

# Emergency Rules

## DECLARATION OF EMERGENCY

### Department of Agriculture and Forestry Office of the Commissioner Livestock Sanitary Board

Diseases of Animals—Brucellosis  
(LAC 7:XXI.305, 307, 309, and 311)

In accordance with the emergency provisions of the Administrative Procedure Act, R. S. 49:953 B, R.S. 3:2221, and R.S. 3:2228, the Office of the Commissioner is declaring an emergency due to the USDA's reclassification for Louisiana as a Brucellosis Class Free state. USDA determined that Louisiana meets the standards for Class Free status. This action relieves certain restrictions on the interstate movement of cattle from Louisiana. The effective date of this emergency rule is September 1, 2000, and it shall be in effect for 120 days or until the final rule takes effect through normal promulgation process, whichever occurs first.

The cattle industry of Louisiana is presently paying \$160,000.00 annually to have heifer calves vaccinated for brucellosis at Louisiana stockyards. Currently, there are about 80,000 calves vaccinated yearly at Louisiana livestock auctions. These vaccinations cost the state about \$32,000 a year (\$.40 per calf). Under the proposed rule there will be a 90 percent reduction in vaccinations. About 8,000 calves will be vaccinated at a cost of \$3,200. This results in an estimated reduction of costs of \$28,800 to state governmental units.

Ninety percent of the calves produced in Louisiana leave the state at the time of sale and move to feedlots in other states. Over the past few years, many states have dropped brucellosis vaccination entry requirements and now that Louisiana has been officially declared brucellosis free by the USDA, all states will accept heifer calves from Louisiana whether they have been vaccinated for brucellosis or not.

The continued imposition of a now useless cost is a burden on Louisiana's cattle industry to such an extent as to constitute an imminent peril to the welfare of that industry, and, consequently, an imminent peril to the welfare of the citizens of Louisiana.

### Title 7

## AGRICULTURE AND ANIMALS

### Part XXI. Diseases of Animals

#### Chapter 3. Cattle

##### §305. Brucellosis Vaccination and Fee

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 15:75 (February 1989), amended LR 22:960 (October 1996) LR 24:1677 (September 1998), repealed LR 27:

##### §307. Livestock Auction Market Requirements

A.1. - d. Y

i. All non-vaccinated heifer calves, between 4 and 12 months of age are to be vaccinated with USDA approved brucellosis vaccine prior to being sold or at the first point of sale, but in no case shall any heifer calf 4 to 12 months of age remain unvaccinated for brucellosis more than 15 days after the date of sale. Exceptions to this paragraph are heifer calves 4 to 12 months of age which are transported out of the state within 15 days of the date of their sale.

d.ii. - g.ii. ...

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

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Livestock Sanitary Board, LR 11:237 (March 1985), amended LR 11:651 (June 1985), amended by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 12:501 (August 1986), LR 12:598 (September 1986), LR 13:556 (October 1987), LR 14:220 (April 1988), LR 14:695 (October 1988), LR 15:813 (October 1989), LR 17:30 (January 1991), LR 18:837 (August 1992), LR 22:960 (October 1996), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:1677 (September 1998), LR 27:

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

All cattle which are sold or offered for sale by livestock dealers, must meet the general requirements of LAC 7:XXI.115 and the following specific requirements:

A.1. - b.i.i. ...

3.a. All heifer calves between 4 and 12 months of age are to be vaccinated with USDA approved brucellosis vaccine prior to being sold or at the first point of sale but in no case shall any heifer calf 4 to 12 months of age remain unvaccinated for brucellosis more than 15 days after the date of sale. Exceptions to this paragraph are: Heifer calves 4 to 12 months of age which are transported out of the state within 15 days of the date of their sale.

A.3.b. - B. ....

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

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Livestock Sanitary Board, LR 11:237 (March 1985), amended LR 11:651 (June 1985), amended LR 12:502 (August 1986), LR 13:558 (October 1987), LR 14:221 (April 1988), LR 17:31 (January 1991), LR 18:838 (August 1992), LR 22:960 (October 1996), LR 17:30 (January 1991), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:1678 (September 1998), LR 27:

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

A. It is a violation of this regulation to sell or purchase cattle, not governed by other regulations of the Livestock Sanitary Board, in Louisiana, for any purpose other than immediate slaughter, unless they meet one of the following requirements.

