a life insurance policy or annuity contract is involved or being used to fund a prearrangement as defined in Section 3.H of these Rules; and
- (2) the nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery

merchandise or services, the administrator and any other person.

**Section 7. Identity of Insurer**

A. The name of the insurer shall be clearly identified in all advertisements, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. If an application is a part of the advertisement, the name of the insurer shall be shown on the application. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

B. No advertisement shall use any combination of words, symbols or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

**Section 8. Jurisdictional Licensing and Status of Insurer**

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond such limits.

B. An advertisement may state that an insurer or insurance producer is licensed in the state where the advertisement appears, provided it does not exaggerate such fact or suggest or imply that competing insurers or insurance producers may not be so licensed.

C. An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by an governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, such fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

**Section 9. Statements About the Insurer**

An advertisement shall not contain statements, pictures or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

**Section 10. Enforcement Procedures**

A. Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies, hereafter disseminated in this State, with a notation indicating the manner and extent of distribution and the form



number of any policy advertisement. Such file shall be subject to inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on the examination of the insurer, whichever is the longer period of time.

B. If the Department determines that an advertisement has the capacity or tendency to mislead or deceive the public, the Department may require an insurer or insurance producer to submit all or any part of the advertising material for review or approval prior to use.

C. Each insurer subject to the provisions of these Rules shall file with this Department with its Annual Statement a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by or on behalf of the insurer in this State during the preceding statement year, or during the portion of such year when these Rules were in effect, complied or were made to comply in all respects with the provisions of these Rules and the Insurance Laws of this State as implemented and interpreted by these Rules.

#### **Section 11. Conflict With Other Rules**

It is not intended that these Rules conflict with or supersede any rules currently in force or subsequently adopted in this State governing specific aspect of the sale or replacement of life insurance including, but not limited to, rules dealing with life insurance cost comparison indices, deceptive practices in the sale of life insurance, and replacement of life insurance policies. Consequently, no disclosure required under any such rules shall be deemed to be an advertisement within the meaning of these Rules.

#### **Section 12. Severability**

If any Section, term or provision of this Rule shall be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other Section, term or provision of this Rule, and the remaining Sections, terms and provisions shall be and remain in full force and effect.

#### **Section 13. Effective Date**

This regulation shall become effective January 1, 1997 and shall apply to any life insurance or annuity advertisement intended for dissemination in this State on or after the effective date.

James H. "Jim" Brown  
Commissioner

9612#020

### **RULE**

#### **Department of Insurance Commissioner of Insurance**

#### **Repeal of Certain Existing Rules and Regulations**

##### **Section 1. Purpose**

The purpose of this regulation is to repeal an existing Rule and certain existing Regulations of the Department of

Insurance (the "Department") deemed no longer needed by the Department.

##### **Section 2. Authority**

This regulation is promulgated by the Department of Insurance under the authority granted by Louisiana Revised Statutes (La. R.S.) Title 22, Section 3 and the Administrative Procedure Act, R.S. 49:950 et seq.

##### **Section 3. Rule Repealed**

Rule 2—Malpractice Self-Insurance of the Department is hereby repealed in its entirety. This Rule set forth requirements for proof of financial responsibility of self-insured health care providers.

##### **Section 4. Regulations Repealed**

The following regulations of the Department are hereby repealed in their entirety:

##### **Regulation 1 Requirements for Qualification of Domestic Insurers**

This regulation provides a list of documents which must be filed with the Commissioner of Insurance.

##### **Regulation 2 Requirements for Qualification of a Foreign or an Alien Insurer**

This regulation provides a list of information and documents which must be filed with the Commissioner of Insurance. It also provides a list of fees and taxes payable to the Commissioner of Insurance.

##### **Regulation 4 Unauthorized Insurance**

This regulation places limitations on insurance contracts covering residents or property or risks in a reciprocal state unless the insurer was authorized in such reciprocal state.

##### **Regulation 5 Warning Public Regarding Placing Insurance with Unauthorized Insurers**

This regulation points out for consumers the difference between purchasing insurance from authorized versus unauthorized companies.

##### **Regulation 6 Tax on Fire Insurance**

This regulation states that all companies writing fire insurance are statutorily mandated to pay a two percent tax on the premiums written.

##### **Regulation 7 Profit-Sharing Policies**

This regulation bans the use of advertising material or statements or representations by life insurance agents or company representatives which indicate expected earnings to the policyholder and prospects based on unreasonable earnings by the company.

##### **Regulation 8 Profit-Sharing Policies**

This regulation concerns representations made in connection with the sale of life insurance policies providing survivorship benefits, with the amount of such benefits being dependent upon several hypothetical factors, including lapse expectancy. It cautions all insurers to see that their agents emphasize that returns dependent upon lapse ratio constitutes an estimate only and does not represent a fixed or guaranteed return, and it also required these agents to use examples which are based upon credible contingency and reasonable probability in illustrating hypothetical benefits possible under the policy.

##### **Regulation 10 Requiring New Policies Issued by Nonprofit Associations to Conform to Minimum Standards; No New Companies**

This regulation prohibits the formation of new nonprofit funeral service associations. This was done in response to

new legislation, and provides that such companies will be subject to the laws and regulations regarding industrial life insurance companies.

**Regulation 11 Licensing of Agents Prior to Their Soliciting of Insurance Applications**

This regulation warns insurance companies that both the insurer and a nonlicensed person soliciting insurance for the insurer will be held responsible for violation of laws regarding licensing of agents.

**Regulation 12 Sale of Insurance Stock and Certain Investment Company Stock**

This regulation requires companies who desire to engage in the sale of insurance securities, and securities in an investment or holding company which has proposed forming an insurance company, are required to comply with Act Number 83 of 1958 and any rules and regulations promulgated with reference thereto.

**Regulation 13 Legislation Affecting all Domestic Insurance Companies**

This regulation provides the insurance industry with a list of acts passed by the 1958 Legislature which affect the industry.

**Regulation 20 Mandatory Uninsured Motorists' Coverage Unless Insured Rejects**

This regulation supplements Act Number 187 of 1962 requiring uninsured motorists' coverage on all policies delivered on or after October 1, 1962. Additionally, companies are required to submit a statement of intention to comply with the law.

**Regulation 22 Industrial Companies: Funeral Benefit Policies**

This regulation required funeral benefit policies issued after July 29, 1964 to contain a new provision mandated by Act 124 of 1964. This provision mandated, for industrial companies, that the policy contain a stated cash payment of the refund of all premiums if the beneficiary did not use the services as set forth in the funeral policy.

**Regulation 23 Service Companies: Funeral Benefit Policies**

This regulation required funeral benefit policies issued after July 29, 1964 to contain a new provision mandated by Act 125 of 1964. This provision mandated, for service companies, that the policy contain a stated cash payment of the refund of all premiums if the beneficiary did not use the services as set forth in the funeral policy.

**Regulation 26 Credit Life and Credit Health and Accident**

This regulation provided methods for the calculation of reserves for credit insurance.

**Regulation 37 Regulation of HMO Agents**

This regulation defined an HMO agent.

**Regulation 50 Miscellaneous Accreditation Standards**

This regulation implemented changes recommended by the National Association of Insurance Commissioners relating to the Financial Regulation Standards and Accreditation Program.

James H. "Jim" Brown  
Commissioner

9612#019

**RULE**

**Department of Public Safety and Corrections  
Office of State Police**

**Explosive Code (LAC 55:I.Chapter 15)**

The Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, Explosive Control Unit, repeals and repromulgates the Explosive Code, LAC 55:I.1501 et seq. as authorized by R.S. 40:1472.1 et seq. and in accordance with R.S. 49:950 et seq.

The full text of this Rule may be obtained from the Office of the State Register, 1051 North Third Street, Capitol Annex, Room 512, Baton Rouge, LA 70802, telephone (504) 342-5015. Please refer to document number 9612#021 when inquiring about this Rule.

Colonel William "Rut" Whittington  
Superintendent

9612#021

**RULE**

**Department of Revenue and Taxation  
Income Tax Division**

**Remittance of Tax Under Protest;  
Suits to Recover (LAC 61:I.4907)**

Under the authority of R.S. 47:1576 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue and Taxation has adopted LAC 61:I.4907 concerning remittance of tax under protest and the suits to recover.

This regulation deals with the ambiguities not directly addressed by R.S. 47:1576(B) by expressly providing three options for giving notification of amounts of income tax or corporation franchise tax paid under protest and the intent to file suit for recovery.

**Title 61**

**REVENUE AND TAXATION**

**Part I. Taxes Collected and Administered  
by the Secretary of Revenue and Taxation**

**Chapter 49. Tax Collection**

**§4907. Remittance of Tax Under Protest; Suits to Recover**

A. For the purposes of this Section, estimated taxes shall include any amounts paid on account of a tax prior to the due date or extended due date of the return required for such tax. Estimated taxes shall also include overpayments of income tax designated on the prior year's return as an amount of overpayment to be credited to the next year's return. The term shall not include any other credits, including, but not limited to, enterprise zone credits or inventory tax credits.

B. R.S. 47:1576(B) makes specific provisions for income and corporation franchise taxes paid under protest. This regulation addresses the ambiguities not directly addressed by

R.S. 47:1576(B) by expressly providing three options for giving notification of amounts of income tax or corporation franchise tax paid under protest and the intent to file suit for recovery.

1. Under the first option a taxpayer may make payments of estimated income and franchise taxes under protest and at that time give Notice of Intent to file suit for recovery. The amount paid under protest will be placed in an escrow account upon receipt of the notice. This is the method that has generally been required prior to this regulation. It is not the intent of this regulation to change any procedures that existed prior to this regulation if the taxpayer chooses to follow this option.

2. Under the second option a taxpayer may consider, for purposes of this option only, payments of estimated taxes and, in the case of individual income tax, withholding taxes as required deposits that do not become payments of the income or franchise taxes until they are so designated on the income or franchise tax return filed for the taxable period. Under this option the taxpayer must make notification of the amount of tax being paid under protest and the intent to file suit for recovery at the time the return for the taxable period is filed. This notification should be in duplicate, once with the return and again as a separate notification to the Secretary. The amount designated as paid under protest will be placed in an escrow account upon receipt of the notice. This regulation does not extend or modify the time within which the taxpayer must file suit as provided by R.S. 47:1576(B).

3. The third option available to a taxpayer is to use a combination of the first two options. The fact that a taxpayer designates some estimated payments as payments under protest and makes the appropriate notification at the time of the estimated payment under the first option listed above will not preclude use of the second option with regard to additional amounts the taxpayer wishes to pay under protest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:1576.

HISTORICAL NOTE: Promulgated by the Department of Revenue and Taxation, Income Tax Division, LR 22:1230 (December 1996).

Kenneth Comeaux  
Director

9612#023

## RULE

### Department of Social Services Office of Family Support

#### Electronic Benefits Transfer for AFDC and Food Stamps (LAC 67:III.401)

The Department of Social Services, Office of Family Support, has amended the LAC 67:III, Subpart 1, General Administrative Procedures.

In accordance with the standards of approval detailed by the United States Departments of Agriculture and Health and Human Services, and pursuant to R.S. 46:450.1 which authorizes the Agency to devise and pilot an Electronic Benefits Transfer (EBT) issuance system as an alternative to issuing both food stamps and certain cash benefits provided by public entitlement programs, the Office of Family Support has begun the process of implementation.

This Rule authorizes the Agency to conduct or test a model program before statewide expansion. The agency plans to begin a pilot of the system in January 1997. Once piloted and approved, EBT can only begin full implementation with authorization of concurrent resolution of the legislature, by appropriation or by legislative act. EBT will be the method for delivery of benefits replacing checks and food stamp authorization cards.

### Title 67

### SOCIAL SERVICES

#### Part III. Office of Family Support

##### Subpart 1. General Administrative Procedures

#### Chapter 4. Electronics Benefits Issuance System

##### §401. Electronic Benefits Transfer (EBT)

A. The Office of Family Support intends to implement an electronic benefits system which will provide AFDC cash grants and/or Food Stamp Program benefits to eligible individuals and households. OFS will pilot the system in Natchitoches Parish prior to statewide implementation. EBT will be the method of delivery of AFDC and Food Stamp benefits in the pilot area and in each subsequent parish into which the system expands, subject only to such exceptions as shall be necessary for the effective functioning of the programs.

B. The EBT system will expand beyond the pilot parish in the following manner:

1. Phase 1 consists of the parishes of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Sabine, Winn, East and West Baton Rouge, East and West Feliciana, Livingston, St. Helena, and Tangipahoa.

2. Phase 2 includes Orleans (five district offices), West and East Jefferson, Plaquemines, St. Bernard, St. Tammany, Washington, Bienville, Bossier, Caddo, Claiborne, DeSoto, Lincoln, Red River, and Webster parishes.

3. Phase 3 consists of Ascension, Assumption, Iberville, Lafourche, St. Charles, St. James, St. John, St. Mary, Terrebonne, Evangeline, Iberia, Lafayette, Pointe Coupee, St. Landry, St. Martin, Vermilion, Acadia, Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis, Vernon, Caldwell, East and West Carroll, Franklin, Jackson, Madison, Morehouse, Ouachita, Richland, Tensas, and Union parishes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:450.1, 7 CFR 274.12 and 45 CFR 95(F).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 22:1231 (December 1996).

Madlyn B. Bagneris  
Secretary

9612#038

**RULE**

**Department of Social Services  
Office of Family Support**

**Family Independence Project (LAC 67:III.1301)**

The Department of Social Services, Office of Family Support, has amended LAC 67:III.Subpart 2, the Aid to Families with Dependent Children (AFDC) Program.

Pursuant to ACT 998 and 1219 of the 1995 Regular Session of the Louisiana Legislature, the Department will implement the Family Independence Project (FIP) which provides new AFDC policies regarding medical immunization and school attendance requirements, time-limited benefits, and refusal to accept full-time employment.

If the AFDC grant is reduced or terminated for failure to comply with Family Independence Project requirements, Medicaid eligibility shall not be affected.

**Title 67**

**SOCIAL SERVICES**

**Part III. Office of Family Support**

**Subpart 2. Aid to Families with Dependent Children (AFDC)**

**Chapter 13. Special Conditions of Eligibility**

**Subchapter A. Family Independence Project (FIP)**

**§1301. Terms and Conditions**

A. Time Limitations. The Office of Family Support shall deny AFDC cash benefits to families if the parent has received AFDC for at least 24 months during the prior 60-month period. Only months of AFDC receipt after the January 1, 1997 date of implementation count toward the 24-month limit. This provision does not apply in the following situations (in two parent households both parents must meet at least one of these criteria):

1. the parent is incapacitated or disabled;
2. the parent has been actively seeking employment by engaging in job-seeking activities and is unable to find employment;
3. factors relating to job availability are unfavorable;
4. the parent loses his job as a result of factors not related to his job performance; or
5. an extension of benefits of up to one year will enable the adult to complete employment related education or training.

B. Sanctions for Refusal to Accept a Job. Eligibility for AFDC shall be terminated for three months if a parent in the assistance unit declines or refuses the opportunity for full-time employment without good cause. The three month sanction period counts as months of AFDC receipt when applying the 24-month time limit.

C. Immunization. Failure to follow the schedule of immunizations as promulgated by the Louisiana Office of Public Health for any child under 18 years of age, without good cause, shall result in the child's removal from the AFDC grant until the child has received the required immunizations, or in the case of an immunization that requires a series of injections, has begun to receive the injections. No person is required to comply with this provision if that person or their

parent or guardian submits a written statement from a physician stating that the immunization procedure is contraindicated for medical reasons, or if the person or their parent or guardian objects to the procedure on religious grounds.

D. School Attendance. At redetermination a child who has missed 15 days of school without good cause during the previous six-month period shall be placed in a probationary status. The child remains in a probationary status for at least six months. If during the probationary period a child is absent from school for more than three days in a given calendar month without good cause, the child's needs shall be removed from the AFDC grant until documentation that the child's attendance meets the requirements is provided.

E. Assistance is not denied to an incapacitated or disabled individual in an assistance unit/household which is subject to the time limitation provision or sanction for refusal to accept employment. Assistance for the incapacitated or disabled individual continues as long as the family continues to meet all other AFDC eligibility requirements.

F. All individuals determined ineligible under any of these provisions shall retain the same Medicaid eligibility that they would have had in the absence of the project.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:447.3, 46:460, 46:474, 46:477, 46:239, 46:459.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 22:1232 (December 1996).

Madlyn B. Bagneris  
Secretary

9612#041

**RULE**

**Department of Social Services  
Office of Family Support**

**Individual and Family Grant Program  
(LAC 67:III.4702 and 4703)**

The Department of Social Services, Office of Family Support, has amended LAC 67:III, Subpart 10, Individual and Family Grant (IFG) Program.

Pursuant to changes at 44 CFR 206.131, a minimum damage threshold of \$201 has been established. Also, a Group Flood Insurance Policy (GFIP) has been established which will apply to those recipients who are mandated to purchase flood insurance as a condition of receiving an IFG award.

**Title 67**

**SOCIAL SERVICES**

**Part III. Office of Family Support**

**Subpart 10. Individual and Family Grant Program  
Chapter 47. Application, Eligibility, and Furnishing Assistance**

**Subchapter C. Need and Amount of Assistance  
§4702. Flood Insurance**

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D. A Group Flood Insurance Policy (GFIP), a policy covering all individuals named by a state as recipients of an

IFG Program award for flood damage, has been established. The criteria for determining who is required to purchase flood insurance has not changed.

1. The amount of coverage provided by the GFIP will be equivalent to the IFG maximum grant and will cover both homeowners and renters.

2. The amount of coverage is adjusted annually according to the Consumer Price Index.

3. Implementation of the GFIP will be at the time of the disaster declaration and coverage will begin 60 days from the date of the disaster declaration.

4. Term of coverage will be 36 months from the inception date of the GFIP.

5. Coverage for IFG recipients will begin on the 30th day after the National Flood Insurance Program (NFIP) receives the premium payment from the state.

6. Premium is set at \$200 for each individual or family, but may be adjusted thereafter to reflect NFIP loss experience and any adjustment of benefits under the IFG Program.

7. Premium sent to the NFIP on behalf of the recipient is considered as part of the grant.

8. Homeowners must maintain flood insurance coverage on the residence at the flood-damaged property address for as long as the structure exists, even if ownership of the property changes.

9. Renters must maintain flood insurance coverage on the contents for as long as the renter resides at the flood-damaged property address.

**AUTHORITY NOTE:** Promulgated in accordance with 44 CFR 206.131 and P.L. 93-288.

**HISTORICAL NOTE:** Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR 15:444 (June 1989), LR 15:744 (September 1989), amended by the Office of Family Support, LR 17:474 (May 1991), LR 17:766 (August 1991), LR 17:888 (September 1991), LR 18:939 (September 1992), LR 18:1351 (December 1992), LR 19:167 (February 1993), LR 19:213 (February 1993), LR 19:606 (May 1993), LR 19:784 (June 1993), LR 20:449 (April 1994), LR 21:402 (April 1995), LR 22:1232 (December 1996).

#### **§4703. Minimum Damage Threshold**

A minimum damage threshold of \$201 or more in real or personal property losses, resulting from any type of incident, must be met in order to be eligible for an IFG Program grant.

**AUTHORITY NOTE:** Promulgated in accordance with 44 CFR 206.131.

**HISTORICAL NOTE:** Promulgated by the Department of Social Services, Office of Family Support, LR 22:1233 (December 1996).

Madlyn B. Bagneris  
Secretary

9612#039

### **RULE**

#### **Department of Social Services Office of Family Support**

#### **Minor Parents (LAC 67:III.1137 and 1138)**

The Department of Social Services, Office of Family Support, has amended LAC 67:III.Subpart 2, the Aid to Families with Dependent Children (AFDC) Program.

Pursuant to 45 CFR 233.107 of the Public Welfare Code of Federal Regulations, the Department will impose certain restrictions in payment to households headed by a minor unmarried parent in order to encourage these minor parents to remain under the supervision of responsible adults.

LAC 67:III.1137 (Minor Parents) is being updated to reflect existing changes in the age of a minor child to age 18 and to remove the phrase "or legal guardians".

### **Title 67**

### **SOCIAL SERVICES**

#### **Part III. Office of Family Support**

#### **Subpart 2. Aid to Families with Dependent**

#### **Children (AFDC)**

#### **Chapter 11. Application, Eligibility and Furnishing Assistance**

#### **Subchapter B. Coverage and Conditions of Eligibility §1137. Minor Parents**

Effective January 1, 1987, AFDC will not be denied to an otherwise eligible child solely because he is legally married or emancipated so long as his parent is responsible for his care and control. If a minor parent up to age 18, even if legally married or emancipated, lives with his/her parent(s), income must be deemed from the minor parent's parents.

**AUTHORITY NOTE:** Promulgated in accordance with 45 CFR 233.20(a)(3)(xviii).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 12:678 (October 1986), amended by the Department of Social Services, Office of Family Support, LR 22:1233 (December 1996).

#### **§1138. Restriction in Payment to Households Headed by a Minor Unmarried Parent**

Eligibility for assistance for minor unmarried parents shall require that the individual and dependent child reside in the residence of the individual's parent, legal guardian, other relative, or in a foster home, maternity home or other adult-supervised supportive living arrangement, and that where possible, aid shall be provided to the parent, legal guardian or other adult relative on behalf of the individual and dependent. The following exceptions apply:

1. the minor parent has no parent or guardian (of his or her own) who is living and whose whereabouts are known;
2. no living parent or legal guardian allows the minor parent to live in his/her home;
3. the minor parent lived apart from his/her own parent or legal guardian for a period of at least one year before the birth of the dependent child or the parent's having made application for AFDC;
4. the physical or emotional health or safety of the minor parent or dependent child would be jeopardized if he/she resided in the same household with the parent or legal guardian;
5. there is otherwise good cause for the minor parent and dependent child to receive assistance while living apart from the minor parent's parent, legal guardian or other adult relative, or an adult-supervised supportive living arrangement.

**AUTHORITY NOTE:** Promulgated in accordance with 45CFR §233.107.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 22:1233 (December 1996).

Madlyn B. Bagneris  
Secretary

9612#042

## RULE

### Department of Social Services Office of Family Support

Parenting Skills Education (LAC 67:III.1136 and 1509)

The Department of Social Services, Office of Family Support, has amended LAC 67:III.Subpart 2, the Aid to Families with Dependent Children (AFDC) Program.

Pursuant to 45CFR 233.10 (a)(1)(ii)(B) of the Public Welfare Code of Federal Regulations and to further encourage responsible parenting in the AFDC population, the Agency proposes to require that parents under the age of 20 attend a parenting skills training program as a condition of eligibility.

Because the Parenting Skills Program as initially implemented is no longer voluntary, §1509 is being repealed.

#### Title 67

### SOCIAL SERVICES

#### Part III. Office of Family Support

#### Subpart 2. Aid to Families with Dependent Children (AFDC)

#### Chapter 11. Application, Eligibility, and Furnishing Assistance

#### Subchapter B. Coverage and Conditions of Eligibility §1136. Parenting Skills Education

As a condition of eligibility for AFDC benefits any parent under age 20 must attend a parenting skills education program provided by the Office of Family Support or provide proof of attendance of this type of training provided by another recognized agency or source. Failure to meet this requirement without good cause shall result in ineligibility for inclusion in the assistance unit. Ineligibility will continue until compliance is demonstrated. Individuals deemed ineligible under this provision will retain the same Medicaid eligibility that they would have had in the absence of this requirement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:920.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 19:351 (March 1993), amended LR 22:1234 (December 1996).

#### Chapter 15. General Program Administration

#### Subchapter D. Parenting Skills Program

#### §1509. Availability

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:290.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 19:351 (March 1993), repealed LR 22:1234 (December 1996).

Madlyn B. Bagneris  
Secretary

9612#040

## RULE

### Department of Transportation and Development Office of Public Works

Dam Safety Program (LAC 70:XIII.2101)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and R.S. 38:24, the Department of Transportation and Development adopts a Rule entitled "Louisiana Dam Safety Program."

#### Title 70

### Transportation

#### Part XIII. Public Works

#### Chapter 21. Dam Safety Program

#### §2101. Dam Safety

A. Introduction. The Public Works and Flood Control Directorate of the Department of Transportation and Development (DOTD) serves as the Water Resources agency for the State of Louisiana, providing engineering and technical support for the orderly planning and development of programs and projects related to flood control, drainage, irrigation, water diversions, reservoirs, navigation, port development, hurricane protection, coastal engineering, and management and development of water resources.

L.R.S. 38:21-28 legislation provides for a Dam Safety and Regulatory Program. The Public Works and Flood Control Directorate is charged with the responsibility for administering the program. The program is operated by the DOTD's Water Resources Design and Development Section, with administrative and enforcement authority vested in the Director of the Public Works and Flood Control Directorate.

B. Purpose. The purpose of L.R.S. 38:21-28 is to recognize the inherent dangers posed by impoundments of significant volumes of water, and to require that owners of structures which impound water (or other liquids) assume the responsibility for that danger by ensuring that such structures are designed, constructed, and maintained so as to minimize the risk to life and property. Regardless of the circumstances of failure, the owner is ultimately responsible for loss of life and property damages that may occur from the failure of his dam. The Department of Transportation and Development, Public Works and Flood Control Directorate, is charged with the responsibility for developing and enforcing a regulatory program to ensure that public safety and welfare is not compromised by the presence of dams or other impoundment facilities. The Louisiana Dam Safety Program defines the minimum standards for the design, construction, operation, and maintenance of dams in the state of Louisiana, and the DOTD has the responsibility and the authority to enforce the standards of the program. This Rule documents the minimum standards for design, construction, operation and maintenance of dams and impoundment structures and the policies for the enforcement of those standards.

#### C. Glossary

*Abutments*—those portions of the valley sides which underlie and support the dam structure, and are usually also considered to include the valley sides immediately upstream and downstream from the dam.

*Auxiliary or Emergency Spillway*—a secondary spillway designed to operate only during unusually large storm events. Louisiana's Dam Safety Program defines "unusually large storm events" as being equal to the 100 year storm event or larger.

*Baffle Blocks*—blocks constructed in a stilling basin to dissipate the energy of fast flowing water.

*Berm*—a horizontal step in a sloping profile. The berm is usually constructed with a slight slope for drainage purposes. The berm is often referred to as a seepage or stability berm.

*Blanket Drain*—a horizontal pervious zone located downstream of the impervious core. This zone is often referred to as a sand blanket.

*Breach*—an eroded opening through a dam that drains the reservoir. A controlled breach is an intentionally constructed opening. An uncontrolled breach is an unintentional opening that allows uncontrolled discharge from the reservoir.

*Chimney Drain*—a vertical pervious zone located just downstream of the impervious core. The chimney drain is usually constructed with a sand material.

*Cofferdam*—a temporary structure enclosing all or part of the construction area so that the construction can proceed in the dry.

*Conduit*—a closed channel to convey discharges through or under a dam. The conduit can be a reinforced concrete pipe, a corrugated metal pipe or a single or multi-barrel reinforced concrete box culvert.

*Crest Length of Dam*—the length of the top of dam. This length includes the spillway(s) and other appurtenant structures. The crest length of dam is basically the length from where the top of dam terminates on one abutment to a similar point on the other abutment.

*Cutoff Trench*—an impervious barrier built into the foundation to reduce seepage under the dam. A cutoff wall or slurry wall could be used as a seepage barrier. The slurry wall is relatively thinner in the horizontal direction when compared to a clay core cutoff trench.

*Dam*—any artificial barrier, including appurtenant works, which does or will impound or divert water or any other liquid substance.

*Downstream Slope*—the inclined surface of an embankment dam that faces away from the reservoir.

*Drawdown Structure*—a low-level outlet which can be used to lower the reservoir below normal pool stage. This may be necessary for lake management purposes, routine repairs or dam safety purposes.

*Earthfill Dam*—a dam constructed predominantly of fine-grained material. Earthfill dams are also known as rolled fill dams where material is placed in layers and compacted by using rollers or rolling equipment.

*End Sill*—the area at the upstream and downstream end of the stilling basin base slab.

*Foundation of Dam*—the natural material on which the dam is placed.

*Heel of Dam*—the junction of the upstream slope with the foundation. The heel of the dam is often referred to as the upstream toe.

*Impervious Core*—a zone of low permeability material. This zone is the water or seepage barrier and is often referred to as the clay core.

*Intake Structure*—the structure placed at the beginning of an outlet works waterway. The intake structure establishes the ultimate drawdown level of the reservoir by the position of its opening(s) to the outlet works. Intake structures may be vertical or inclined towers (drop inlets).

*Maximum Cross Section of Dam*—cross section of a dam at the point where the height of the dam is at its maximum.

*Maximum Storage Capacity*—the capacity at maximum storage is the volume in the reservoir in acre-feet when the level in the reservoir is at top of dam elevation.

*Non-overflow Wall*—a wall which is usually constructed parallel to the spillway crest at an elevation equal to the top of dam elevation. This wall is not designed to be overtopped and are often referred to as a closed dam section.

*Normal Pool Stage*—the water level at the dam to which water may rise under normal operating conditions and for uncontrolled spillways is defined as the lowest crest elevation of the principal spillway. This does not include flood surcharge.

*Outlet Gate*—a gate on the drawdown structure or spillway which is used to control the outflow of water.

*Piping*—the progressive internal erosion of an embankment, foundation, or abutment material. The erosion (piping) begins on the downstream side and progresses upstream.

*Primary or Principal Spillway*—the first used spillway during flood flows.

*Probable Maximum Flood (PMF)*—the flood that may be expected from the most severe combination of critical meteorologic conditions that are possible in the region.

*Retaining/Training Walls*—walls which are usually constructed perpendicular to the spillway crest. Retaining walls are walls which support an overturning load. Training walls are walls which confine or guide the flow of water. In many instances, these walls serve both purposes and can be referred to as either a retaining or training wall.

*Riprap*—a layer of large uncoursed stones, broken rock or precast blocks placed in a random fashion on the upstream slope of the dam and stilling basin outlets. Riprap is a flexible type of slope protection which will deform if material is displaced from beneath.

*Riser*—a type of drop inlet spillway with a vertical section of metal or concrete pipe that allows the reservoir to rise to a predetermined level before water flows into the pipe.

*Slope Protection*—protection against wave action or erosion. The two most common types of slope protection, are riprap and soil cement.

*Sluice*—a low-level opening for releasing water from a dam.

*Soil Cement*—a well compacted mixture of soil, portland cement and water that produces a hard pavement. Soil cement is usually placed in horizontal layers. Soil cement is a rigid type of slope protection which attempts to span voids.

*Spillway Crest*—the overflow section or top of weir section of the spillway.



**Stilling Basin**—a basin constructed to dissipate the energy of fast flowing water. The stilling basin area is located just downstream of the spillway crest between the training/retaining walls.

**Structural Height**—the distance between the lowest point in the excavated foundation and the top of the dam.

**Surcharge/Flood Surcharge**—the volume or space between normal pool and the maximum design water level.

**Tailwater**—the level of water immediately downstream of the dam.

**Toe of Dam**—the junction of the downstream slope with the foundation. The toe of the dam is often referred to as the downstream toe.

**Top of Dam/Crown**—the uppermost surface of the dam. The top of dam can also be referred to as the crest of the dam. When the term "crest" is used, it must be specified that it is the "crest of the dam" and not the "crest of the spillway."

**Uncontrolled or Ungated Spillways**—spillways where the flows over the spillway crest are controlled only by the elevation of the spillway crest. This type of spillway is often referred to as a fixed crest spillway. **Normal Pool Stage** for uncontrolled spillways is defined as the lowest crest elevation of the principal spillway.

**Upstream Slope**—the inclined surface of an embankment dam that is in contact with the reservoir.

#### D. Applicability

1. The regulations of this program will govern the construction, enlargement, alteration or repair, maintenance and operation of all dams as defined by L.R.S. 38:21-28. The terms "dam" and "impoundment structure" are used interchangeably and shall mean the embankment, spillway(s), outlet works and other attendant parts. Included are all artificial barriers together with all appurtenant works which impound or divert water or any other liquid and which are:

a. twenty-five feet or more in height and have an impounding capacity at maximum storage greater than 15 acre-feet, (See Appendix 1) or;

b. have an impounding capacity at maximum storage of 50 acre-feet or more and are greater than 6 feet in height (See Appendix 1).

2. All barriers which are 6 feet or more in height with maximum storage capacities of 15 acre-feet or more must be submitted to the DOTD for review (See Appendix 2). The height of a dam is measured from the natural bed of the stream or watercourse at the downstream toe of the barrier, or if it is not across a stream or watercourse, the height from the lowest elevation of the outside limit of the barrier, to the top of the dam.

#### E. Permitting

1. Application for Permit. Written approval for construction from the DOTD will be required prior to constructing any new impoundment structure or commencing any structural modifications to existing impoundment structures. Permit forms may be obtained from the Director, Public Works and Flood Control Directorate, Louisiana Department of Transportation and Development, P.O. Box 94245, Baton Rouge, Louisiana, 70804-9245. The permitting process is intended to ensure that new structures and modifications to existing structures are designed and

constructed in accordance with the requirements documented herein. (See Appendix 3, Procedural Sequence)

2. National Resources Conservation Service (NRCS), formally called Soil Conservation Service (SCS). The approval process may be abbreviated if dams meet the requirements of "Pond Standard 378" of the National Resources Conservation Service *National Handbook for Conservation Practices* and the National Resources Conservation Service's engineering staff provides the design, layout, and construction inspection. In this case, the National Resources Conservation Service will certify that the dam design and construction meets the requirements of "Pond Standard 378" and they will provide the DOTD with the Pond Data Sheet, a map showing the location of the pond, and a letter signed by the owner of the dam (See Appendix 4). The National Resources Conservation Service will agree to periodically inspect the structure to ensure that "Pond Standard 378" is being maintained, and to inform the DOTD if the structure ever falls below "Pond Standard 378."

3. Public Hearings. After an application has been filed and accepted, the public in the affected locale will be notified by publication in the local news publication. The Director of Public Works and Flood Control will prepare a notice, assigning a date and place for a public hearing of the application. The notice will contain information describing the application and the name and address of the applicant (See Appendix 5). It will be the applicant's responsibility to have the notice published once a week for two consecutive weeks in the official journal of the parish in which the project will be constructed, and shall provide notarized proof of publication on or before the hearing date. The applicant will bear the cost of the publication. The DOTD will conduct the public hearing, and the applicant will be required to attend to describe the nature and purpose of the proposed project and to answer questions.

4. Issuance of a Permit. An "Impoundment Permit/Certificate of Completion" shall be issued for all dams, both existing and new construction. The "Impoundment Permit/Certificate of Completion" is not transferable. The owner of a dam must notify the DOTD 30 days prior to transferring ownership of the dam, and must return the "Impoundment Permit/Certificate of Completion" to the DOTD.

5. Failure to Obtain Approval. If, prior to beginning construction, the owner fails to obtain approval, the owner will be cited and fined under the statutory authority of L.R.S. 38:28. Also, the lake may be ordered to be drained until all approvals have been obtained.

#### F. Submittals

1. All designs for work to be permitted under the program will be submitted for review and approval with all necessary supportive documentation (See Appendix 6). Normally it is expected that an owner or prospective owner will establish contact with the DOTD to apply for a permit to construct or modify a dam. An example of a letter notifying the DOTD of intent to construct or modify a dam is provided (See Appendix 7). In some cases, however, structures are built and water is impounded without the knowledge or approval of the DOTD. When such structures are discovered,

the owners will be contacted by the DOTD and required to furnish documentation that their structure meets the safety requirements of the program. In either case, the applicant shall be guided by the Water Resources Design and Development Section throughout the review and approval process. The documentation required shall be formal engineering designs and calculations, supported by sufficient field information, and certified by a professional civil engineer registered to practice in Louisiana. Because each step in the design of a dam is dependant upon the quality of the design judgments made in the previous steps, the applicant is advised to coordinate each of the design stages identified in the next Section with the DOTD review team prior to proceeding to the next step.

