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STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF HEALTH

In the Matter of the Proposed Adoption of Rules of the Department of Health Governing the Registration of Respiratory Care Practitioners.

REPORT OF THE ADMINISTRATIVE LAW JUDGE

The above-entitled matter came on for hearing before Howard L. Kaibel, Jr., Administrative Law Judge, on February 26, 1991, in the Veterans Services Building, in St. Paul.

This is a rulemaking proceeding under Minn. Stat. §§ 14.131 - 14.20 held to determine whether the Department of Health has fulfilled all relevant substantive and procedural requirements of law applicable to the adoption of the rules, whether the proposed provisions are needed and reasonable, and whether any suggested modifications would constitute impermissible substantial changes.

Tom Hiendlmayr, Director, Health Occupations Program, 717 Delaware Street S.E., P.O. Box 9441, Minneapolis, Minnesota 55440, presented the proposed rules and acted as chief spokesman for the Department staff. Richard Wexler, Special Assistant Attorney General, also assisted with the staff presentation.

This Report must be available for review to all affected individuals upon request for at least five working days before the Commissioner of Health takes any further action on the rule(s). The Commissioner may then adopt a final rule or modify or withdraw its proposed rule. If the Commissioner makes changes in the rule other than those recommended in this report, s/he must submit the rule with the complete hearing record to the Chief Administrative Law Judge for a review of the changes prior to final adoption. Upon adoption of a final rule, the Commissioner must submit it to the Revisor of Statutes for a review of the form of the rule. The Commissioner must also give notice to all persons who requested to be informed when the rule is adopted and filed with the Secretary of State.

Based upon all the testimony, exhibits, and written comments, the Administrative Law Judge makes the following:

## FINDINGS OF FACT

### Procedural Requirements

1. On January 3, 1991, the Health Department Staff filed the following documents with the Chief Administrative Law Judge:

(a) A copy of the proposed rules certified by the Revisor of Statutes.
(b) The Order for Hearing.
(c) The Notice of Hearing proposed to be issued.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.
(e) The Statement of Need and Reasonableness (SONAR).
(f) A Statement of Additional Notice.

2. On January 14, 1991, a Notice of Hearing and a copy of the proposed rules were published at 15 State Register 1565, et seq.

3. On January 11, 1991, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Department of Health for the purpose of receiving such notice.

4. On January 31, 1991, the Department Staff filed the following documents with the Administrative Law Judge:

(a) The Notice of Hearing as mailed.
(b) The Agency's certification that its mailing list was accurate and complete.
(c) The Affidavit of Mailing the Notice to all persons on the Agency's list.
(d) An Affidavit of Additional Notice.
(e) The names of Department personnel who would represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.
(f) A copy of the State Register containing the proposed rules.
(g) All materials received following a Notice of Intent to Solicit Outside Opinion published at 14 State Register 112 and a copy of the Notice.
(h) The Petition requesting a rule hearing.

The documents were available for inspection at the Office of Administrative Hearings from the date of filing to the date of the hearing.

5. The deadline for submission of written comments was March 18, 1991, because it was extended at the request of the participants from five (5) working days to twenty (20) calendar days following the hearing. The record closed on March 21, 1991, the third business day following the close of the comment period.

Fiscal Note

6. Under Minn. Stat. § 14.11, subd. 1, the Commissioner is required to prepare a fiscal note giving his reasonable estimate of the total cost to all local public bodies in the state to implement the rule for the two years immediately following adoption, if the estimated total cost exceeds $100,000 in either of the next two years after adoption. There is a paucity of evidence on the magnitude of the indisputable increase in health care costs that will be attributable to adoption of these proposed rules. It appears that most of these increases will be borne by mostly rural consumers of health care, at least initially, rather than local public bodies. No one disputed

the staff's allegation that these rules would not increase local government costs by more than $100,000. They consequently have met their burden of satisfying this statutory requirement.

Small Business Considerations

7. Pursuant to Minn. Stat. § 14.115, an agency's SONAR must, in some situations, consider the effect of rules on small businesses. The SONAR in this proceeding extensively considered such small business impacts. It concluded that inserting special provisions in these rules to lessen small business impacts would not be feasible or appropriate. No one disputed those conclusions anywhere in this extensive record. Minn. Stat. § 14.115 has been adequately complied with.