1.a. Heifers 4 to 12 months of age, are to be official brucellosis calfhood vaccinates prior to being sold or be vaccinated at the first point of sale but in no case shall any heifer 4 to 12 months of age remain unvaccinated for

brucellosis more than 15 days after the date of sale. Exceptions to this paragraph are:

- i. heifers sold to move directly to slaughter;
- ii. heifers sold to be moved directly to a quarantine feed lot;
- iii. heifers which are transported out of Louisiana within 15 days of the date of their sale.

b. Any person found in violation of paragraph 1.a. of this regulation shall be fined no less than \$1,000.00 dollars or more than \$5,000.00 for each count. Each non-vaccinated heifer shall be considered a separate violation and each day on which the violation occurs shall be considered a separate count.

c. Any person who has knowledge of and does not report to the LDAF any violation of Paragraph 1.a. of this regulation shall be considered in violation of this regulation and subject to the same penalties as stated in paragraph 1.b. of this regulation.

2. - 5. ...

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

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Livestock Sanitary Board, LR 11:238 (March 1985), LR 11:615 (June 1985), amended 12:502 (August 1986), LR 13:559 (October 1987), LR 17:31 (January 1991), LR 18:837 (August 1992), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:1678 (September 1998), amended LR 27:

Bob Odom  
Commissioner

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## DECLARATION OF EMERGENCY

### Department of Economic Development Racing Commission

#### Account Wagering (LAC 35:XIII.Chapter 120)

The Louisiana State Racing Commission is exercising the emergency provisions of the Administrative Procedures Act, R.S. 49:953(B), and pursuant to the authority granted under R.S. 4:141 et seq., adopts the following emergency rule (chapter) effective December 29, 2000, and it shall remain in effect for 120 days or until this rule takes effect through the normal promulgation process, whichever comes first.

The Louisiana State Racing Commission finds it necessary to adopt this rule chapter to provide for account wagering at Louisiana race tracks, off-track wagering facilities and other locations which may have the potential of increasing the handle by allowing patrons to set up an account whereby wagers will be placed in lieu of cash transactions.

### Title 35 HORSE RACING Part XIII. Wagering

#### Chapter 120. Account Wagering

##### §12001. Definitions

*Account Holder*Ca person authorized by the licensee to place wagers via account wagering.

*Account Wager*Ca wager placed by means of account wagering.

*Account Wagering*Ca form of pari-mutuel wagering in which an individual may deposit money in an account with a licensee and use the account balance to pay for pari-mutuel wagering authorized by R.S. 4:149.5 to be conducted by the licensee. An account wager may be made by the account holder in person, via telephonic device or by communication through other electronic media.

*Account Wagering Center*the facility or facilities for maintaining and administering the account wagering system.

*Wagering Account* or *Account*the account maintained and administered through an account wagering center for account holders who wish to place account wagers and otherwise participate in account wagering.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

##### §12003. Authorization

A. A system of account wagering may be operated only by a licensee, or employees or agents of such licensee, who is/are authorized to do so pursuant to R.S. 4:149.5(B)(1). The authorized licensee may, subject to applicable state and federal laws, conduct account wagering on any races conducted at its facility and on any races conducted at other facilities, within or outside of this state. Wagering accounts may be established for an individual whose principal residence is outside this state if the racing association complies with all applicable provisions of federal and state law. All wagers placed through the licensee's system of account wagering shall be considered to have been made in this state.

B. An authorized licensee may not accept wagers from residents located in proximity to the racing facility of another licensee as provided for in R.S. 4:214(A)(3), without having provided the commission with sufficient evidence of how the authorized licensee intends to identify such account holders and pay to such other licensee the source market percentage required to be paid pursuant to R.S. 4:149.5(B)(2).

C. A licensee of race meetings shall provide the commission with written evidence of its consent to the acceptance, by an operator of a system of account wagering located outside this state, of wagers placed with such account wagering system by residents or other persons located within or outside of this state on races conducted in this state by that licensee. In the absence of such written evidence, no system of account wagering located outside this state may accept such wagers.

D. A licensee of race meetings authorized pursuant to R.S. 4:149.5(B)(1) to conduct account wagering in this state shall provide the commission with written evidence of its consent to the acceptance, by an operator of a system of account wagering located outside this state, of wagers placed with such account wagering system by residents or other persons located within this state on races conducted outside this state. In the absence of such written evidence, no system of account wagering located outside this state may accept such wagers.