2. After general designs have been approved, the applicant may proceed with plans and specifications, which will also require approval before construction can begin. Plans and specifications will be of professional engineering detail and quality and will include all information and directions necessary to construct the dam in accordance with the design intent.

**G. Design**

1. The proper design of a dam involves a complex combination of engineering applications. It is not within the scope or intent of this document, nor will it be the practice of the staff of the DOTD, to instruct in the detailed procedures for the design of a dam. All dams and impoundment structures to be permitted under this program will be designed by a professional civil engineer(s), registered by the Louisiana State Board of Registration for Professional Engineers and Land Surveyors. The registered civil engineer will certify the designs and plans by professional seal. Designs must conform to nationally recognized standards, further explained in the following Paragraphs and in the Appendices. The completed design package will state the intended design life of the structure, and will include the operations and maintenance procedures necessary to ensure that the structure will function as designed for its stated design life.

2. Failure of an impoundment structure and the instantaneous release of large volumes of water is referred to as a dam breach. It is the primary risk associated with dams, and is the fundamental reason for the state to assume regulatory authority over dams through the Louisiana Dam Safety Program. Breaching may occur during fair weather due to the cumulative effects of erosion or seepage, or it may occur as a result of stresses caused by excess water produced during a storm event. The hydraulic and hydrologic (H and H) design will determine which of the two scenarios poses the greater hazard, the volume of water which is likely to be released, and the rate of flow.

3. It is the H and H design which determines the volumes and flow rates with which the impoundment structure(s) must contend. The geotechnical and structural designs must ensure that the impoundment structure(s) can safely accommodate the hydraulic forces imposed by the conditions predicted by the H and H design. Following are the sequential steps which are necessary in any dam/impoundment structure design, and each step must be

documented with design calculations and all supporting data, certified by a Registered Professional Civil Engineer:

- a. Hydrology and Hydraulics (H and H) Design
  - i. Impact (Hazard) Classification.
  - ii. Determination of controlling design condition and associated storm runoff.

- iii. Setting of spillway and stilling basin widths and elevations, top of embankment elevation, and normal pool stage.

- b. Structural and geotechnical design of embankment, spillways, and drawdown structures.

- c. Development and documentation of operations and maintenance procedures.

NOTE: For the purpose of the Dam Safety Program, the "Emergency Spillway" shall be defined as being overtopped by the 100-year storm or greater and the "Principal Spillway" shall be defined as being overtopped by a storm less than the 100-year storm.

**4. Hydrology and Hydraulics (H and H) Design**

a. Before the structural design of the dam can begin, the requirements of hydraulic capacity must be determined. The height of the dam, the amount of freeboard above normal pool elevation, the size and capacity of the principle and emergency spillways, must all be designed to balance the hydrological and hydraulic properties of the location of the reservoir. A properly designed drawdown structure, capable of reducing the stage of the reservoir at a suitable rate in the event of emergency, must also be designed to meet the capacity requirements of the site.

b. H and H design begins with the Impact Classification (also referred to as Hazard Classification in some texts) of the dam. The Impact Classification is determined by an evaluation of the probable maximum impacts of a dam breach. Low impact structures are those for which, because of size and/or location, little or no significant damage to life or property is likely to result from a failure of the structure. Significant impact structures are those which could cause appreciable damage to property or could pose possible threat to human life in the event of failure. High impact structures are those for which failure would cause excessive property damage or make loss of human life likely.

Note: The inflow design flood (IDF) is determined by the various Hydrograph Methods after the precipitation amount is developed. The major source of precipitation data is the National Weather Service (NWS). The DOTD has final authority for approval of the method to be utilized to determine the IDF.

TABLE I IMPACT CLASSIFICATION AND INFLOW DESIGN FLOOD			
IMPACT CATEGORY	POTENTIAL LOSS OF LIFE	POTENTIAL ECONOMIC LOSS	MINIMUM INFLOW DESIGN (IDF)
LOW	NOT LIKELY	MINIMAL	50-Yr. Freq.
SIGNIFICANT	POSSIBLE	APPRECIABLE	100-Yr. Freq.
HIGH	LIKELY	EXCESSIVE	1/2 PMF

c. Further guidance in assessing the potential hazards and associated impact classification for dams may be found in the publication referred to in Subsection N. It is the responsibility of the owner/applicant to establish impact

classification, and all dams will be considered to be of High Impact potential until demonstrated to be otherwise by a documented analysis provided by the applicant. The proposed impact classification must be supported by sufficient analysis and documentation, and the DOTD will have final authority for assigning Impact Classification.

d. Having established the Impact Classification for the structure, the next step is to establish the magnitude of the meteorological event on which the entire design is to be based. Dams must be designed to be able to safely withstand the passage of a flood of design magnitude. The Inflow Design Flood (IDF) is the largest storm event to be considered in the design of the structure, and the magnitude of the storm event for which the IDF is computed is related to the Impact Classification. The values shown for IDF in Table I are minimums, and the storm event to be used as the IDF will be determined by a site specific analysis. For low impact structures, the primary consideration is the protection against loss of the dam and its benefits in the event of failure, while for significant and high impact structures, adequate protection of life and property must be assured.

e. For dams classified as high impact, the IDF is defined as the flood event above which a breach of the dam does not increase hazard to downstream interests. The upper limit of the IDF for high impact structures is the Probable Maximum Flood (PMF), which is the flood which may be expected from the most severe combination of critical meteorological and hydrological conditions which are reasonably possible. While the PMF is the upper limit for the IDF, the IDF for high impact dams may be an event of smaller magnitude, depending upon an incremental hazard assessment. The incremental assessment is a routing of floods of increasingly larger magnitude through the structure and downstream channel reaches, comparing conditions with and without a dam failure, until a flood magnitude is reached for which the dam failure condition does not appreciably increase the hazard potential.

f. Dams classified as having significant impacts may or may not require a formal incremental hazard evaluation, depending upon the extent of existing and potential downstream development, the size of the reservoir, and the type and use of the dam. The upper limit of the IDF for significant impact structures is the PMF.

g. For dams with low impact classification, the incremental hazard evaluation is not required, and the IDF can be based upon factors related to loss of service of the dam, potential maintenance costs, etc., but with the 50-year frequency storm being the minimum design event.

h. The Water Resources Design and Development Section should be a partner in establishing the IDF, and designs should not proceed until agreement has been reached between the DOTD and the owner's engineer on the choice of the IDF. Establishing the IDF is the foundation for the entire design process, since the dam must be designed to safely pass and/or contain the IDF. A guideline for performing the incremental hazard evaluation necessary to establish the IDF is provided in the publication referred to in Subsection N.

i. How the IDF is to be safely passed by the dam structure and the stability of the dam against the long-term

effects of hydrostatic forces is the subject of the balance of the design effort, including the general configuration of the dam; length, elevation, and composition of principal and emergency spillways; storage capacity above normal pool elevation; erosion protection; and stability design. The most practical way of assuring the integrity of the dam during an IDF is to provide a concrete spillway which is capable of carrying the peak flow of the storm. Principal spillways are normally sized to carry flows from all but the largest of storms, with emergency spillways, which are not normally armored, functioning only during major storm events. If the peak flow from the IDF can be contained within the principal and emergency spillways, the stability of the dam is not likely to be threatened by the erosive action of water flowing over the embankment. The designer may wish to balance the relative economy of providing spillway capacity versus storage capacity above normal pool stage. But, if design calculations indicate that the embankment will be overtopped by the IDF, provisions must be included in the design to prevent the embankment from failing under the erosive forces of the overtopping flows.

5. Geotechnical Design

a. It is essential to the stability of the structure that the material used in the impoundment structure, as well as the foundation and adjoining earth have the necessary structural properties to withstand the hydrostatic forces required by the design, that potential for destructive seepage is identified and appropriately dealt with, and that the surfaces of the structure are adequately protected from surface erosion.

b. Field investigations shall be adequate to define the soils and ground water conditions with respect to stability and seepage control. Stability analysis should consider after-construction conditions, based on the undrained shear strength parameters determined by laboratory tests. Long-term steady seepage, partial pool, and rapid drawdown analyses should also be performed, using shear properties appropriate to the subject materials and minimum safety factors shown in the following Table:

TABLE II FACTOR OF SAFETY FOR STABILITY ANALYSIS	
ANALYSIS CONDITION	FACTOR OF SAFETY
Rapid Drawdown	1.25
Partial Pool	1.40
Steady Seepage	1.40
After Construction	1.30
Earthquake	1.15

6. Structural Design. Structural Designs are to be prepared in accordance with generally accepted structural engineering practices such as those of the American Concrete Institute, the American Institute of Steel Construction and the American Institute of Timber Construction. Components of the spillway or other appurtenant structures shall be designed

to resist the most critical loading combination of dead loads plus live loads that may occur during its construction or design life. Some of the loads which must be considered in the design are: buoyancy forces, sliding forces, hydrostatic uplift forces, bearing forces, overturning forces, water drag forces, wing drag forces, gate-lifting and closing forces, soil and water pressure forces, impact forces, uniform and point live load forces, etc. The minimum factors of safety for buoyancy and sliding shall be 1.5 and 2.0, respectively. The overturning analysis must indicate that the resultant force falls within the center 1/3 of the base. The minimum factor of safety for pile design shall be 2.0.

#### H. Construction

1. It will be the owner's responsibility to ensure by the presence of professional construction supervision personnel that the structure is built in strict compliance with the approved designs and specifications. Adequate records shall be maintained to document that all materials and construction procedures meet or exceed those specified. The owner shall report on the construction to the DOTD. The work of construction, enlargement, alteration, repair or removal of a dam or reservoir for which approved application, designs, plans and specifications are required shall be under the responsible charge of a registered civil engineer. Upon completion of the work and prior to the impoundment of water, the engineer shall certify that all work has been done in compliance with the approved plans and specifications (See Appendix 8).

2. During construction, periodic inspections may be made by representatives of the DOTD. The owner will be required to provide such works or tests as may be needed to disclose sufficient information to enable the DOTD to determine that conformity with approved plans and specifications is being maintained. Inspections made by the DOTD are "limited inspections" and do not relieve the owner or the owner's engineer from their responsibilities for conformance to accepted designs and procedures.

#### I. Maintenance and Operations

1. Once in service, the integrity of the impoundment structure must be sustained by regular maintenance, in accordance with the approved Operations and Maintenance document provided by the designer. The Operations and Maintenance Manual should contain forms and schedules for records and documentation of inspections, maintenance procedures, and repairs. The owner will be responsible for certifying, through properly documented records, to the DOTD that the required periodic inspections have been made, for correcting any deficiencies revealed during such inspections, and for maintaining records of all operations and maintenance activities, as well as of original construction and any subsequent modifications.

2. An Emergency Preparedness Plan is required for all dams and reservoirs. The plan shall comply with the guidelines of the current issue of Louisiana's *Emergency Action Plan Guidelines*, available from the DOTD's Director of Public Works and Flood Control. The Emergency Preparedness Plan will be a condition of the permit for the project, and it will be the owner's responsibility to implement the provisions of the plan in the event of emergency.

#### J. Inspections

1. The DOTD will periodically inspect every dam in the jurisdiction of the program. The purpose of the DOTD inspections is to ascertain whether the structure is being properly maintained in accordance with the approved Operations and Maintenance procedures. The DOTD inspections are "limited inspections" and do not relieve the owner of responsibility to perform and document periodic inspections. If an inspection by the DOTD reveals that a dam is unsafe or in danger of becoming unsafe, the DOTD, through the Director of Public Works and Flood Control, shall direct the owner to take whatever action is necessary to restore the dam to its design condition.

2. The owner has the primary responsibility for insuring the safe condition of the structure by regular maintenance and periodic inspection. The owner is required to immediately inform the Director of Public Works and Flood Control of any unusual circumstances or occurrences which may affect the condition or safety of the reservoir. Also, the Director will be notified prior to any planned draw downs of the reservoir.

K. Enforcement. If any dam or impoundment structure is determined to be unsafe, the Director of Public Works and Flood Control, pursuant to L.R.S. 38:21-28, shall direct any such repairs or remediations for a dam or impoundment structure as he deems necessary to insure that life and property are not unduly threatened by the impoundment. such remedial action may include:

1. direction that the water level behind the structure be lowered to a safe level; or

2. that the impoundment be completely drained until all necessary corrections to the structure have been made.

#### L. Existing Structures

1. All dams constructed or under construction prior to promulgation of these Rules will be reviewed to assess their disposition under the program regulations. Each dam is unique and must be judged on the basis of its own particular set of circumstances. Based on the circumstances of each individual case, a judgment will be made of what modifications or repairs are necessary to meet program standards. It is the intent of the program to eventually have every dam upgraded to meet program standards. The DOTD will be the sole judge of whether an existing deficiency creates an unacceptable risk to the general public. While it is not the intent of this program to lower the standards for existing dams, the DOTD recognizes that it is not practical to require all dam owners to immediately retrofit their structures to meet new minimum Inflow Design Flood standards.

2. An "Impoundment Permit" is required for existing dams and will be issued after reviewing all historical data (designs, plans, specifications, operation and maintenance records, etc.) and performing a technical inspection (or inspections) to adequately assess the safety of the dam. The owner shall provide all historical data, if available.

#### M. Emergency Preparedness Plan

1. An Emergency Preparedness Plan is required for all dams and reservoirs both existing and new construction. The plan will comply with the guidelines of the current issue of Louisiana's *Emergency Action Plan Guidelines*, available from the Director of Public Works and Flood Control, and

shall be submitted as a necessary component of the Maintenance and Operating Procedures and as a condition of the permitting process. It is the owner's responsibility to assure that the provisions of the Emergency Action Plan are implemented in the event of an emergency situation.

2. A breach analysis is required to develop the emergency preparedness plan. The breach analysis will establish the magnitude of the inundated area (inundation map), peak flood elevations and arrival times of the peak flood elevations at critical locations. The worst case scenario breaching event will be somewhere between the "sunny day" breach and that event above which a breach of the dam does not increase hazard to downstream interests. If the dam owner prefers to perform only one breach analysis rather than performing incremental analyses to discover the worst case scenario breaching event, he may perform a breach analysis where the tail water is at the average annual elevation and the reservoir is at maximum design surcharge.

N. References

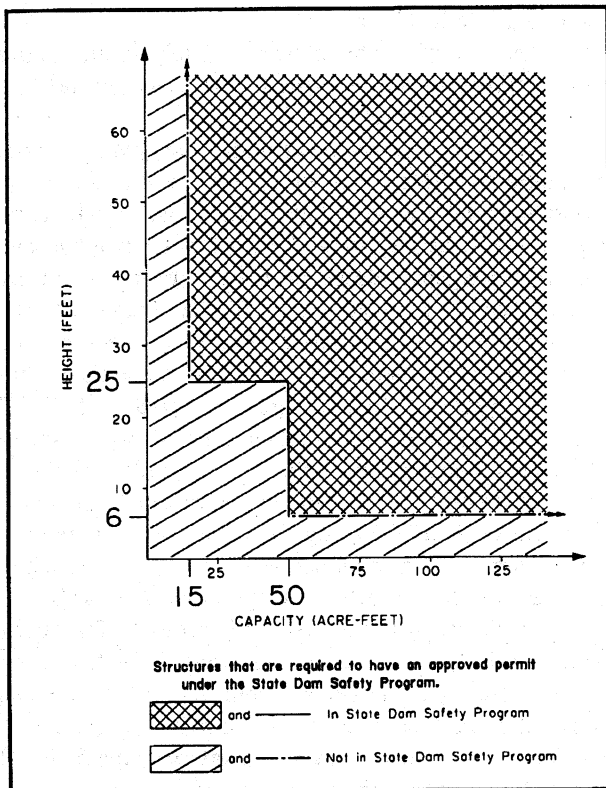
1. Jerrold W. Gotzmer, William C. Jenkins, Ramon G. Lee, Joseph R. McCormick, Harvey H. Richardson, and David L. Sveum, *Training Aids for Dam Safety, Module: Evaluation of Hydrologic Adequacy, Interagency Committee on Dam Safety* (Available from: Louisiana Transportation Research Center, 4101 Gourrier, Baton Rouge, Louisiana 70808, telephone (504) 767-9131).

2. Peter G. Grey, Terry G. Fairbanks, Tasso Schmigall, and Charles D. Wagner, *Training Aids for Dam Safety, Module: Evaluation of Hydraulic Adequacy, Interagency Committee on Dam Safety* (Available from: Louisiana Transportation Research Center, 4101 Gourrier, Baton Rouge, Louisiana 70808), telephone (504) 767-9131).

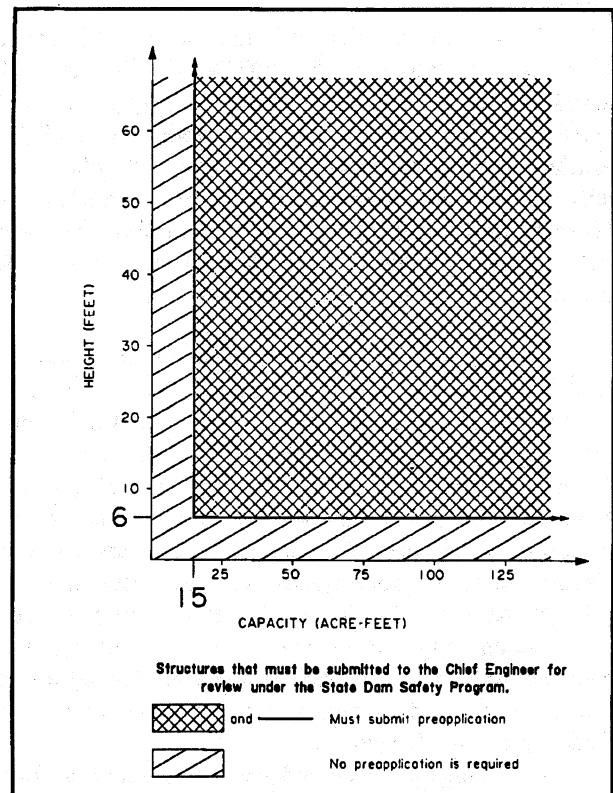
AUTHORITY NOTE: Promulgated in accordance with R.S. 38:24.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Public Works, LR 22:1234 (December).

APPENDIX 1



APPENDIX 2



APPENDIX 3  
PROCEDURAL SEQUENCE

- 1) Applicant or his Engineer submits "Letter of Intent".
- 2) Applicant or his Engineer submits "Pre-Application for Construction of Dam".
- 3) Applicant publishes "Notice of Application" and a "Public Hearing(s)" is (are) held.
- 4) Applicant or his Engineer submits "Designs, Plans and Specifications" as follows and submits "Application for Construction of Dams".
  - a) "Impact (Hazard) Classification.
  - b) Determination of controlling design condition and associated storm runoff.
  - c) Setting of spillway and stilling basin widths and elevations, top of embankment elevation, and normal pool stage.
  - d) Plans, Specifications, Designs and other Submittals.
- 5) The DOTD issues "Approval or Denial of Application"; Approval is an "Approval for Construction".
- 6) Construction begins; Applicant or his Engineer performs "Construction Inspections".
- 7) If "Deficiencies" are found by the DOTD, Applicant or Applicant's Engineer; then the Applicant or his Engineer shall correct the deficiencies.
- 8) Supervision of Construction by the Owner.
- 9) Applicant or his Engineer submits "Notice of Completion" and "As-Built Drawings" and revised "Application for construction of Dam".
- 10) The DOTD issues "Certificate of Completion/Impoundment Permit".
- 11) Applicant or his Engineer submits "Maintenance and Operation Procedures" for the DOTD's approval.
- 12) Applicant or his Engineer submits "Emergency Preparedness Plan" for the DOTD's approval.

APPENDIX 4

DATE:

Dam Safety Administrator  
Louisiana DOTD  
P. O. Box 94245, Capitol Station  
Baton Rouge, Louisiana 70804-9245

RE: Pond Construction

I am aware that the design, construction and operation of all dams within Louisiana is regulated by the Rules and Regulations for Dam Safety Program as developed by the State of Louisiana, Department of Transportation and Development. I am also aware of the liability that is associated with owning a dam.

Since I am receiving design and construction assistance from the National Resources Conservation Service, the dam described below is excluded from the approval process outlined in the Dam Safety Regulations. However, if for some reason (such as a land use change) the dam no longer comes within the criteria of the National Resources Conservation Service National Handbook for Conservation Practices - Standard 378, I agree to modify the structure if necessary to comply with the requirements of the Dam Safety Regulations. I also agree to allow access for inspection of this structure.

Sincerely,

OWNER

DAM LOCATION:  
DESCRIPTION:

APPENDIX 5  
NOTICE OF APPLICATION

Pursuant to the Rules and Regulations of the Louisiana Dam Safety Program as established by L.R.S. 38:21-28 interested parties are hereby notified that a "Letter of Intent" and a "Pre-Application for Construction of Dam" have been received by the DOTD Public Works and Flood Control Directorate to construct the proposed Dam and Reservoir Pre-Application Number PA \_\_\_\_\_ located in Section \_\_\_\_\_ Township \_\_\_\_\_, Range \_\_\_\_\_ Parish \_\_\_\_\_.

Applicant:  
(Name)  
(Address)  
(Phone)

Purpose and Brief Description of Dam:

All interested parties are hereby notified that a public hearing on the application will be held at \_\_\_\_\_ p.m. on \_\_\_\_\_ at \_\_\_\_\_

Any interested party shall have the right to request a public hearing on the application. Requests for additional public hearings must be in writing and must be submitted no later than the close of the public hearing on \_\_\_\_\_. Letters must state, with particularity, the reasons for holding a public hearing, applicant's name and Pre-application number. On receiving a written request for an additional hearing(s) within the time limits set forth in this notice, the DOTD Public Works and Flood Control Directorate shall set a date, time and place for conducting a hearing on the application. During the hearings, any interested party shall have the right to protest the application and to appear and present evidence and testimony in support of such protest.

APPENDIX 6  
MINIMUM REQUIRED SUBMITTALS

1) All structural, geotechnical, hydrologic and hydraulic design calculations. An engineer's report shall also be submitted which summarizes the design analyses and shall include, but is not limited to, the following:

- a) Formulas, methods and basic data assumptions used in the designs.
- b) List of all pertinent design codes.
- c) Summary tables which list design load cases, computed design factors of safety and required factors of safety as specified in these Rules and Regulations or required by pertinent design codes.
- d) All other information which aided in evaluating the design, supported assumptions and conclusions, and will facilitate an independent review.

2) Plans with sufficient details to construct all features of the dam in accordance with the design intent. Also, the plans shall include details to construct a permanent reference mark (bench mark) near, but separate from, the project. The exact location and elevation above mean sea level must be noted on the "As-Built" plans.

3) Specifications with sufficient details to construct all features of the dam in accordance with the design intent. The specifications shall also provide that the plans and specifications may not be changed without prior written approval by the DOTD.

4) Document(s) to show proof of ownership.

5) An inspection plan specific to the construction activity. The inspection plan is to detect deficiencies or situations that may result in a threat to life and property.

6) An emergency action plan specific to the construction activity. The inspection plan in item 5 is part of the emergency action plan under this item.

7) If the applicant has an agreement or contract with another entity who will be responsible for the operation and maintenance of the dam, the applicant must provide copies of the agreement or contract document(s).

8) If the applicant is constructing the dam for the specific purpose of transferring ownership to a homeowners' association, a landowners' association, or any other entity, the applicant must provide a document which clearly states his intent, i.e., a dam which is constructed for a subdivision development where ownership will be transferred to a homeowners' association.

9) All other "Permits" required to construct the dam and "Letters of No Objection" which were obtained from various regulatory entities.

10) "As-Built" plans.

11) "Operation and Maintenance Manual".

12) "Emergency Preparedness Plan".

NOTE: The applicant should submit 2 copies of all preliminary submittals. The applicant must submit 5 copies of all final submittals.

APPENDIX 7  
LETTER OF INTENT

Purpose: To notify the Louisiana Dam Safety Program of the applicant's intent to construct, enlarge, alter, repair or remove a dam within the state.

Address To: Louisiana Dam Safety Program  
Louisiana Department of Transportation and Development  
Public Works and Flood Control Directorate  
Post Office Box 94245  
Baton Rouge, Louisiana 70804-9245

Contents: 1) Name of proposed or existing dam  
2) Purpose of dam:  
3) Owner's:  
Name:  
Address:  
Telephone:  
4) Location of dam (section, township, range, parish).  
5) Brief description of proposed dam construction, enlargement, alteration, repair or removal.  
\*6) Height of Dam (height in feet from top of dam to lowest point at downstream toe of dam).  
\*7) Reservoir Capacity (volume in acre-feet with water at top of dam).

NOTE: Items 6 and 7 can be approximated at this time.

APPENDIX 8  
LETTER OF  
"NOTICE OF COMPLETION AND AS-BUILT DRAWINGS"

Purpose: To notify the Louisiana Dam Safety Program that the construction of the subject project is complete and to certify that said construction was done in accordance with the approved designs, plans, drawings and specifications.

From: Applicant's Consulting Engineering Firm (letter must be signed and sealed by a Registered Professional Civil Engineer licensed in the State of Louisiana).

Address To: Louisiana Dam Safety Program  
Louisiana Department of Transportation and Development  
Public Works and Flood Control Directorate  
Post Office Box 94245  
Baton Rouge, Louisiana 70804-9245

NOTE: As-Built Drawings must be received by the DOTD Public Works and Flood Control Directorate within 30 days after completion.

APPENDIX 9  
LETTERS OF NO OBJECTION AND OTHER PERMITS

The applicant must forward copies of the pre-application to the appropriate state, federal and local agencies to obtain letters of no objection and/or permits as required by these agencies. Copies of the letters of no objection and permits must be submitted to the Louisiana Dam Safety Program as part of the applicant's application under this program.

APPENDIX 10  
MINIMUM HYDROLOGIC AND HYDRAULIC SUBMITTALS TO  
ESTABLISH IMPACT CLASSIFICATION AND INFLOW DESIGN FLOOD (IDF)

Since the required submittals may vary for each dam, it is recommended that applicant or his engineer obtain copies of references number 1 and 2 of the Dam Safety Rules and Regulations. After reviewing these documents, the applicant or his engineer is advised to contact the Dam Safety Program of the Water Resources Design and Development Section of the DOTD for further guidance.

Frank M. Denton  
Secretary

9612#045

**RULE**

**Department of Treasury  
Board of Trustees of the Teachers' Retirement System**

**Mandatory Submission of Contribution Reports  
on Computer Tape/Diskette (LAC 58:III)**

In accordance with the authority granted the Board of Trustees of the Teachers' Retirement System in R.S. 11:873(2), the Board of Trustees of the Teachers' Retirement System of Louisiana (TRSL) adopted the following rule to be effective January 1, 1997, for reporting employees' contributions to TRSL pursuant to the Notice of Intent published September 20, 1996.

All employers with 125 or more employees being reported must submit information to TRSL by computer tape/diskette in the manner described below:

Each month the employer shall certify to the Board of Trustees, by means of computer tape/diskette, the amounts of salary and deductions from the employees' salaries to be paid to the annuity savings fund and credited to the individual accounts of members from whose compensation the deductions were made. All computer tape/diskette formats and specifications must be in accordance with criteria established by TRSL. Both computer tapes/diskettes and printed copies thereof must be submitted by the fifteenth of the month following the end of the month covered by the report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:873(2)

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 22:1242 (December 1996).

James P. Hadley, Jr.  
Director

9612#013

**RULE**

**Department of Treasury  
Board of Trustees of the Teachers' Retirement System**

**Voluntary Deductions from Retiree  
Benefits Payroll (LAC 58:III)**

In accordance with the legal authority granted under R.S. 11:821 that provides for the general administration and



responsibility for the proper operation of the retirement system, the Board of Trustees of the Teachers' Retirement System of Louisiana (TRSL) hereby provides notice of its adoption of the following rules to establish a program of voluntary deductions from the retiree benefits payroll pursuant to the Notice of Intent published September 20, 1996.

#### **General**

Any TRSL retiree, beneficiary or survivor is eligible to participate in a program established for the voluntary deduction from his/her retirement benefit for life, health, supplemental, dental, cancer or other insurance premiums and for deductions for savings, loans, or other payments to be sent to banks and credit unions.

#### **Application Process**

1. Application for participation in the program must be made by the insurance carrier, bank, or credit union which is the provider of the coverage, product, service or depositor of monies and shall be signed by two officers of the company, bank or credit union. The completed application must be submitted to TRSL for approval prior to any deductions being withheld from the retiree's monthly benefit.

#### **Requirements:**

1. Domestic companies shall:
  - (a) have been licensed to do business in the state of Louisiana for not less than five years;
  - (b) have a current rating in A. M. Best of B or better;
  - (c) have been doing business under the same name for not less than three years;
  - (d) provide a like product, service, or coverage to citizens of Louisiana;
  - (e) be in compliance with all procedural, accounting, and reporting requirements governing employee deductions.
2. Foreign companies shall:
  - (a) have been licensed to do business in the state of Louisiana for not less than five years;
  - (b) have a current rating in A. M. Best of B+ or better;
  - (c) have been doing business under the same name for not less than three years;
  - (d) offer a like product, service, or coverage to citizens of Louisiana;
  - (e) be in compliance with all procedural, accounting, and reporting requirements governing employee deductions.
3. Companies/credit unions must be regulated by the Department of Insurance or the Office of Financial Institutions.
4. Companies/credit unions are responsible for submitting a computer diskette of monthly deductions to TRSL by the twelfth day of the month preceding the month for which the deduction will be made using the format and specifications established by TRSL. Diskettes received after the twelfth day will not be processed. (Magnetic tapes will be accepted only under certain conditions). All deductions for a single vendor shall be submitted on one monthly diskette and the retiree will be allowed only one monthly deduction per vendor. This deduction may cover more than one product for a single vendor. Only deductions received on computer tape/diskette will be processed.

5. Companies/credit unions shall be responsible for obtaining and maintaining appropriate deduction authorization from individual retirees. Copies shall be made available to TRSL upon request.

6. Companies/credit unions are responsible for contract/loan terms between companies/credit union and retirees. TRSL assumes no responsibility for the contract or terms of agreement.

7. Retirees may discontinue any voluntary payroll deduction from their monthly benefit check by providing written notification to the vendor.

8. A retiree cannot authorize total deductions which would cause the net amount of the benefit to fall below \$5.

9. Companies/credit unions must have a minimum of 50 TRSL retirees to participate in the program. However, companies will be allowed six months after initial approval to meet the minimum participation requirements.

10. TRSL will not deduct monthly premium amounts for any retiree who owes monies to TRSL or has their benefit suspended.

11. Companies/Credit Unions shall notify TRSL immediately upon learning of the death of a retiree. In the event TRSL has remitted funds to the company/credit union after the death of a retiree and these funds were not due the retiree, company/credit union shall refund said monies to TRSL after notification.

12. Upon learning of the death of a retiree, even if not notified by the company/credit union, TRSL shall be refunded any monies transmitted but not due after notification. The company/credit union will accept the certification of TRSL as to date of death of retiree as sufficient evidence of date of death in regard to any funds owed to TRSL.

#### **Disclaimer:**

1. The company/credit union is prohibited from stating that any product offered has been endorsed or approved by TRSL.

#### **Transmittal of Withheld Amounts**

1. Amounts will normally be transmitted to company/credit union by wire transfer by the tenth of each month. If the tenth is a weekend, the first working day after the tenth will be the date of transmittal. In the event of computer/technical production problems beyond the control of TRSL, it is possible that transmittal of funds would not be made on the tenth day of the month.

2. TRSL will provide the company/credit union a computer print-out of the names of individuals, social security numbers and the amounts withheld.

3. TRSL may adjust print-out totals by amounts owed TRSL due to death of an individual. These individuals will be identified by name and social security number.

#### **Termination of Payroll Deduction**

1. The Board of Trustees may terminate the voluntary payroll deduction program by providing the company/credit union with at least 30 days written notice.

2. Immediately upon notice from TRSL individual company/credit unions may be terminated for unethical conduct or practices.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:821.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System, LR 22:1243 (December 1996).

James P. Hadley, Jr.  
Director

9612#014

## RULE

### Department of Treasury Bond Commission

#### Line of Credit

**15. Line of Credit** - a cash line of credit is an authorization to a state agency to proceed with a project and draw from the State Treasury funds for the project prior to the sale of bonds for that project. The maximum amount of lines of credit in any fiscal year which may be authorized by the Commission shall be the amount set forth in the comprehensive capital outlay act adopted by the Legislature. Bonds shall be issued to replenish lines of credit granted in the fiscal year in which the line of credit was granted. No lines of credit may be granted for a project unless and until either the bonds have been sold, lines of credit have been granted, or a certificate of impossibility and impracticality has been issued for all projects of higher priority as stated in the comprehensive capital budget adopted by the Legislature. The maximum amount of lines of credit provided herein shall not apply in cases where the Commission shall deem an item to be an emergency matter.

Monies advanced on a line of credit for any project shall be spent only in accordance with the description in the bond authorization act authorizing bonds to be issued for that project.

Prior to the execution of any contract or agreement obligating the expenditure of monies received by any state department or agency or any other entity from line of credit funds, the Attorney General's Office shall be requested to review such proposed contracts or agreements for the sole purpose of determining whether expenditure of funds thereunder is for the purpose of furthering the applicable project adopted by the Legislature. If given, such prior approval by the Attorney General's Office shall be in writing to the appropriate state department, agency or other entity with a copy to be furnished to the State Bond Commission.

Should the Attorney General's Office determine that the proposed expenditure of line of credit funds not be in order, no funds may be used to pay obligations which may be incurred if such contracts are executed after an adverse conclusion by the Attorney General's Office.

All approvals of lines of credit shall be conditioned on compliance by the state department, agency or other entity with the aforementioned procedure, and it shall be their duty to request approval from the Attorney General's Office, stating to which bond act and to which project the contract or agreement in question pertains. Failure to comply with such procedure by any such department, agency or other entity shall result in the immediate revocation of the line of credit,

and all information regarding the possible expenditure of line of credit funds for other than authorized purposes shall be forwarded immediately by the Commission to the Attorney General's Office and the District Attorney's Office.

Sharon B. Perez  
Director

9612#012

# Notices of Intent

## NOTICE OF INTENT

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

#### Sanitary Disposal of Dead Poultry (LAC 7:XXI.11701 and 11771)

In accordance with provisions of the Administrative Procedure Act, the Department of Agriculture and Forestry, Livestock Sanitary Board proposes to amend the Regulations governing the sanitary disposal of dead poultry. These Rules comply with and are enabled by R.S. 3:2091 et seq.

#### Title 7

### AGRICULTURE AND ANIMALS

#### Part XXI. Diseases of Animals

#### Chapter 117. Livestock Sanitary Board

#### Subchapter A. General Provisions

#### §11701. Definitions

\* \* \*

*Digester*—a specially designed water tight system which is buried in the ground below the frost line and has the ability and strength to hold liquid, without leakage or seepage, and is used to dispose of dead poultry through use of bacteria.

\* \* \*

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 3:2093.

**HISTORICAL NOTE:** Promulgated by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 11:615 (June 1985), amended LR 12:289 (May 1986), LR 12:498 (August 1986), LR 14:217 (April 1988, LR 15:811 (October 1989), LR 16:391 (May 1990), LR 17:29 (January 1991), LR 18:840 (August 1992), LR 23:

#### Subchapter D. Poultry

#### §11771. Governing the Sanitary Disposal of Dead Poultry

A. All commercial poultry producers are required to obtain a certificate of approval. Failure to obtain a certificate shall be considered a violation of this Regulation. Certificates of approval are continuous, but subject to review and cancellation should the poultry producer fail to dispose of dead poultry in accordance with this Regulation.