Statutory Authority

8. The statutory authority to adopt the proposed rules is found in Minn. Stat. § 214.13, subd. 1. No one questioned the authority of the Commissioner of Health to adopt the provisions at any point in this proceeding. The Department staff adequately documented the jurisdiction of the Commissioner to consider and adopt all of the proposed requirements.

Nature of the Proposed Rules

9. The proposed rules would establish a registration system for some of the medical technicians who specialize in rendering particular kinds of cardio-pulmonary assistance to physicians, referred to generally in this proceeding as Respiratory Care Practitioners (RCPs). Some of these practitioners who have sought recognition of their occupation as a distinct "specialty" have formed state and national trade associations to establish occupational standards, accredit training programs and certify members who demonstrate proficiencies in meeting those standards. In recent years, these associations have also sought governmental recognition for and regulation of their specialty in the form of state licensing and registration laws. In response to a petition from this state's affiliate, the Minnesota Society for Respiratory Care (MSRC), the Commissioner of Health determined in 1989 that the public interest would be furthered by establishing a separate credentialing system for RCPs and that a registration scheme would serve that interest better than licensing.

10. Registration regulations allow anyone to perform functions which might be called "respiratory" for compensation without government oversight, as long as they don't use particular protected titles. Licensing regulations carefully define "respiratory" activities and prohibit anyone from performing them without a license. Registration is consequently often called "voluntary" as opposed to "mandatory". The concern of many members of the potentially affected public in this proceeding was that employers and/or insurers might essentially make registration mandatory by making it a condition of employment and/or reimbursement.

11. This was an excellent example of proficient rulemaking. The Department's staff deserves commendation for thorough consideration of public

input and thoughtful responsiveness. Maximizing public input was emphasized from the outset. Organized RCPs and those who disdained organization were intensively involved in drafts and redrafts. Staff's exhaustive final comments and responses are an outstanding example of willingness to incorporate further reasonable revisions sought by the public.

12. Because Department personnel completed their homework so assiduously, there is no need here for a detailed discussion of each subpart of the proposed rules. That has been done in the SONAR which details the need for and reasonableness of each of the provisions. Any provisions not commented on in this Report are specifically hereby found to be needed and reasonable. All of the concerns expressed at the hearing and in written comments have been carefully considered. Department staff's proposed revisions in response to those concerns are also found to be needed and reasonable, based on the Department's affirmative presentation of facts. None of their proposed revisions are "substantial changes" requiring a new hearing.

Specific Provisions

13. The virtually single issue in this case was whether every registrant should be required to pass the National Board for Respiratory Care (NBRC) entry level exam. Many practitioners who have graduated from accredited training institutions and passed the exam argued vigorously for making that exam a minimum qualification for registration for everyone, including many existing practitioners who have been respiratory therapists since before the NBRC and the exam were created. Other leaders among certified practitioners and the general counsel for the Minnesota Hospital Association urged with equal vigor that the state should proceed more cautiously and considerately, "grandfathering" some of the existing practitioners with the most extensive documented on-the-job practical experience without forcing them to study for and pass the NBRC examination.

In the first drafts of the proposed rules, Department staff followed the approach of the "Model Act" for licensure of the American Association for Respiratory Care (AARC) which would require all registrants to pass the examination within 18 months of enactment. This generated substantial opposition from numerous therapists and hospitals, particularly from outstate communities.

The User's Guide for the Model AARC Act discusses the alternative of inserting what it calls a "true" grandfather clause which would allow for licensing or registration of existing practitioners who can document sufficient experience practicing respiratory care under medical direction. Staff adopted this alternative approach in their final draft of the rules heard herein.

14. The Department staff adequately documented the need for, reasonableness of and statutory authority for its proposed grandfather clause by an affirmative presentation of facts. Such clauses are common in the initial adoption of credentialing regulations.