E. A licensee, as defined in R.S. 4:149.5, may conduct account wagering made in person, by telephonic device or by communication through other electronic media. The maintenance and operation of account wagering shall be in accordance with the *Rules of Racing* and R.S. 4:149.5. The

licensee shall request authorization and receive approval from the commission before a system of account wagering is offered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12005. Establishment**

A. The licensee may offer a system of account wagering to its patrons whereby wagers are debited in, and payouts credited to, an account in the name of the patron, that is held by the licensee. The licensee shall notify the patron, at the time of opening the account, of any rules or procedures the licensee has adopted concerning deposits, withdrawals, average daily balances, user or service fees, interest payments, hours of operation, and any other aspect of the operation of the account. The licensee shall notify the patron whenever the rules governing the account are changed and shall endeavor to provide such notification before the new rules are applied to the account and including the opportunity to close or cash-in the account. The patron shall be deemed to have accepted the rules of account operation upon opening or not closing the account.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12007. Compliance**

A. Account wagering shall be conducted in compliance with the *Rules of Racing* and all applicable state and federal laws. Unless elsewhere specifically set forth, an account wager shall be subject to the statutory provisions and rules and regulations which govern all pari-mutuel wagers placed within the enclosure at which the licensee is authorized to conduct race meetings. From each account wager, there shall be deducted the same percentage as is deducted on a wager if made in person in the same wagering pool at the licensee's race track.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12009. Wagering Pools**

A. The total amount of all account wagers shall be included in the respective pools for each race and shall be combined into the licensee's pools or, with approval of the commission, directly into the corresponding pools of a host track in another jurisdiction. The amount wagered in such pools from wagering accounts shall be debited accordingly, and any winnings shall be automatically credited to such accounts upon the race being declared official.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12011. Hours of Operation**

A. Account wagers shall be accepted during such times and on such days as designated by the licensee, subject to state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12013. Service Fees**

A. As part of its rules, the licensee may, with the approval of the commission and prior notice to the account holder, impose user or service fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12015. Account Wagering Center**

A. The licensee shall operate an account wagering center(s) for the purpose of keeping wagering accounts, recording wagers, maintaining records of credits and debits to the accounts, and otherwise administering the account wagering system. The location of such account wagering center(s) shall be subject to the approval of the commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12017. Licensee's Employees and Agents**

A. The licensee shall appoint officers, employees or agents of the licensee to have management and control of the various aspects of the account wagering system for the licensee, including the account wagering center. As used herein, *licensee* includes the officers, directors and employees of the licensee, and persons, agents or other entities with the authority to accept deposits and wagers on behalf of the licensee and otherwise maintain and administer the system of account wagering. Such persons or entities may also provide services linking transactions from an account holder to a totalizator company.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12019. Wagering Accounts**

A. Only those persons who have a wagering account with an account wagering center shall be permitted to wager through account wagering. An account may be established at an account wagering center, at a racetrack or off-track wagering facility within the state, by mail, or by other means approved by the commission.

B. The licensee shall accept accounts in the name of a natural person only. The licensee shall not accept any corporate, partnership, limited liability company, joint, trust, estate, beneficiary or custodial account. The account is nontransferable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12021. Account Holder's Responsibilities**

A. Wagering accounts are for the personal use of the account holder. Account holders are responsible for all bets placed through their accounts by any person using the account. The account holder bears full responsibility for maintaining the secrecy of his/her account number and confidential identification code.

B. Except as otherwise set forth herein, no person shall in any manner place any account wager on behalf of an account holder, or otherwise directly or indirectly act as an intermediary, transmitter or agent in the placing of wagers for an account holder. The licensee is not prohibited from

conducting account wagering through employees or agents. Nothing in §12021 is intended to prohibit the use of credit or debit cards or other means of electronic funds transfer, or the use of checks, money orders or negotiable orders of withdrawal.