B. Dead poultry must be removed from the presence of live poultry without delay. The carcasses, parts of carcasses and offal must be held in covered containers until disposal is

made by one of the approved methods. In no instance, however, will the storage of dead poultry be allowed to create sanitary problems. Commercial poultry producers shall be required to dispose of dead poultry by one of the following methods:

1. Disposal Pits. Disposal pits shall be constructed in a manner and design capable of providing a method of disposal of dead poultry to prevent the spread of diseases. Disposal pits that are currently in use will be allowed to operate until July 1, 1997.

2. Incinerators. Incinerators shall be constructed in a manner and design capable of providing a method of disposal of dead poultry to prevent the spread of diseases. The design and construction must be approved by an authorized representative of the Livestock Sanitary Board.

3. Rendering Plant. Dead poultry, parts of carcasses and poultry offal may be transported in covered containers to approved rendering plants. Poultry carcasses may be held on the premises of commercial poultry producers as long as the storage does not create a sanitary problem. All such methods of storage and transportation of dead poultry to approved rendering plants must be approved by an authorized representative of the Livestock Sanitary Board.

4. Composting. The design, construction, and use of compost units must be approved by an authorized representative of the Livestock Sanitary Board.

5. Digesters. Poultry digesters may be used if the following conditions are met:

a. the design, construction, location, and use of digesters must be approved by an authorized representative of the Livestock Sanitary Board;

b. the bacteria being used in the digester must be approved by an authorized representative of the Livestock Sanitary Board;

c. the digester must be maintained according to recommendations of an authorized representative of the Livestock Sanitary Board.

C. In the event of the death of more than 1 percent of broilers or 0.5 percent of pullets or breeders over four weeks of age on the same premises within a 24-hour period of time, the death of which is not known to be caused by a contagious or infectious disease, the dead poultry may be disposed of by on-site burial. The State Veterinarian's Office must be notified immediately by telephone or facsimile in the event of excessive mortality requiring on-site burial.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 3:2093.

**HISTORICAL NOTE:** Promulgated by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 11:615 (June 1985), amended LR 17:874 (September 1991), LR 18:1355 (December 1992), LR 20:550 (August 1994), LR 23:

All interested persons may submit written comments on the proposed Rule through January 28, 1997 to Dr. Maxwell Lea, Jr., Department of Agriculture and Forestry, 5825 Florida Boulevard, Baton Rouge, LA 70806. No preamble concerning the proposed Rule is available.

Bob Odom  
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Sanitary Disposal of Dead Poultry**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There would be no estimated costs or savings to local government units to implement this Rule change.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is estimated that there will be no effect on revenue collections of state or local government units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
It is estimated that there would be no costs or economic benefits to directly affected persons or nongovernmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
This Rule change will have no effect on competition and employment.

Richard Allen  
Assistant Commissioner  
9612#056

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Agriculture and Forestry  
Office of Forestry**

**Forest Management Fees (LAC 7:XXXIX.20701)**

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Department of Agriculture and Forestry, Office of Forestry, Louisiana Forestry Commission intends to amend LAC 7:XXXIX.20701, Forest Management Fees. The proposed Rule provides for an increase in the fees charged for various forest management services provided by the Office of Forestry. These fee increases are necessary due to an increase in costs to the Office of Forestry in providing forest management services, and due to new forestry practices and services which the Office of Forestry can offer to forest landowners. These Rules comply with and are enabled by R.S. 3:1476 and R.S. 3:4274.

**Title 7**

**AGRICULTURE AND ANIMALS**

**Part XXXIX. Forestry**

**Chapter 207. Forest Landowner Assistance  
§20701. Management Service Fees**

The Department of Agriculture and Forestry, Office of Forestry, shall, under the direction of the state forester, provide private landowners with assistance in the management of their forestlands.

A. Basic Services. Performed on an as-requested basis in all Office of Forestry Districts.

1. Prescribed Burning Services
  - a. Reforestation (cutover areas) \$10/acre plus \$60/hour for fireline establishment. Minimum \$100
  - b. Afforestation (pasture, etc.) \$7/acre. Minimum \$100
  - c. Helicopter Assisted Burns \$5/acre plus \$60/hour for fireline establishment. Minimum \$100
  - d. Other Prescribed Burns (fuel reduction, hardwood control, wildlife habitat, etc.) \$7/acre. Minimum 100
  - e. Fireline Plowing Only \$60/hour. Minimum \$100
2. Timber Marking \$15/acre

**B. Special Services.** Performed when approved on a case-by-case basis.

1. Tree Planting\* 42/acre
2. Direct Seeding\* 5/acre
3. Tractor Work \$60/hour

\*Seedlings or seed not included.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 56:1476 [renumbered R.S. 3:4276] and R.S. 3:4274.

**HISTORICAL NOTE:** Promulgated by the Department of Natural Resources, Office of Forestry, Forestry Commission, LR 8:419 (August 1982), amended by the Department of Agriculture and Forestry, Office of Forestry, Forestry Commission, LR 11:1178 (December 1985), LR 19:1414 (November 1993), LR 23:

Interested persons should submit written comments on the proposed Rules to Cyril LeJeune through January 28, 1997, at 5825 Florida Boulevard, Baton Rouge, LA 70806. No preamble regarding these Rules is available.

Bob Odom  
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Forest Management Service Fees**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
 

Implementation of this Rule will result in an increase of self-generated revenue of \$44,500 that is calculated to offset the actual costs of providing the related services. There will be no administrative or mandatory fiscal impact on local government units from the implementation of this proposed Rule. If a local government requested forest management services from this Agency, they would pay the same minor fee increase assessed to any individual or other user.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
 

This Rule will result in an increase of approximately \$44,500 in self-generated revenue for the Office of Forestry, if demand for services continues at present levels.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

Forest landowners who choose to use the Office of Forestry services affected by this Rule will be impacted. The Office of Forestry offers forest management services to all forest landowners with some restrictions on the amount of work that can be done for a single owner. The service fees increased by this Rule could result in additional charges of up to 25 percent depending on the service requested.

Vendors providing similar services as the Office of Forestry may realize an increase in business and income, if the fee increases by the Office of Forestry send more landowners to them for services. The goal of the Office of Forestry continues to be the provision of needed forest management services to private landowners whose enterprises may not be commercially manageable otherwise.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

The Office of Forestry provides management services to landowners whose enterprises may not be commercially manageable otherwise. The Agency's role is to assist landowners for their benefit and for the benefit of the forest resource in the state. This Agency fee increase, designed to recover expenses for these operations, may allow more private vendors to provide these services profitably, increasing their business, revenue and employment.

Richard Allen  
Assistant Commissioner  
9612#086

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Agriculture and Forestry  
Office of Forestry**

**Indian Creek Recreation Area User Fees  
(LAC 7:XXXIX.20501)**

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Department of Agriculture and Forestry, Office of Forestry, intends to amend LAC 7:XXXIX.20501, Indian Creek Recreation Area, Usage Fees. The proposed Rule provides for an increase in some of the fees charged to users of the Indian Creek Recreation Area which is located on the Alexander State Forest near Woodworth, Louisiana. These fee increases are necessary to cover the increased cost of operation of the park. These Rules comply with and are enabled by Act 591 of 1970.

**Title 7  
AGRICULTURE AND ANIMALS  
Part XXXIX. Forestry  
Chapter 205. Indian Creek Recreation Area  
§20501. Usage Fees**

The Department of Agriculture and Forestry, Office of Forestry, hereby announces the following usage fee revisions:

A. Entrance Fees (Day Use)	\$3/per vehicle with up to six occupants. Additional \$ .50 per person for additional occupants.
B. Regular Campsite	\$12/day
C. Pull-through Campsite	\$16/day
D. Primitive Campsite	\$7/day
E. Pavilion Rental	\$35/day
F. Boat Launch	\$3/per boat
G. 30-day Off-season Rate for Regular Campsite (Oct. - Feb. only)	\$180/month
H. 30-day Off-season Rate for Pull-through Campsite (Oct. - Feb. only)	\$240/month

area. Improved recreation facilities will benefit tourism and should have a positive effect on employment and income in the area.

Richard Allen  
Assistant Commissioner  
9612#085

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

### NOTICE OF INTENT

#### Department of Economic Development Economic Development Corporation

#### BIDCO Investment and Co-Investment Program (LAC 19:X.Chapter 1)

In accordance with R.S.51:2341-51:2344, notice is hereby given that the Department of Economic Development, Board of the Economic Development Corporation, proposes to amend Rules and Regulations for the BIDCO Investment and Co-Investment Program.

These Rules revise an existing program designed to address private capital market failures through the provision of risk capital (typically mezzanine or subordinated debt or equity investment capital) to qualified business and industrial development corporations (BIDCOs) for reinvestment/relending to small businesses in need of capital. The proposed amendments improve the flexibility, consistency and accountability of the program.

#### Title 19

#### CORPORATIONS AND BUSINESS

#### Part X. Economic Development Corporation

#### Subpart 1. BIDCO Investment Program

#### Chapter 1. BIDCO Investment and Co-Investment Program

#### §103. Definitions

A. - D. ...

E. A *Specialty BIDCO* shall be defined in accordance with the Office of Financial Institution's BIDCO policy.

F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 18:1357 (December 1992), amended LR 23:

#### §105. LEDC Application Process

A. - B. ...

1. Applications will be processed in the order in which they are received.

2. - 5. ...

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 18:1357 (December 1992), amended LR 23:

#### §109. Amount of Investment

A. Co-Investment

1. If a nonspecialty BIDCO can show commitment or cash capital contributions, as defined in §103 of at least \$1,000,000, LEDC may co-invest \$1 for each \$2 for each

AUTHORITY NOTE: Promulgated in accordance with Act 591 of 1970.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Forestry, and the Louisiana Forestry Commission, LR 6:734 (December 1980), amended LR 11:1178 (December 1985), amended by the Department of Agriculture and Forestry, Office of Forestry, LR 17:476 (May 1991), LR 23:

Interested persons should submit written comments on the proposed Rules to Cyril LeJeune through January 28, 1997, at 5825 Florida Boulevard, Baton Rouge, LA 70806. No preamble regarding these Rules is available.

Bob Odom  
Commissioner

#### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

#### RULE TITLE: Indian Creek Recreation Area User Fees

#### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Implementation of this Rule will result in an increase in self-generated state revenue of approximately \$17,462 per year, which is needed to provide for the operation and maintenance of the recreation area on which the user fees are collected. There will be no mandatory fiscal impact on local government units from the implementation of the proposed Rule.

#### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

This Rule will result in an increase of approximately \$17,462 in self-generated revenue for the Office of Forestry, based on activity at Indian Creek Recreation Area in FY 95-96.

#### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Users of Indian Creek Recreational Area will be affected by the proposed action. Those individuals who rent the facilities included in the fee increase proposal would pay the additional amounts. The maximum increase for any item is 15 percent (primitive camping). The other increases are less than 10 percent.

#### IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The additional funds collected will be spent on local labor and at local businesses who supply items used by this recreation

LEDC approved project submitted to it by the BIDCO. The LEDC investment will participate pro-rata with the BIDCO share of the investment. The LEDC investment will not exceed 33 percent of any project nor will LEDC funding exceed \$1 for each \$2 of other BIDCO capital committed. On each project submitted for review, an application fee of \$250 is required.

2. If a specialty BIDCO can show commitment or cash capital contributions, as defined in §103 of at least \$250,000, LEDC may co-invest \$1 for each \$1 for each LEDC approved project submitted to it by the BIDCO. The LEDC investment will participate pro-rata with the BIDCO share of the investment. The LEDC investment will not exceed 50 percent of any project nor will LEDC funding exceed \$1 for each \$1 of other BIDCO capital committed. On each project submitted for review, an application fee of \$250 is required.

**B. Match Investment**

1. If a nonspecialty BIDCO can show committed cash capital contributions, as defined in §103, of \$2,000,000, exclusive of any previous investments by LEDC, the BIDCO may request a matching equity capital contribution from LEDC. Each request should be accompanied by a \$500 application fee. If the BIDCO is considered an acceptable risk, based upon LEDC review of its credentials, performance, and business plan, or some combination thereof, LEDC may make a matching cash contribution on the basis of \$1 for each \$2 of the BIDCO capital not to exceed \$2,500,000, reduced for any previous LEDC capital contributions. LEDC will base its matching equity capital contribution on the amount of non-LEDC capital as calculated in accordance with §103(D). Thereafter it will participate in all future BIDCO investments on a pro-rata basis with all other BIDCO funds. Any BIDCO which has received a LEDC match investment is ineligible to present portfolio projects to LEDC for assistance through any of LEDC's other programs.

2. If a specialty BIDCO can show commitment and cash capital contributions, as defined in §103, of \$250,000, exclusive of any previous investments by LEDC, the BIDCO may request a matching equity capital contribution from LEDC. Each request should be accompanied by a \$500 application fee. If the BIDCO is considered an acceptable risk, based upon LEDC review of its credentials, performance, and business plan, or some combination thereof, LEDC may make a matching cash contribution on the basis of \$1 for each \$1 of the BIDCO capital not to exceed \$2,500,000, reduced for any previous LEDC capital contributions. LEDC will base its matching equity capital contribution on the amount of non-LEDC capital as calculated in accordance with §103(D). Thereafter it will participate in all future BIDCO investments on a pro-rata basis with all other BIDCO funds. Any BIDCO which has received a LEDC match investment is ineligible to present portfolio projects to LEDC for assistance through any of LEDC's other programs.

*(Editor's Note: Existing Subsections E. and F. are renumbered 3. and 4., respectively.)*

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:2312(C).

**HISTORICAL NOTE:** Promulgated by the Department of Economic Development, Economic Development Corporation, LR 18:1357 (December 1992), amended LR 23:

**§111. Terms of Investments**

A. ...

B. LEDC will have the right to appropriate representation on and control of the BIDCO's management and governance as negotiated with the BIDCO. This may include but not be limited to board seat(s); veto authority or supermajority requirements for key management and financial decisions; board visitation rights.

C.1. LEDC's stock may be repurchased by the BIDCO or, secondarily, by its private-capital stockholders at the end of the fifth year or each subsequent annual operating period for a discounted amount of LEDC's then-current book value or market value, whichever is higher, subject to LEDC's concurrence on the valuation methodology and the achievement of BIDCO performance objectives specified at the time of LEDC's investment. The BIDCO or its private-capital investors can experience an appreciation in their investment commensurate with the amount of discount granted by LEDC in the sale of its stock back to the BIDCO or its shareholders. The discount at the end of the five years or annually thereafter, is:

	DISCOUNT	LEDC RECEIVES
End of 5 Years	25%	75%
6th Year	20%	80%
7th Year	15%	85%
8th Year	10%	90%
9th Year and Beyond	5%	95%

2. This scenario provides greater incentives for the BIDCO/shareholders to repurchase LEDC's interest earlier than later, but retains incentive for the buy-out beyond the ninth year. See Exhibit 1 for an example of the buy-out scenarios. This provision is not applicable to non-profit BIDCO's.

D. LEDC may negotiate additional operating requirements with individual applicant BIDCO's on a case-by-case basis, as needed to safeguard the quality of LEDC's investment or to promote achievement of the objectives of the program or LEDC. Such requirements may include but not be limited to a put (sell) option to liquidate LEDC's investment in the BIDCO.

E. All agreements will be executed by duly authorized persons outlining the details of the transaction.

F. The LEDC's funding under its commitment will be made on a quarterly basis subject to verification of non-LEDC funds received by the BIDCO.

G. Capital match investments in a nonprofit BIDCO will be in the form of a debenture with terms and rates to be negotiated consistent with the BIDCO's business plan and LEDC's investment objectives and policies.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:2312(C).

**HISTORICAL NOTE:** Promulgated by the Department of Economic Development, Economic Development Corporation, LR 18:1357 (December 1992), amended LR 23:

### §113. Application Requirements

To apply for LEDC financing, A BIDCO shall submit to LEDC evidence of its OFI approval or preliminary approval. The applicant must desirably submit to LEDC information in the sequence outlined below. The Applicant may provide other information which it believes relevant. LEDC may request further information beyond what is specified below.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 18:1357 (December 1992), amended LR 23:

This proposed Rule is scheduled to become effective March 20, 1997, or as soon thereafter, as is practical upon publication in the *Louisiana Register*.

Interested persons may comment on the proposed Rules in writing until January 30, 1997, to Brett Crawford, Executive Director, Economic Development Corporation, Box 44153, Baton Rouge, LA 70804 or 339 Florida Street, Suite 402, Baton Rouge, LA 70801.

Brett Crawford  
Executive Director

#### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

##### RULE TITLE: BIDCO Investment and Co-investment Program

#### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Rule changes are expected to increase significantly the amount of activity experienced and funded by this program. The implementation costs associated with the proposed Rule changes are projected to be \$2,002,300 in FY 96/97, \$2,004,780 in FY 97/98 and \$2,004,980 in FY 98/99. Of those costs, 100 percent will be funded by LEDC's dedicated fund, the Louisiana Economic Development Fund, there are no cost impacts anticipated for local government units.

#### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

An essential purpose of the program is to foster the development of emerging small businesses through the timely provision of capital to finance their growth and sustenance. As a result of that growth, it is likely that income and employment tax revenues will increase somewhat. However, owing to the uncertainty and variety of businesses and locations receiving investments from BIDCOs, as well as other economic factors beyond the control of LEDC, we are not able to estimate the revenue impact on local communities or the state's General Fund. In addition, LEDC's investments in BIDCOs will be expected to achieve long-term average annual returns on investment of at least 10 percent. However, most returns will likely not be realized until at least 4-5 years after the date of investment, and possibly extending out as far as 10-12 years in some cases, depending on the investments made by individual BIDCOs.

#### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Small Louisiana businesses should benefit from greater opportunities for growth and profitability as a result of

increased availability of non-traditional forms of financial capital. BIDCOs will benefit from additional financial returns and fund management fees resulting from the additional small business financings made possible by LEDC's investment in the BIDCOs. No additional costs are anticipated.

#### IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

LEDC's investment in BIDCOs does not substitute public investment for private investment in the provision of financial capital to small businesses. Notably, LEDC seeks to fill capital gaps while strengthening the private sector's ability to mobilize capital on its own. By mobilizing additional risk capital in the state and both broadening and deepening the base of higher risk, non-traditional business financing, the proposed changes should enhance the competitiveness of the state's financial markets and lower the effective cost of capital to small businesses. Furthermore, the proliferation of small businesses, particularly in the high value-added and microenterprise sectors expected to be targeted by some BIDCOs, will help diversify the state's economic base and increase the competitiveness of the general business sector as a result of the creation or expansion of markets for additional goods and services. Such benefits can also accrue to the state as a whole as a vibrant, diversified business climate can significantly affect the attractiveness of the state for outside investment in the state. Finally, the small businesses receiving investments from BIDCOs will in most cases be expected to use the funds to expand or sustain their operations, likely resulting in employment growth and/or retention.

Brett Crawford  
Executive Director  
9612#065

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

### NOTICE OF INTENT

#### Department of Economic Development Economic Development Corporation

##### Micro Loan Program (LAC 19:VII.Chapter 101)

In accordance with R.S. 51:2341-51:2344, notice is hereby given that the Department of Economic Development, Board of the Louisiana Economic Development Corporation, proposes to implement Rules and Regulations for the Micro Loan Program.

This proposed Rule establishes the Louisiana Micro Loan Program designed to address private capital market failures through the provision of loan guarantees, loan participations and direct loans for viable small businesses seeking very small amounts of debt capital (typically less than \$50,000), which frequently are unprofitable for banks to make without assistance from Louisiana Economic Development Corporation (LEDC).

#### Title 19

#### CORPORATIONS AND BUSINESS

#### Part VII. Economic Development Corporation

#### Subpart 9. Micro Loan Program

#### Chapter 101. Loan Policies

#### §10101. Purpose

A. The Louisiana Economic Development Corporation (LEDC) wishes to stimulate the flow of private capital, long-



term loans, and other financial assistance for the sound financing of the development, expansion, and retention of small business concerns in Louisiana as a means of providing high levels of employment, income growth, and expanded economic opportunities, especially to disadvantaged persons and within distressed and rural areas.

B. The Corporation will consider sound loans so long as resources permit. The Board of the Corporation recognizes that guaranteeing, participating, or lending money carries certain risks and is willing to undertake reasonable exposure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

### §10103. Definitions

*Disabled Person's Business Enterprise*—a small business concern which is at least 51 percent owned and controlled by a disabled person as defined by the federal Americans With Disabilities Act of 1990.

*Economically Disadvantaged Business*—a Louisiana business certified as economically disadvantaged by the Department of Economic Development's Division of Economically Disadvantaged Business Development.

*Micro Loans*—those loans ranging in size from \$5,000 to \$50,000.

*Small Business Concerns*—as defined by SBA for purposes of size eligibility as set forth by 13 CFR 121.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

### §10105. Application Process

A. Applicant is required to first contact a financial lending institution that is willing to entertain such a loan with the prospect of additional credit support provided by a LEDC guaranty or a participation and complete the application process. An applicant may also apply to LEDC directly for loan consideration, provided it is based upon documented eligibility as established as follows. Only after rejection by at least two lending institutions for participation on the basis of either a loan participation or a loan guaranty shall an applicant be eligible to be considered for a direct loan by LEDC. Such applications may be forwarded directly to LEDC.

B. Information submitted to LEDC with the application representing the applicant's business plan, financial position, financial projections, personal financial statements and background checks will be kept confidential to the extent allowed under the Public Records Law, R.S. 44:1 et seq. Confidential information in the files of LEDC and its accounts acquired in the course of duty will be used solely by and for LEDC.

#### C. Submission and Review Policy

1. A completed Louisiana Economic Development Corporation application form along with information identified by LEDC as appropriate must be submitted to LEDC. Applications will be processed, with decisions confirmed promptly.

2. Economically disadvantaged businesses applying for assistance under that provision will have to submit certification from the Division of Economically Disadvantaged Business Development Office of the Department of Economic Development along with the request for financial assistance.

3. Businesses applying for consideration under the Disabled Persons provision shall submit adequate information to support the disabled status.

4. LEDC staff will review the applications for completeness and submit only complete packages for analysis. Any applications not receiving approval in the initial analysis process shall be individually reviewed and exceptions to underwriting criteria noted. The LEDC staff will report to the Screening Committee monthly those applications approved, and those not recommended for approval with reasons.

5. Loans guaranteed or participated in by LEDC must qualify under LEDC pre-approved underwriting criteria using standardized LEDC documentation. The originating bank is responsible for all loan closing documentation. Closing will occur only after a site visit by an LEDC staff member or designated representative.

6. Direct loans by LEDC must qualify under LEDC pre-approved underwriting criteria, or be approved by the Board of Directors as an exception to such criteria. Such loans will be closed by LEDC or its designated agents using standardized LEDC documentation.

7. Only those applicants and/or their designated representatives asked to be present by the LEDC staff need to be present for the screening committee.

8. The Board of Directors will review the results of all applications processed and screened. Loans recommended for approval by the LEDC staff as exceptions to standard underwriting criteria will be presented to the Screening Committee of the Board for approval. Loans approved under standard underwriting procedures requiring direct LEDC funding, LEDC guarantees or participation shall be approved by LEDC in accordance with established policies and procedures.

9. The applicant will be notified promptly from date accepted for processing by mail of the outcome of the application.

10. A LEDC commitment letter, standard guaranty or participation agreement will be mailed to the bank promptly after approval by the LEDC staff applying standardized evaluation processes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

### §10107. Eligibility

A. Small business concerns as defined by SBA for purposes of size eligibility as set forth by 13 CFR 121.

B. Small businesses whose owner(s) or principal stockholder(s) shall be a resident of Louisiana and the business is domiciled in Louisiana with preference given to certified economically disadvantaged businesses or businesses owned by disabled persons.

C. Funding request for all but the following may be considered:

1. restaurants, except for regional or national franchises;
2. bars;
3. any project established for the principal purpose of dispensing alcoholic beverages;
4. any establishment which has gaming or gambling as its principal business;
5. any establishment which has consumer or commercial financing as its business;
6. funding for the acquisition, renovation, or alteration of a building or property for the principal purpose of real estate speculation;
7. funding for the principal purpose of refinancing existing debt in excess of 10 percent of the total requested loan amount;
8. funding for the purpose of buying out any stockholder or equity holder by another stockholder or equity holder in a business;
9. funding for the purpose of establishing a park, theme park, amusement park, or camping facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

#### §10109. General Loan Provisions

A. The Louisiana Economic Development Corporation will be guided by the following general principles in making loans:

1. The Corporation shall not knowingly approve any loan guarantee, loan participation or loan if the applicant has presently pending or outstanding any claim or liability relating to failure or inability to pay promissory notes or other evidence of indebtedness including state or federal taxes, or bankruptcy proceeding; nor shall the Corporation approve any loan or guarantee if the applicant has presently pending, at the federal, state, or local level, any proceeding concerning denial or revocation of a necessary license or permit.

2. The terms or conditions imposed and made part of any loan or loan guaranty authorized by vote of the Corporation Board shall not be amended or altered by any member of the Board or employee of the Department of Economic Development except by subsequent vote of approval by the Board at the next meeting of the Board in open session with full explanation for such action.

3. The Corporation shall not subordinate its position.

#### B. Interest Rates

1. On all loan guarantees the interest rate is to be negotiated between the borrower and the bank but may not exceed four percentage points above New York prime as published in the Wall Street Journal at either a fixed or variable rate.

2. On all participation loans the interest rate to LEDC shall be determined by utilizing the rate for a U.S. Government Treasury Security for the time period that coincides with the term of the participation and adding 1 percent.

3. On all direct loans by LEDC the interest rate to LEDC shall be negotiated at a rate commensurate with the loan risk for either variable or fixed rate loans.

#### C. Collateral

1. Collateral to loan ratio will be no less than 1:1, except for direct loans where the ratio will be 1.2:1.

2. Collateral position shall be negotiated but will be no less than a sole second position.

#### 3. Collateral Value Determination

a. The appraiser must be certified by recognized organization in area of collateral.

b. The appraisal cannot be over 90 days old.

c. The percentage of value considered shall be consistent with the underwriting criteria established by the LEDC Board from time to time.

4. Acceptable Collateral may include, but not be limited to, the following:

a. fixed assets—real estate, buildings, fixtures;

b. equipment, machinery, inventory;

c. personal guaranties are open for negotiation, if used, there must be signed and dated personal financial statements;

d. accounts receivable with supporting aging schedule, except for direct loans where accounts receivable are ineligible;

5. unacceptable collateral may include but not be limited to the following:

a. stock in applicant company and or related companies;

b. personal items.

#### D. Equity

1. Will be no less than 10 percent of the loan amount for a start-up operation, acquisition, or expansion.

2. Equity is defined to be:

a. cash;

b. paid in capital;

c. paid in surplus and retained earnings;

d. partnership capital and retained earnings.

3. No research, development expense or intangibles will be considered equity.

#### E. Amount

1. For Small Businesses the Corporation's guarantee shall be no greater than 80 percent of a loan.

2. For certified economically disadvantaged businesses or businesses owned by disabled persons, the guarantee shall be no greater than 90 percent of a loan.

3. The Corporation's participation in loans shall be no greater than 50 percent, but in no case shall it exceed \$25,000.

F. Terms. Terms may be negotiated with the bank but in no case shall the terms exceed five years.

G. Fees. LEDC will charge a minimum guaranty fee of one percent of the guaranty amount.

#### H. Use of Funds

1. Purchase of fixed assets, including buildings that will be occupied by the applicant to the extent of at least 51 percent.

2. Purchase of equipment, machinery, or inventory.

3. Line of credit for accounts receivable or inventory.
4. Debt restructure may be considered by LEDC but will not be considered when the debt:
  - a. exceeds 10 percent of total loan; and/or
  - b. pays off a creditor or creditors who are inadequately secured; and/or
  - c. provides funds to pay off debt to principals of the business; and/or
  - d. provides funds to pay off family members.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

#### §10111. General Agreement Provisions

##### A. Guaranty Agreement

1. Originating Bank or LEDC agent responsible for proper administration and monitoring of loan and proper liquidation of collateral in case of default.
2. The loan shall not be sold, assigned, participated out, or otherwise transferred without prior written consent of the LEDC Board.
3. If liquidation through foreclosure occurs, the bank sells collateral and handles legal proceedings.
4. There will be a reduction of the guarantee:
  - a. in proportion to the principal reduction of the amortized portion of the loan;
  - b. if no principal reduction has occurred in any annual period of the loan, a reduction in the guarantee amount will be made proportional to the remaining guarantee life.
5. The guarantee will cover the unpaid principal amount owed only.
6. Delinquency will be defined according to the bank's normal lending policy and all remedies will be outlined in the guarantee agreement. Notification of delinquency will be made to the Corporation in writing and verbally in a time satisfactory to the bank and the Corporation as stated in the guarantee agreement.

##### B. Participation Agreement

1. The bank is responsible for administration and monitoring of the loan.
2. The lead bank will hold no less participation in the loan than that equal to LEDC's but not to exceed its legal lending limit.
3. The lead bank may sell other participation with LEDC's consent.
4. Should liquidation through foreclosure occur, the bank will sell the collateral and handle the legal proceedings.
5. The bank is able to set its rate according to risk. A blend with the LEDC rate to yield a lower overall rate to project.
6. Delinquency will be defined according to the bank's normal lending policy and all remedies will be outlined. Notification of delinquency will be made to the Corporation in writing and verbally in a time satisfactory to the bank and the Corporation.

C. Borrower Agreement. At the discretion of LEDC the borrower will agree to strengthen management skills by participation in a form of continuing education acceptable to LEDC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

#### §10113. Confidentiality

Confidential information in the files of the Corporation and its accounts acquired in the course of duty is to be used solely for the Corporation. The Corporation is not obliged to give credit rating or confidential information regarding applicant. Also see Attorney General Opinion Number 82-860.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

#### §10115. Conflict of Interest

No member of the Corporation, employee thereof, or employee of the Department of Economic Development, members of their immediate families shall either directly or indirectly be a party to or be in any manner interested in any contract or agreement with the Corporation for any matter, cause, or thing whatsoever by reason whereof any liability or indebtedness shall in any way be created against such Corporation. If any contract or agreement shall be made in violation of the provisions of this Section the same shall be null and void and no action shall be maintained thereon against the Corporation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 23:

This proposed Rule is scheduled to become effective March 20, 1997, or as soon thereafter, as is practical upon publication in the *Louisiana Register*. Interested persons may comment on the proposed Rules in writing until January 20, 1997 to Brett Crawford, Executive Director, Economic Development Corporation, Box 44153, Baton Rouge, LA 70804 or 339 Florida Street, Suite 402, Baton Rouge, LA 70801.

Brett Crawford  
Executive Director

#### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Micro Loan Program

##### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The implementation costs associated with the program are projected to be \$4,530 in FY 96/97, \$30,430 in FY 97/98 and \$51,800 in FY 98/99. Of those costs, LEDC's dedicated fund will finance 40.4 percent in FY 96/97, 82.3 percent in FY 97/98, and 89.6 percent in FY 98/99. The remaining costs will be supported by self-generated funds. However, only \$8,270 and \$18,790 in FY 97/98 and FY 98/99, respectively, will represent an increase in LEDC's operating budget due to the fact that the program has been in existence and operating since

FY 92/93. There are no cost impacts anticipated for local government units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

LEDC's self-generated funds resulting from the program are expected to be, on average, \$2,700 during the second half of FY 96/97, and \$5,400 for both FY 97/98 and FY 98/99. State and local tax revenues are likely to increase as a result of increased commercial activity stemming from the micro loans, but the actual amount of increase is uncertain and subject to numerous influences beyond the control of the program. Thus, no specific projection is being made.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Approximately 12 small Louisiana businesses annually will gain access to financial capital that otherwise would have been denied them. Banks will have a greater incentive to make small loans with the potential to be profitable for the banks. In addition, the small businesses and their banks will experience minimal costs in complying with the program requirements due to the streamlined approval policies to be used.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

As a general rule, LEDC does not compete with the private sector in the provision of commercial credit. The program requires bank involvement for a small business to qualify for a LEDC loan guarantee or loan participation. Direct loans are considered by LEDC only in rare instances where a true credit gap can be identified, the small businesses are viable, and the loans can be priced to reflect their inherently higher risks. General business sector competition is likely to be enhanced by the creation or expansion of markets for additional goods and services resulting from the small business receiving micro loans. It is anticipated that the proceeds of the micro loans will be used to help create and/or sustain jobs in the recipient small businesses.

Brett Crawford  
Executive Director  
9612#066

H. Gordon Monk  
Staff Director  
LegislativeFiscalOffice

## NOTICE OF INTENT

### Department of Economic Development Economic Development Corporation

#### Venture Capital Match Program (LAC 19:VII.2301-2313)

In accordance with R.S. 51:2341-2344, notice is hereby given that the Department of Economic Development, Board of the Louisiana Economic Development Corporation, proposes to revise and implement Rules and Regulations for the Venture Capital Match Program.

These Rules revise an existing program designed to address private capital market failures through the provision of risk capital (typically longer-term equity investment capital) to qualified venture capital funds for reinvestment in small businesses possessing significant growth potential. The proposed revisions improve the flexibility, effectiveness and accountability of the program.

## Title 19

### CORPORATIONS AND BUSINESS

#### Part VII. Economic Development Corporation

##### Subpart 2. Venture Capital Program

#### Chapter 23. Venture Capital Match Program

##### §2301. Eligibility

Eligible applicants are:

1. Venture Capital Funds with a minimum of \$5,000,000 of privately raised capital for risk investment under management with:

a. proven, experienced management recognized in the venture capital community. The management should have significant management experience in recognized venture capital funds;

b. a Louisiana based production office. The production office shall have permanent employees employed by the fund capable of evaluating potential investment opportunities;

c. funds without headquarters located in Louisiana must have a minimum of one year operating history.