The clause proposed is very limited in scope and will allow for registration of a small number of existing very qualified, mostly rural

practitioners. Unlike most other professions and occupations, there is little danger here of misleading the public, because RCPs are not hired directly by the public. They are employed by doctors and medical institutions fully capable of evaluating their qualifications. They carry out functions prescribed and directly supervised by physicians.

On the other hand, there are serious dangers involved in adoption of a registration scheme without such a clause, which could adversely affect the provision of respiratory care, particularly in rural Minnesota communities. Experience in Louisiana, for example, which proceeded without a grandfather clause, indicates that the potential for disruption and increased costs is real and significant.

The disparate adverse impacts of registration without grandfathering will likely be exacerbated if Medicare and other insurers (referred to in Department staff comments as "third party payors") begin insisting on it as a condition of reimbursement. Department staffers believe that such a reimbursement requirement is a likely result of the registration system and cited it in final written comments as a reason for adopting the temporary registration provision. The Minnesota Medical Association stressed that it has not taken any position on the grandfathering issue and that its member physicians are divided. However, their legal counsel did state flatly, as everyone else seems to agree in this record, that "health care in the rural setting is already suffering because of lack of health care providers . . .."

Relative to most other occupations, specialized training and credentialing in this field is in its infancy. According to the SONAR, there were no accredited academic programs at all prior to 1964, anywhere in the country. The result is a recognized shortage of certified practitioners, particularly in rural areas.

The predominantly urban certified professionals are justly proud of their private voluntary efforts to upgrade their skills and are understandably anxious for state recognition and perhaps commensurate increased compensation. The proposed rules are a very significant, generally acceptable step in that direction, provided the grandfather clause is included to minimize the inherent dangers involved in the transition.

The clause is possibly too limited, based on the minimal studying that has been done of potential registrants. If there are any practitioners whose job experience has been interrupted by two years of military service, who would otherwise qualify for the exemption, they should certainly not be prohibited from registering. If an exception is included in the clause to exclude military service, it would certainly not be a substantial change.

15. The factual evidence in this record would not support the need for or reasonableness of adopting the rule without a grandfather clause, as was urged by several practitioners. The best and most recent evidence regarding potential registrants is the survey which was done of RCPs by MSRC. It is apparently accurate and adequate for its purpose -- proving the Department staff initially underestimated the pool of potential registrants and that consequently there may be a sufficient number of RCPs, if they are willing to register, to support lower per-capita registration fees. However, the survey data cannot be cited as support for the need for or reasonableness of requiring all practitioners rendering respiratory care in Minnesota to take

the NBRC entrance examination. On the contrary, this recently compiled data calls into serious question the reasonableness of proceeding with registration at all, even with a grandfather clause, given its surprising new insight into the gravity of the disparate impact in rural areas.

The original decision of the previous Commissioner in 1989, was "based on the record" before her at that time. It was based on data from an undisclosed source indicating that there were only "approximately 750 RCPs currently practicing in Minnesota." She specifically assumed that only 1% of metropolitan practitioners and 16% of outstate practitioners did not meet the criteria proposed for the registration system. The Commissioner was expressly concerned with this potentially disparate impact on the Minnesota health care delivery system. She concluded on balance, however, that "Despite this disparity, I believe that benefits from registration will outweigh any adverse effects on Greater Minnesota facilities who employ RCPs."

The latest survey found 1,049 RCPs currently practicing with a rural-urban disparity that is much greater than she assumed when she made the decision. It found that 6% of Twin City, Rochester, Duluth and St. Cloud RCPs are not already voluntarily certified, as opposed to 39% of Greater Minnesota RCPs. One-fourth of these uncertified rural RCPs are not graduates of an accredited academic program.

Moreover, the manner in which this survey data was compiled may have masked the full extent of the disparity. The surveyors asked for credentials of people who are called RCPs by their employers or called themselves RCPs, because it was aimed at ascertaining the number of people who might want (and/or be required by their employer) to register to use the title. It is clear in this record that respiratory care functions in outstate facilities are often performed by therapists who do not think of themselves as RCPs such as licensed and registered nurses, frequently on a less than full-time basis. If insurers decide to reimburse only for care performed by registered RCPs, the disparate impact on Greater Minnesota facilities would doubtless be more severe than the survey suggests, even if many present practitioners are grandfathered in and allowed to register.