C. Neither the licensee nor any officer, director, employee or agent of the licensee shall be responsible for any loss arising from the use of or access to a wagering account by any person or persons other than the account holder, except where the licensee or its employees or agents act without good faith or fail to exercise ordinary care. The account holder must immediately notify the account wagering center of a breach of the account's security.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12023. Minors Prohibited**

A. No person below the age of 18 shall be permitted to open an account or place a wager, directly or indirectly, through account wagering.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12025. Others Prohibited**

A. No officer, director or employee of any firm, entity or agency which is retained by the licensee with responsibility for the operation or maintenance of the account wagering system or of the account wagering center shall be permitted to place a wager, directly or indirectly, through the licensee's system of account wagering.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12027. Opening Wagering Account**

A. An applicant for a wagering account shall make application in writing on the appropriate form supplied by the licensee at an account wagering center, at a racetrack or off-track wagering facility within the state, by mail, or by other means approved by the commission. The applicant shall provide his/her full name, current address and telephone number, social security number, and such additional information as the licensee may require. It is the account holder's responsibility to keep his/her mailing address current with the account wagering center. The application shall be signed by the applicant or otherwise authorized in a manner acceptable to the commission. Applicants must state in their application whether they are below the age of 18.

B. Each account shall have a unique identification account number (and such other methods of identification as the licensee may require). Such number may be changed at any time provided the licensee informs the account holder in writing of the change.

C. At the time of applying for an account, each applicant shall select a confidential identification code to be used as further identification when wagering. Both the licensee and the account holder have the right to change this code at any time without explanation by informing the other party in writing of such change and the effective date thereof.

D. An account holder shall receive at the time the account is opened a unique identification account number; an identification card; a summary of the rules; an explanation of the procedures then in force for depositing to, withdrawing from and closing the account; a telephone number to be utilized by the account holder; a description of the mechanics of wagering; and such other information as the licensee or commission may deem appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12029. Deposits and Withdrawals**

A. Deposits to and withdrawals from existing accounts shall be permitted in such form and by such procedures as the licensee may require, provided that any requirements set forth in these rules shall be included therein.

B. Deposits made to a wagering account may be made as follows.

1. Deposits made to a wagering account by the account holder shall be submitted or mailed by the account holder to the staff or agents of the licensee at such locations and addresses as the licensee may designate from time to time, and shall be in the form of one of the following:

a. cash given to the staff at an account wagering center, or a racetrack or off-track wagering facility within the state; or

b. check, money order or negotiable order of withdrawal; or

c. charges made to an account holder's credit or debit card or other means of electronic funds transfer, upon the direct and personal instruction of the account holder, which may be given by telephone or other electronic device (or other means approved by the commission) to the licensee by the account holder if the use of the card or other means of funds transfer has been approved by the account wagering center.

2. Credit for winnings from wagers placed with funds in a wagering account, credit for account wagers on horses that are scratched, and other payments or refunds to which the account holder is entitled shall be posted to the account by the account wagering center.

3. The account wagering system shall not accept wagers or information assisting in the placement of wagers in excess of the amount posted to the credit of an account at the time the wager is placed.

C. Debits to a wagering account may be made as follows.

1. Upon receipt by a licensee of a wager or information assisting in the placement of wagers properly placed under applicable statutes and the *Rules of Racing*, the licensee shall debit the account holder's account in the amount of the wager.

2. A licensee may authorize a withdrawal from a wagering account when one of the following exists.

a. The holder of a wagering account applies in person at an account wagering center, or a racetrack or off-track wagering facility within the state, and provides proper identification, the correct personal identification account number, and a properly completed and signed withdrawal form.

b. The account holder has authorized the licensee to make such a withdrawal. Where there are sufficient funds in

the account to cover the withdrawal, the account wagering center shall, within five business days of receipt, send a check to the account holder at the current address on record for the wagering account. The check shall be payable to the holder of the account and in the amount of the requested withdrawal, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws (including but not limited to compliance with federal rules concerning the reporting or withholding of federal income tax). If funds are not sufficient to cover the withdrawal, or the full amount requested is otherwise not being sent, the account holder will be notified in writing and those funds in the account, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws, will be withdrawn and sent to the account holder within five business days. Electronic transfers may be used for withdrawals in lieu of a check at the discretion of the account holder and the account wagering center.

3. A licensee may debit an account for fees for service or other transaction-related charges.

D. Checks offered for deposit shall not be posted to the credit of the account holder until the hold period established by the licensee has elapsed. Holding periods will be determined by the licensee and advised to the account holder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12031. Deceased Account Holder**

A. In the event an account holder is deceased, funds accrued in the account shall be released to the decedent's legal representative upon receipt of a copy of a court order or judgment of possession.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12033. Licensee's Rights and Responsibilities**

A. Notwithstanding any other rules, the licensee, through its managing employee of the account wagering center, or other employee or agent designated by the licensee, shall have the following rights and responsibilities.