2. For the purposes of this Chapter, *Risk Investment* means an investment which may provide equity through the purchase of common stock, preferred stock, partnership rights or any other equity instrument. Additionally it may mean debt positions which may act as equity or have equity features such as subordinated debt, debentures or other such instruments used in conjunction with features intended to yield significant capital appreciation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 15:463 (June 1989), amended LR 23:

##### §2303. Valuation of Investment Fund

The amount of privately raised funds under management shall mean the value of any monies invested or otherwise used as risk capital in businesses plus the unexpended monies available for investment or used as risk capital. The value of an equity investment and/or risk capital investment shall be the amount of dollars actually invested. For the purpose of calculating private capital, only cash and commitments which are available for risk investments at the time of LEDC's match, may be counted in the match amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 15:463 (June 1989), amended LR 23:

##### §2305. Application Procedure

The application shall contain but not be limited to:

An offering memorandum which includes but is not limited to the following:

a. name of fund, address (mailing and physical);

b. specify the amount of LEDC investment/commitment requested;

c. specify the minimum and maximum amounts of non-LEDC capital to be raised if LEDC makes the requested investment/commitment;

d. specify applicant's projected timetable, with milestones for completion of the fund raising;

e. specify whether applicant anticipates taking in all of the committed capital investment at closing, or whether applicant plans a phase in. If a phase-in is planned, specify the proposed schedule. It is permissible to have different scenarios based on the actual amount of capital raised;

f. market—identify the proposed market of the applicant:

i. describe and discuss the types of businesses that the fund will finance. Discuss the extent to which the Fund intends to specialize in certain industries, or if special circumstances will be addressed;

ii. describe the size range of businesses that it is contemplated the fund will finance, with a general indication of where most of the focus is expected;

iii. discuss the life cycle stage or stages of the companies which the fund will likely finance, with an indication of where most of the focus is contemplated, e.g., start-up, expansion;

iv. discuss the geographic area in which the fund plans to focus. Specify the city or parish in which the fund's principal office will be located, and discuss intentions, if any, to establish any additional offices;

v. describe the types of financing instruments that are intended to be utilized for investments, e.g., debentures, notes, preferred stock, royalties, etc.;

g. management assistance—discuss the plans of the Fund to provide management and/or technical assistance to companies for which the Fund provides financing. Discuss the fund's plans for monitoring its financing, and enforcing provisions of loan or investment agreements. Discuss how the Fund plans to handle problem loans and investments;

h. idle funds—describe plans for the management of the idle funds of the Fund;

i. realization of returns by investors—discuss long-term plans and strategies for providing a tangible return to the investors in the fund ;

j. tax and accounting issues—discuss relevant tax and accounting issues for the fund;

k. management structure—describe the proposed management structure for the Fund;

l. describe the proposed responsibilities of each of the members of the management team. If any of these people will not be full time, describe their other activities;

m. describe the responsibilities of any management position for which a person has not been identified;

n. specify any other key people including any advisors, consultants, attorneys and accountants, and submit resumes and/or descriptions of firms. LEDC reserves the right to perform general and criminal background checks on these key people.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 15:463 (June 1989), amended LR 23:

#### **§2307. Amount of Investment**

The Corporation may invest up to \$5,000,000. The Corporation may use its discretion to set the ratio of Corporation investment to private investment. However, the

ratio shall not exceed \$1 of Corporation monies to \$2 of privately raised dollars.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 15:463 (June 1989), amended LR 23:

#### **§2309. Investment Criteria**

The criteria for investment may include but not be limited to the following:

1. The applicant will be required to make a best effort attempt to invest in Louisiana businesses.

2. The investment made by LEDC shall be made no less than the same terms and conditions as others and with the same expected return on investment as other private investors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 15:463 (June 1989), amended LR 23:

#### **§2311. Reporting Requirements**

Funds receiving investments under this program shall submit quarterly and annual financial and narrative reports on the use of monies and all investments made by the fund during the reporting period. The narrative report shall include the number of applications received in addition to other activities. The narrative report shall include a listing of all investors in each business and all subsequent financings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 15:463 (June 1989), amended LR 23:

#### **§2313. Inactivity**

If no activity has occurred in the fund for a period of one year or reporting requirements are not met, the Venture Fund shall be reviewed by the Board of the Corporation. After review the Board may choose to revoke its investment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(C).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Economic Development Corporation, LR 15:463 (June 1989), amended LR 23:

This proposed Rule is scheduled to become effective March 20, 1997, or as soon thereafter, as is practical upon publication in the *Louisiana Register*. Interested persons may comment on the proposed Rules in writing until January 30, 1997, to Brett Crawford, Executive Director, Economic Development Corporation, Box 44153, Baton Rouge, LA 70804 or 339 Florida Street, Suite 402, Baton Rouge, LA 70801.

Brett Crawford  
Executive Director

#### **FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

**RULE TITLE: Venture Capital Match Program**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The implementation costs are projected to be \$4,001,300 in FY 96/97, \$4,002,700 in FY 97/98 and \$4,002,810 in FY

98/99. Of those costs, 100 percent will be funded by LEDC's dedicated fund, the Louisiana Economic Development Fund. There are no cost impacts anticipated for local government units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

An essential purpose of the program is to foster the development of emerging small businesses through the timely provision of risk capital to finance their expansion. As a result of that expansion, it is likely that income and employment tax revenues will increase somewhat. However, owing to the uncertainty and variety of businesses and locations receiving investments from venture funds, as well as other economic factors beyond the control of LEDC, we are not able to estimate the revenue impact on local communities or the state's General Fund. In addition, LEDC's investments in venture funds will be expected to achieve long-term average annual returns on investment of at least 15-20 percent. However, most returns will likely not be realized until at least 4-5 years after the date of investment, and possibly extending out as far as 10-12 years in some cases, depending on the investments made by individual venture funds.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Small Louisiana businesses should benefit from greater opportunities for growth and profitability as a result of increased availability of risk capital. Venture capital funds will benefit from additional financial returns and fund management fees resulting from the additional small business investments made possible by LEDC's investment in the funds. No additional costs are anticipated.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

LEDC's investment in venture funds does not substitute public investment for private investment in the provision of risk capital to small businesses. Notably, LEDC seeks to fill capital gaps while strengthening the private sector's ability to mobilize risk capital on its own. By mobilizing additional risk capital in the state and both broadening and deepening the venture capital industry's base, the proposed changes should enhance the competitiveness of the state's venture capital industry and lower the effective cost of capital to small businesses. Furthermore, the proliferation of small businesses, particularly in the high value-added technology sectors targeted by many venture funds, will help diversify the state's economic base and increase the competitiveness of the general business sector as a result of the creation or expansion of markets for additional goods and services. Such benefits can also accrue to the state as a whole, as a vibrant, diversified business climate can significantly affect the attractiveness of the state to outside investors, particularly in its competitive efforts vis-à-vis other states. Finally, the small businesses receiving investments from venture funds will in most cases be expected to use the funds to significantly expand their operations, likely resulting in employment growth.

Brett Crawford  
Executive Director  
9612#064

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

## NOTICE OF INTENT

### Department of Economic Development Office of Commerce and Industry

#### Enterprise Zone—Advance Notification Timely Filing (LAC 13:I.Chapter 9)

In accordance with the provisions of the Administrative Procedure Act R.S. 49:950 et seq., the Department of Economic Development, Office of Commerce and Industry, Business Incentives Division hereby gives notice of its intention to amend the Board of Commerce and Industry Rules.

As a result of the provisions of Act 194 of 1995, the Board of Commerce and Industry, at its October 23, 1996, meeting voted to adopt a Rule affecting all businesses which do not file timely in applying for financial incentives under the Enterprise Zone Program, under the authority of R.S. 51:1786(5).

#### Title 13 ECONOMIC DEVELOPMENT Part I. Commerce and Industry

##### Subpart 1. Finance

#### Chapter 9. Enterprise Zone Program

##### §905. Endorsement Resolution

Applicants who intend to recover local sales/use taxes must submit a resolution, stating that fact, from the taxing body(s) which intends to refund sales/use taxes for the project, with their application for State benefits. This resolution shall be passed by the local governmental subdivision prior to the applicant receiving approval of that application from the Board of Commerce and Industry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, LR 8:230 (May 1982), amended LR 9:544 (August 1983), LR 11:95 (February 1985), amended by the Department of Economic Development Office of Commerce and Industry, Financial Incentives Division, LR 17:252 (March 1991), LR 22:445 (June 1996), amended by the Business Incentives Division, LR 23:

##### §918. Advance Notification, Timely Filing

A. An Advance Notification received by the Office of Commerce and Industry after the beginning of the project's construction, will obligate the company to file written reason(s) for the late filing. Lack of knowledge of the existence of the Enterprise Zone Program or its benefits will not be accepted as a valid reason for waiving the timely filing requirement and will result in the return of the filing fee. However, the Board will only accept reasons that fall within the following two categories in determining if it will consider waiving the late filing:

1. Events beyond control of the applicant caused the late filing, or

2. There was some fault or error on behalf of the Business Incentives Division that caused the company's late filing.



B. Only after receiving the Board's waiver of timely filing of the Advance Notification will the following apply:

1. If the Advance Notification is received by the Office of Commerce and Industry during the construction period shown on that form, the sales tax rebate will begin the day the Advance Notification with the correct filing fee is received by the Office of Commerce and Industry. The new jobs tax credits, however, may be calculated from the first day that construction began but no earlier.

2. If the Advance Notification is filed after the construction period listed on the Advance Notification form has passed, the company will not be eligible for sales tax rebates. However, the new jobs tax credits may be calculated from the first day the construction began but no earlier.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, Business Incentives Division, LR 23:

### **§919. Filing of Applications**

A. - G. ...

H. Applications must be submitted to the Office of Commerce and Industry, Business Incentives Division at least 60 days prior to the Board of Commerce and Industry meeting where it is intended to be heard.

I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5)

HISTORICAL NOTE: Promulgated by the Department of Commerce, LR 8:230 (May 1982), amended LR 9:544 (August 1983), LR 11:95 (February 1985), LR 12:660 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, Financial Incentives Division, LR 17:252 (March 1991), LR 22:445 (June 1996), amended by the Business Incentives Division, LR 23:

### **§923. Application Shall be Presented to the Board of Commerce and Industry**

The Office of Commerce and Industry, Business Incentives Division shall present an agenda of applications to the Board of Commerce and Industry with the written recommendations of the Secretaries of Economic Development and Revenue and Taxation and, if applicable, the endorsement resolutions outlined in §905 and shall make recommendations to the Board based upon its findings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, LR 8:230 (May 1982), amended LR 9:544 (August 1983), LR 11:95 (February 1985), amended by the Department of Economic Development, Office of Commerce and Industry, Financial Incentives Division, LR 17:252 (March 1991), LR 22:445 (June 1996), amended by the Business Incentives Division, LR 23:

### **§935. Job Creation Requirements - Five New Jobs Must be Created**

For a business to qualify for the benefits of this Chapter, there must be an expansion in the total number of employees. A minimum of five new jobs credits must be generated within the first two years of the contract period. The "base number" from which the number of new jobs will be determined shall meet one of the following:

1. the number of employees that an applicant has on the day before the effective date of the contract. (The effective date will be either the day that the Advance notice was received by the Business Incentives Division or the date that construction begins on the project shown on the Advance Notice but not earlier than the date received unless a waiver of timely filing has been approved by the Board); or

2. the highest number of employees that was certified under an Enterprise Zone contract that was still valid the day before the effective date on the anticipated new Enterprise Zone contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, LR 9:544 (August 1983), amended LR 11:95 (February 1985), amended by the Department of Economic Development, Office of Commerce and Industry, Financial Incentives Division, LR 17:252 (March 1991), LR 22:445 (June 1996), amended by the Business Incentives Division, LR 23:

### **§943. Appeals and Petition Procedure**

A. Applicants who wish to appeal an action of the Board of Commerce and Industry must submit their appeals along with any necessary documentation to the Office of Commerce and Industry, Business Incentives Division at least one month prior to the meeting of the Board of Commerce and Industry or any of its committees during which their appeal will be heard.

B. Petitions, and all documentation, on matters not yet presented to or ruled on, by the Board, must be submitted to the Office of Commerce and Industry, Business Incentives Division at least one month prior to the meeting of the Board or any of its committees in which the petition will be made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, LR 9:544 (August 1983), amended LR 11:95 (February 1985), LR 12:660 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, Financial Incentives Division, LR 17:252 (March 1991), LR 22:445 (June 1996), amended by the Business Incentives Division, LR 23:

Persons who wish to submit comments should contact Paul Adams, Director of Business Incentives, Office of Commerce and Industry, Box 94185, 101 France Street, Baton Rouge, LA 70804, (504) 342-5398. Comments may be made through January 20, 1997.

Harold Price  
Assistant Secretary

### **FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

**RULE TITLE: Enterprise Zone Program**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The State will incur no additional costs to implement the proposed Rule. The proposed Rule will be added to existing Rules used to administer the Enterprise Zone Program. There should be no additional costs to any local government.



II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be some impact to state and local government sales tax revenue collections. The proposed Rule will restrict and effectively deny certain financial incentives to companies applying for the benefits of the Enterprise Zone Program. The estimated annual impact to state sales taxes is \$193,724; and \$48,453 annually to local government sales tax revenues.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

A company applying for state and/or local sales tax refunds, under the Enterprise Zone Program, may be denied refunds of any sales taxes paid on purchases made prior to the date of application. The application date is the date the Business Incentives Division receives the Advance Notification Form and fee. The Board of Commerce and Industry may waive the restriction only if the applicant company can provide a valid reason contained in two categories defined in the proposed Rules. The estimated costs to affected companies would be the same amount as in Section II.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition. All applicants will be subject to rule. There will be no measurable effect on employment. The proposed Rule should have a positive impact on employment. Previously, if an application was denied due to late filing, both the sales tax refund and the job tax credit - financial incentives were denied.

However, the legislative intent of the Enterprise Zone Program is to provide an incentive for companies to create jobs. Therefore, although all sales tax credits may be denied, the proposed Rule will make it possible for the applicant company to still receive the job tax credit for each new permanent job created.

Harold Price  
Assistant Secretary  
9612#025

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**  
**Department of Economic Development**  
**Office of Financial Institutions**

**Capital Companies Tax Credit Program**  
**(LAC 10:XV.301-321)**

In accordance with the authority granted by the Administrative Procedure Act, R.S. 49:950 et seq., and under the authority granted by R.S. 51:1929, the Commissioner of the Office of Financial Institutions proposes to repeal LAC 10:XV.321 and amend LAC 10:XV.301-319 entitled "Louisiana Capital Companies Tax Credit Program," to provide for administration of the Program, definitions and guidelines for participation in the Program by licensed Certified Louisiana Capital Companies.

**Title 10**

**FINANCIAL INSTITUTIONS, CONSUMER CREDIT,  
INVESTMENT SECURITIES, AND UCC**

**Part XV. Other Regulated Entities**

**Chapter 3. Capital Companies Tax Credit Program**

**§301. Description of Program**

These Rules implement the Louisiana Capital Companies (CAPCOs) Tax Credit Program pursuant to R.S. 51:1921 et seq. and R.S. 22:1068(E). This program was created by Act 642 of the 1983 Legislature, amended by Act 891 in 1984, Acts 695 and 915 in 1986, Act 496 in 1989, Acts 279 and 724 of 1993, and Act 21 of 1996.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1921 - 1932.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), LR 18:251 (March 1992), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

**§303. Definitions Provided By Rule**

The following terms shall have the meanings provided herein, unless the context clearly indicates otherwise:

*Affiliate and/or Affiliated Company*—

a. When used with respect to a specified person or legal entity, means a person or legal entity controlling, controlled by or under common control with, another person or legal entity, directly or indirectly through one or more intermediaries.

b. Two or more corporations, partnerships or juridical entities closely related through common ownership or stock ownership; stockholders, members, partners, shareholders or other equivalent owners of the same legal entity that invests in a CAPCO; the surviving entity after a merger into that entity of an insurance company; the transferee from an insurance company in rehabilitation, receivership or liquidation, or, with respect to any insurer, a broker or reinsurer that enters into a bonafide reinsurance contract with such insurer, when used for the purposes of the transfer or sale of income and premium tax credits, pursuant to R.S. 51:1924(F) and R.S. 22:1068(E)(4) and LAC 10:XV.305.B.

c. When used with respect to a qualified Louisiana business means a legal entity that directly or indirectly through one or more intermediaries controls, is controlled by or under common control with a qualified Louisiana business.

d. For purposes of R.S. 22:1068(E)(2)(c), a *Group of Affiliates* shall mean a person and not less than all affiliates of such person.

*Allowable Organization Costs*—those direct costs incurred to incorporate and charter an entity; however, such costs are limited to 25 percent of capitalization, before any reduction for disallowed organization costs.

a. Direct organization costs include, but are not limited to legal, accounting, consulting fees and printing costs directly related to the chartering or incorporation process, pre-opening and development stage enterprise costs that may be capitalized under Generally Accepted Accounting Principles (GAAP) and filing fees paid to chartering authorities.

Allowable organization costs may be capitalized and amortized over a period not to exceed five years.

b. Pre-opening and development stage enterprise costs that generally are not capitalized under GAAP, such as salaries and employment benefits, rent, depreciation, supplies, directors' fees, training, travel, expenses associated with the establishment of business relationships, postage and telephone fees are examples of costs that shall be expensed and not capitalized. Similarly, direct costs associated with the offering and issuance of capital stock are not considered to be organization costs and shall not be capitalized; these costs shall be deducted from the proceeds in recording initial capitalization.

*Application*—a completed application as determined by the Commissioner.

*Associate of a CAPCO*—

a. means any of the following:

i. any person serving as an officer, director, employee (provided such employee has significant management and policy responsibilities and powers, or is highly compensated in comparison with the other people employed with the employee), agent, investment or other advisor, manager (in the case of a manager-managed limited liability company), managing member (in the case of a member-managed limited liability company), accountant, or serving in the capacity as a general/special counsel for the CAPCO or any person that controls the CAPCO, directly or indirectly;

ii. any person directly or indirectly owning, controlling or holding with the power to vote 10 percent or more of the outstanding voting securities or other ownership interests of the CAPCO;

iii. a person that invests in the CAPCO and has received an income tax credit or premium tax reduction under the CAPCO Program;

iv. any affiliate of any person described in Subparagraph a.iii of this Paragraph;

v. any person individually or collectively controlled by or under common control, directly or indirectly, with any person described in Subparagraph a.i and a.ii of this Paragraph;

vi. any officer, director, partner (other than a limited partner), manager (in the case of a manager-managed limited liability company), managing member (in the case of a member-managed limited liability company), agent, or employee (provided such employee has significant management and policy responsibilities and powers, or is highly compensated in comparison with the other people employed with the employee) of any person described in Subparagraph a.i, a.ii, a.iii, a.iv and a.v of this Paragraph;

vii. any person that the CAPCO or any of its affiliates exercises control over and more than 50 percent of whose voting stock or equivalent ownership interests is owned by such CAPCO and its affiliates;

viii. any person, except persons operated by the CAPCO as a means of protecting the CAPCO's investment or resulting from a material breach of any financing agreement, that is operated or acquired by the CAPCO or any of its affiliates with the intention of operating as an on-going

business enterprise. The preceding sentence does not include instances involving transitory or short-term operation of a person by a CAPCO (or an affiliate of the CAPCO) solely: to remedy actions by the person that may cause the CAPCO's investment in such person to fail to be treated as a qualified investment; on the good faith belief that such operation of the person is necessary to ensure that the investment in the person will be treated as a qualified investment; or in response to a 120-day notice issued pursuant to R.S. 51:1927(B);

ix. any current or former spouse, parent, child, sibling, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law or daughter-in-law of any person described in Subparagraphs a.i and a.ii of this Paragraph.

b. For the purposes of this definition, if any associate relationship described in Subparagraph a.i-ix of this Paragraph exists between a person and the CAPCO at any time within six months before or after the date that the CAPCO makes its initial investment in such person, that associate relationship is considered to exist on the date of the financing.

*BIDCO*—a Business and Industrial Development Corporation licensed pursuant to the Louisiana Business and Industrial Development Corporation Act, R.S. 51:2386 et seq.

*Business*—for the purposes of determining if a qualified Louisiana business operates primarily in Louisiana or performs substantially all of its production in Louisiana means an entity, together with all of that entity's affiliates that would directly or indirectly receive an economic benefit from a financing by a CAPCO. For purposes of this definition, an affiliate of the entity includes any entity which will become an affiliate of the entity as a result of a financing from a CAPCO.

*CAPCO*—a Certified Louisiana Capital Company certified pursuant to the Louisiana Capital Companies Tax Credit Program, R.S. 51:1921 et seq.

*Capitalization*—for purposes of initial certification, pursuant to R.S. 51:1925(B):

a. Generally Accepted Accounting Principles (GAAP) Capital: Common stock, preferred stock, general partnership interests, limited partnership interests, and any other equivalent ownership interest, all of which shall be exchanged for cash; surplus; undivided profits or loss which shall be reduced by a fully-funded loan loss reserve; contingency or other capital reserves and minority interests; reduced by disallowed organization costs;

b. LESS: the following, when any preferred or common stock, or partnership interests, or other equivalent ownership interests are subject to redemption or repurchase by the CAPCO:

Preferred stock, common stock, partnership interests, or limited partnership interests, and other equivalent ownership interests shall be multiplied by the following percentage reductions and deducted from capital:

Within 5 years from redemption or repurchase	20 %
Within 4 years from redemption or repurchase	40 %
Within 3 years from redemption or repurchase	60 %
Within 2 years from redemption or repurchase	80 %
Within 1 year from redemption or repurchase	100 %

c. Notwithstanding the foregoing, there will be no reduction for a withdrawal within five years after certification, provided the withdrawal is contemplated by all governing documents and disclosed to all prospective investors and any such withdrawal is concurrently replaced by an equal amount of cash GAAP capital. Moreover, the amount contemplated to be withdrawn shall not be the basis for any income tax credit or premium tax reduction.

*Commissioner*—the Commissioner of the Office of Financial Institutions.

*Control*—

a. the power or authority, whether exercised directly or indirectly, to direct or cause the direction of management and/or policies of a legal entity by contract or otherwise; or

b. to directly or indirectly own of record or beneficially hold with the power to vote, or hold proxies with discretionary authority to vote, 25 percent or more of the then outstanding voting securities issued by a legal entity, when such control is used with respect to a specified person or legal entity; or

c. the power or authority, whether exercised directly or indirectly, to direct or cause the direction of management and/or policies of a legal entity by contract or otherwise; or to directly or indirectly own of record or beneficially hold with the power to vote, or hold proxies with discretionary authority to vote 50 percent or more of the then outstanding voting securities issued by a legal entity, when such control is used with respect to the definition of a qualified Louisiana business.

*Date Certified, Newly Certified or Designated as a Certified Louisiana Capital Company*—the date that the Department notifies a CAPCO of its certification.

*Date on Which an Investment Pool Transaction Closes*—for purposes of LSA-R.S. 51:1923(8) and (9) means all investments of certified capital received during any calendar month and shall be treated as a single investment pool and such investment pool's investment date shall be the last day of the month in which the certified capital was received.

For example: if a CAPCO receives certified capital on March 3 and March 15, the investment pool is the total of both investments received between the period of March 1 and March 31 and the investment date that the transaction closes is March 31.

*Equity Features*—includes [pursuant to R.S. 51:1923(4) and Qualified Investment as hereinafter defined pursuant to R.S. 51:1923(5)] the following:

a. *Royalty Rights*—rights to receive a percent of gross or net revenues, may be either fixed or variable, may provide for a minimum or maximum dollar amount per year or in total, may be for an indefinite or fixed period of time, and may be based upon revenues in excess of a base amount.

b. *Net Profit Interests*—rights to receive a percent of operating or net profits, may be either fixed or variable, may provide for a minimum or maximum dollar amount per year or in total, may be for an indefinite or fixed period of time, and may be based upon operating or net profits in excess of a base amount.

c. *Warrants for Future Ownership*—options on the stock of the Qualified Louisiana Business. The Qualified

Louisiana Business may repurchase a warrant (a "call") or the Qualified Louisiana Business may be required to repurchase a warrant (a "put") at some fixed amount or an amount based on a pre-agreed upon formula.

d. *Equity Sale Participation Rights*—conversion options of debt, to convert all or a portion of the debt to the Qualified Louisiana Business's stock, then to participate in the sale of the stock of the qualified Louisiana business.

e. Subordinated debt with a maturity of not less than five years that is issued concurrently with the purchase of a significant equity interest in a qualified Louisiana business.

f. And such other conceptually similar rights and elements as the OFI may approve.

*Financing Assistance Provided in Cash and the Investment of Cash*—a transaction, which in substance and in form, results in a disbursement of cash. Examples of transactions excluded from this definition are: circular transactions as determined by the Commissioner; capitalization of accrued principal, interest, royalty or other income; letters of credit; loan guarantees; loan collection expenses or legal fees incurred by a CAPCO in protecting its collateral interest in an investment.

*Investment*—for purposes of earning tax credits or reductions under LSA-R.S. 51:1923(1), 1924(A) and (B), or R.S. 22:1068(E), means a transaction that, in substance and in form, is an exchange of cash for:

a. common stock, preferred stock, or an equivalent ownership interest in a CAPCO; or

b. a loan receivable or note receivable from a CAPCO which has a stated final maturity date of not less than five years from the origination date of the loan or note;

c. notwithstanding the above, an investment shall also include debt instruments which are obligations of the investing insurance company to a certified Louisiana capital company. Such debt instruments shall be converted into cash at a rate of not less than 10 percent per year from the date of the investment. However, at all times, the CAPCO shall have at least 50 percent of its certified capital which is received in cash available for investment in or invested in qualified investments in qualified Louisiana businesses.

*Investment Furthers Economic Development within Louisiana*—if the proceeds from the investment are used in a manner consistent with representations contained in the affidavit required to be obtained from the qualified Louisiana business prior to an investment in the business and the documented use of such proceeds promote Louisiana economic development. Proceeds shall be determined to promote Louisiana economic development if more than 50 percent of the proceeds derived from the investment are used by the qualified Louisiana business for two or more of the following purposes:

a. to hire significantly more Louisiana employees;

b. to purchase furniture, fixtures or equipment that will be used in the Louisiana operations of the business or construct or expand production or operating facilities located in Louisiana;

c. to purchase inventory for resale from Louisiana-based operations or outlets;

d. to capitalize a business in order for the business to secure future debt financing to support the Louisiana operations of the business;

e. to increase working capital for Louisiana operations of the business;

f. to preserve or expand Louisiana corporate headquarters operations;

g. to support research and development or technological development within Louisiana;

h. to fund start-up businesses that will operate primarily in Louisiana;

i. the CAPCO requests in writing and the Commissioner issues a written response to the CAPCO that, based upon relevant facts and circumstances, the proposed investment will further specific Louisiana economic purposes and create a net benefit to the state as a result of the financing. The Commissioner's letter opinion shall be issued within 30 days of the request by the CAPCO, and shall be part of the annual review required to be performed by the Department and billed according to provisions contained in §307.D of this Section.

*Louisiana Employees*—full-time employees and part-time employees converted on a full time equivalent basis, and independent contractors of the business that would be subject to Louisiana withholding taxes (treating for this purpose all such payees as employees and ignoring any exemptions from Louisiana withholding taxes that a payee may be able to use based on the specific circumstances of such payee.)

*Net Income*—net income as defined under or consistent with Generally Accepted Accounting Principles.

*Net Worth*—net worth as defined under or consistent with Generally Accepted Accounting Principles.

*Office*—the Office of Financial Institutions (OFI).

*Operates Primarily in Louisiana*—a business operates primarily in Louisiana if, at the time of the initial investment, the business is in good standing with the Louisiana Secretary of State, if applicable, and meets one or more of items in Subparagraph(s) a-d below:

a. the business has more than 50 percent of its total assets located in Louisiana;

b. more than 50 percent of the business' income is allocable or apportionable to Louisiana in accordance with Louisiana income tax law, but disregarding whether the business is taxable or tax-exempt for Louisiana income tax purposes;

c. more than 50 percent of the total wages paid to all employees of the business are subject to Louisiana withholding taxes;

d. the CAPCO has, prior to investing in the business, received a written opinion from the Commissioner that, based upon relevant facts and circumstances, the business has demonstrated it operates primarily in Louisiana and will continue to operate primarily in Louisiana for at least one year from the date of any financing by a CAPCO. The Commissioner's letter opinion shall be issued within 30 days of the request by the CAPCO, and shall be part of the annual review required to be performed by the Department and billed according to provisions contained in §307.D of this Chapter.

*Participations Between CAPCOs*—are loans in which one or more CAPCOs have an ownership interest. If the loan is determined to meet the definition of a qualified investment, a CAPCO may only include its participation (ownership interest) as a qualified investment.

*Performs Substantially all of its Production in Louisiana*—a business performs substantially all of its production in Louisiana if it derives more than 50 percent of its gross receipts from the sale of manufactured, produced or processed goods and in which more than 50 percent of the total value added to the finished product is performed within Louisiana.

*Permissible Investments*—for purposes of R.S. 51:1926(B), cash deposited with a federally-insured financial institution; certificates of deposit in federally-insured financial institutions; investment securities that are obligations of the United States, its agencies or instrumentalities, or obligations that are guaranteed fully as to principal and interest by the United States; investment-grade instruments (rated in the top four rating categories by a nationally recognized rating organization); obligations of any state, municipality or of any political subdivision thereof; or any other investments approved in advance and in writing by the Commissioner.

*Person*—a natural person or juridical entity. If used with respect to acquiring control of or controlling a specified person, *Person* includes a combination of two or more persons acting in concert.

*Primary Business Activity of a CAPCO*—that a CAPCO is expected to invest its certified capital primarily in qualified investments in qualified Louisiana businesses. Such activity is demonstrated by having at all times, a minimum of 50 percent of total certified capital, which has been collected in cash, available for investment in or having been invested as qualified investments.

*Total Certified Capital or Certified Capital*—for purposes of R.S. 51:1926, 1927 and 1928, the total of all investments into a given investment pool or CAPCO, as applicable, pursuant to R.S. 51:1924(A) and (B) and R.S. 22:1068(E).

*Total Certified Capital Under Management*—for purposes of investment limits, pursuant to R.S. 51:1926(B):

a. *GAAP Capital*—common stock, preferred stock, general partnership interests, limited partnership interests and other equivalent ownership interests, all of which shall be exchanged for cash; surplus; undivided profits or loss which shall be reduced by a fully-funded loan loss reserve; contingency or other capital reserves and minority interests; reduced by disallowed organization costs.

b. *PLUS Qualified NON-GAAP Capital*—the portion of debentures, notes or any other quasi-equity/debt instruments with a maturity of not less than five years which is available for investment in qualified investments.

c. *LESS*—the following, when any GAAP capital or qualified non-GAAP capital is subject to redemption or repurchase by the CAPCO:

The GAAP capital and qualified non-GAAP capital subject to redemption or repurchase shall be multiplied by the following percentage reductions and deducted from capital:

Within 5 years from redemption or repurchase	20 %
Within 4 years from redemption or repurchase	40 %
Within 3 years from redemption or repurchase	60 %
Within 2 years from redemption or repurchase	80 %
Within 1 year from redemption or repurchase	100 %

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1921 - 1932.

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), LR 18:251 (March 1992), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

### §305. Income and Premium Tax Credits

A. In order to be eligible for any income or premium tax credits, debentures, notes or any other quasi-equity/debt instruments shall have an original maturity date of not less than five years from the date of issuance. If an investment is in the form of stock, a partnership interest, or any other equivalent ownership interest, such investments shall not be subject to redemption or repurchase within five years from the date of issuance. Except in the case where a CAPCO voluntarily decertifies and preserves all income and premium tax credits, if debentures, notes or any other quasi-equity/debt instruments or stock, partnership interests, or other equivalent ownership interests are redeemed or repurchased within five years from issuance, any income or premium tax credits previously taken, to the extent applicable to the investment redeemed or repurchased, shall be repaid to the Department of Insurance or the Department of Revenue and Taxation at the time of redemption, and any remaining tax credits shall be forfeited, pursuant to R.S. 51:1927 and R.S. 51:1928. Amortization of a note over its stated maturity does not constitute a redemption or repurchase under this Subpart.

B. Income or premium tax credits may be sold or transferred, subject to the following conditions:

1. The transfer or sale of income or premium tax credits, pursuant to R.S. 51:1924(F) or R.S. 22:1068(E)(4), will be restricted to transfers or sales between affiliates.

2. Companies shall submit to the Commissioner in writing, a notification of any transfer or sale of income or premium tax credits within 30 days of the transfer or sale of such credits. The notification shall include the original investor's income or premium tax credit balance prior to transfer, the remaining balance after transfer, all tax identification numbers for both transferor and acquiror, the date of transfer, and the amount transferred. The notification shall include the original investor's income or premium tax credit balance

3. If an insurance company transfers premium tax credits between affiliates the notification submitted to the Office must include a worksheet, which the company and each affiliate shall also attach to their premium tax returns, that shall contain the following information for each affiliate:

- a. name of each affiliate;
- b. the gross premium tax liability;
- c. credits taken under R.S. 22:1068(A);
- d. credits taken under R.S. 22:1068(B);
- e. credits taken under R.S. 22:1068(C);
- f. credits taken under R.S. 22:1068(D);
- g. Louisiana Insurance Guaranty Association (LIGA) Credits;

h. Louisiana Life and Health Insurance Guaranty Association (LHIGA) Credits;

i. net premium tax liability before CAPCO Premium Tax Reductions;

j. credits taken under R.S. 22:1068(E); and

k. net premium tax liability after all credits.

4. If income tax credits are transferred between affiliates, the notification submitted to the Office must include a worksheet, which the transferor and each affiliate shall also attach to their Louisiana corporate and individual income tax returns for all affiliates claiming income tax credits, which shall contain the following information, for each corporation or individual involved:

a. name of each affiliate;

b. the Gross Louisiana Corporation or individual income tax liability of each affiliate; and

c. credits taken under R.S. 51:1924(A) and (B).

5. Failure to comply with this Rule will jeopardize the income or premium tax credit transferred.

6. The Office will notify the Department of Revenue and Taxation or the Department of Insurance of all transactions involving the transfer or sale of premium or income tax credits granted under R.S. 51:1924 or R.S. 22:1068, and reported pursuant to R.S. 51:1925(D).

7. The transfer or sale of income or premium tax credits, pursuant to R.S. 51:1924(F) or R.S. 22:1068(E)(4), shall not affect the time schedule for taking such tax credits, as provided in R.S. 51:1924(A) and (E) or R.S. 22:1068(E)(3), respectively. Any income or premium tax credits transferred or sold pursuant to R.S. 51:1924(F) or R.S. 22:1068(E)(4), which credits are subsequently recaptured pursuant to R.S. 51:1927(C) and 51:1928(A) or R.S. 22:1068(E)(4), shall be the liability of the taxpayer which actually claimed the credit.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1924(F) and 1929, and R.S. 22:1068(E).

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended LR 12:664 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), LR 16:762 (September 1990), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

### §307. Application Fees, Other Fees

A. An "advance notification" of intent to seek certification shall be filed by a company or entity, "the applicant," prior to filing an application. An advance notification fee of \$100 shall be submitted with the advance notification form.

B. An application fee shall be submitted with the application based on 0.2 percent of the estimated total amount of taxes to be exempted. In no case shall an application fee be smaller than \$200 and in no case shall a fee exceed \$5,000.

If, at the close of the 12-month funding period, 0.2 percent of the total taxes to be exempted exceeds the amount of the application fee originally submitted, the CAPCO shall submit the difference, up to the \$5,000 maximum, to the Office. Checks should be payable to: Louisiana Office of Financial Institutions.

C. The Office reserves the right to return the advance notification, application, or affidavit of final cost to the applicant if the estimated exemption or the fee submitted is incorrect. The document may be resubmitted with the correct fee. The document will not be considered officially received and accepted until the appropriate fee is submitted. Processing fees, for advance notifications and applications which have been accepted, will not be refundable.

D. The Commissioner shall conduct an annual review of each CAPCO to determine the company's compliance with the Rules and Statutes. Examiner time shall be billed at a rate not less than \$50 per hour, per examiner, or \$500 per review, whichever is greater.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1925, 1927 and 1929.

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 12:664 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

#### **§309. Application Process**

A. A company organized and existing under the laws of Louisiana, created for the purpose of making qualified equity investments, or financing assistance as a licensed BIDCO, as required in R.S. 51:1921 et seq., shall make written application for certification to the Commissioner on application forms provided by the Office.

B. The form for applying to become a CAPCO may be obtained from the Office of Financial Institutions, P.O. Box 94095, Baton Rouge, Louisiana 70804-9095, and shall be filed at the same address. The time and date of filings shall be recorded at the time of filing in the Office and shall not be construed to be the date of mailing.

C. Said application and all submissions of additional information reported to the Office, shall be forwarded via United States Mail or private or commercial interstate carrier, properly addressed and postmarked and signed by a duly authorized officer, manager, member or partner and shall be made pursuant to procedures established by the Commissioner.

D. The Commissioner shall cause all applications to be reviewed by the Office and designate those he determines to be complete. In the event that an application is deemed to be incomplete in any respect, the applicants will be notified within 30 days of receipt. An incomplete application shall be resubmitted, either in a partial manner or totally, as deemed necessary by the Commissioner. A previously incomplete application may be resubmitted, which will establish a new time and date received for that application.

E. The submission of any false or misleading information in the application documents will be grounds for rejection of the application and denial of further consideration, as well as

decertification, if such information discovered at a subsequent date would have resulted in the denial of such license. Whoever knowingly submits a false or misleading statement to a CAPCO and/or the Department may be subject to civil and criminal sanctions.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1925 and 1929.