In light of the new data, the present Commissioner may wish to reconsider the previous decision to proceed with registration and/or direct the staff to do a more intensive study of at least a sizable sampling of outstate institutions to determine the likely practical impact of the system as proposed. It is of course possible that the Department staff has already looked at this impact in the course of its prehearing consultations and simply did not include the information in the record. The general counsel for the Minnesota Hospital Association seems satisfied with the proposed rules, provided the grandfathering clause is retained, so perhaps there is no reason for concern.

If insurers decide to limit reimbursement for respiratory care to services performed by registered RCPs, registration will essentially become mandatory for medical personnel providing those services. This would mean in Breckenridge, for example, that at least two LPNs who currently are the regular providers of such care may be forced to register, pay annual renewal fees, and meet continuing education requirements. Presumably they would receive some commensurate increase in compensation. The likelihood and extent of this impact is difficult to assess, based on this record.

The only other factual data presented on the need for and reasonableness of grandfathering, was an AARC newsletter excerpt containing a table of "regulation status" in 30 states submitted with Mr. Adams' post-hearing comments. Department staff correctly points out that this table does not show how many of these states may have started with a true grandfather clause that has since expired.

Moreover, the information is unreliable promotional material put out by AARC proponents of state credentialing that is of dubious validity. It states, for example that in 1989 Minnesota became one of 30 states that have established a credentialing system and that our system does not have a grandfathering clause. Minnesota obviously still has not adopted any legal credentialing system (that's what this hearing is about) and it appears likely that Minnesota will have a grandfathering clause, if staff's proposal is ultimately adopted. Obviously, anyone in any other state relying on this "table" for what's happening in Minnesota would be fundamentally misled as to the specifics of AARC's progress in this state in its drive for governmental recognition and regulation. Likewise, there is no reason for Minnesota decisionmakers to lend any greater credibility to the allegations concerning credentialing status in any other state.

16. A serious question would be presented here over whether there were statutory authority to adopt the registration system if it did not contain an effective grandfather clause for existing experienced practitioners. This is not a negative finding in this regard, only a word of caution. The Commissioner's attention is merely called to the potential problem of statutory authority, if consideration is given to eliminating grandfathering, as some have recommended.

There is potential for appeal from existing practitioners if they are not grandfathered. Typical of the vigorous reaction of existing practitioners, for example, is found in a prehearing letter from a director of respiratory care at an outstate hospital:

> I have no intention of attending their school or spending the next two years studying for a test to appease anyone. I have 21 years in the field and am as qualified to work in it as anyone. You are attempting to strip me and my family of our security and I strongly resent it. The testing process for people in the field is wrong.

The statute delegating the authority to the Commissioner to credential occupations is silent on the subject of grandfathering. Arguably however, the Legislature intended and assumed reasonable attention to the concerns and livelihoods of existing practitioners in newly adopted regulation of their occupations. Grandfather clauses are ordinarily assumed in such situations, as the Florida Supreme Court noted in Anderson v. Department of Professional Regulation, 462 So.2d 118 (Fla. 1985) at 120:

> "Grandfather" provisions of a licensure statute which permit licensing of those who have engaged in a particular business, occupation or profession before enactment of the statute commonly, if not typically, include less strict standards to be applied to those to be "grandfathered". (Citations omitted).

While the Commissioner doubtless has broad authority to adopt credentialing rules, it is not unlimited. The courts are frequently called upon to examine such rules and they pay close attention to their impact on the livelihoods of existing practitioners:

> Where the statute not only affects a change in the common law but is also in derogation of the common right it must be construed with especial strictness. Examples of such statutes are those which operate in restraint of . . . any trade or occupation or the conduct of any business. State v. Gillen, 268 P. 94 (Ks. 1928).

In a fact situation similar to the one here, that court held that cosmetologists could register without taking a newly imposed examination, if they were actively involved in cosmetology prior to its adoption. Accord: Downs v. Nebraska State Board of Examiners, 296 N.W. 151 (Neb. 1941) and Schweitzer v. Michigan State Board of Forensic Poligraph Examiners, 77 Mich. App. 749, 259 N.W.2d 362 (Mich. 1977).