1. The licensee has the right to refuse the establishment or maintenance of accounts for what it deems good and sufficient reason.

2. The licensee has the right to refuse deposits to accounts for what it deems good and sufficient reason.

3. The licensee has the right at any time to refuse to accept all or part of any wager for what it deems good and sufficient reason.

4. The licensee has the right at any time to declare the account wagering system closed for receiving wagers on any pari-mutuel pool, race, group of races, or closed for all wagering.

5. The licensee has the right to suspend or close any account at any time. When an account is closed, the licensee shall, within five business days, return to the account holder such monies as are on deposit at the time of said action, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws, by sending a check to the account holder's current address.

6. The licensee has the right to close any account when the holder thereof attempts to operate with an insufficient balance or when the account is dormant for a period established by the licensee. In either case, the licensee shall refund the remaining balance of the account, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws.

7. No employee or agent of the licensee employed or engaged at the account wagering center shall divulge any confidential information related to the placing of any wager or any confidential information related to the operation of the account wagering center, except to the account holder or the commission, as required by these rules, and as otherwise required by federal or state law, or the *Rules of Racing*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### **§12035. Account Operations and Procedures**

A. Account wagers shall be accepted during such times and on such days as designated by the licensee, subject to state law.

B. The account holder shall provide the licensee with the correct personal identification account number previously assigned by the licensee to the holder of the wagering account, as well as the account holder's confidential identification code.

C. Any account wagering system must provide for the account holder's review and finalization of a wager or information assisting in the placement of a wager before it is accepted by the licensee. The wager shall not be changed after the account holder has reviewed and finalized the wager, and the conversation or wagering transaction has been concluded.

D. Payment on winning account wagers shall be posted as a credit to the account of the account holder as soon as practicable after the race is declared official.

E. No licensee may accept an account wager, or series of account wagers, in an amount in excess of funds on deposit in the account of the account holder placing the wager. Funds on deposit include amounts credited and in the account at the time the account wager or account wagers are placed. Account wagers will not be accepted which would exceed the available balance in the account.

F. When an account holder is entitled to a payout or refund, such monies will be credited to the respective accounts, thus increasing the credit balance. It is the responsibility of the account holder to verify proper credits and, if in doubt, notify the licensee within the agreed upon time frame for consideration. Unresolved disputes may be forwarded to the commission by the licensee or the account holder. No claim will be considered by the commission unless submitted in writing and accompanied by supporting information or evidence.

G. Monies deposited with the licensee for account wagering shall not bear any interest to the account holder.

H. The licensee shall maintain equipment capable of recording all wagering conversations and transactions conducted through the account wagering system. The recording device must be used at all times when wagering communications are received.

I. For wagers made by voice telephone, the licensee shall make a voice recording of the entire transaction and

shall not accept any such wager if the voice recording system is inoperable. The voice recording of the transaction shall be deemed to be the actual wager, regardless of what was recorded by the pari-mutuel system.

J. All wagering conversations, transactions or other wagering communications through the account wagering system, verbal or electronic, shall be recorded by means of the appropriate electronic media, and the tapes or other records of such communications kept by the account wagering center for a period of time which the commission may establish. These tapes and other records shall be made available to commissioners, employees and/or designees of the commission in accordance with the *Rules of Racing*.

K. The address provided in writing by the account holder to the account wagering center is deemed to be the proper address for the purposes of mailing checks, account statements, account withdrawals, notices, or any other appropriate correspondence. It is the account holder's responsibility to maintain a current address of record with the account wagering center. The mailing of checks or other correspondence to the address given by the account holder shall be at the sole risk of the account holder.

L. The account wagering center shall, from time to time, but not less than once per year, provide written statements of account activity during the period to all account holders. In addition, an account holder has the right to request and be provided a statement at any time. Unless written notice to the contrary is received by the licensee within 30 days of the date that any such statement is rendered to an account holder, said statement shall be deemed accepted as correct in any and all particulars.

M. Subject to commission approval, the licensee may implement procedures for the use of wagering accounts for wagering while at facilities in this state where pari-mutuel wagering is permitted and for wagering by any other electronic means.