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended LR 12:664 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

#### **§ 311. Conditions of Certification**

A. All CAPCOs, through an act under private signature executed by the business, duly acknowledged pursuant to Louisiana law, shall certify and acknowledge all of the following conditions for certification as a certified Louisiana capital company and shall certify and acknowledge that the act statement is true and correct:

1. The CAPCO has an initial capitalization of not less than \$200,000. If any capitalization is repurchased or contemplated to be repurchased by the CAPCO within five years after certification, the CAPCO will concurrently replace any repurchased capital with cash capital, as defined under Generally Accepted Accounting Principles. Furthermore, any contemplated repurchases shall be disclosed in all governing documents to all prospective investors. The amount repurchased shall not be the basis for any income tax credits or premium tax reductions.

2. The CAPCO will notify, in writing, the Office prior to the sale or redemption of stock, partnership interests or debentures constituting 10 percent or more of the then outstanding shares, partnership interests or debentures.

3. The Board of Directors will not elect new or replace existing board members or declare dividends without prior written consent of the Office for the first two years of business.

4. The CAPCO will immediately notify the Office when its total certified capital under management is not sufficient to enable the CAPCO to operate as a viable going concern.

5. The CAPCO will not engage in any activity which represents a material difference from the business activity described in its application without first obtaining prior written approval by the Office.

6. The CAPCO will comply with the CAPCO Act and all applicable rules, regulations and policies that are currently in effect or enacted after the date of certification.

7. The CAPCO will adopt OFI's valuation guidelines and record retention policies.

8. Any other conditions deemed relevant to the Commissioner.

B. If a CAPCO contemplates any public or private securities offerings, prior to the certification of any tax benefits resulting from the Certified Capital raised through such offerings, the CAPCO shall have a securities attorney provide a written opinion that the company is in compliance with Louisiana securities laws, federal securities laws, and the securities laws of any other states where the offerings have



been made. Copies of all offering materials to be used in investor solicitations must be submitted to the Office, prior to investor solicitation.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1925 and 1929.

**HISTORICAL NOTE:** Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

### **§313. Requirements for Continuance of Certification and Voluntary Decertification**

A. In calculating the percentage requirements for continued certification under Subsection A of R.S. 51:1926, and voluntary decertification under R.S. 51:1928;

1. The numerator shall be:

a. 100 percent of the sum of all qualified investments held for a minimum of one year; and

b. 50 percent of the sum of all qualified investments held less than one year; and

c. 50 percent of the sum of all qualified investments intended to be held less than one year; and

d. 100 percent of the sum of all qualified investments that are intended to be held for a minimum of one year, as determined by the Commissioner, if, at the time that the percentage requirements for continued certification under Subsection A of R.S. 51:1926 and voluntary decertification under R.S. 51:1928 are reviewed, the investment is on the books and is intended to remain on the books for a minimum of one year.

2. For purposes of the calculation of the numerator, no qualified investment may be counted more than once.

3. The denominator shall be total certified capital.

B. If a CAPCO invests a portion of its total certified capital in a majority-owned BIDCO the qualified investments made by the majority-owned BIDCO shall be added to the numerator under Subsection A of this Section.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1926 and 1929.

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), LR 18:251 (March 1992), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

### **§315. Information Required from Qualified Louisiana Businesses**

Prior to making an investment in a business, a CAPCO shall obtain, from an authorized representative of the business, a signed affidavit, the original of which shall be maintained by the CAPCO in its files. The affidavit shall contain all of the following:

a. full and conclusive legal proof of the representative's authority to act on behalf of the business. For example, a board resolution;

b. a binding waiver of rights and consent agreement sufficient to allow the CAPCO, upon request to the business, full access to all information and documentation of the business which is in any way related to the investment of the CAPCO in the business;

c. completed forms, certifications, powers of attorney, and any other documentation, as determined by the Commissioner,

sufficient to allow acquisition by the CAPCO of any of the information and/or records of the business in the possession of any other business or entity, including but not limited to, financial institutions and state and federal governmental entities;

d. a statement certifying the intended use of proceeds, and that the business will provide to the CAPCO, documentation of the use of proceeds.

e. an act under private signature executed by the business, duly acknowledged pursuant to Louisiana law, certifying all of the above and foregoing as being true and correct.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1926, 1927, 1928 and 1929.

**HISTORICAL NOTE:** Promulgated by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

### **§317. CAPCO Report and Record Requirements**

A. Reporting Requirements. Pursuant to LSA-R.S. 51:1926(F)(2), CAPCOs are required to submit to the Department reports of selected information for each Qualified Investment made in the previous calendar year. Senate Concurrent Resolution Number 40 of the 1996 Regular Session also requires that the Department determine the economic development impact of the CAPCO Program on the state. In order to provide such a report to the Senate, economic information for each company in which a CAPCO has invested shall be obtained and reported to the Department by each CAPCO. Such reports shall be submitted on forms provided or approved by OFI.

B. Record Requirements. In order for the Commissioner to properly review and analyze a CAPCO's compliance with this Rule and all relevant statutes, each CAPCO shall obtain from each business in which the CAPCO has invested, and maintain in its possession for review, any and all records deemed necessary by the Commissioner.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1926 and 1929.

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), LR 18:251 (March 1992), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

### **§319. Premium Tax Reductions for Insurance Companies**

A. The Allowable Annual Premium Tax Credit (AAPTC) that may be taken during any year shall be the lesser of:

1. 10 percent of premium tax reduction allowable; or

2. 25 percent of the gross premium tax liability for the base year of investment. Furthermore, the credit taken in any year shall not exceed the net premium tax liability for that year.

B. The Premium Tax Reduction Allowable (PTRA) is 120 percent of the investment in a CAPCO.

C. The Gross Premium Tax Liability in the base year of Investment (GPTLB) is the gross premium tax liability in the year of investment, before any credits.

D. The Gross Premium Tax Liability (GPTL) is the gross premium tax liability during any year for which the CAPCO credit may be taken, before any credits.



E. The Net Premium Tax (NPT) is the GPTL, reduced by credits provided in R.S. 22:1068(A), (B), (C) and (D), and credits for Louisiana Insurance Guaranty Association (LIGA) and Louisiana Life and Health Insurance Guaranty Association (LHIGA) assessments. If the AAPTC ever exceeds the NPT in any year, the excess may be carried forward until utilized.

**EXAMPLE:**

Base ("Taxable") years of investment, assuming multiple investments of \$2,000,000 and \$1,000,000, respectively, by an insurer in CAPCOs.

	1993	1994
Investment by Insurer *	2,000,000	1,000,000
Premium Tax Reduction Allowable "PTRA" (120 percent of Investment)	2,400,000	1,200,000
Gross Premium Tax Liability "GPTL" of Insurer	1,000,000	1,100,000
Credits from R.S. 22:1068(A), (B), (C), (D), LIGA or LHIGA	(600,000)	(540,000)
Net Premium Tax Before CAPCO Credits "NPT"	400,000	560,000
Allowable Annual Premium Tax Credit "AAPTC" For the Base Year of Investment is the Lesser of:		
(1) 10 percent of PTRA	240,000	120,000
(2) 25 percent of GPTLB	250,000	275,000
And further limited to		
100 % of NPT	400,000	560,000
For subsequent years, the AAPTC for each investment is the		
(1) The Base Year Reduction	240,000	120,000
(2) 100% of NPT for the Subsequent Years		

If Net Premium Tax liabilities of \$500,000 per year are estimated for the period of 1993 through 2003, the following amount of AAPTC may be taken:

YEAR	1993	1994	AAPTC
1993	(240,000 + 0	)	\$ 240,000
1994	(240,000 + 120,000)		360,000
1995	(240,000 + 120,000)		360,000
1996	(240,000 + 120,000)		360,000
1997	(240,000 + 120,000)		360,000
1998	(240,000 + 120,000)		360,000
1999	(240,000 + 120,000)		360,000
2000	(240,000 + 120,000)		360,000
2001	(240,000 + 120,000)		360,000
2002	(240,000 + 120,000)		360,000
2003	( 0 + 120,000)		120,000
<b>TOTAL</b>			<b>\$3,600,000</b>

\* Note: The amount of investment by an insurer in a CAPCO, in any one year, that would maximize the use of premium tax credits is calculated as follows: (GPTLB x 25 % x 10 yrs) / 1.20. In this example, the formula would yield an investment amount of \$2,083,333 in 1993 and \$2,291,666 in 1994.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 22:1068(E) and R.S. 51:1929.

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), LR 18:251 (March 1992), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), LR 23:

**§321. Reports to the Office of Financial Institutions Repealed.**

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 51:1926.

**HISTORICAL NOTE:** Promulgated by the Department of Commerce, Office of Commerce and Industry, Finance Division, LR 10:872 (November 1984), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 15:1050 (December 1989), LR 18:251 (March 1992), amended by the Department of Economic Development, Office of Financial Institutions, LR 20:154 (February 1994), repealed LR 23:

Written comments regarding this Rule shall be submitted no later than February 14, 1997 to John P. Ducrest, Deputy Chief Examiner, Office of Financial Institutions, Box 94095, Baton Rouge, LA 70804-9095, or by delivery to 8660 United Plaza Boulevard, Second Floor, Baton Rouge, LA 70809-7024.

Larry L. Murray  
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Louisiana Capital Companies  
Tax Credit Program**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
Implementation costs are estimated at \$1,600 and are composed of the following: publishing fees for the *Louisiana Register* of \$1,500 and \$100 for copies of the Rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
Examination fee revenue is expected to increase by \$9,600 in FYE 96/97; \$8,000 in FYE 97/98; and \$6,400 in FYE 98/99.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
Individual CAPCOs can expect to pay \$800 in additional examination fees for FYE 96/97, 97/98, and 98/99. This will result in the CAPCO industry, as a whole, paying increased examination fees of \$9,600 in FYE 96/97; \$8,000 in FYE 97/98; and \$6,400 in FYE 98/99.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
Competition and employment are not expected to be affected by this Rule.

Larry L. Murray  
Commissioner  
9612#073

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Economic Development  
Office of Financial Institutions**

**Fees and Assessments (LAC 10:I.201)**

In accordance with R.S. 49:950 et seq., the Louisiana Administrative Procedure Act, and as provided under R.S. 6:126(A), the Commissioner of the Office of Financial Institutions gives Notice of Intent to amend the Rule promulgated in LR 19:1546 (December 1993), and subsequently amended in LR 21:1069 (October 1995), to reduce the fee charged Louisiana state-chartered banks, savings and loan associations and savings banks for the establishment of an electronic financial terminal.

**Title 10**

**FINANCIAL INSTITUTIONS, CONSUMER CREDIT  
INVESTMENT SECURITIES AND UCC**

**Part I. Financial Institutions**

**Chapter 2. Fees and Assessments**

**§201. Establishment of Fees and Assessments**

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no effect on the revenue collections of state or local governmental units. In addition to fee income, this Office charges a variable assessment on financial institutions in order to cover our costs of operation. The amount of the assessment is calculated by first estimating expenditures for the next six-month period. From this estimate, expected fee income is subtracted to yield the amount which will be assessed. Therefore, all fee income lost will be offset by a proportional increase in the variable assessment charged to banks, savings and loan associations, and savings banks.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

The proposed revision will have a neutral effect on the entities covered by this Rule with respect to any estimated costs. The proposed revision will have no effect on the economic benefits of the entities covered by this Rule.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

There will be no effect on competition and employment.

Larry L. Murray  
Commissioner  
9612#074

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Board of Elementary and Secondary Education**

**Bulletin 741—Class Size Waivers**

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary approved for advertisement, an amendment Bulletin 741, Policy 1.00.40.c as stated below:

**1.00.40.c Administrative Waivers of Bulletin 741 Standards**

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

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

i. a letter from the local superintendent detailing each class that exceeds the class size;

ii. documentation from the principal and the superintendent showing how efforts have been made to comply with standards; and

iii. a copy of the school's master schedule with class sizes included;

iv. class sizes above the limit of two will go directly to the appropriate board committee with an executive recommendation from the Department.

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

i. a letter of justification from the local superintendent;

DESCRIPTION	FEE
A. - D. ...	
E. Notification by a state bank, savings and loan association, or savings bank for an off-site electronic financial terminal machine. Fee is nonrefundable.	\$100
F. - AE. ...	

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 6:126 A.

**HISTORICAL NOTE:** Promulgated by the Department of Economic Development, Office of Financial Institutions LR 19:1546 (December 1993), amended LR 21:1069 (October 1995), LR 23:

All interested persons are invited to submit written comments on this proposed Rule no later than 5 p.m., February 14, 1997, to John P. Ducrest, Deputy Chief Examiner, Officer of Financial Institutions, Box 94095, Baton Rouge, LA 70804-9095, or by delivery to 8660 United Plaza Boulevard, Second Floor, Baton Rouge, LA 70809.

Larry L. Murray  
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Fees and Assessments**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The only anticipated cost associated with the implementation of this Rule is the \$60 publication cost in the *Louisiana Register*.

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

2. Waivers for Deadlines

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

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

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

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

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

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

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

Implementation to begin with the 1990-91 school year.

4. Waivers for Time Requirements

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

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

5. Waivers for Integrated Curricula

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

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

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

HISTORICAL NOTE: Amended by the Board of Elementary and Secondary Education, LR 23:

Interested persons may submit comments on the proposed amendment until 4:30 p.m., February 10, 1996 to: Jeannie Stokes, State 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—Class Size Waivers**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
BESE estimated cost for printing this policy change and first page of fiscal and economic impact statement in the *Louisiana Register* is approximately \$140. Funds are available.

- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There is no estimated 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 estimated costs and/or economic benefits to directly affected persons or nongovernmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There is no estimated effect on competition and employment.

Marlyn Langley  
Deputy Superintendent  
Management and Finance  
9612#078

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Board of Elementary and Secondary Education**

**Bulletin 741—GED Minimum Score**

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 a revision to Bulletin 741, Standard 1.124.05, referenced in the *Louisiana Administrative Code*, Volume 18, Title 29, Section 28:1.953.E.5. Standard 1.124.05 in Bulletin 741 is revised as follows:

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

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

HISTORICAL NOTE: Amended by the Board of Elementary and Secondary Education, LR 23:

Interested persons may submit written comments on the proposed revision until 4:30 p.m. February 10, 1997 to: Jeannie Stokes, State 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—GED Minimum Score**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There is no implementation cost to local governmental units. It is estimated that at least one page of Bulletin 741 will need to be printed and disseminated. The estimated cost is \$100.  
BESE estimated cost for printing this policy change and first page of fiscal and economic impact statement in the *Louisiana Register* is approximately \$40. Funds are available.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There is no effect on revenue collections of state and local governments.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There are no costs and/or economic benefits to directly affected persons or nongovernmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no effect on competition and employment.

Marlyn Langley  
Deputy Superintendent  
Management and Finance  
9612#076

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Board of Elementary and Secondary Education**

**Bulletin 1638—Cardiopulmonary Resuscitation (CPR)**

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, revised Bulletin 1638 and an amendment to Louisiana Handbook for School Administrators, and Bulletin 741, Standard 2.105.15 to revise the procedural block immediately following this standard as stated below:

“Cardiopulmonary Resuscitation (CPR) shall be taught. Refer to Bulletin 1638, Revised, 1996”

With CPR instruction a required part of the curriculum in Louisiana schools, guidelines were developed to assist local school districts in implementation of CPR instruction. These guidelines were developed by the State Department of Education, Coordinator of Comprehensive School Health of the State Department of Education, the American Heart Association, and the American Red Cross.

Revised Bulletin 1638, Standards for CPR Training in Louisiana Schools, Revised 1996 which provides guidelines and/or standards for instruction in Cardiopulmonary Resuscitation, will be distributed to all parishes and all health education coordinators. The Bulletin may also be seen in the Department of Education, or in the office of the Board of Elementary and Secondary Education located in the Education Building in Baton Rouge, Louisiana.

Interested persons may submit comments until 4:30 p.m., February 10, 1997 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 1638—CPR**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Four hundred copies of the revised Cardiopulmonary Resuscitation (CPR), Bulletin Number 1638, (formerly titled "Guidelines for CPR Training in Louisiana Schools," now titled

"Standards for CPR Training in Louisiana Schools") will be produced for distribution to all parishes and all health education coordinators. At least 100 copies will remain with the Department for distribution as needed. Costs for all copies will be \$650.

Funds are available. BESE estimated cost for printing this policy change and first page of fiscal and economic impact statement in the *Louisiana Register* is approximately \$75. Funds are available.

BESE estimated cost for printing

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no costs and/or economic benefits to directly affected persons or nongovernmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition and employment.

Marlyn Langley  
Deputy Superintendent  
Management and Finance  
9612#077

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Board of Elementary and Secondary Education**

**Required Services (LAC 28:I.1713)**

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement, a revision to LAC 28:I.1713 B.4 as follows:

**Title 28**

**EDUCATION**

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

\* \* \*

**B. Required Services Act: Guidelines**

1. - 3. ...

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

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

HISTORICAL NOTE: Amended by the Board of Elementary and Secondary Education, LR 23:

Interested persons may submit written comments on the proposed revision until 4:30 p.m. February 10, 1997 to: Jeannie

Weegie Peabody  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Required Services**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be no cost of implementation of this change to either the schools or the Department.  
BESE estimated cost for printing this policy change and the first page of fiscal and economic impact statement in the *Louisiana Register* is approximately \$80. Funds are available.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
This policy has been in effect since 1980. There will be no effect on revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
There will be no costs and/or economic benefits which directly affect persons or nongovernmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There will be no effect on competition and employment.

Marlyn Langley  
Deputy Superintendent  
Management and Finance  
9612#075

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

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

Adoption by Reference (LAC 33:IX.2301)(WP022\*)

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Secretary gives notice that rulemaking procedures have been initiated to amend the Water Pollution Control Division Regulations, LAC 33:IX.2301.F (WP022\*).

This proposed Rule is identical to a federal law or regulation which is applicable in Louisiana, therefore, no fiscal or economic impact will result from the proposed Rule. The Rule will be promulgated in accordance with R.S. 49:953(F)(3) and (4).

This Rule clarifies that references to the Code of Federal Regulations (CFR) contained in LAC 33:IX.Chapter 23 (e.g., 40 CFR 122.29) shall refer to those Regulations published in the July 1994 Code of Federal Regulations, unless otherwise noted.

**Title 33  
ENVIRONMENTAL QUALITY**

**Part IX. Water Quality**

**Chapter 23. The 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 1994 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:

A public hearing will be held on January 24, 1997, at 1:30 p.m. in the Maynard Ketcham Building, Room 326, 7290 Bluebonnet Boulevard, Baton Rouge, LA 70810. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate please contact Patsy Deaville at the address given below or at (504)765-0399.

All interested persons are invited to submit written comments on the proposed Regulations. Commentors should reference this proposed Regulation by WP022\*. Such comments should be submitted no later than January 24, 1997, at 4:30 p.m., to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70810 or to FAX (504)765-0486. The comment period for this Rule ends on the same date as the public hearing.

Linda Levy  
Assistant Secretary

9612#069

**NOTICE OF INTENT**

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

Best Management Practices (LAC 33:IX.2560)(WP021\*)

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Secretary gives notice that rulemaking procedures have been initiated to amend the Water Pollution Control Division Regulations, LAC 33:IX.2560 (WP021\*).

This proposed Rule is identical to a federal law or regulation which is applicable in Louisiana, therefore, no fiscal or economic impact will result from the proposed Rule. The Rule will be promulgated in accordance with R.S. 49:953(F)(3) and (4).

LAC 33:IX.Chapter 23.Subchapter P, §§2561-2569 mirrors 40 CFR 125 Subpart K. The effect of these federal regulations

was stayed until further notice by the U.S. Environmental Protection Agency (44 FR 47063, August 10, 1979 and 45 FR 17997, March 20, 1980). Therefore, to maintain equivalency with the federal regulations, the state hereby postpones the effective date of Subchapter P until further notice.

#### Title 33

### ENVIRONMENTAL QUALITY

#### Part IX. Water Quality

### Chapter 23. The LPDES Program

#### Subchapter P. Criteria and Standards for Best Management Practices Authorized Under Section 304(e) of the Act

#### §2560. Effective Date

The state hereby suspends this Subchapter until further notice.

[Note: LAC 33:IX.Chapter 23.Subchapter P mirrors 40 CFR 125 Subpart K. The effect of these federal regulations was stayed until further notice by the U.S. Environmental Protection Agency (44 FR 47063, August 10, 1979, and 45 FR 17997, March 20, 1980). Therefore, to maintain equivalency with the federal regulations, the state hereby suspends this Subchapter until further notice.]

**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 23:

A public hearing will be held on January 24, 1997, at 1:30 p.m. in the Maynard Ketcham Building, Room 326, 7290 Bluebonnet Boulevard, Baton Rouge, LA 70810. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate please contact Patsy Deaville at the address given below or at (504) 765-0399.

All interested persons are invited to submit written comments on the proposed Regulations. Commentors should reference this proposed Regulation by WP021\*. Such comments should be submitted no later than January 24, 1997, at 4:30 p.m., to Patsy Deaville, Investigations and Regulation Development Division, Box 82282, Baton Rouge, LA 70810 or FAX (504)765-0486. The comment period for this Rule ends on the same date as the public hearing.

Linda Levy  
Assistant Secretary

9612#068

### NOTICE OF INTENT

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

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

Notice is hereby given, in accordance with R.S. 49:950 et seq., that the State Board of Medical Examiners (Board), pursuant to the authority vested in the Board by the Louisiana Clinical Exercise Physiologists Licensing Act, R.S. 37:3421-3433, the Louisiana Medical Practice Act, R.S. 37:1270(B)(6), and the provisions of the Administrative Procedure Act, intends to adopt LAC 46:XLV.3701-3767 to

govern the licensing of clinical exercise physiologists to engage in the practice of clinical exercise physiology in the state of Louisiana. The proposed Rules are set forth below.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XLV. Medical Professions

#### Subpart 2. Licensure and Certification

### Chapter 37. Clinical Exercise Physiologists

#### Subchapter A. General Provisions

#### §3701. Scope of Chapter

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

#### §3703. Definitions

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

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

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

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

**Board**—the Louisiana State Board of Medical Examiners.

**Clinical Exercise Physiologist**—a person who, under the direction, approval, and supervision of a licensed physician, formulates, develops, and implements exercise protocols and programs, administers graded exercise tests, and provides education regarding such exercise programs and tests in a cardiopulmonary rehabilitation program to individuals with deficiencies of the cardiovascular system, diabetes, lipid disorders, hypertension, cancer, chronic obstructive pulmonary disease, arthritis, renal disease, organ transplant, peripheral vascular disease, and obesity.

**Exercise Physiology**—the enhancement of physical capabilities for the purposes of improving performance of activities for daily living, increasing the potential for physical, social and economic independence, reducing risks for premature development or recurrence of chronic disease and promoting behavioral patterns consistent with maintenance of health. The clinical exercise physiologist designs, implements, supervises and evaluates outcome for exercise services provided to individuals with chronic disease and/or functional deficits; measures, evaluates and provides support and consultation to other allied health providers relative to multidimensional physical fitness and exercise testing; and educates, motivates and counsels individuals with medical considerations in their efforts to reduce functional deficits, safely improve and maintain their physical fitness and develop healthy lifestyles. Clinical exercise physiology services

include, but are not limited to, exercise testing, evaluation and assessment, exercise prescription, exercise leadership, patient education and behavior change counseling, and outcome assessment of clinical programs. Implementation of direct clinical exercise physiology or exercise physiology to individuals for the specific medical condition or conditions shall be based upon a referral or order from a physician licensed to practice in the state of Louisiana. Practice shall be in accordance with standards established by The American College of Sports Medicine (ACSM) and the essentials of accreditation established by the agencies recognized to accredit specific facilities and programs.

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

## **Subchapter B. Qualifications for License**

### **§3705. Scope of Chapter**

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### **§3707. Qualification for License**

- A. To be eligible for a license, an applicant shall:
1. be at least 21 years of age;
  2. be of good moral character as defined by §3303 of this Chapter;
  3. be a citizen of the United States or possess a valid and current legal authority to reside and work in the United

States, duly issued by the Commissioner of Immigration and Naturalization of the United States under and pursuant to the Immigration and Nationality Act (66 Stat. 163) and the Commissioner's regulations thereunder (8 CFR);

4. have successfully completed a Masters of Science degree or a Master of Education degree in an exercise studies curriculum at an accredited school, which school at the time of the applicant's graduation, was approved by the American College of Sports Medicine or the Board;

5. be certified by as an exercise specialist by the American College of Sports Medicine (ACSM), having taken and successfully passed the ACSM certifying examination, as administered by ACSM or by the Board pursuant to Subchapter D of these Rules; and

6. have successfully completed an internship of 300 hours in exercise physiology under the supervision of a licensed exercise physiologist.

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

C. In addition to the substantive qualifications specified in Subsection A to be eligible for a license, an applicant shall satisfy the procedures and requirements for application provided in §§3711-3715 of Subchapter C of this Chapter and the procedures and requirements for examination provided by §§3717-3337 of Subchapter D of this Chapter.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### **§3709. Exemptions from Licensure**

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

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:



## **Subchapter C. Application**

### **§3711. Purpose and Scope**

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### **§3713. Application Procedure**

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

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

C. Application forms and instructions pertaining thereto may be obtained upon written request directed to the office of the Board. Application forms will be mailed by the Board within 30 days of the Board's receipt of request, therefore, to ensure timely filing and completion of application, forms must be requested not later than 40 days prior to the deadlines for initial applications specified in the preceding Subsection.

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

1. proof, documented in a form satisfactory to the Board as specified by the Secretary, that the applicant possesses the qualifications set forth in the Chapter;
2. three recent photographs of the applicant; and
3. such other information and documentation as the Board may require to evidence qualification for licensing.

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

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

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### **§3715. Effect of Application**

A. The submission of an application for licensing to the Board shall constitute and operate as an authorization by the applicant to each educational institution at which the applicant has matriculated, each state or federal agency to which the applicant has applied for any license, permit, certificate or registration, each person, firm, corporation, clinic, office or institution by whom or with whom the applicant has been

employed in the practice of clinical exercise physiology or exercise physiology, each physician or other health care practitioner whom the applicant has consulted or seen for diagnosis or treatment and each professional organization to which the applicant has applied for membership, to disclose and release to the Board any and all information and documentation concerning the applicant which the Board deems material to consideration of the application. With respect to any such information or documentation, the submission of an application for licensing to the Board shall equally constitute and operate as a consent by the applicant to disclosure and release of such information and documentation and as a waiver by the applicant of any privilege or right of confidentiality which the applicant would otherwise possess with respect thereto.

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

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

## **Subchapter D. Examination**

### **§3717. Purpose and Scope**

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### **§3719. Eligibility for Examination**

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3721. Dates, Places of Examination

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3723. Observance of Examination

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

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

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

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3725. Subversion of Examination Process

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

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

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

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

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

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

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

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

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

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

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

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3727. Finding of Subversion

A. When, during the administration of the examination the Board's representative has reasonable cause to believe that an applicant-examinee is engaging or attempting to engage, or has engaged, or attempted to engage, in conduct which subverts or undermines the integrity of the examination process, the Board's representative shall take such action as he deems necessary or appropriate to terminate such conduct and shall report such conduct in writing to the Board and the American College of Sports Medicine.

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

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

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3729. Sanctions for Subversion of Examination

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

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

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

1. revoke, suspend or impose probationary conditions on any license issued to such applicant;
2. disqualify the applicant, permanently or for a specified period of time, from eligibility for licensure in the state of Louisiana; or
3. disqualify the applicant, permanently or for a specified number of subsequent administrations of the examination, from eligibility for examination for purposes of licensure.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3731. Passing Score

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3733. Reporting of Examination Score

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3735. Restriction, Limitation on Examinations

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3737. Lost, Stolen, or Destroyed Examination

The submission of an application for examination by the Board shall constitute and operate as an acknowledgment and agreement by the applicant that the liability of the Board, its members, committees, employees and agents, and the state of Louisiana to the applicant for the loss, theft or destruction of all or any portion of an examination taken by the applicant,

prior to the reporting of scores, thereon by the Board shall be limited exclusively to the refund of the fees paid for examination by the applicant.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

## Subchapter E. Licensure Issuance, Expiration, Renewal, Termination

### §3739. Issuance of License

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

B. A license issued by the Board on the basis of examination by the Board shall be issued by the Board within 30 days following the reporting of the applicant's licensing examination scores to the Board. A license issued under any other Section of this Chapter to an applicant not required to be examined by the Board shall be issued by the Board within 15 days following the meeting of the Board next following the date on which the applicant's application, evidencing all requisite qualifications, is completed in every respect.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3741. Expiration of License

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3743. Renewal of License

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### §3745. Reinstatement of License

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### Subchapter F. Advisory Committee on Clinical Exercise Physiology

#### §3747. Organization; Authority and Responsibilities

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

B. The Committee shall:

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

#### §3749. Delegated Duties and Responsibilities

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

1. advise and assist the Board in the ongoing evaluation of the clinical exercise physiology licensing examination required by the Board;
2. provide advice and recommendations to the Board respecting the modification, amendment and supplementation of rules and regulations, standards, policies and procedures respecting clinical exercise physiology licensure and practice;
3. serve as a liaison between and among the Board, licensed clinical exercise physiologists and exercise physiology professional associations;
4. receive reimbursement for attendance at Board meetings and for other expenses when specifically authorized by the Board;
5. evaluate organizations and entities providing or offering to provide continuing professional education

programs for clinical exercise physiologists and provide recommendations to the Board with respect to the Board's recognition and approval of such organizations and entities as sponsors of qualifying continuing professional education programs and activities pursuant to §3759 of these Rules;

6. review documentation of continuing professional education by clinical exercise physiologists, verify the accuracy of such documentation, and evaluation of and make recommendations to the Board with respect to whether programs and activities evidenced by applicants for renewal of licensure comply with and satisfy the standards for such programs and activities prescribed by these Rules; and

7. request and obtain from applicants for renewal of licensure such additional information as the Advisory Committee may deem necessary or appropriate to enable it to make the evaluations and provide the recommendations for which the Committee is responsible.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

### Subchapter G. Continuing Professional Education

#### §3751. Scope of Subchapter

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

#### §3753. Requirements

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§3755. Qualifying Continuing Professional Education Programs**

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§3757. Approval of Program Sponsors**

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§3759. Approval of Programs**

A. A continuing professional education program sponsored by an organization or entity not deemed approved by the Board pursuant to the information above may be pre-approved by the Board as a program qualifying and acceptable

for satisfying continuing professional education requirements under this Subchapter upon written request to the Board therefor, upon a form supplied by the Board, providing a complete description of the nature, location, date, content and purpose of such program and such other information as the Board or the Advisory Committee may request to establish the compliance of such program with the standards prescribed by §3755. Any such request for pre-approval respecting a program which makes and collects a charge for attendance shall be accompanied by a nonrefundable processing fee of \$30.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§3761. Documentation Procedure**

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§3763. Failure to Satisfy Continuing Professional Education Requirements**

A. An applicant for renewal of licensure who fails to evidence satisfaction of the continuing professional education requirements prescribed by these Rules shall be given written notice of such failure by the Board. The license of the

applicant shall remain in full force and effect for a period of 60 days following the mailing of such notice, following which it shall be deemed expired, unrenewed and subject to revocation without further notice, unless the applicant shall have, within such 60 days furnished the Board satisfactory evidence, by affidavit, that:

1. the applicant has satisfied the applicable continuing professional education requirements;
2. the applicant is exempt from such requirements pursuant to these Rules; or
3. the applicant's failure to satisfy the continuing professional education requirements was occasioned by disability, illness or other good cause as may be determined by the Board.

B. The license of a clinical exercise physiologist which has expired by nonrenewal or been revoked for failure to satisfy continuing professional education requirements of these Rules may be reinstated by the Board upon written application to the Board, accompanied by payment of the reinstatement fee prescribed by §3745.B hereof, together with documentation and certification that the applicant has, for each calendar year since the date on which the applicant's license lapsed, expired or was revoked, completed and aggregate of 10 contact hours (1.0 CEU) of qualifying continuing professional education.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

#### **§3765. Waiver of Requirements**

The Board may, in its discretion and upon the recommendation of the Advisory Committee, waive all or part of continuing professional education required by these Rules in favor of a clinical exercise physiologist who makes written request for such waiver to the Board and evidences to the satisfaction of the Board a permanent physical disability, illness, financial hardship or other similar extenuating circumstances precluding the individual's satisfaction of the continuing professional education requirements.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

#### **§3767. Exception to Continuing Professional Education Requirements**

The continuing professional education requirements prescribed by this Subchapter as requisite to renewal of licensure shall not be applicable to a clinical exercise physiologist who has held an initial license on the basis of examination for a period of less than one year.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

Inquiries concerning the proposed Rules may be directed in writing to Delmar Rorison, Executive Director, State Board of Medical Examiners, at the address set forth below.

Interested persons may submit data, views, arguments, information or comments on the proposed Rules, in writing, to the State Board of Medical Examiners, at Box 30250, New

Orleans, LA 70190-0250 (630 Camp Street, New Orleans, LA 70130).

Written comments must be submitted to and received by the Board within 60 days from the date of this notice. A request pursuant to R.S. 49:953(A)(2) for oral presentation, argument or public hearing must be made in writing and received by the Board within 20 days of the date of this notice.

Delmar Rorison  
Executive Director

### **FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Clinical Exercise Physiologists; Licensing**

- I. **ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**  
The Board estimates that it will incur additional expenses in the amount of \$11,086 in FY 96/97, \$9,023 in FY 97/98 and \$9,181 in FY 98/99 in connection with the licensure of clinical exercise physiologists, as mandated by the Louisiana Clinical Exercise Physiologists Licensing Act, R.S. 37:3421-3433 and as implemented by the proposed Rules.
- II. **ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**  
It is estimated that the fees applicable to the licensing of clinical exercise physiologists and the annual renewal of such licenses will generate additional revenue for the Board of \$5,250 in FY 96/97, \$6,700 in FY 97/98, and \$7,700 in FY 98/99.
- III. **ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**  
Persons trained as clinical exercise physiologists who are eligible for and obtain licensure are expected to receive indirect economic benefit from such licensure in an amount which cannot be quantified. Such persons will also incur licensure and licensure renewal application fees in the amount of \$75 for initial licensure and \$25 for annual licensure renewal.
- IV. **ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**  
The proposed Rule amendments are not anticipated to have any impact on competition and employment in either the public or private sector.

Delmar Rorison  
Executive Director  
9612#032

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

### **NOTICE OF INTENT**

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

**Nonmalignant Chronic or Intractable Pain Medications  
(LAC 46:XLV.6915-6923)**

Notice is hereby given, in accordance with R.S. 49:950 et seq., that the Board of Medical Examiners (Board), pursuant to the authority vested in the Board by the Louisiana Medical Practice Act, R.S. 37:1270(A)(1), 1270(B)(6) and 1285(B), and the provisions of the Administrative Procedure Act, intends to adopt Rules and Regulations governing physician



prescription, dispensation, administration or other use of medications for the treatment of nonmalignant chronic or intractable pain (LAC 46:XLV, Subpart 3, Chapter 69, §§6915-6923). The proposed Rules are set forth below.

LAC 46:LXLV.6915-6923 shall be adopted, so that, as adopted, said Sections shall read and provide as follows:

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part XLV. Medical Professions**

**Subpart 3. Practice**

**Chapter 69. Prescription, Dispensation and  
Administration of Medications**

**Subchapter B. Medications Used in the Treatment of  
Nonmalignant Chronic or Intractable  
Pain**

**§6915. Scope of Subchapter**

The Rules of this Subchapter govern physician prescription, dispensation, administration or other use of medications for the treatment of nonmalignant chronic or intractable pain.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6) and 1285(B).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§6917. Definitions**

As used in this Subchapter, unless the content clearly states otherwise, the following terms and phrases shall have the meanings specified:

**Addiction**—a behavioral pattern of drug use, characterized by an individual's overwhelming involvement with the use of a drug, the securing of its supply, and the tendency to relapse after withdrawal.

**Board**—the Louisiana State Board of Medical Examiners.

**Chronic Pain**—pain which persists beyond the expected usual course of a disease or process or, in the case of bodily trauma, beyond the expected time for healing and which interferes with the usual functioning of the individual.