The courts frequently cite and rely on grandfather clause protections in upholding the reasonableness of newly imposed credentialing schemes. See, e.g., McWhorter v. State Board of Registration for Professional Engineers and Land Surveyors, 359 So.2d 769 (Ala. 1978); and New York State Society of Professional Engineers, Inc. v. Education Department of New York, 262 App. Div. 602, 31 N.Y.S.2d 305.

The closest Minnesota case uncovered in some very limited research on this subject is Krausmann v. Streeter, 226 Minn. 458, 33 N.W.2d 56 (Minn. 1948). There the Supreme Court overturned a decision of the Barber Board which denied a license to a grandfathered teacher because of a 2-year lapse in his practice during the war. The court called the result absurd, citing the principle that the Legislature never intends such a result, instructing the Board to grandfather the teacher:

> The purpose of an exception or grandfather clause is to exempt from the statutory regulations imposed for the first time on a trade or profession, those members thereof who are then engaged in the newly regulated field on the theory that they who have acceptably followed such profession or trade for a period of years, or who are engaged therein on a certain date, may be presumed to have the qualifications which subsequent entrants to the field must demonstrate by examination.

17. In final written comments, Department staff continues to recommend adoption of the rule with the proposed grandfather clause. It should be clear, nonetheless, that adoption of the rules without the grandfather clause would be a substantial change which could only be accomplished after a new notice and hearing, pursuant to Minn. Rule 1400.1100. Omitting the transitional registration provision would seriously affect a class of persons that could not reasonably have been expected to comment on the proposed rules at the hearing. Prehearing written comments make it clear that this class of potentially affected people is very extensive and deserving of notice and an opportunity to be heard prior to the adoption of such a change.

18. In final written comments and in its March 21, 1991 final response, the Department staff proposed numerous minor revisions suggested by the public testimony and comments. Detailing them all here would needlessly lengthen this Report and increase its reproduction cost to interested members of the public. They are all thoughtful, constructive improvements which are specifically found to be needed and reasonable. They are not substantial changes which would require a new hearing prior to their adoption.

19. Staff has also declined to recommend other revisions which the Commissioner may wish to consider on final adoption, based on the record. Requiring applicants to list all felonies and misdemeanors on their applications, for example, has been specifically found to be a defect in a previous rule proceeding, where the public objected vigorously to the requirement. There was no similar objection raised in this proceeding by any member of the potentially affected public, so the matter has not been dealt with in this Report. The required listing has not been specifically found to be a defect, but the Commissioner may nonetheless consider limiting the listing to crimes "related to the delivery of respiratory care" when the rules are finally adopted. Such a revision would not be a substantial change.

20. An earlier finding noted the praiseworthy way in which Department staff has carried out a fundamental aspect of the rulemaking process -- involving and being responsive to the public. Considerable attention has not been paid to another fundamental aspect of the rulemaking process -- affirmatively presenting facts documenting the need for and reasonableness of the proposal. This proceeding is a somewhat unusual exception to the shiboleth that "government always studies things to death before taking action."

It appears that this was a result mostly of the public reaction, which was centered in prehearing comments almost entirely on two concerns -- on-the-job trainees and excessive fees. Most of this concern was minimized by adding grandfathering and lowering fees. Perhaps this also was partly due to the fact that the decision to establish the registration system had already been made (albeit on deficient data) and rule drafters were not given a mandate or resources to study impacts. However, it should not be inordinately expensive or time consuming to gather factual data on some of the apparently unexamined questions, which impact the need for and reasonableness of several provisions.

For example, a fundamental recurring issue in prehearing comments was the size of the proposed registration fees. This led staff to request the MSRC to do a survey of the number of potential registrants. MSRC was the major proponent of the proposed registration system and has a strong interest in the basic issues involved, including the size of the fee. Its predominantly urban, already certified membership is also inherently biased on those issues.

This observation is not intended as criticism of the surveyors or of the validity of the data. MSRC officials are professionals of unquestioned integrity who sincerely seek to upgrade occupational standards. Although they did not detail their survey results, no one has suggested that they are inflated.