N. The commission may review and audit the account wagering system's equipment configuration and account wagering center. Any telephone communications system, whether touch tone, voice response, or operator controlled, and all other electronic media utilized for account wagers, shall be linked to a totalizer system in a manner approved by the commission. For the purposes of account wagering, totalizer equipment utilized by or linked to the licensee shall be capable of accounting for all wagering and other transactions which may affect customer accounts. The licensee must maintain complete records of every deposit, withdrawal, wager, refund and winning payout for each account. These records shall be made available to the commission in accordance with the *Rules of Racing*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

Charles A. Gardiner III  
Executive Director

0101#006

## DECLARATION OF EMERGENCY

### Department of Economic Development Racing Commission

Account Wagering Source Market Commissions  
(LAC 35:XIII.12001 and 12014)

The Louisiana State Racing Commission hereby gives notice that it intends to amend LAC 35:XIII.Chapter 120 "Account Wagering," because additional definitions are needed, and distribution of commissions must be provided for.

This proposed Rule has no known impact on family formation, stability, and/or autonomy as described in R.S. 49:972.

#### Title 35

#### HORSE RACING

#### Part XIII. Wagering

#### Chapter 120. Account Wagering

#### §12001. Definitions

\* \* \*

*Source Market Area* the circular area within a 55-mile radius of a licensed racing facility and any additional area within which the consent of such facility is required as a prerequisite to the acceptance of off-track wagers by another licensee.

\* \* \*

*Source Market Commission* Call fees or commissions received by any racing association as a result of account wagers being placed with the entity that pays such fee or commission or any entity other than the racing association receiving said fee or commission by persons residing within a defined market area near the racing association and shall include a fee which shall be paid by a licensed racing facility which accepts an account wager to another licensed racing facility whenever the person placing the account wager:

1. resides within the source market area surrounding the latter licensed racing facility; and

2. does not place the wager in person at the facility accepting the wager. The percentage used to calculate the source market commission shall be, with respect to each account wager accepted on a particular day, equal to the highest source market percentage paid on that day to the licensed racing facility within the source market area by any other account wagering carrier located outside of the state.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

#### §12014. Source Market Commissions

A. Fifty percent of all source market commissions shall be distributed at the licensed racing facility which receives such source market commissions for the purposes and in the percentages provided in the provisions of R.S. 4:183(A)(4)(a) and (b).

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2, R.S. 4:149.5 and R.S. 4:183.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

The domicile office of the Louisiana State Racing Commission is open from 8 a.m. to 4 p.m., and interested

parties may contact Charles A. Gardiner III, executive director, or C. A. Rieger, assistant director, at (504) 483-4000 (Fax 483-4898), holidays and weekends excluded, for more information. All interested persons may submit written comments relative to this proposed rule through Friday, February 9, 2001, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, Louisiana 70119-5100.

Charles A. Gardiner III  
Executive Director

0101#008

**DECLARATION OF EMERGENCY**

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

Exclusive Provider Organization (EPO) Plan of Benefits  
(LAC 32:V.Chapters 1-7)

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

The board finds that it is necessary to revise and amend provisions of the EPO Plan Document, including increasing the calendar year deductible for employees, imposing a calendar year deductible for prescription drugs, increasing the deductible applicable to emergency room services, imposing a pre-existing condition limitation on new employees and their dependents, eliminating benefits for glucometers, and providing for limited availability of a 90-day supply of maintenance drugs.

Failure to adopt this rule on an emergency basis will adversely affect fiscal solvency of the State Employees Group Benefits Program and impact the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, revising and amending the EPO Plan of Benefits, is effective January 1, 2001 and shall remain in effect for a maximum of 120 days, or until the final rule is promulgated, which ever occurs first.

**Title 32**

**EMPLOYEE BENEFITS**

**Part V. Exclusive Provider (EPO) Plan of Benefits**

**Chapter 1. Eligibility**

**§101. Persons to be Covered**

Eligibility requirements apply to all participants in the Program, whether in the PPO Plan, the EPO Plan or an HMO plan.

**A. Employee Coverage**

1. - 2. ...

3. Effective dates of coverage, New Employee, Transferring Employee. Coverage for each Employee who completes the applicable Enrollment Form and agrees to

make the required payroll contributions to his Participant Employer is to be effective as follows:

a. - b. ...

c. Employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date of employment. An employee who completes an enrollment form after 30 days following the date of employment will be considered an overdue applicant.

d. An employee that transfers employment to another participating employer must complete a transfer form within 30 days following the date of transfer in order to maintain coverage without interruption. An employee who completes a transfer form after 30 days following the date of transfer will be considered an overdue applicant.