**Controlled Substance**—any substance defined, enumerated or included in federal or state statute or regulations 21 C.F.R. §§1308.11-15 or R.S. 40:964, or any substance which may hereafter be designated as a controlled substance by amendment or supplementation of such regulations and statute.

**Drug Abuse or Misuse**—the acquisition or use of a drug, usually by self-administration, in a manner that deviates from approved medical, legal, and social standards.

**Intractable Pain**—a pain state in which the cause of the pain can not be eliminated or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts have been documented in the patient's medical records.

**Nonmalignant Pain**—that pain which is not directly related to viable, symptomatic cancer.

**Physician**—physicians and surgeons licensed by the Board.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6) and 1285(B).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§6919. General Conditions/Prohibitions**

The treatment of nonmalignant chronic or intractable pain with controlled substances constitutes legitimate medical therapy when done in the usual course of professional practice. A physician duly authorized to practice medicine in Louisiana and to prescribe controlled substances in this state shall not be subject to disciplinary action by the Board for prescribing, ordering, administering or dispensing controlled substances for the treatment or relief of nonmalignant chronic or intractable pain, provided, however, that a physician shall not prescribe, dispense, administer, supply, sell, give or otherwise use for the purpose of treating such pain, any controlled substance unless done in strict compliance with applicable state and federal laws and the Rules enumerated in this Subchapter.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6) and 1285(B).

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

**§6921. Use of Controlled Substances, Limitations**

**A. Requisite Prior Conditions.** Prior to utilizing any controlled substance for the treatment of nonmalignant chronic or intractable pain on a protracted basis (in excess of 12 weeks), a physician shall comply with the following Rules:

1. **History/Physical Examination.** A physician shall obtain a clinical history, perform a physical examination and insure that all necessary laboratory and diagnostic testing is, or has been, performed. In addition, such history shall include an evaluation of the patient's pain, physical, psychological, social and biological functioning, a history of alcohol and/or drug addiction, drug abuse or drug misuse or the presence of a character disorder, as well as an assessment of underlying or coexisting diseases or conditions. Such history and examination should establish the presence of a recognized medical indication for the use of a controlled substance.

2. **Drug Screen.** A physician shall document in his medical record that he has obtained a current drug screen which reveals the absence of any controlled substance, other than one which has been prescribed by a physician.

3. **Collection/Review of Medical Records.** A physician shall obtain and review all necessary medical information from other treating physicians, pharmacists and hospitals.

4. **Concurrence by Another Physician.** A physician shall obtain the written concurrence by another physician, for the medical necessity for controlled substance therapy.

5. **Medical Diagnosis.** A medical diagnosis shall be established which indicates not only the presence of nonmalignant chronic or intractable pain, but also the nature of the underlying disease and pain mechanism if such are determinable.

6. **Treatment Plan.** An individualized treatment plan shall be formulated and documented in the patient's medical record, which includes medical justification for controlled substance therapy. Such plan shall include documentation that all other reasonable alternative treatments at analgesia have been attempted without success. Such plan shall also specify the intended role of the controlled substance therapy within the overall plan, identify appropriate intervals for further attempts at analgesia with reasonable alternatives to controlled substances, state objectives by which treatment



successes can be evaluated, and indicate if and when further diagnostic evaluations or other treatments are planned. A physician shall tailor controlled substance therapy to the individual medical needs of each patient.

7. Informed Consent. A physician shall document in the patient's medical record that he has explained to the patient or the patient's guardian the benefits, risks, contraindications, warnings and dangers of controlled substance therapy including, but not limited to, the potential of addiction, and that he has answered any questions posed by the patient or the patient's guardian.

B. Controlled Substance Therapy. Upon completion and satisfaction of the conditions prescribed by Subsection A of this Section and upon the physician's judgment that the prescription, dispensation or administration of a controlled substance is medically warranted, the physician shall adhere to the following Rules:

1. Lowest Effective Dosage of Controlled Substance. A physician shall document in the patient's medical record that he has initiated and attempted treatment with the lowest dosage of a controlled substance expected to be effective, as reported by the manufacturer's approved dosage recommendation submitted to the United States' Food and Drug Administration.

2. Medications Employed. Use of a single controlled substance is preferable when practicable. A physician shall document in the patient's medical record the medical necessity for the use of more than one controlled substance when such is used in the management of a patient's nonmalignant chronic or intractable pain.

3. Partial Analgesia. Upon failure to achieve at least partial analgesia at the lowest dosage of a controlled substance expected to be effective, a physician shall reassess the potential treatability of the nonmalignant chronic or intractable pain with controlled substance therapy.

4. Assessment and Monitoring. Patients shall be seen at appropriate regular and frequent intervals and shall be reassessed regularly for the efficacy of treatment, progress toward treatment objectives, adverse drug effects, and the appearance of either addiction, drug abuse or drug misuse during each visit.

5. Responsibility for Treatment. One physician shall take primary responsibility for controlled substance therapy employed in the treatment of a patient's nonmalignant chronic or intractable pain.

6. Consultation. There shall be evidence of adequate documented consultation in the physician's medical records at all appropriate stages of diagnosis and management. Such consultations shall be performed by another physician.

7. Documentation of Controlled Substance Therapy. At a minimum, a physician shall document the quantity, dosage, route, frequency of administration and the number of refills authorized, as well as the frequency of visits to obtain refills. A date for terminating controlled substance therapy shall be projected when possible.

C. Terminating Controlled Substance Therapy. Evidence of addiction, drug abuse or drug misuse, acquisition of controlled substances from other physicians, uncontrolled dose escalation, a positive drug screen which reveals the presence of controlled substances other than those prescribed by the physician, or other aberrant behavior shall be followed by tapering and discontinuation of controlled substance therapy. Such therapy shall thereafter be reinitiated only upon the documented written concurrence of the medical necessity of controlled substance therapy by another physician consultant, based upon his physical examination of the patient and a review of the patient's medical records.

D. Treatment Records. The physician shall keep accurate and complete records of each of those items required by this Subchapter, including, but not limited to, history, physical and other examinations and evaluations, consultations, laboratory and diagnostic reports, including drug screens, treatment plans and objectives, controlled substance and other medication therapy, informed consent, periodic assessments and reviews and the results of all other reasonable attempts at analgesia alternative to controlled substance therapy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6) and 1285(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

#### **§6923. Effect of Violation**

Any violation of or failure of compliance with the provisions of this Subchapter, §§6915-6923, shall be deemed a violation of R.S. 37:1285(A)(6) and (14), providing cause for the Board to suspend or revoke, refuse to issue, or impose probationary or other restrictions on any license held or applied for by a physician to practice medicine in the state of Louisiana culpable of such violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6) and 1285(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:

Inquiries concerning the proposed Rules may be directed in writing to Delmar Rorison, Executive Director, Board of Medical Examiners, at the address set forth below.

Interested persons may submit data, views, arguments, information or comments on the proposed Rules, in writing, to the Board of Medical Examiners, at Box 30250, New Orleans, LA 70190-0250 (630 Camp Street, New Orleans, LA 70130). Written comments must be submitted to and received by the Board within 60 days from the date of this notice.

A request pursuant to R.S. 49:953(A)(2) for oral presentation, argument or public hearing must be made in writing and received by the Board within 20 days of the date of this notice. Should such a timely request be received, notice is hereby given that the Board will entertain such oral presentation, argument or public hearing at its offices, (630 Camp Street, New Orleans, LA 70130) on Wednesday, January 29, 1997, at 3 p.m.

Delmar Rorison  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Nonmalignant Chronic or Intractable Pain  
Medications**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is not anticipated that the proposed Rules will result in any additional costs to the Board of Medical Examiners.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is not anticipated that the proposed Rules will have any affect on the Board's revenue collections.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
The Board's response is somewhat constrained by the lack of reliable data. At the same time, while it is believed that a small number of physicians involved in the treatment of chronic pain may continue to prescribe medications in a manner restricted under the proposed Rules, it is also believed that such physicians are few in number and that even they would only be economically impacted to the extent that they dispense medications at a charge to the patient in excess of the physician's costs. It is not, however, anticipated that such Rules will have a material effect on costs, paperwork or workload of affected physicians. Moreover, to the extent that there is a loss of revenue to such physicians, such would constitute an equal or greater costs savings to patients.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
It is not anticipated that the proposed Rules will have any impact on competition or employment in either the public or private sector.

Delmar Rorison  
Executive Director  
9612#030

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Health and Hospitals  
Office of Public Health**

**Genetic Diseases—Neonatal Screening (LAC 48:V.6303)**

Under the authority of R.S. 40:5 and 40:1229 et seq., and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Health and Hospitals, Office of Public Health proposes to amend Subsections F and G and restate supporting references of LAC 48:V.6303 as follows.

The proposed Rule specifies requirements for laboratories providing state-mandated newborn screening tests. It also restates current requirements for patients with inborn errors of metabolism disorders to receive medical and nutritional management services offered by the Office of Public Health.

**Title 48  
PUBLIC HEALTH - GENERAL  
Part V. Public Health Services  
Subpart 19. Genetic Diseases Services  
Chapter 63. Neonatal Screening  
§6303. Purpose, Scope, Methodology**

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F. Medical/Nutritional Management. In order for a patient with PKU or other rare inborn errors of metabolism to receive the special formulas for the treatment of these disorders from the state's Genetic Diseases Program and/or Special Supplemental Nutrition Program for Infants, Women, and Children (WIC), the following guidelines must be met:

a. The patient must be a resident of the State of Louisiana.

b. The patient must receive a medical evaluation at least once annually at Tulane Human Genetics Program Clinic or from another medical center program providing specialized management of metabolic patients under the supervision of a physician who is board certified in clinical biochemical genetics. A licensed and/or registered dietitian must also be on staff and readily available for both acute and chronic dietary needs of the patient. Medical centers not meeting these criteria must consult with one of the medical geneticists of the Tulane Human Genetics Program on the diagnosis and treatment regimen.

c. The patient must provide necessary specimens as requested by the medical specialist at Tulane Human Genetics Program or a specialist at another medical center whose evaluation and treatment plan has been approved by Tulane. Laboratory test results for phenylalanine and tyrosine levels must be submitted to the Genetics Program Office by the treating medical center.

d. The patient must include dietary records with the submission of each blood specimen if the patient is receiving services through the Tulane Human Genetics Program.

e. All insurance forms relative to charges for special formula must be signed and submitted by the parent or appropriate family member.

f. The parent or guardian must inform the Genetics Program Office immediately of any changes in insurance coverage.

G. Acceptable Newborn Screening Testing Methodologies and Procedures for Medical Providers not Using the State Laboratory. Laboratories performing or intending to perform the state mandated newborn screening battery on specimens collected on Louisiana newborns must meet the conditions specified below pursuant to R.S. 40:1299.1:

1. The laboratory must be located in Louisiana.

2. The testing battery must include testing for phenylketonuria (PKU), congenital hypothyroidism and sickle cell disease.

3. The laboratory must perform the newborn screening testing battery on at least 50,000 specimens a year unless the said laboratory has been routinely performing the full screening battery since January 1, 1995.

4. The laboratory must participate in the proficiency testing program of the Centers for Disease Control for newborn screening.

5. Only the following testing methodologies are acceptable with prior approval:

Disease	Testing Methodology
PKU	Fluorometric Guthrie Phenylalanine level cut-off: >4mg/dl, call Genetics Office immediately for obtaining phenylalanine/tyrosine ratio  Controls: 2mg/dl, 4mg/dl, 6mg/dl, 8mg/dl, 12mg/dl
Congenital Hypothyroidism	Radioimmunoassay (RIA) or Enzyme Immunoassay (EIA) methods for T4 and Thyroid Stimulating Hormone (TSH) which have been calibrated for neonates
Sickle Cell	Hemoglobin Electrophoresis (cellulose acetate and citrate agar or isoelectric focusing) or high performance liquid chromatography (HPLC)  (Sickle Dex is NOT acceptable)  Controls must include: F, A, S, C, E Result reporting: by phenotype, e.g., FS, FSC, etc. Positive/Negative is NOT acceptable
New Food and Drug Administration approved methodologies may be used if found to be acceptable by the Genetic Diseases Program. Approval should be requested in writing 60 days before the intended date of implementation (see Genetic Diseases Program mailing address below). Requests for approval will be based on documentation of FDA approval and an in-house validation study of said methodology.	

6. To ensure appropriate and timely follow-up, all initial positive results must be immediately reported, along with patient demographic information to the Genetic Diseases Program Office either by FAX at (504) 568-7722 or by telephone at (504) 568-5070 and followed up by the mailing of the information to the following address: Genetic Diseases Program, P. O. Box 60630 - Suite 308, New Orleans, LA 70160, telephone (504) 568-5070.

7. Guidelines and recommendations on quality assurance of newborn screening from nationally recognized committees and authors should be considered in the establishment and operation of a newborn screening system<sup>2</sup>.

<sup>1</sup>Reference

American Academy of Pediatrics, Committee on Genetics: New Issues in Newborn Screening for Phenylketonuria and Congenital Hypothyroidism. Pediatrics 1982; 60:104-6.

<sup>2</sup>References pertaining to Subsection G:

a. Committee on Genetics, American Academy of Pediatrics Issues in Newborn Screening. Pediatrics 1992; 89:345.

b. CORN Newborn Screening Committee, Council on Regional Networks for Genetic Services. U.S. Newborn Screening System Guidelines: Statement of the Council of Regional Networks for Genetic Services. Screening, 1 (1992 pp. 135-147).

c. Andrews I Legal Liability and Quality Assurance in Newborn Screening. Chicago, American Bar Foundation (1985), pp. 82-83.

d. National Committee for Clinical Laboratory Standards (NCLS) Standards for Blood Collection on Filter Paper for Neonatal Screening. Document LA4-A2 July 1992.

e. Committee on Assessing Genetic Risks, Division of Health Sciences Policy, Institute of Medicine Assessing Genetic Risks National Academy Press, Washington DC (1994).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299, et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Preventive and Public Health Services, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of Public Health, LR 17:378 (April 1991), LR 18:1131 (October 1992), LR 20:1386 (December 1994), LR 23:

A public hearing will be held on January 27, 1997 in the Fourth Floor Conference Room of the DOTD Building, DHH Annex, located at 1201 Capitol Access Road, Baton Rouge, LA.

Interested persons may submit written comments on the proposed Rule until January 20, 1997 to: Charles Myers, MSW, Administrator, Louisiana Genetic Diseases Program, Office of Public Health/DHH, Section of Genetics, Room 308, 325 Loyola Avenue, New Orleans, LA 70112.

Bobby Jindal  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Genetic Diseases—Neonatal Screening**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Subpart F: There are no costs or savings to state or local governmental units relative to the change in the Subpart.

Subpart G: New restrictions on laboratories performing or intending to perform the newborn screening battery could cause the state central lab to receive 6,000 more specimens a year. There will be no cost associated with the purchase of equipment or new positions as the additional specimens will be absorbed into the current testing system if sent to the state central laboratory. Cost will be for additional laboratory supplies which for \$5 per specimen will total \$30,000. The costs for FY 96-97 is \$7,680; FY 97-98 is \$30,000; and for FY 98-99, \$30,900. This includes publishing cost of \$180 for FY 96-97. No other governmental units will incur any costs.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Subpart G: If the state central lab performs the additional testing, fees collected from private patients will be the same as those charged to Medicaid patients. It is estimated that approximately \$35,379 will be generated in FY 97 (April-June); and \$141,522 in FY 98 and FY 99.

The revenues from lab test collections will be used to meet total program costs. The fee for performing the battery of tests will be assessed in two ways:

1. The lab form is sold to hospitals and physicians for use with their private patients, at a cost of \$12.

2. Medicaid is billed by OPH on Medicaid patients receiving the testing battery. The fee for service is based on the current reimbursement rate.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Subpart F, Subparagraph b: The restriction of having the treating physician be board certified in clinical biochemical genetics or receive documented consultation from one is not

seen as having any additional fiscal effect. This is because provision for the consultation is already provided through an OPH contract and will be of no additional cost to any party.

Subpart G: Out-of-state laboratories will no longer receive specimens from Louisiana for newborn screening.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

Subpart F: A doctor, who is not board certified in clinical biochemical genetics, will be restricted from ordering special formulas for his or her patients with PKU and other rare inborn errors of metabolism through the Genetics Program and WIC Program. This only affects a few geneticists, some of whom have always referred such patients to a specialist. Physicians without this board certification may still treat and order formula through the Genetics Program if they submit their patient treatment plan to the Tulane Human Genetics Program for consultation and approval. Therefore, the effect on competition and employment is minimal.

Subpart G: Out-of-state laboratories performing newborn screening will no longer be permitted to perform this service for Louisiana newborns. The specimens from the hospitals that had been sending them out-of-state may send them to the two private laboratories that are in compliance with the new Rule or the state central laboratory. However, it is uncertain at this time which labs will be used by hospitals and physicians currently not using the central lab. Revenues would be reduced if some hospitals opt to send specimens to the two private labs in Louisiana that are in compliance with these Rules.

and Drug Administration's Interstate Certified Shellfish Shippers List and located less than 30 minutes from dockside, all land based deliveries of shell stock shall be made aboard mechanically refrigerated trucks with an internal air temperature of 45°F or less as measured 12 inches from the blower. For shipments by air, an internal meat temperature of 45°F or less shall be maintained at all times. To accomplish this it shall be necessary to pre-chill shell stock to an internal temperature of 40°F or less prior to being packed into insulated containers with frozen gel packs. Land based deliveries of molluscan shell stock to a steam factory for thermal processing and canning shall be exempt from these refrigeration requirements during the months November through May provided that the shellfish are delivered to the cannery in accordance with the requirements cited in Paragraph (A) of this Section and the Department of Wildlife and Fisheries, Enforcement Division is notified via their toll free telephone number (1-800-442-2511) prior to making each delivery.

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Interested persons may submit questions or written comments to: Charles C. Conrad, Administrator, Seafood Sanitation Program, Box 60630, New Orleans, LA 70160. He is responding to inquires regarding these proposed Rule changes. All questions or comments must be viewed by February 1, 1997.

Jimmy Guidry, M.D.  
Assistant Secretary  
9612#079

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

Bobby P. Jindal  
Secretary

**NOTICE OF INTENT**

**Department of Health and Hospitals  
Office of Public Health**

**Sanitary Code—Seafood Sanitation (Chapter IX)**

The Department of Health and Hospitals, Office of Public Health intends to amend Chapter IX of the State Sanitary Code, Section 9:052-3, Paragraph (C). The proposed Rule change is necessary to correct an error that was made during previous rule making. Language will be added to this Section that will exempt under certain conditions the requirement that trucks utilized for hauling shell stock oysters to a steam factory for thermal processing and canning be refrigerated. The refrigeration requirements that were previously adopted were intended by this Agency to apply only to shellfish offered for sale in the fresh and frozen market place.

Section 9:052-3, Paragraph (C) shall be amended as follows:

**Chapter IX. Seafood**

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**9:052-3 General Provisions**

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C. Except for deliveries made to a shellfish dealer certified by the Office of Public Health for inclusion on the U.S. Food

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Seafood Sanitation Program**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be an implementation cost of \$20 for printing in the *Louisiana Register*.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be no effect on revenue collection of state or local governmental units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
Each person who chooses to deliver shellfish to a cannery will be spared the necessity of purchasing a truck refrigeration unit, at a minimum savings of \$20,000 each.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There should be no measurable effect on competition and employment.

Jimmy Guidry, M.D.  
Assistant Secretary  
9612#080

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**

### Reimbursement for Rehabilitation Services

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

The Medicaid Program provides coverage and reimbursement for rehabilitative services provided in rehabilitation clinics and in hospital settings as an outpatient service. Rehabilitation clinics are defined as facilities that are not part of a hospital, but are organized to provide a variety of outpatient rehabilitative services including physical, occupational, speech, hearing, and language therapies. Outpatient hospital rehabilitation services are reimbursed at an interim rate of 60 percent of billed charges with final reimbursement adjusted to 83 percent of allowable costs through the cost settlement process. Rehabilitation clinics are paid at 90 percent of the established payment schedule which was in effect as of July 6, 1995. The Department has determined that it is necessary to revise the reimbursement methodology for rehabilitation services in the following manner. The payment schedule for rehabilitation clinics will be based on the hourly rates of \$40 per hour for physical therapy, \$32 per hour for occupational therapy, and \$30 per hour for speech/hearing therapy. Reimbursement for outpatient hospital rehabilitation services will be at 110 percent of the rate established for rehabilitation clinics. Rehabilitation clinics will be reimbursed for evaluations at the rate which was in effect for those services as of July 6, 1995. Outpatient hospitals will be reimbursed for evaluations at 110 percent of the rate paid to rehabilitation clinics for that service. Outpatient hospital rehabilitation services shall no longer be included in the cost report for settlement.

#### Proposed Rule

The Department of Health and Hospitals, Bureau of Health Services Financing shall reimburse rehabilitative services as follows:

1. the payment schedule for rehabilitation clinics shall be based on the hourly rates of \$40 per hour for physical therapy, \$32 per hour for occupational therapy, and \$30 per hour for speech therapy;
2. outpatient hospital rehabilitation services shall be reimbursed at 110 percent of the rates paid to rehabilitation clinics;
3. rehabilitation clinics shall be reimbursed for evaluations at the rate which was in effect for those services as of July 6, 1995; and

4. outpatient hospitals shall be reimbursed for evaluations at 110 percent of the rate paid to rehabilitation clinics for that service.

Outpatient hospital rehabilitation services shall no longer be included in the cost report for settlement. Hospitals shall now be required to use the same state-assigned HCPCS procedure codes used by rehabilitation clinics in addition to the applicable hospital revenue code when submitting a claim for rehabilitation services.

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

A public hearing is scheduled for Tuesday, January 28, 1997 at 9:30 a.m. in the Auditorium of the Department of Transportation and Development, Capital Access Road, Baton Rouge, LA. At this time, all interested parties will be afforded the opportunity to submit data, views, or arguments, orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the day following the public hearing.

Bobby P. Jindal  
Secretary

#### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

##### RULE TITLE: Reimbursement for Rehabilitation Services

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
It is anticipated that implementation of this proposed Rule on the reimbursement changes for Rehabilitation Services will reduce state costs by approximately \$223,657 for SFY 1997, \$424,539 for SFY 1998 and \$424,539 for SFY 1999. Included in this projected state cost savings is the operating expense of \$150 expected for the promulgation of this proposed Rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
The decrease in federal revenue collections expected from this proposed Rule is approximately \$983,348 for SFY 1997, \$1,506,938 for SFY 1998 and \$1,506,938 for SFY 1999.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
Rehabilitation clinics and outpatient hospital clinics enrolled in the Medicaid Program will experience reimbursement reductions of approximately \$1,207,155 for SFY 1997, \$1,931,477 for SFY 1998 and \$1,931,477 for SFY 1999.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
There is no known effect on competition and employment.

Thomas D. Collins  
Director  
9612#087

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

#### Targeted Case Management Services and Reimbursement

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

The Bureau of Health Services Financing currently funds case management services to the following specific population groups:

1. developmentally delayed infants and toddlers (termed infants and toddlers with special needs under this proposed Rule);
2. pregnant women in need of extra perinatal care (termed high-risk pregnant women under this proposed Rule) (limited to the metropolitan New Orleans area);
3. HIV disabled individuals (termed persons infected with HIV under this proposed Rule);
4. participants in Home and Community Based Services Waiver Program who receive case management as a separate service;

The following groups have previously received case management services: Seriously Mentally Ill, MR/DD persons who were not participants of the MR/DD Waiver Program; and Ventilator-Assisted Children.

Previously these services have been implemented and governed under specific program regulations. The Department seeks to enhance all these services to the optimal level while streamlining their administration and establishes enhanced regulations governing consumer eligibility, provider enrollment, provider standards for participation and reimbursement methodology and requirements, and general provisions. The Department adopted Emergency Rules to ensure uniform standards for the quality of the services delivered to these persons with special physical and/or health needs and conditions effective July 22, 1994 and August 13, 1994 (*Louisiana Register*, Volume 20, Numbers 6 and 7). Subsequent Emergency Rules continued this initiative in force as published in the *Louisiana Register* (November 20, 1994, Volume 20, Number 11; April 20, 1995, Volume 21, Number 4; August 20, 1995, Volume 21, Number 8; November 20, 1995, Volume 21, Number 11; March 20, 1996, Volume 22, Number 3; July 20, 1996, Volume 22, Number 7 and November 20, 1996, Volume 22, Number 11). In addition the Bureau adopted emergency rulemaking to revise the reimbursement methodology based on the 15-minute unit of service for the on-going services component to adoption of the flat rate. This revised reimbursement methodology was implemented effective October 1, 1995 (*Louisiana Register*, Volume 21, Number 10) which included a monthly reimbursement rate for both components of case management

services, the initial assessment/service plan development and the ongoing services. Monthly reimbursement rates were assigned for each population group based upon minimum standards for service delivery for each of these groups. Effective March 1, 1996 the Department adopted an Emergency Rule (*Louisiana Register*, Volume 22, Number 3) which provided for the payment of a one hour minimum of service delivery and additional 15 minute incremental units up to a cap of the monthly rate once the initial one hour service minimum is met. The June 11, 1996 Emergency Rule (*Louisiana Register*, Volume 22, Number 6) continued the flat rate methodology and the subsequent modification of this methodology as cited above. These provisions were continued with the adoption of the October 9, 1996 Emergency Rule (*Louisiana Register*, Volume 22, Number 10) which also continued the program reductions implemented this state fiscal year (*Louisiana Register*, Volume 22, Number 6 pages 556 and 574). In addition the Department also adopted emergency rulemaking effective September 24, 1996 (*Louisiana Register*, Volume 22, Number 9) limiting case management services to infants and toddlers who either receive services under the MR/DD waiver or who receive two or more specified Medicaid services. The Department subsequently determined it was necessary to repeal the limitations on Infants and toddler Case Management Services in the September 24, 1996 Emergency Rule and to reduce the reimbursement rate for these services as incorporated in the December 1, 1996 Emergency Rule (*Louisiana Register* Volume 22, Number 11). The following proposed Rule incorporates the latest programmatic and reimbursement changes.

#### Proposed Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to adopt the following provisions to govern case management services including consumer eligibility requirements, provider enrollment, provider standards for participation and reimbursement methodology and general provisions. These provisions apply to case management services provided either to targeted population groups or to waiver participants who receive case management services as a separate service. These include the following groups of individuals:

1. infants and toddlers with special needs;
2. high-risk pregnant women;
3. persons infected with HIV;
4. persons in Waiver Program(s) who receive case management as a separate service.

All case management providers must follow the policies and procedures included in this notice as well as in the Department of Health and Hospitals *Case Management Provider Manual*. Under this Rule the term *Case Management* has the same meaning as the term *Family Service Coordination*. Case management services must be delivered in accordance with all applicable federal and state laws and regulations.

The Department repeals the limitations on infants and toddlers case management services in the September 24, 1996 Emergency Rule and reduces the reimbursement rate for these services.



## I. Standards of Participation

In order to be reimbursed by the Medicaid Program, a provider of targeted or waiver case management service must comply with all of the requirements listed below:

A. **Provider Enrollment Requirements.** Case management agencies who wish to provide Medicaid-funded targeted or waiver case management services must contact the Department to request an enrollment packet and copy of the *DHH Case Management Provider Manual*. Applicants must indicate the population(s) and the geographical areas they wish to serve. The provider must meet all applicable licensure, general standards for participation in the Medicaid Program and specific provider enrollment and participation requirements for the population(s) to be served. Each enrolling agency must also submit a separate provider agreement (Form PE-50) and Disclosure of Ownership form to DHH for each targeted or waiver population and geographical area (DHH region) the agency plans to serve. Each office site of a case management agency must be enrolled separately. Approval by DHH entitles the agency to provide services in the parishes of that DHH region only. This requirement is applicable to both new providers and existing providers already enrolled. When an agency wishes to provide case management services in a parish in another region and that parish is not contiguous to the parish in which an enrolled office site is located, the agency must establish an office in the other region, submit a separate enrollment packet, and receive DHH approval to provide services in that DHH region regardless of the number of case managers providing services in the new region. When there are less than three case managers providing services in a parish in another region and that parish is contiguous to the parish in which an enrolled office site is located, the agency is not required to establish an office in the other region.

In accordance with Section 4118(i) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, Public Law 100-203, the Department may restrict enrollment and service areas of agencies that are enrolled in the Medicaid Program to provide case management services to developmentally disabled consumers including infants and toddlers with special needs in order to ensure that the case management providers available to these targeted groups and any subgroups are capable of ensuring that the targeted consumers receive the full range of needed services. Case management agencies must meet the enrollment requirements listed below to be approved for enrollment.

All applicant case management agencies must meet the requirements listed in 1-16 below to participate as a case management provider in the Medicaid Program, regardless of the targeted or waiver group served:

1. have demonstrated direct experience in successfully serving the target population and demonstrated knowledge of available community services and methods for accessing them including all of the following:
  - a. have established linkages with the resources available in the consumer's community;
  - b. maintain a current resource file of medical, mental health, social, financial assistance, vocational, educational,

housing and other support services available to the target population;

- c. demonstrate knowledge of the eligibility requirements and application procedures of federal, state, and local government assistance programs which are applicable to consumers served;

- d. employ a sufficient number of qualified case manager and supervisory staff who meet the skills, knowledge, abilities, education, training, supervision, staff coverage and maximum caseload size requirements described in this document;

2. possess a current license to provide case management/service coordination in Louisiana or written proof of application for licensure;

3. demonstrate administrative capacity to provide all core elements of case management and insure effective case management services to the target population in accordance with licensing and DHH requirements by DHH review of the following:

- a. current detailed budget for case management;
- b. report of annual outside audit by a Certified Public Accountant performed in accordance with generally accepted accounting principles;
- c. cost report by September 30 of each year following 12 months of operation;
- d. provider policies and procedures;
- e. functional organization chart depicting lines of authority; and
- f. program philosophy, goals, services provided, and eligibility criteria that define the target population or waiver group to be served;

4. assure that all case manager staff is employed by the agency in accordance with Internal Revenue Service (IRS) Regulations (including submission of a W-2 Form on each case manager). Contracting case manager staff is prohibited. Contracting of supervisors must comply with IRS Regulations. Each case manager must be employed at least 20 hours per week;

5. assure that all new staff satisfactorily complete an orientation and training program in the first 90 days of employment and possess adequate case management abilities, skills and knowledge before assuming sole responsibility for their caseload and each case manager and supervisor satisfactorily complete case management related training on an annual basis to meet at least minimum training requirements described below. The provision and/or arranging of such training is the responsibility of the provider;

6. have a written plan to determine the effectiveness of the program and agrees to implement a continuous quality improvement plan approved by the Department;

7. document and maintain an individual record on each consumer which includes all of the elements described in licensing standards for case management and in this document;

8. agree to safeguard the confidentiality of the consumer's records in accordance with federal and state laws and regulations governing confidentiality;



9. assure a consumer's right to elect to receive case management as an optional service and the consumer's right to terminate such services;

10. assure that no restriction will be placed on the consumer's right to elect to choose a case management agency, a qualified case manager, and other service providers and change the case management agency, case manager and service providers consistent with Section 1902(a)(23) of the Social Security Act;

11. if currently enrolled as a Medicaid case management provider, assure that the agency and case managers will not provide case management and Medicaid reimbursed direct services to the same consumer(s);

12. have financial resources and a financial management system capable of:

a. adequately funding required qualified staff and services;

b. providing documentation of services and costs;

c. complying with state and federal financial reporting requirements; and

d. submitting reports in the manner specified by Medicaid;

13. maintain a written policy for intake screening, including referral criteria;

14. maintain a written policy for transition and closure;

15. with the consumer's permission, agree to maintain regular contact with, share relevant information and coordinate medical services with the consumer's primary care or attending physician or clinic;

16. fully comply with the *Code of Governmental Ethics*.

Applicants must meet the following additional enrollment requirements for specific target groups:

17. demonstrate the capacity to participate and agree to participate in the Case Management Information System (CAMIS) and provide up-to-date data to the Regional Office and/or Program Office on a weekly basis via electronic mail (applicable to infants and toddlers with special needs). CAMIS and electronic mail software will be provided without charge to the provider;

18. have demonstrated successful experience with delivery and/or coordination of services for pregnant women; have a working relationship with a local obstetrical provider/acute care hospital providing deliveries for 24-hour medical consultation; have a multidisciplinary team consisting, at a minimum, of: a physician; primary nurse associate or Certified Nurse Manager; registered nurse; social worker; and nutritionist. All team members must meet DHH licensure and perinatal experience requirements (applicable to high-risk pregnant women only);

19. satisfactorily complete a one-day training as approved by the Department of Health and Hospitals HIV Program Office (applicable to HIV only).

An enrolled case management provider must re-enroll requesting a separate Medicaid provider number and is subject to the above-described enrollment requirements and procedures in order to provide case management services to an additional target population. Applicants will be subject to review by DHH to determine ability and capacity to serve the target population and a site visit to verify compliance with all

provider enrollment requirements prior to a decision by the Medicaid Program on enrollment as a case management provider or at any time subsequent to enrollment. Enrolled case management providers will be subject to review by the DHH and the U.S. Department of Health and Human Services to verify compliance with all provider enrollment requirements at any time subsequent to enrollment.

If the applicant agency is determined to be eligible for enrollment, the agency will be notified in writing by the Medicaid Program of the effective date of enrollment and the unique Medicaid case management provider number for each office site and targeted or waiver group. If the Department determines that the applicant case management agency does not meet the general or specific enrollment requirements listed above, the applicant agency will be notified in writing of the deficiencies needing correction. The applicant agency must submit appropriate documentation of corrective action taken. If the applicant agency fails to submit the required documentation of corrective action taken within 30 days of the notice, the application will be rejected. If the case management agency does not meet all of the requirements above, the applicant agency will be ineligible to provide case management services to any targeted or waiver group.

## II. Standards of 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. Exceptions may be granted by the Secretary on a case-by-case basis based on an assessment of available services in the community.

A. Staff Coverage. All case managers must be employed by the case management agency a minimum of 20 hours per week and work at least 50 percent of the time during normal business hours (8 a.m. to 5 p.m., Monday through Friday). Contracting of case manager staff is prohibited. Case management supervisors must be employed a minimum of eight hours per week for each full-time case manager (four hours a week for each part-time case manager) they supervise and maintain on-site office hours at least 50 percent of the time. A supervisor must be continuously available to case managers by telephone or beeper at all other times when not on site when case management services are provided. The provider agency must ensure that case management services are available 24 hours a day, seven days a week.

B. Staff Qualifications. Each Medicaid-enrolled provider must ensure that all staff providing targeted case management services have the skills, qualifications, training and supervision in accordance with licensing standards and the Department requirements listed below. In addition, the provider must maintain sufficient staff to serve consumers within mandated caseload sizes described below.

1. Education and Experience for Case Managers. All case managers hired or promoted must meet all of the following minimum qualifications for education and experience:

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

direct consumer services or case management in the human-service-related field; or

b. a licensed registered nurse; and one year of paid experience as a registered nurse in public health or a human-service-related field providing direct consumer services or case management in the human-service-related field; 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 general minimum qualifications for case managers are applicable for all targeted and waiver groups. Thirty hours of graduate level course credit in the human-service-related field may be substituted for the year of required paid experience.

d. additional qualifications are required for service provision to High-Risk Pregnant Women:

1) a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; and one year of paid experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; and demonstrated knowledge about perinatal care; or

2) a licensed registered nurse; and one year of paid experience as a registered nurse in public health or a human-service-related field providing direct consumer services or case management in the human-service-related field; and demonstrated knowledge about perinatal care; or

3) a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; and demonstrated knowledge about perinatal care; or

4) a registered dietician; and one year of paid experience in providing nutrition services to pregnant women.