The need for and reasonableness of the $59 per capita annual fee ($78 during the first five years) is directly dependent on how many qualified RCPs ultimately choose to register. The SONAR and Finance Commissioner approval both assume that 90% of RCPs will register. If only 45% register, the fees will have to be doubled, because state law requires fees adequate to cover the cost of the program.

Responsible professionals sincerely differ on the question of what proportion of RCPs will register. The Director of Respiratory Care at Fairmont Community Hospital, for example, wrote, "the credentialing process is expensive, self-serving and I remain skeptical as to how many people will even apply for it." The Clinical Director of the Respiratory Care Practitioner Program at the Duluth and Hibbing Technical Colleges wrote:

> If costs are prohibitive (and $94 WILL BE for many), there will be few seeking registration. This will defeat the purpose of registration.

It would have been a simple matter during the course of the two-week MSRC survey identifying RCPs (or after the survey but prior to the hearing) to ask a representative cross-section of 100 of them whether they would register if: (1) the fee were $78 per year; (2) they were required to complete 12 hours of continuing education per year; and perhaps (3) uncertified RCPs would have to study for and pass the NBRC exam. Such a survey would have elicited important facts, but the questions weren't asked.

Of course, if insurers make registration mandatory for reimbursement, all RCPs will have to register and all hospitals may have to hire a staff of at least four registered RCPs to provide round-the-clock reimburseable care. Thus, the probability of this occurring is a crucial fact to consider in assessing the need and reasonableness of several rule provisions. It would have been a relatively simple matter to contact Medicare, Medicaid and other major insurance officials inquiring as to the likelihood that this would happen. The 26 states who have adopted credentialing systems could have been surveyed to see if insurers there had made registration a condition of reimbursement. (Contacts in each of the states are identified in the AARC newsletter excerpt). These investigations were not made and the facts regarding this important consideration cannot be found, based on this record.

The extent to which respiratory care is currently delivered by nurses is another important consideration which has not been surveyed or even sampled. Several prehearing comments indicate that this may be common, particularly in Greater Minnesota. The prehearing comment from the Minnesota Nursing Association urged that the rules be revised to mandate better interaction between nurses and RCPs, "often it is nurses, and not the supervising physician, who are expected to carry out RCP functions in their absence." Several hospitals apparently employ nurses exclusively to render RCP services and many LPNs appear to devote a regular portion of their time to delivery of respiratory care. Some LPNs wrote to urge grandfathering and objected to being forced to keep up double registration, fees, and continuing education. The extent to which this may be a problem under the proposed rules has not been investigated. It appears doubtful that nurses will opt for dual registration, unless insurers make registration a condition of reimbursement. What will happen if they don't and the reimbursement condition is imposed after the two-year grandfather window expires? Should institutions require

nurses to register prior to that expiration to protect against this eventuality? Should they all employ at least one registered RCP so they can claim the nurses were rendering care under the supervision of the RCP?

There was also apparently no attempt to gather information on the impact of registration on escalating health care costs, with or without grandfathering. No one disputed the contention of primarily outstate institutions that registration will inflate the cost of care. To the extent that outstate institutions increase salaries to attract the short supply of registrants, the bidding will probably increase the cost of care generally throughout the state. The extent of that potential increase has not been studied. If evidence exists of the impact in the 26 states that have already adopted licensing and registration schemes, it apparently has not been gathered.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

## CONCLUSIONS

1. That the Minnesota Department of Health gave proper notice of the hearing in this matter.

2. That the Department has fulfilled the procedural requirements of Minn. Stat. §§ 14.14, and all other procedural requirements of law or rule.

3. That the Department has documented its statutory authority to adopt the proposed rules, and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1, 14.15, subd. 3 and 14.50 (i) and (ii).

4. That the Department has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii).

5. That the additions and amendments to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 14.15, subd. 3, Minn. Rule 1400.1000, Subp. 1 and 1400.1100.

6. That any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

7. That a finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department staff from further modification of the rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

It is hereby recommended that the proposed rules be adopted consistent with the Findings and Conclusions made above.

Dated this 9TH day of April, 1991.

HOWARD L. KAIBEL, JR.
Administrative Law Judge