4. - 7. ...

8. Pre-Existing Condition (PEC) New employees (on and after January 1, 2001)

a. The terms of the following paragraphs apply to all eligible employees whose employment with a participant employer commences on or after January 1, 2001, and to the dependents of such employees.

b. The Program may require that such applicants complete a statement of physical condition and an acknowledgement of pre-existing condition form.

c. Medical expenses incurred during the first 12 months that coverage for the employee and/or dependent is in force under the plan will not be considered as covered medical expenses if they are in connection with a disease, illness, accident or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period immediately prior to the effective date of coverage. The provisions of this section do not apply to pregnancy.

d. If the covered person was previously covered under a group health plan, medicare, medicaid or other creditable coverage as defined in the health insurance portability and accountability act of 1996 (HIPAA), credit will be given for previous coverage that occurred without a break of 63 days or more for the duration of prior coverage against the initial 12-month period. Any coverage occurring prior to a break in coverage 63 days or more will not be credited against a pre-existing condition exclusion period.

B. - G ...

H. Medicare Risk HMO Option for Retirees (Effective July 1, 1999). Retirees who are eligible to participate in a Medicare Risk HMO plan who cancel coverage with the program upon enrollment in a Medicare Risk HMO plan may re-enroll in the program upon withdrawal from or termination of coverage in the Medicare Risk HMO plan, at the earlier of the following.

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1804 (October 1999), LR 27:

**§103. Continued Coverage**

A. - B.2. ...

C. Surviving Dependents/Spouse. The provisions of this section are applicable to surviving dependents who elect to continue coverage following the death of an Employee or Retiree. On or after July 1, 1999, eligibility ceases for a Covered Person who becomes eligible for coverage in a

Group Health Plan other than Medicare. Coverage under the Group Health Plan may be subject to HIPAA.

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

a. ...

b. The surviving unmarried (never married) children of an employee or retiree may continue coverage until they are eligible for coverage under a Group Health Plan other than Medicare, or until attainment of the termination age for Children, whichever occurs first;

1.c. - D.3. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer shall pay the employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1806 (October 1999), LR 27:

### **§107. Change of Classification**

A. Adding or Deleting Dependents. the plan member must notify the program whenever a dependent is added to, or deleted from, the plan member's coverage that would result in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), LR 27:

### **Chapter 3. Medical Benefits**

#### **§301. Medical Benefits Apply when Eligible Expenses are Incurred by a Covered Person**

A. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable deductibles, limits of the fee schedule, schedule of benefits, exclusions and other provisions of the plan. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. - 8.1. ...

9. Services of licensed speech therapist when prescribed by a physician and pre-approved through outpatient procedure certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease;

10. - 11.c. ...

d. Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

12. Durable Medical Equipment, subject to the lifetime maximum payment limitation as listed in the schedule of benefits.

[The Program will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of Durable Medical Equipment will be considered an eligible expense only upon showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of Durable Medical Equipment exceed the purchase price of such item.]

13.-18. ...

19. Acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;

20. - 20.d. ...

21. Services of a physical therapist and occupational therapist licensed by the state in which the services are rendered when:

a. - e. ...

f. approved through case management when rendered in the home;

23.-23.c.iii. ...

24. Not subject to the annual deductible:

a. ...

b. Mammographic examinations performed according to the following schedule:

i. One mammogram during the five-year period a person is 35-39 years of age;

24.b.ii. - 26.iii. ...

27. Services rendered by the following, when billed by the supervising physician:

a. Perfusionists and registered nurse assistants assisting in the operating room;

b. Physician's Assistants and Registered Nurse Practitioners;

28. - 32. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1810 (October 1999), LR 27:

#### **§307. Utilization Review - Pre-Admission Certification, Continued Stay Review**

A. - A.2. ...

B. For a routine vaginal delivery, PAC is not required for a stay of two days or less. If the mother's stay exceeds or is expected to exceed two days, PAC is required within 24 hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate pre-certification number must be obtained for the baby. in the case of a caesarean section, PAC is required if the mother's stay exceeds or is expected to exceed four days;

C. No benefits will be paid under the Plan:

1. ...