2. Education and Experience for Case Management Supervisors. A case management supervisor hired or promoted or any other individual supervising case managers must meet all of the education and experience requirements listed below. Staff supervising case management for high risk pregnant women must meet the same qualifications as the case managers for these populations:

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

b. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; and two years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field. One year of this experience must be in providing direct services to the target population to be served; or

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

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

The above general minimum qualifications for case management supervisors are applicable for all targeted and waiver groups. Thirty hours of graduate level course credit in the human-service-related field may be substituted for one year of required paid experience. Additional qualifications for specific targeted or waiver groups are delineated below:

e. each Medicaid-enrolled provider must ensure that all case management supervisory staff for high-risk pregnant women meet the following qualifications:

1) a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; and four years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to the target population to be served; and demonstrated knowledge about perinatal care;

2) a licensed registered nurse; and three years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to the target population to be served; and demonstrated knowledge about perinatal care; or

3) a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; and two years of paid post bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; one year of this experience must be in providing direct services to the target population to be served; demonstrated knowledge about perinatal care; or

4) a registered dietician; and three years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to pregnant women.

3. Requisite Knowledge, Skills and Abilities. Each Medicaid-enrolled provider must look for the following knowledge, skills and abilities in hiring case management staff and must ensure that all staff providing targeted or

waiver case management services possess the following basic knowledge, skills, and abilities prior to assuming full caseload responsibilities.

- a. Knowledge:
  - (1) community resources;
  - (2) medical terminology;
  - (3) case management principles and practices;
  - (4) consumer rights;
  - (5) state and federal laws for public assistance.

- b. Skills:
  - (1) time management;
  - (2) assessment;
  - (3) interviewing;
  - (4) listening.

- c. Abilities:
  - (1) preparing service plans;
  - (2) coordinating delivery of services;
  - (3) advocating for the consumer;
  - (4) communicating both orally and in writing;
  - (5) establishing and maintaining cooperative

working relationships;

- (6) maintaining accurate and concise records;

and formulating service plans accordingly;

- (8) problem solving;

(9) remaining objective while accepting the consumer's lifestyle.

4. Training. Case manager and supervisor training must be provided by or arranged by the case manager's employer at the employer's expense.

a. Training for New Case Managers. Orientation of at least 16 hours must be provided to all staff, volunteers, and students within one week of employment. A minimum of eight hours of the orientation training must cover orientation on the target population including but not limited to specific service needs and resources. Other topics covered by the orientation must include, at a minimum:

- 1) provider policies and procedures;
- 2) Medicaid/Program Office policies and procedures;
- 3) confidentiality;
- 4) documentation in case records;
- 5) consumer rights protection and reporting of violations;
- 6) consumer abuse and neglect policies and procedures;
- 7) professional ethics;
- 8) emergency and safety procedures;
- 9) data management and record keeping;
- 10) infection control and universal precautions.

b. In addition to the required 16 hours of orientation, all new employees with no documented required experience and training must receive a minimum of 16 hours of training during the first 90 calendar days of employment which is related to the target population served and specific knowledge, skills, and techniques necessary to provide case management to the target population. This training must be

provided by an individual with demonstrated knowledge of the training topics and the target population. This training must include the following at a minimum:

- 1) assessment techniques;
- 2) service planning;
- 3) resource identification;
- 4) interviewing and interpersonal skills;
- 5) data management and record keeping;
- 6) communication skills.

c. Annual Training. A case manager must satisfactorily complete 40 hours of case-management related training annually which may include training updates on subjects covered in orientation and initial training. For new employees, the 16 hours of orientation training are not included in the 40-hour minimum annual training requirement. The 16 hours of training for new staff required in the first 90 days of employment may be part of this 40-hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required 40 hours of annual training. The Department of Health and Hospitals *Case Management Provider Manual* contains a list of suggested additional training topics.

Each case management supervisor must complete 40 hours of training a year, at a minimum. In addition to the required and topics for case managers, the following are required topics for supervisory training:

- 1) professional identification/ethics;
- 2) process for interviewing, screening, and hiring of staff;
- 3) orientation/in-service training of staff;
- 4) evaluating staff;
- 5) approaches to supervision;
- 6) managing caseload size;
- 7) conflict resolution;
- 8) documentation;
- 9) time management.

The required orientation and training for case managers and supervisors described above must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and orientation/training agenda.

d. Training—Infants and Toddlers with Special Needs

1) A minimum of eight hours of orientation for new family service coordination staff must be ChildNet specific training as defined by the Department of Education. A minimum of 24 additional hours of training must be provided to new family service coordinators hired in the first 90 days of employment. This training must cover advanced subjects as defined by the Department of Education in addition to the subjects listed above. Initial training specific to ChildNet must be arranged and/or coordinated by the Regional Infant/Toddler Coordinator. Advanced training in specific subjects must be satisfactorily completed prior to the case manager/family service coordinator assuming those duties. Ongoing annual training is the responsibility of the family service coordination agency.

2) New family service coordination supervisors must satisfactorily complete a minimum of 40 hours of family service coordination training before assuming supervisory duties for this target population. Experienced supervisors must also complete a minimum of 40 hours per calendar year on advanced ChildNet specific subjects defined by the Department of Education.

e. **Mandatory Medicaid Training.** Enrolled case management agencies must ensure that all case management staff satisfactorily complete DHH provider required training on case management policies and procedures when provided.

C. **Supervision.** Each case management agency must have and implement a written plan for supervision of all case management staff. Face-to-face supervision must occur at least one time per week per case manager for a minimum of one hour per week. Supervisors must review at least 10 percent of each case manager's case records each month for completeness, compliance with these standards, and quality of service delivery. Case managers must be evaluated at least annually by their supervisor according to written provider policy on evaluating their performance. Supervision of individual staff must include the following:

1. direct review, assessment, problem solving, and feedback regarding the delivery of case management services;
2. teaching and monitoring of the application of consumer centered principles and practices;
3. assuring quality delivery of services;
4. managing assignment of caseloads; and
5. arranging for training as appropriate.

The case manager supervisor must assess staff performance, review individual cases, provide feedback and help staff 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 consumers.

**Documentation:** Each supervisor must maintain a file on each case manager supervised and document supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum:

1. date and content of the supervisory sessions; and
2. results of the supervisory case review which shall address, at a minimum: completeness and adequacy of records; compliance with standards; and effectiveness of services.

Each case management supervisor must not supervise more than five full-time case managers or a combination of full-time case managers and other human service staff. A supervisor may carry one-fifth of a caseload for each case manager supervised less than five supervisees. If the supervisor carries a caseload, he or she must be supervised by an individual who meets the supervisor qualifications.

D. **Caseload Size Standards.** Each full-time case manager is subject to a maximum caseload of consumers as indicated below:

GROUP	CASES
MR/DD Waiver	45
Infants and toddlers with special needs	35
High-risk pregnant women	60
HIV infected	45
Fragile elderly	40

*Mixed* caseloads are those where a case manager serves at least five consumers from a second target population or five waiver participants. For caseloads containing consumers who are MR/DD waiver participants in addition to those who are infants and toddlers with special needs, the maximum caseload is 35. For other "mixed" caseloads, the number of cases must be prorated.

E. **Consumer Eligibility Requirements for Targeted Populations.** Case management providers must ensure that consumers of Medicaid-funded targeted case management services are Medicaid-eligible and meet the additional eligibility requirements specific to the targeted or waiver population group. The eligibility requirements for each targeted and waiver group are listed below. With respect to infants and toddlers with special needs, this determination is made through the Multidisciplinary Evaluation (MDE) process and is not the responsibility of the case management/family service coordination agency. Also, the service plan for case management services provided to mentally retarded/developmentally disabled individuals and infants and toddlers with special needs is subject to prior authorization by the Medicaid agency or its designee. Providers are required to participate in provider training and technical assistance as required by the Medicaid agency or its designee.

1. **Infants and Toddlers with Special Needs.** The infant/toddler must meet the following criteria:

a. have a medical condition established and documented by a licensed medical doctor. In the case of a hearing impairment, a licensed audiologist or licensed medical doctor must make the determination; or

b. be developmentally delayed in one or more of the following areas:

- 1) cognitive development;
- 2) physical development, including vision and hearing; eligibility must be based on a documented diagnosis made by a licensed medical doctor (vision); or a licensed medical doctor or licensed audiologist (hearing);
- 3) communication development;
- 4) social or emotional development;
- 5) adaptive development.

The determination of a developmental delay must be made in accordance with applicable federal regulations and ChildNet policies and procedures.

2. **High-Risk Pregnant Women**

a. pregnancy must be verified by a licensed physician, licensed primary nurse associate, or certified nurse midwife;

b. reside in the metropolitan New Orleans area including Orleans, Jefferson, St. Charles, St. John and St. Tammany parishes;

c. be determined high risk based on a standardized medical risk assessment. A medical risk assessment (screening) must be performed by a licensed physician, a licensed primary nurse associate, or a certified nurse-midwife to determine if the patient is high risk. A pregnant woman is considered high risk if one or more risk factors are indicated on the form used for risk screening. Providers of medical risk assessment must use the standardized Risk Screening Form approved by DHH;

d. must require services from multiple health, social, informal and formal service providers and is unable to access the necessary services.

### 3. HIV Infected Persons

a. Written verification of HIV infection by a licensed physician or laboratory test result is required.

b. The adult consumer must have reached, as documented by a physician, a level 70 on the Karnofsky scale (or cares for self but is unable to carry on normal activity or do active work) at some time during the course of HIV infection.

c. The pediatric consumer must display symptoms of illness related to HIV infection. All consumers must require services from multiple health, social, informal and formal service providers and be unable to access the necessary services.

4. Frail Elderly. The consumer must be a participant in the Home Care for the Elderly waiver.

5. MR/DD Waiver. The consumer must be participant in the MR/DD Waiver.

F. Description of Case Management Services/Provider Responsibilities. The definition of *Case Management* adopted by the Department is "services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services." Targeted and waiver case management services consist of intake, assessment, service planning, linkage/service coordination, monitoring/follow-up, re-assessment, and transition/closure. The Department utilizes a broker model of case management in which consumers are referred to other agencies for specific services they need. These services are determined by professional assessment of the consumer's needs and provided according to a comprehensive individualized written service plan. All case management services must be provided by qualified staff as defined in Section A above. The provider must ensure that there is no duplication of payment, that there is only one case manager for each eligible consumer and that the consumer is not receiving other targeted case management services from any other provider.

The required core elements of targeted or waiver case management services and provider responsibilities which all Medicaid enrolled case management agencies must comply with are described below.

1. Case Management Intake. *Intake* is defined as the determination of eligibility and need for targeted case management services. Intake is the entry point into case

management. The purpose of intake is to gather baseline information to determine the consumer's need, appropriateness, eligibility and desire for case management. The case management provider must have written eligibility criteria for case management services provided by the agency. The required procedures of intake screening are:

a. interview the consumer within three working days of receipt of a referral, preferably face-to-face;

b. determine if the consumer is currently Medicaid-eligible;

c. determine if the consumer is eligible for services by virtue of the eligibility requirements of the target population described in Section B above;

d. determine if the consumer's needs require case management services;

e. inform the family of procedural safeguards, rights and grievance/appeal procedure and which include the following:

1) determine if the consumer freely accepts case management as optional;

2) provide the consumer freedom of choice of available targeted case management providers as well as case managers. Advise the consumer of his right to change case management providers and case managers;

3) provide the consumer freedom of choice of available service providers. The consumer must sign a standardized intake form to verify the above procedural safeguards;

f. obtain signed release form(s) from the consumer/guardian.

Intake activities performed solely to determine eligibility and need for targeted case management are not billable to Medicaid.

The above general case management intake procedures are applicable for all targeted and waiver groups. Additional or other procedures for specific targeted or waiver groups are delineated below.

2. *Intake for Infants and Toddlers with Special Needs* is defined as a comprehensive interagency multidisciplinary, ongoing process which ensures that eligible children are appropriately identified, located, referred and evaluated for early intervention services. The child search coordinator in the local education agency is the single point of entry into ChildNet. The child search coordinator is responsible for completion of the following intake procedures:

a. Upon receipt of a referral, the child search coordinator must assist the family in identifying and choosing an enrolled family service coordinator provider to assist in the MDE process. Referrals received directly by a family service coordination provider must be immediately referred to the appropriate child search coordinator.

b. The child search coordinator must provide the family freedom of choice to select an enrolled family service coordination provider, and advise the family of the right to change family service coordinator provider agencies, family service coordinators and other service providers.

c. The child search coordinator must advise the family of their procedural safeguards and provide them with a copy of their rights under ChildNet.

3. Intake for High-Risk Pregnant Women must include a standardized medical risk assessment. A medical risk assessment (screening) must be performed by a licensed physician, a licensed primary nurse associate, or a certified nurse-midwife to determine if the patient is high risk. A pregnant woman is considered high risk if one or more risk factors are indicated on the form used for risk screening. Providers of medical risk assessment must use the standardized Risk Screening Form approved by DHH;

4. Case Management Assessment. *Assessment* is defined as the process of gathering and integrating formal/professional and informal information concerning a consumer's goals, strengths, and needs to assist in the development of a comprehensive, individualized service plan. The purpose of assessment is to establish a service plan and contract between the case manager and consumer. The following areas must be addressed in the assessment when relevant:

- a. identifying information;
- b. medical/physical;
- c. psychosocial/behavioral;
- d. developmental/intellectual;
- e. socialization/recreational;
- f. financial;
- g. educational/vocational;
- h. family functioning;
- i. personal and community support systems;
- j. housing/physical environment; and
- k. status of other functional areas or domains.

Providers may be required to use standardized assessment instruments for certain targeted populations. The assessment must identify the consumer's strengths, needs and priorities. The assessment must be conducted by the case manager through in-person contact, individualized observations and questions with the consumer and, where appropriate, in consultation with the consumer's family and support network, other professionals, and service providers. The assessment must identify areas where a professional evaluation is necessary to determine appropriate services or interventions. The case manager must arrange for any necessary professional/clinical evaluations needed to clearly define the consumer's specific problem areas. Authorization must be obtained from the consumer/guardian to secure appropriate services.

The assessment must be initiated as soon as possible, preferably within seven calendar days of receipt of the referral, and must be completed no later than 30 days after the referral for case management services. A face-to-face interview with the consumer is required as part of the assessment process. The initial assessment interview with the consumer must be conducted in the consumer's home to accurately assess the actual living conditions and health and mental status of the consumer unless this is not the consumer's preference or there are genuine concerns regarding safety. If the interview cannot be conducted in the consumer's home, an alternative setting in the consumer's community must be chosen jointly with the consumer and documented in the case record. All assessments must be written, signed, dated, and documented in the case record.

Assessments performed on children in the custody of the Office of Community Services (OCS) or Office of Youth Development (OYD) must actively involve the assigned foster care worker or probation officer and must be approved by the agency with legal custody of the child. Assessments performed on consumers in the custody of the Office of Developmental Disabilities (OCDD) must actively involve the assigned Regional Office OCDD staff and must be approved by OCDD.

The above general case management assessment procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

5. Assessment for Infants and Toddlers with Special Needs. The child search coordinator is responsible for ensuring all the components of the assessment/multidisciplinary evaluation (MDE) are fulfilled within the required timeliness. In addition, the child search coordinator must coordinate with the family service coordinator to ensure the development of the initial Individualized Family Service Plan within the required 45-day time lines. The case manager/family service coordinator is responsible for assisting the family through the multidisciplinary evaluation process including the following:

- a. informing the family of the steps involved in the MDE process, explaining their rights and procedural safeguards and securing their participation;
- b. reviewing relevant medical information and prior evaluations;
- c. coordinating the performance of identified or necessary evaluations and KIDMED screenings and immunizations, and an examination by a licensed physician to ensure timely completion of the MDE and IFSP;
- d. identifying or coordinating the identification of the family's concerns, priorities and resources;
- e. the MDE must include the following:
  - 1) a review of pertinent records related to the child's current health status and medical history;
  - 2) results of a KIDMED screening or documented referral for KIDMED screening;
  - 3) an evaluation of the child's level of functioning in each of the following developmental areas: cognitive development; physical development, including vision and hearing (by a licensed physician or hearing by a licensed audiologist); communication development; social or emotional development; and adaptive development;
  - 4) an assessment of the child's strengths and needs and the identification of appropriate early intervention services to meet those needs; and
  - 5) with family consent, the family's identification of their concerns, priorities and resources related to enhancing the development of their child;
  - 6) be signed and dated by multidisciplinary team participants.

6. Assessment for High-Risk Pregnant Women is a multidisciplinary evaluation of the high-risk patient to identify factors that may adversely affect health status. Professionals from nursing, nutrition and social work disciplines working as



a team must each evaluate the consumer and family needs through interactions and interviews.

a. Each professional assessment must reflect the identified areas for counseling, intervention and follow up services.

b. The nursing, nutritional, and psychosocial assessments must be documented on standardized forms approved by the Department.

c. Assessments must be completed within 14 calendar days after the risk assessment is completed or receipt of the referral. There may be extenuating circumstances with certain patients that may hinder compliance with this time frame for assessment.

d. The case manager is responsible for assisting the family through the multidisciplinary evaluation process including the following:

1) coordinating the performance of identified or necessary evaluations to ensure timely completion in preparation for the multidisciplinary team staffing;

2) identifying or coordinating the identification of the consumer's concerns, priorities and resources.

e. A home assessment must be completed by the case manager as part of the initial assessment. If a home visit is refused by the consumer/guardian or there are genuine concerns regarding safety, an alternative setting in the consumer's community may be chosen jointly with the consumer and documented in the case record.

7. Case Management Service Planning. *Service Planning* is defined as the development of a written agreement based upon assessment data (which may be multidisciplinary), observations and other sources of information which reflect the consumer's needs, capacities and priorities, and specifies the services and resources required to meet these needs.

a. The service plan must be developed through a collaborative process involving the consumer, family, case manager, other support systems and appropriate professionals and service providers. It should be developed in the presence of the consumer and, therefore, cannot be completed prior to a meeting with the consumer. The consumer, case manager, support system and appropriate professional personnel must be directly involved and have agreed to assume specific functions and responsibilities.

b. The service plan must be completed within 45 calendar days of the referral for case management services.

1) The consumer must be informed of his or her right to refuse a service plan after carefully reviewing it.

2) The service plan must be signed and dated by the consumer and the case manager.

c. Although service plans may have different formats, all plans must incorporate all of the following required components:

1) statement of prioritized long-range goals (problems or needs) which have been identified in the assessment;

2) one or more short-term objectives or expected outcomes linked to each goal that is to be addressed in order of priority;

3) specification of action steps, services or interventions planned, and payment mechanism, if applicable;

4) assignment of individual responsibility for goal accomplishment; and

5) time frames for completion or review.

d. The service plan must document frequency and/or intensity of contacts between the consumer and case manager, service providers and others, the persons to be contacted and whether the visits must be to the consumer's place of residence or to another location, such as a service delivery site. Each service plan must be kept in the consumer's record. The assessment and service plan must be completed prior to providing ongoing case management services.

The above general case management service planning procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

e. Service Planning for Infants and Toddlers with Special Needs. The family service coordinator's responsibilities in the Individual Family Service Plan (IFSP) must include all of the following;

1) convening a meeting to develop the IFSP within 45 calendar days of referral;

2) attending the IFSP meeting;

3) ensuring that the IFSP meeting is conducted in settings and at times that are convenient to families; in the native language of the family or other mode of communication used by documentation to the regional office within prescribed time lines in accordance with Office of Mental Health procedures.

8. Case Management Linkage. *Linkage* is defined as the implementation of the service plan involving the arranging for a continuum of both informal and formal services. After obtaining authorization from the consumer, the case manager must contract with the direct service providers or direct the consumer to contact the service providers, as appropriate. The case manager must contract with the consumer for formal and informal services and supports to be arranged. Attempts must be made to meet service needs with informal service providers as much as possible. The responsibilities of the case manager in service coordination are:

a. translating assessment findings into services;

b. determining which services and connections are needed;

c. being aware of community resources (Food Stamps, SSI, Medicaid, etc.);

d. exploration of both formal and informal services for consumers;

e. communicating and negotiating with service providers;

f. training and support of the consumer in the use of personal and community resources identified in the service plan;

g. linking consumers through referrals to services that meet their needs as identified in the service plan; and

h. advocacy on behalf of the consumer to assist them in accessing appropriate benefits or services.

9. *Case Management Follow-Up/Monitoring*—defined as the follow-up mechanism to assure applicability of the service plan.



a. The purpose of monitoring/follow-up contacts made by the case manager is to determine if the services are being delivered as planned, and/or services adequately meet consumer needs and to determine effectiveness of the services and the consumer's satisfaction with them.

b. The consumer must be contacted within the first 10 working days after the initial service plan is completed to assure appropriateness and adequacy of service delivery.

c. Thereafter, face-to-face follow-up visits must be made with the consumer/guardian at least monthly as part of the linkage and monitoring follow-up process, or more frequently as dictated by the service plan or determined by the needs of the consumer/guardian.

d. In addition, visits must be made to consumer's home on a quarterly basis, at a minimum. If the consumer refuses home visits or there are genuine concerns regarding safety, an alternative setting in the consumer's community may be chosen jointly with the consumer.

e. The case manager must communicate regularly by telephone, in writing and in face-to-face meetings and home visits with the consumer/guardian, professionals and service providers involved in the implementation of the service plan. The nature of these follow-up contacts (e.g., telephone, home visit) and the individuals contacted is determined by the status and needs of the consumer, as identified in the service plan and determined by the case manager.

Through follow-up/monitoring activity, the case manager must determine whether or not the service plan is effective in meeting the consumer's needs and identify when changes in the consumer's status occur, necessitating a revision in the service plan. Reassessment is required when a major change in status of the consumer/guardian occurs.

f. Monitoring of services provided includes the following:

1) following up to assure that the consumer actually received the services as scheduled;

2) assuring that consumer/consumer's family is able and willing to comply with recommendations of service providers;

3) measuring progress of consumer in meeting service plan goals and objectives and determining whether the services adequately address the consumer's needs.

Monitoring information must be obtained by the case manager through direct observation and direct feedback. The case manager must gather information from direct service providers for monitoring purposes. The case manager must obtain verbal or written service reports from direct service providers.

The above general case management service planning procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

g. Follow-Up/Monitoring for High-Risk Pregnant Women. The case manager must maintain at least weekly face-to-face or telephone contact with the consumer/guardian, family, informal and/or formal providers to implement the service plan and follow up/monitoring service provision and the consumer's progress in accordance with the service plan.

10. Case Management Reassessment. *Reassessment* is defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for evaluating and revising the overall service plan.

a. After the initial assessment is completed and initial service plan is implemented, the consumer's needs and progress toward accomplishing the goals listed in the service plan goals must be re-evaluated on a routine basis or when a significant change in status or needs occurs. If indicated, the identified needs, short-term goals or objectives, services, and/or service providers must be revised.

b. Reassessment is accomplished through interviews and periodic observations.

c. A schedule for re-assessing and modifying the initial goals and service plans must be part of the initial workup. Reassessment and review and/or updating of the service plan must be done at intervals of no less than 90 calendar days. If there is a minor change in the service plan, the case manager must revise the plan and initial and date the change. More frequent re-assessments may be required, depending upon the consumer's situation.

d. At least every six months, a complete review of the service plan must be done to assure that goals and services are appropriate to the consumer's needs identified in the assessment/re-assessment process.

1) A home-based re-assessment must be done on at least an annual basis unless this is not the consumer's preference or there are genuine concerns regarding safety.

2) If the re-assessment cannot be conducted in the consumer's home, an alternative setting in the consumer's community must be chosen jointly with the consumer and documented in the case record.

The above general case management re-assessment procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

e. Reassessment for Infants and Toddlers with Special Needs. Ongoing assessment is a component of the IFSP process.

1) A review of the IFSP must be conducted at least every six months, or more often if conditions warrant, or if the family requests a review to determine the following:

a) the degree to which progress is being made toward achieving the outcomes; and

b) whether modifications or revisions of the outcomes or services are necessary.

2) The review may be carried out by a meeting or by other means that are acceptable to the families and other participants.

3) An annual meeting must be conducted to evaluate the IFSP and, as appropriate, revise the IFSP. The results of any ongoing assessments of the child and family, and any other pertinent information must be used in determining what early intervention services are needed and will be provided.

11. Case Management Transition/Closure. Discharge from case management must occur when the consumer no longer needs or desires the services, or becomes ineligible for

them. The closure process must ease the transition to other services or care systems.

a. When closure is deemed appropriate, the consumer must be notified immediately so that appropriate arrangements can be made.

b. The case manager must complete a final re-assessment identifying any unresolved problems or needs and discussing with the consumer methods of arranging for their own services.

c. Criteria for closure include but are not limited to the following:

- 1) resolution of the consumer's service needs with low probability of recurrence;
- 2) consumer requests termination of services;
- 3) death;
- 4) permanent relocation out of the service area;
- 5) long-term admission to a hospital, institution or nursing facility;
- 6) does not meet the criteria for the case management established by the funding source (e.g., Medicaid or the Program Office);
- 7) the consumer requires a level of care beyond that which can safely be provided through case management;
- 8) the safety of the case manager is in question; or
- 9) noncompliance.

All cases which do not have an active service plan and necessary linkage or monitoring activities must be closed. Infants and toddlers eligible under ChildNet are no longer eligible for Medicaid-funded case management services if they do not require and receive two or more of the required Medicaid services.

12. Procedures for Changing Providers. A consumer may freely change case management providers or case managers or terminate services at any time. DHH maintains a listing of enrolled and approved case management providers for each target and waiver population which consumers and service providers may access for referral purposes.

a. Once the consumer has chosen a new case management provider, the new provider must complete the standardized "Provider Change Notification" form, obtain the consumer's written consent and forward the original change form to the previous case management provider. Upon receipt of the completed form, the previous provider must send copies of the following information as required by licensing standards within 10 working days:

- 1) most current service plan;
- 2) current assessments on which service plan is based;
- 3) number of services used in the calendar year;
- 4) current and previous quarter's progress notes.

b. The new provider must bear the cost of copying which cannot exceed the community's competitive copying rate. The previous provider may not provide case management services after the date the notification is received.

The above general procedures for changing case management providers are applicable for all targeted and waiver groups except as otherwise specified for particular groups delineated below.

c. Procedures for Changing Family Service Coordination Providers-Infants and Toddlers with Special Needs. If a family chooses to change family service coordination agencies or a change is necessary for any reason, the following procedures will be followed:

1) The family will be referred back to the child search coordinator. This referral can be made by the family, the current family service coordinator, or other service providers.

2) The child search coordinator will provide the family with the official list of family service coordination providers and the freedom of choice form.

3) The child search coordinator will review the family's rights under ChildNet with the family including the right to change family service coordinators or agencies.

4) The child search coordinator or the family, if the family chooses, will notify the newly selected agency.

5) The child search coordinator will notify the old agency at termination.

6) After receiving written informed paternal consent, the new agency will request records from the previous agency. The previous agency will make these records available within 10 working days of receipt of the request.

### III. General Provisions

A. Components of the Case Record. The provider must keep sufficient records to document compliance with licensing and Medicaid case management requirements for the target population served and provision of case management services. Separate case management records must be maintained on each consumer which fully document services for which Medicaid payments have been made. The provider must maintain sufficient documentation to enable the Medicaid Program to verify that each charge is due and proper prior to payment. The provider must make available all records which the Medicaid Program finds necessary to determine compliance with any federal or state law, rule, or regulation promulgated by the Medicaid Program, DHH or DHHS or other applicable state agency.

The consumer's case record must consist of the following information, at a minimum:

1. Medicaid eligibility information;
2. documentation verifying that the consumer meets the requirements of the targeted population;
3. a copy of the standardized procedural safeguard form signed by the consumer;
4. copies of any professional evaluations and other reports used to formulate the service plan;
5. case management assessment;
6. progress notes;
7. service logs;
8. copies of correspondence;
9. at least six months of current pertinent information relating to services provided. (Records older than six months may be kept in storage files or folders, but must be available for review.)

10. if the provider is aware that a consumer has been interdicted, a statement to this effect must be noted.

B. **Service Logs.** Service logs are the means for recording units of billable time. There must be case notes corresponding to each recorded time of case management activity. The notes should not be a narrative with every detail of the circumstances. Service logs must reflect service delivered, the "paper trail" for each service billed. Logs must clearly demonstrate allowable services billed.

1. Services billed must clearly be related to the current service plan.

2. Billable activities must be of reasonable duration and must agree with the billing claim.

3. All case notes must be clear as to who was contacted and what allowable case management activity took place. Use of general terms such as "assisted consumer to" and "supported consumer" do not constitute adequate documentation.

4. Logs must be reviewed by the supervisor to insure that all billable activities are appropriate in terms of the nature and time and documentation is sufficient. Federal requirements for documenting case management claims require the following information must be entered on the service log to provide a clear audit trail:

- a. name of consumer;
- b. name of provider and person providing the service;
- c. names and telephone numbers of persons contacted;
- d. start and stop time of service contact and date of service contact;
- e. place of service contact;
- f. purpose of service contact;
- g. content and outcome of service contact.

C. **Progress Notes** are the means of summarizing billable activities, observations and progress toward meeting service goals in the case management record. Progress notes must:

1. be clear as to who was contacted and what case management activity took place for each recorded time of case management. It must be clear why that time period was billed;

2. record activities and actions taken, by whom, and progress made; and indicate how goals in the service plan are progressing;

3. document delivery of each service identified on the service plan;

4. record any changes in the consumer's medical condition, behavior or home situation which may indicate a need for a re-assessment and service plan change;

5. be legible, as well as legibly signed, including functional title, and fully dated;

6. be complete, entered in the record preferably weekly but at least monthly and signed by the primary case manager;

7. be recorded more frequently (weekly) when there is frequent activity or significant changes occur in the consumer's service needs and progress;

8. quarterly progress notes are required in addition to the minimum monthly recording;

9. a summary must also be entered in the consumer's record when a case is transferred or closed.

D. The organization of individual case management records on consumers and location of documents within the

record must conform with state licensing standards and be consistent among records. All entries made by staff in consumer records must be legible, fully dated, legibly signed and include the functional title of the individual. Any error made by the staff in a consumer's record must be corrected using the legal method which is to draw a line through the erroneous information, write "error" by it and initial the correction. Correction fluid cannot be used in consumer records.

E. **Availability of Case Records.** Providers must make all necessary consumer records available to appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of consumer information. Under no circumstances should providers allow case management staff to take records home. The case management agency can release confidential information only under the following conditions:

1. by court order; or

2. by the consumer's written informed consent for release of the information. In cases where the consumer has been declared legally incompetent, the individual to whom the consumer's rights have devolved must provide informed written consent.

F. **Storage of Case Records.** Providers must provide reasonable protection of consumer records against loss, damage, destruction, and unauthorized use. Administrative, personnel and consumer records must be retained until records are audited and all audit questions are answered or three years from the date of the last payment, whichever is longer.

#### IV. Reimbursement

A. All reimbursement for optional targeted and waiver case management services shall be made in accordance with all applicable federal and state regulations. Providers shall not bill for failed attempts to make contact with either consumers or collateral.

B. The reimbursement rate for optional targeted and waiver case management services is a monthly rate for the provision of mandated monthly minimum services. It is not a capitated rate. Interim billing of one hour and additional 15-minute increments is permitted up to the monthly rate. Interim billing for case management services for Elderly Waiver, MR/DD Waiver and Infants and Toddlers must meet the following criteria for billing and cannot occur prior to providing at least one 15-minute continuous face-to-face encounter in the 30-day cycle and:

1. completion of at least 60 minutes of case management services;

2. additional 15-minute periods of services provided in a 30-day cycle can be billed only after the first hour and the face-to-face encounter has been provided.

C. Hour- or 15-minute codes cannot be accumulated across 30-day cycles and must count anew for each cycle or authorized period if less.

D. Billed case management services shall be monitored through the use of provider record review, consumer survey for verification of services provision and quality of service, and verification with collateral of contacts made on behalf of the recipient. Any situation involving fraud and/or abuse in the provision of case management services will be referred to

the SURS Unit for investigation. A subsequent referral will be made to the State Attorney General's Medicaid Fraud Control Unit by the SURS Unit if a criminal investigation is warranted.

**E. Reimbursement Rates**

SERVICE	HOUR RATE	MAX UNITS	15 MIN RATE	MAX UNITS	MAX MO PAYMENT
MR/DD Waiver	\$49.00	1	\$12.25	8	\$147
Elderly Waiver	\$49.50	1	\$12.38	4	\$ 99
Infants and Toddlers with special needs	\$49.00	1	\$12.25	4	\$ 98
HIV infected individuals					\$ 99
High Risk Pregnant Women (on-going Services)					\$ 57
High Risk Pregnant Women Assessment Only		1 time only			\$130

F. The following Minimum Program Standards are required for the reimbursement of Case Management Services.

**1. Mentally Retarded/Developmentally Disabled Individuals in the MR/DD Waiver Program.**

a. A minimum of three hours of documented case management services provided in each month in which services are billed is necessary to receive the full monthly fee. The three hours must include one continuous 15-minute face-to-face contact with the recipient in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up/monitoring. Two home visits are required in a six-month period. Service provider records for MR/DD waiver participants must be monitored by the case management agency every 60 days.

b. Services shall be authorized for a maximum three-month time period. All services must be documented on the MRCAMIS service log and be entered into MRCAMIS. Weekly submission of MRCAMIS data is required.

c. The procedure codes applicable to case management services for the MR/DD population are Z0192 (hourly code) and Z1192 (15-minute code) for waiver participants. The maximum monthly payment rate is \$147 for the MR/DD population.

**2. Infants and Toddlers with Special Needs**

a. A minimum of two hours of documented case management services provided in each month in which services are billed is necessary to receive the full monthly fee. The two hours must include one continuous 15-minute face-to-face contact with the recipient in addition to case management activities such as assessment/service plan development/update, linkage to services and follow-up/monitoring. Two home visits are required in a six-month period. Service provider records for MR/DD waiver participants must be monitored by the case management agency every 60 days.

b. Services shall be authorized for a maximum three-month time period. All services must be documented on the

MRCAMIS service log and be entered into MRCAMIS. Weekly submissions of MRCAMIS data are required.

3. Persons Infected with HIV. A minimum of two hours of documented case management services provided in each month in which services are billed is necessary to receive the full monthly fee. The two hours must include one face-to-face contact with the recipient in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up/monitoring. A home assessment is a required component of the initial assessment for HIV case management services.

**4. High Risk Pregnant Women of the Metropolitan New Orleans Area**

a. A minimum of one hour of documented case management services provided in each month in which services are billed is necessary to receive the full monthly fee. This must include one face-to-face contact with the recipient in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up monitoring. A home assessment is a required component of the initial assessment for high risk pregnant women case management services.

b. In addition, the following contacts are required:

- 1) a minimum of monthly verbal contact with the recipient's obstetrician or his staff;
- 2) weekly verbal contact with the recipient beginning with her 37th week of pregnancy until the delivery;
- 3) quarterly home visits with the recipient;
- 4) weekly contact with other service providers and/or informal supports; and
- 5) a postpartal home visit to be made within 10 to 14 calendar days after delivery focusing on postpartal concerns and infant care.

c. Only one assessment service shall be reimbursed for each pregnancy.

**5. Home Care for the Elderly Waiver Program Participants**

a. A minimum of two-hours of documented case management services provided in each month in which services are billed is necessary to receive the full monthly fee. The two hours must include one face-to-face contact with the consumer in addition to case management activities such as assessment, service plan development/update, linkage to services and follow-up/monitoring.

b. Service provider records must be monitored by the case management agency every 60 days.

G. General Requirements. Payment for targeted or waiver case management services is dictated by the nature of the activity and the purpose for which the activity is performed. All case management services billed must be provided by qualified case managers and meet the definition of *Case Management*, "services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services." This definition encompasses assisting eligible consumers in gaining access to needed services including:

1. identifying services needed;

2. linking consumer with the most appropriate providers of services; and

3. monitoring to ensure needed services are received.

Case management does not consist of the provision of other needed services, but is to be used as a vehicle to help an eligible consumer gain access to them. If there is no interaction in person, by telephone or in correspondence on behalf of the consumer, it is most likely not a billable case management activity without sufficient justification.

H. Nonbillable Activities. Federal regulations require that the Medicaid Program ensure that payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority as an administrative function or as an integral part of a covered service.

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 Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs) and services furnished through Title V public health agencies, 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.

Time spent in activities which are not a direct part of a contact are not Medicaid reimbursable. Activities that, while they may be necessary, do not result in a service identified in the service plan being provided to the consumer are not reimbursed. The following examples of activities are not considered targeted case management services for Medicaid purposes and are not reimbursable by the Medicaid Program as case management:

1. outreach, case finding or marketing;
2. counseling or any form of therapeutic intervention;
3. developing general community or placement resources or a community resource directory;
4. legislative or general advocacy;
5. professional evaluations;
6. training;
7. providing transportation;
8. telephone calls to a busy number, leaving messages, faxing or mailing information;
9. travel to a consumer's home for a home visit, and the consumer is not at home so that the visit cannot be held but a note is left;
10. "housekeeping" activities in connection with record keeping (Recording a contact in the case record at the time service is provided is billable.);
11. in-service training, supervision;
12. discharge planning;

Exception: 10 days (30 days for developmentally disabled waiver participant) before discharge from an inpatient facility to assist the consumer in the transition from inpatient to outpatient status, and in arranging appropriate services and 10 days after institutionalization or hospitalization to arrange for closure of community services.

13. intake screening which takes place prior to and is separate from assessment;

14. general administrative, supervisory or clerical activities;

15. record keeping;

16. general interagency coordination;

17. program planning;

18. Medicaid billing or communications with Medicaid Program;

19. running errands for family (shopping, picking up medication, etc.);

20. accompanying family to appointments or recreational activities, waiting for appointments with family;

21. lengthy interaction to "get acquainted", "provide support", or "hand holding";

22. activities performed by agency staff other than the primary case manager;

23. accompanying another case manager for safety reasons.

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

A public hearing on this proposed Rule is scheduled for Tuesday, January 28, 1997, at 1 p.m., in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments, orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m., on the next business day following the public hearing.

Bobby P. Jindal  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Targeted Case Management Services**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

It is anticipated that implementation of this proposed Rule on the reimbursement revisions for Targeted Case Management Services will reduce state costs by approximately \$1,701,871 for SFY 1997; \$2,055,654 for SFY 1998; and \$2,117,324 for SFY 1999. Included in this projected state costs savings is the operating expense of \$680 expected for the promulgation of this proposed Rule.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The decrease in federal revenue collections is approximately \$7,480,573 for SFY 1997; \$7,296,729 for SFY 1998; and \$7,515,631 for SFY 1999.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

Providers of targeted case management services will experience a reimbursement reduction of approximately \$9,182,444 for SFY 1997; \$9,352,383 for SFY 1998; and \$9,632,955 for SFY 1999 for their services to Medicaid recipients.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no known effect on competition and employment.

Thomas D. Collins  
Director  
9612#067

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Social Services  
Office of Family Support**

**Child Support Collections—Distribution (LAC 67:III.2514)**

The Department of Social Services, Office of Family Support, proposes to amend the LAC 67:III.Subpart 4, Support Enforcement Services (SES), the child support enforcement program.

Pursuant to Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, revisions have been made to the method in which Support Enforcement Services distributes child support collections. Prior federal law totally mandated the manner of distribution. Federal law now requires that reimbursement of the federal portion of benefits from the Aid to Families with Dependent Children Program (AFDC) or Family Independence Temporary Program (FITAP) be made first. The state may then retain or distribute the remainder as it chooses. Therefore, the state now proposes to establish a procedure to distribute funds.

**Title 67**

**SOCIAL SERVICES**

**Part III. Office of Family Support**

**Subpart 4. Support Enforcement Services**

**Chapter 25. Support Enforcement**

**Subchapter D. Collection and Distribution of Support Payments**

**§2514. Distribution of Child Support Collections**

A. Effective November 1, 1996 the Agency will distribute child support collections in the following manner:

1. In cases in which the applicant/recipient (AR) currently receives AFDC or Family Independence Temporary Assistance Program (FITAP) benefits, collections received in a month will be retained by the state to reimburse previous and current assistance amounts, with the following exceptions:

a. in cases in which the collection amount and the court-ordered monthly obligation exceed the AFDC/FITAP amount, the AR will be refunded an amount that, added to the AFDC/FITAP amount, will bring the AR up to the court-ordered monthly obligation amount, or the collection amount, whichever is smaller;

b. in cases in which the collection amount exceeds the amount of unreimbursed grant, the excess will be refunded to the AR up to the current arrearage amount.

2. In cases in which the AR previously received AFDC or FITAP, and there are amounts owed to the state, collections received in a month will be distributed as follows:

a. the AR will be refunded an amount equal to the court-ordered monthly obligation;

b. any excess amount will be applied to amounts owed to the state;

c. any remaining amounts will be paid to the AR.

3. In cases in which the AR never received assistance, or the AR previously received AFDC or FITAP and no amount is owed to the state, all collections will be refunded to the AR.

4. In IV-E Foster Care cases, all amounts collected are sent to the IV-E Agency for appropriate distribution.

B. There are general exceptions to distribution. Any collections received through intercept programs or income assignments, are subject to refund to the noncustodial parent based on federal and state laws and regulations. Amounts collected through IRS and/or state tax intercepts will be applied to arrears in this order:

1. amounts owed to the state; and
2. amounts owed to the AR.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 23:

Interested persons may submit written comments within 30 days to: Vera W. Blakes, Assistant Secretary, Office of Family Support, Box 94065, Baton Rouge, LA 70804-9065. She is responsible for responding to inquiries regarding this proposed Rule.

A public hearing on the proposed Rule will be held on January 28, 1997, at the Department of Social Services, Second Floor Auditorium, 755 Third Street, Baton Rouge, Louisiana beginning at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at said hearing. Individuals with disabilities who require special services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call 504-342-4120 (Voice and TDD).

Madlyn B. Bagneris  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Child Support Payments—Distribution**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There are no implementation costs or savings to state or local governmental units.

No real costs or savings can be attributed to the new Rule. The Rule represents a shift in revenues. Although the major impact is that the state will no longer distribute a portion of collections, the expenditures for this distribution are not budgeted and the funds generated will only serve to increase the revenue used as state match and federal offset.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

This Rule results in a shift in state revenue distribution. Although the state will retain funds (\$3,193,962) that were previously distributed to some AFDC recipients, these funds will now be applied as revenue used for state match (\$914,751)



and federal offset funds (\$2,279,211). There will be no effect on revenue collection of local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Eligible recipients on whose behalf child support payments are collected will no longer receive income of up to \$50 per month. The total impact on AFDC recipients will be \$3,193,962 in FY 96/97.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated impact on competition and employment.

Vera W. Blakes  
Assistant Secretary  
9612#043

H. Gordon Monk  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Treasury  
Board of Trustees of the State Employees  
Group Benefits Program**

**Plan Document—Catastrophic Illness Endorsement**

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(A)(2), vesting the Board of Trustees with the sole 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 gives Notice of Intent to amend to the Plan Document of Benefits.

In order to implement changes to the Catastrophic Illness Endorsement to provide a more meaningful benefit to members who purchase the endorsement, as well as to facilitate adjudication of claims for benefits under the endorsement, the Board intends to amend the Plan Document of Benefits for the State Employees Group Benefits Program.

The full text of this proposed Rule may be viewed in the Emergency Rule Section of this December 1996 issue of the *Louisiana Register*.

Interested persons may present their views, in writing, to James R. Plaisance, Executive Director, State Employees Group Benefits Program, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Friday, January 24, 1997.

James R. Plaisance  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Plan Document—Catastrophic Illness  
Endorsement**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no implementation costs to state or local governmental units as these benefit modifications are being

made to the current Catastrophic Illness Endorsement of the current health plan.

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.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

These benefit modifications will result in a true increase in the amount of benefits paid under CIE of approximately \$40,000 in the first 12-month period following the enactment of the modifications. Current rates charged for CIE should be sufficient to fund these benefit modifications. This endorsement is based on 100 percent employee contributions with no state or local participation.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected.

James R. Plaisance  
Executive Director  
9612#072

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Department of Treasury  
Board of Trustees of the State Employees  
Group Benefits Program**

**Plan Document—Continuation of Coverage**

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(A)(2), vesting the Board of Trustees with the sole 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 gives Notice of Intent to amend the Plan Document of Benefits.

In order to implement changes included in the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191), effective January 1, 1997, the Board intends to amend Article 1, Section III, Subsection K, Paragraph 5 of the Plan Document of Benefits for the State Employees Group Benefits Program to read as follows:

"5. Effective January 1, 1997, if a Covered Employee or Covered Dependent is determined by Social Security, or by the State Employees Group Benefits Program staff in the case of a person who is ineligible for Social Security disability due to insufficient "quarters" of employment, to have been totally disabled on the date such person became eligible for continued coverage under this Section, or within the first 60 days thereafter, and such person elects to continue coverage pursuant to the provisions of Article 1, Section III (E) or (J), coverage under this Plan for the Covered Person who is totally disabled may be extended AT HIS OR HER OWN EXPENSE up to a maximum of 29 months from the date coverage would have otherwise terminated in the absence of Article 1, Section III (E). To qualify under this Section III (K)(5) the Covered Person must:

\* \* \*



Interested persons may present their views, in writing, to James R. Plaisance, Executive Director, State Employees Group Benefits Program, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Friday, January 24, 1997.

James R. Plaisance  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Plan Document—Continuation of Coverage**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be no costs associated with the implementation of this Rule on state or local governmental units.
- 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.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
This Rule relates only to the extension of coverage from 18 to 29 months for persons who become disabled within the first 60 days of COBRA continuation coverage. Under present law and our current Rule, the disability must exist at the time of the COBRA qualifying event.  
No one has been identified to be in this new category of coverage at the present time.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
Competition and employment will not be affected.

James R. Plaisance  
Executive Secretary  
9612#071

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Department of Treasury  
Board of Trustees of the State Employees Group  
Benefits Program**

**Plan Document—Emergency Room  
Facility Charges at Non-PPO Hospitals**

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(A)(2), vesting the Board of Trustees with the sole 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 gives Notice of Intent to adopt amendments to the Plan Document of Benefits.

In order to provide a higher benefit for those cases in which emergency treatment is received at an emergency room in a hospital which is outside the Group Benefits preferred provider network, the Board intends to amend the Plan

Document of Benefits for the State Employees Group Benefits Program.

The full text of this proposed Rule is printed in the Emergency Rule Section of this December, 1996 issue of the *Louisiana Register*.

Interested persons may present their views, in writing, to James R. Plaisance, Executive Director, State Employees Group Benefits Program, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Friday, January 24, 1997.

James R. Plaisance  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Plan Document—Emergency Room Facility  
Charges at Non-PPO Hospitals**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)  
There will be no implementation costs to state or local governmental units. The current fiscal year rate structure established for the State Employees Group Benefits Program is sufficient to cover the additional claim 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.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)  
The economic benefit of this Rule change will be to plan members of the State Employees Group Benefits Program that receive emergency room treatment at a non-PPO hospital. The current reimbursement rate for these charges is currently 50 percent. The proposed Rule change will increase the reimbursement percentage to 80 percent.  
Claim payments from the State Employees Group Benefits will increase by approximately \$40,000 (prorated for 7.5 months) in FY 96/97 as a result of this Rule change.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)  
Competition and employment will not be affected.

James R. Plaisance  
Executive Director  
9612#070

Richard W. England  
Assistant to the  
Legislative Fiscal Officer

# Potpourri

## POTPOURRI

**Department of Agriculture and Forestry  
Office of Agricultural and Environmental Sciences  
Horticulture Commission**

### Retail Floristry Exam

The next retail floristry examination will be given January 27-31, 1997, at 9:30 a.m. at the 4-H Mini Farm Building,

Louisiana State University Campus, Baton Rouge, LA. The deadline for sending in application and fee is December 26, 1996. No applications will be accepted after September 24, 1996.

Further information pertaining to the examinations may be obtained from Craig Roussel, Director, Horticulture Commission, Box 3118, Baton Rouge, LA 70821-3118, telephone (504) 925-7772.

Any individual requesting special accommodations due to a disability should notify the Office prior to December 26, 1996. Please refer questions to (504) 925-7772.

Bob Odom  
Commissioner

9612#026

### POTPOURRI

#### Department of Economic Development Office of Financial Institutions

##### 1997 Judicial Interest Rate

Pursuant to LSA-C.C. Art. 2924(B)(3), as amended by Act 774 of 1989 and Act 1090 of 1992, the Commissioner of Financial Institutions has made the determination that the rate of judicial interest beginning January 1, 1997 and ending December 31, 1997 will be 9.25 percent per annum, in accordance with the formula mandated by LSA-C.C. Art. 2924(B)(3).

The terms *Prime Rate* and *Reference Rate* shall be deemed synonymous for purposes of this calculation. *Prime Rate* is the rate of interest established by a financial institution for its "most favored corporate clients" in commercial loan transactions.

The Prime Rate or Reference Rate was decreased on February 1, 1996 from 8.75 percent per annum to 8.25 percent per annum and that rate remained in effect on October 1, 1996, the "index" date for purposes of computing the prime rate or reference rate charged by:

- (1) The Chase Manhattan Bank, now a state chartered bank domiciled in New York City, which has acquired Chemical Bank, which had previously acquired Manufacturers Hanover Trust Company of New York on June 22, 1992;
- (2) Morgan Guaranty Trust Company of New York;
- (3) Citibank, N.A.; and
- (4) Bank of America National Trust and Savings Association.

LSA-C.C. Art. 2924(3)(a) mandates that "[t]he effective judicial interest rate for the calendar year following the calculation date shall be one percentage point above the average prime or reference rate of the five financial institutions named in this Subparagraph or their successors."

The effective judicial interest rate for the calendar year beginning on January 1, 1997 shall be 9.25 percent per annum.

This calculation and its publication in the *Louisiana Register* shall not be considered rulemaking, within the intendment of R.S. 49:950 et seq., the Administrative Procedure Act, particularly R.S. 49:953; thus, neither a Fiscal Impact Statement nor a Notice of Intent is required.

Larry L. Murray  
Commissioner

9612#024

### POTPOURRI

#### Department of Environmental Quality Office of Air Quality and Radiation Protection

##### Gas-fired Internal Combustion Engines

The Louisiana Department of Environmental Quality, Office of Air Quality and Radiation Protection gives notice that as of November 25, 1996, monitoring of gas-fired internal combustion engines has been changed from quarterly to semiannually.

By this notice, the Office of Air Quality and Radiation Protection hereby approves semiannual monitoring for gas-fired internal combustion engines in existing permits. Semiannual testing can be conducted without a modification to an existing permit.

Additionally, the semiannual test may be conducted using a portable analyzer or an approved equivalent method.

Questions should be directed by calling Hilry Lantz at (504) 765-0197 or by writing to him at Air Quality Permits, Box 82135, Baton Rouge, LA 70884-2135.

Gus Von Bodungen  
Assistant Secretary

9612#082

### POTPOURRI

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

##### State Implementation Plan (SIP) (LAC 33:III.Chapters 1-25)

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 1, 2 (previously 65), 5, 7, 9, 11, 13, 21, 23, and 25.

The hearing will be held on January 24, 1997, 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 January 31, 1997 to Carla Reiprecht, 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 a.m. to 4:30 p.m., at the following DEQ locations:

Headquarters  
Air Quality Division  
7290 Bluebonnet Boulevard  
Second Floor  
Baton Rouge, LA

Capitol Regional Office  
5222 Summa Court  
Baton Rouge, LA

Acadiana Regional Office  
100 Asma Boulevard  
Suite 151  
Lafayette, LA

Northeast Regional Office  
804 31st Street, Suite D  
Monroe, LA

Bayou Lafourche Regional Office  
104 Lococo Drive  
Raceland, LA

Northwest Regional Office  
1525 Fairfield, Room 11  
Shreveport, LA

Kisatchie Central Regional Office  
402 Rainbow Drive  
Pineville, LA

Southeast Regional Office  
3501 Chateau Boulevard  
W Wing  
Kenner, LA

Southwest Regional Office  
3519 Patrick Street, Room 265A  
Lake Charles, LA

The SIP is also distributed to the State Library of Louisiana, Louisiana Section, 760 North Third Street, Baton Rouge, LA, and 25 other depository libraries throughout the state. Please contact the State Library for locations and viewing times.

Please direct questions or comments to Carla Reiprecht at (504) 765-0916.

Gustave A. Von Bodungen, P.E.  
Assistant Secretary

9612#081

### POTPOURRI

#### Department of Health and Hospitals Board of Veterinary Medicine

##### Board Meeting Dates

The Louisiana Board of Veterinary Medicine will meet on the following dates in 1997:

Tuesday, January 28, 1997  
Wednesday, March 26, 1997  
Tuesday, May 6, 1997  
Tuesday, June 17, 1997  
Wednesday, August 20, 1997  
Wednesday, October 15, 1997  
Tuesday, December 2, 1997

Virginia Anthony  
Interim Executive Director

9612#028

### POTPOURRI

#### Department of Health and Hospitals Board of Veterinary Medicine

##### Board Nominations

The Louisiana Board of Veterinary Medicine announces that nominations for the position of board member will be taken by the Louisiana Veterinary Medical Association at the annual winter meeting.

Interested persons should submit the name of nominees directly to that organization as per R.S. 37:1515. It is not necessary to be a member of the LVMA to be nominated.

The LVMA may be contacted at (504)928-5862.

Virginia Anthony  
Interim Executive Director

9612#029

### POTPOURRI

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

##### Pharmacy—Authorized Prescribers

The Medicaid Program provides reimbursement for prescriptions provided to eligible recipients under Regulations governing the Pharmacy Program. The prescriptions may be written by appropriate professionals authorized to do so under state law. This is not a change in policy but merely a clarification, and notification is provided to interested persons through this medium.

Bobby P. Jindal  
Secretary

9612#083

### POTPOURRI

#### Department of Natural Resources Office of Conservation Injection and Mining Division

##### Public Hearing—Nonhazardous Oilfield Waste Disposal Facility

Pursuant to the provisions of the laws of the State of Louisiana and particularly Title 30 of the Louisiana Revised Statutes of 1950 as amended, and the provisions of the Statewide Order Number 29-B, notice is hereby given that the Commissioner of Conservation will conduct a hearing at 6 p.m., Monday, January 27, 1997, in the Jonesboro City Hall, Jonesboro Community Room, located on the First Floor, at 128 Allen Ave, Jonesboro, Louisiana.

At such hearing, the Commissioner, or his designated representative will hear testimony relative to the application of LADEP of Louisiana, Incorporated, Box 187, Haynesville,

LA 71038. The applicant intends to construct and operate a commercial nonhazardous oilfield waste disposal facility in Section 16, Township 17N, Range 01W approximately five miles northeast from Eros, Louisiana.

The application is available for inspection by contacting Pierre Catrou, Office of Conservation, Injection and Mining Division, Room 257 of the State Land and Natural Resources Building, 625 North Fourth Street, Baton Rouge, LA or by visiting the Jackson Parish Police Jury Office or the Parish Library Jonesboro, Louisiana. Verbal information may be received by calling Mr. Catrou at 504/342-5567.

All interested persons will be afforded an opportunity to present data, views or arguments, orally or in writing, at said public hearing. Written comments which will not be presented at the hearing must be received no later than 5 p.m., February 3, 1997, at the Baton Rouge Office.

Comments should be directed to:

Office of Conservation  
Injection and Mining Division  
Box 94275  
Baton Rouge, LA 70804  
Re: Docket Number IMD 96-11  
Commercial Facility  
Jackson Parish

George L. Carmouche  
Commissioner

9612#027

**POTPOURRI**

**Department of Natural Resources  
Office of the Secretary**

**Agreement to Facilitate Isles Dernieres  
Coastal Restoration Plan**

Pursuant to Act 55 (R.S. 41:1702) of the 1996 Extraordinary Session of the Louisiana Legislature, the Secretary of the Department of Natural Resources proposes the following Agreement. This Agreement, affecting the Isles Dernieres Coastal Restoration Plan, is proposed with The Louisiana Land and Exploration Company, and is necessary in order to facilitate the development, design and implementation of projects included in the Plan.

**AGREEMENT**

BETWEEN

THE LOUISIANA LAND AND  
EXPLORATION COMPANY

UNITED STATES OF AMERICA

AND

STATE OF LOUISIANA

THE STATE OF LOUISIANA

PARISH OF TERREBONNE

BE IT KNOWN, by these presents, effective as of the \_\_\_\_\_ day of, in the year of our Lord, one thousand nine hundred and ninety-six (the

"Effective Date"), upon execution by all signatory parties indicated below (the "Parties").

BEFORE ME, the undersigned Notary Public duly commissioned and qualified in and for the Parish stated hereinbelow, State of Louisiana, and in the presence of the witnesses hereinafter named and undersigned:

PERSONALLY CAME AND APPEARED: H. Leighton Steward, Chairman, Chief Executive Officer and President of the Louisiana Land and Exploration Company ("LL&E"), J. Terry Ryder, Special Counsel, Deputy Chief of Staff, Office of the Governor, State of Louisiana appearing herein pursuant to authority specifically delegated to him by the Secretary of the Department of Natural Resources ("DNR") and James H. Jenkins, Jr., Secretary of the Department of Wildlife & Fisheries, who recited that:

WHEREAS, LL&E holds record title to those barrier islands known as Isles Dernieres (hereinafter referred to as "Said Property"), and additionally illustrated on Exhibit "A", attached hereto and made a part hereof;

WHEREAS, as the owner of Said Property, LL&E, pursuant to Louisiana Constitution Article IX, Section 3 and La. R.S. 41:1702 has the right to reclaim and recover any portion thereof lost through erosion, compaction, subsidence or sea level rise occurring on or after July 1, 1921;

WHEREAS, pursuant to La. R.S. 41:1702, and to facilitate the development, design, and implementation of the Isles Dernieres Restoration Plan (Restoration Plan) the State desires to evidence its understanding with LL&E with respect to Said Property;

NOW THEREFORE, to permit implementation of the Restoration Plan, LL&E and the State, through their undersigned representatives, in consideration of the premises, hereby make the following agreements upon, and subject to, the terms and conditions hereinafter set forth:

1. LL&E does by these presents irrevocably donate and transfer Said Property, and all rights of reclamation associated therewith, to the State of Louisiana, subject to the reservations, restrictions and limitations hereinafter noted:

- A. This transfer is made without warranty of title, expressed or implied, but with full substitution in and to all rights and actions of preceding vendors;
- B. LL&E expressly reserves all of the oil, gas and other minerals of every kind and character located under Said Property, together with rights of ingress and egress for the exercise of those rights.
- C. The prescription of nonuse shall not run against the subsurface mineral right reserved in Paragraph B hereinabove as long as any portion of Said Property remains. In the event Said Property completely erodes, compacts, subsides, or through sea level rise, becomes a part of the seabed, prescription begins to run against LL&E at that time, in accordance with the provisions of the Louisiana Mineral Code. LL&E and the State of Louisiana herein agree that notwithstanding the provisions of R.S.31:29, et seq., all rights of LL&E shall terminate ninety-nine (99) years from the date Said Property completely erodes and becomes part of the seabed.
- D. LL&E expressly reserves a servitude of use of a 22.96-acre tract more particularly described on Exhibit "B ", attached hereto and made a part hereof, for a campsite, together with the following rights, to be exercised by LL&E at its sole cost, risk and expense (i) ingress and egress by way of the existing canal shown in yellow color on Exhibit "A" hereto, together with the right to dredge and maintain the same for navigation purposes (as to which canal the State hereby agrees it will not grant any oyster lease thereon for as long as LL&E's right of use hereunder remains in effect), (ii) to construct, maintain, renew and repair campsite related improvements on said tract, (iii) to moor boats, barges and/or houseboats in bayous or canals adjacent to the said campsite tract, (iv) to use such canals and waterways for landings and take offs by seaplanes or amphibious aircrafts, and (v) to operate recreational type

vehicles along the shores of Said Property, said 22.96 acre tract being additionally shown for illustration on Exhibit "B-1", attached hereto and made a part hereof;

- E. A portion of Said Property is subject to and affected by that certain contract (of mineral lease and sublease) dated November 12, 1928, between LL&E and Texaco, Inc. as shown on Exhibit "C" hereto, that portion of Said Property affected thereby being additionally described on Exhibit "C-1", attached hereto and made a part hereof;
- F. Surface Leases and/or Permits as listed on Exhibit "D", attached hereto and made a part hereof; and
- G. LL&E's execution of this instrument is conditioned upon and subject to ratification by its Board of Directors, which shall be obtained by LL&E and furnished to the Secretary, failing which execution of this instrument on behalf of the State shall be null and void, at the State's option, notice of which may be delivered to LL&E at any time prior to such ratification being received by the State from LL&E.

TO HAVE AND TO HOLD the hereinabove described donated property, forever; and the State of Louisiana hereby accepts said donation, subject to all of the foregoing reservations, restrictions and limitations.

2. LL&E shall own 50% of the subsurface mineral rights relating to any emergent lands that emerge from waterbottoms between the present shoreline and LL&E's 1955 shoreline survey as shown on Exhibit "E", attached hereto and made part hereof.

- A. By these presents, LL&E acquires a servitude for use of the surface of any emergent lands for locating, accessing, extracting and transporting any subsurface minerals, subject to acquiring appropriate State and State Agency permissions, approvals and permits.
- B. In the event subsequent erosion should cause any emergent lands to become part of the seabed, ownership of all mineral rights and mineral production therefrom shall be vested in the State.
- C. If production is established prior to the aforesaid subsequent erosion, it will continue to be shared equally between LL&E and the State for as long as said production continues.
- D. Emergent land shall mean land on the seaward side of Said Land that emerges from waterbottoms to the lowest elevation sufficient to support emergent vegetation on the landward side of Said Property. However, no land which lies below the elevation of ordinary low water, shall be considered emergent land.

3. LL&E and DNR shall endeavor to agree in writing on a delineation of the boundary between lands belonging to the State and those of LL&E.

4. Nothing herein shall prevent the State from exercising its rights prior to the emergence of any emergent land through the granting, for a lawful purpose, of any right-of-way or servitude, or any mineral, geothermal, geopressure, or any other lease. Any lease or grant by the State prior to said emergence shall not be affected by this Agreement and LL&E shall have no claim for compensation out of the proceeds of the grant or lease.

5. All references to "State" herein mean the State of Louisiana acting through its appropriate executive officers, departments and/or agencies who are signatories to this Agreement.

6. This Agreement shall be binding upon, and inure to the benefit of the Parties hereto and their successors in interest and assigns.

7. This Agreement shall be submitted for review and approval of the House and Senate Committees on Natural Resources. In the event said approval is not granted, this Agreement shall be null and void.

THUS DONE AND PASSED in my office on this \_\_\_\_ day of \_\_\_\_\_, 1996 in the presence of the undersigned competent witnesses, who hereunder sign their names with the said appearer(s) and me, Notary, after reading of the whole.

WITNESSES:

THE LOUISIANA LAND AND EXPLORATION COMPANY

\_\_\_\_\_  
\_\_\_\_\_

H. LEIGHTON STEWARD  
Chairman, Chief Executive Officer  
and President

NOTARY PUBLIC  
for the PARISH OF ORLEANS

THUS DONE AND PASSED in my office on this \_\_\_\_ day of \_\_\_\_\_, 1996, in sextuplicate originals, in the presence of the undersigned competent witnesses, who hereunder sign their names with the said appearer(s) and me, Notary, after reading of the whole.

WITNESSES:

\_\_\_\_\_  
\_\_\_\_\_

J. TERRY RYDER  
Office of the Governor  
State of Louisiana

NOTARY PUBLIC  
for the PARISH OF EAST BATON ROUGE

THUS DONE AND PASSED in my office on this \_\_\_\_ day of \_\_\_\_\_, 1996, in sextuplicate originals, in the presence of the undersigned competent witnesses, who hereunder sign their names with the said appearer(s) and me, Notary, after reading of the whole.

WITNESSES:

\_\_\_\_\_  
\_\_\_\_\_

JAMES H. JENKINS, JR.  
Secretary  
Department of Wildlife & Fisheries

NOTARY PUBLIC  
for the PARISH OF EAST BATON ROUGE

Act 55 requires the above proposed Agreement to be published in the *Louisiana Register* prior to submittal to the House and Senate Committees on Natural Resources for review and approval.

Jack C. Caldwell  
Secretary

9612#061

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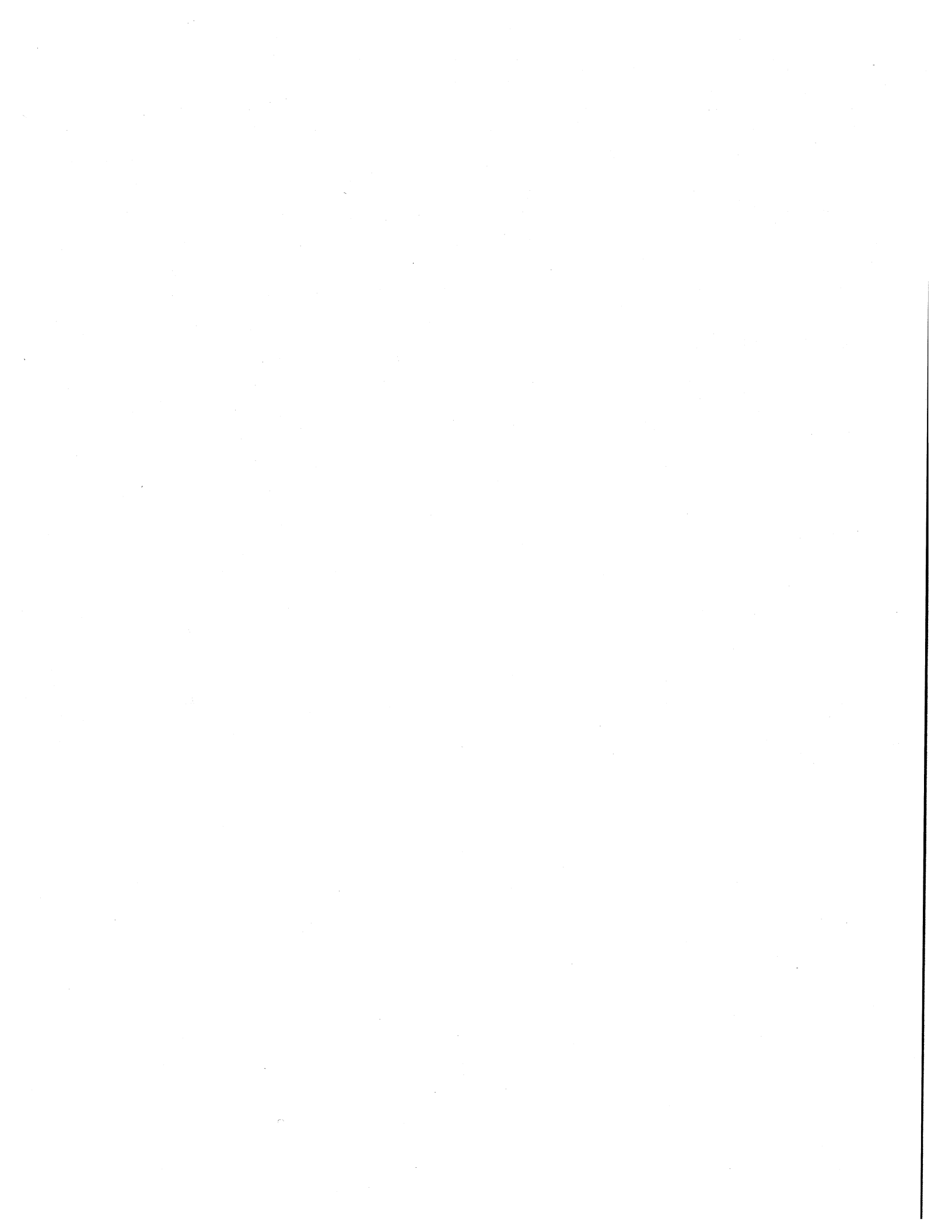
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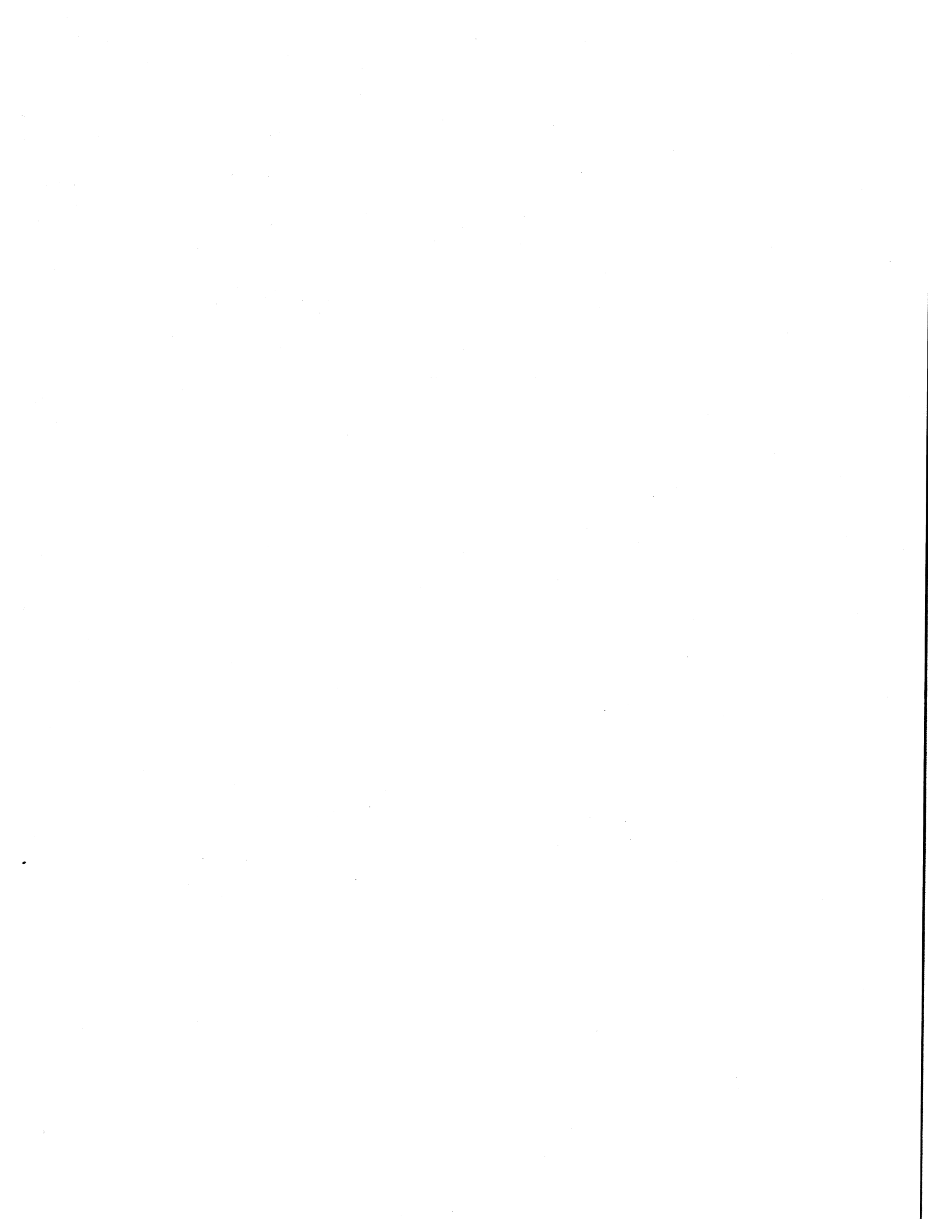




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