2. Unless PAC is requested within two business days following admission in the case of an emergency;

C.3. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 27:

**§309. Outpatient Procedure Certification**

- A. ...
- B. OPC is required on the following procedures:
  - 1. - 6. ...
  - 7. Speech Therapy
- C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

C.1. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 27:

**§311. Case Management**

A. - E.8. ...

9. Physical and occupational therapy rendered in a home setting.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 27:

**§313. Dental Surgical Benefits**

A. ...

B. Eligible expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the deductible, co-insurance and the maximum benefit provisions of the Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 27:

**§315. Medicare Reduction**

A. ...

B. Retiree 100-Medicare COBC Upon enrollment and payment of the additional monthly premium, a plan member and dependents who are covered under medicare, both parts A and B, may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare or within 30 days of retirement if already eligible for Medicare and at the annual open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 27:

**§317. Exceptions and Exclusions for All Medical Benefits**

A. No benefits are provided under this Plan for:

1. - 24. ...

[Note: Paragraph 25 is being repealed.]

26. - 40. ...

41. Glucometers

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 26:488 (March 2000), LR 27:

**§325. Prescription Drug Benefits**

A. This Plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor, requiring a prescription, and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a covered person as an inpatient Hospital patient or an outpatient hospital patient, including insulin, retin-a dispensed for covered persons under the age of 26, vitamin b12 injections, prescription potassium chloride, and over-the-counter diabetic supplies including, but not limited to, strips, lancets and swabs.

B. The following drugs, medicines, and related services are not covered:

1. - 10. ...

11. Drugs for Treatment of impotence, except following surgical removal of the prostate gland; and Glucometers.

C. ...

1. Upon presentation of the group benefits program health benefits identification card at a network pharmacy, and after satisfying the prescription drug deductible set forth in the schedule of benefits, the plan member will be responsible for copayment of \$6 per prescription when a generic drug is dispensed, \$20 per prescription when a preferred brand name drug is dispensed, and \$30 per prescription when a non-preferred brand name drug is dispensed. The copayment cannot exceed the actual charge by the pharmacy for the drug.

2. - 4. ...

5. Prescription drug dispensing and refills will be limited in accordance with protocols established by the prescription benefits manager, including the following limitations:

a. up to a 34-day supply of acute drugs may be dispensed at one time;

b. up to a 90-day supply of maintenance drugs may be dispensed at one time only at pharmacies identified as participating in the 90-day Maintenance Drug Plan administered by the prescription benefits manager; up to a 34-day supply of maintenance drugs may be dispensed at one time at any other network pharmacy; and

c. refills will be available only after 75 percent of drugs previously dispensed should have been consumed.

6. *Acute or Non-maintenance Drug* Ca covered drug other than a maintenance drug as define herein.

7. *Brand Drug* C the trademark name of a drug approved by the U. S. Food and Drug Administration.

8. *Generic Drug* Ca chemically equivalent copy of a brand name drug.

9. *Maintenance Drug* Ca covered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition

10. *Non-Preferred Brand Drug* Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

11. *Pharmacy and Therapeutic Committee* Ca committee created by the Program's contracted prescription

benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a *preferred brand drug* or a non-preferred brand drug. In making these determinations, the pharmacy and therapeutic committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

12. *Preferred Brand Drug* A brand name drug that has received a classification of preferred brand from the pharmacy and therapeutic committee based on the following criteria:

- a. clinical uniqueness of the medication;
- b. positive efficacy profile;
- c. good side effect, safety, and drug interaction profile;
- d. positive quality of the implications;
- e. clinical experience with the medication; and
- f. cost (only considered when clinical parameters are equal to other products in its class).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1815 (October 1999), LR 27:

#### **Chapter 4. Uniform Provisions**

##### **§403. Properly Submitted Claim Form**

- A. For Plan reimbursements, all bills must show:
  1. employee's name;
  2. name of patient;
  3. name, address, and telephone number of the provider of care;
  4. diagnosis;
  5. type of services rendered, with diagnosis and/or procedure codes;
  6. date of service;
  7. charges;
  8. employee's member number;
  9. provider tax identification number; and
  10. Medicare explanation of benefits, if applicable.

B. The program can require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish the requested information within 90 days of the request will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), LR 27:

##### **§501. Claims Review Procedures and Appeals**

- A. ...
- B. The request for review must be directed to Attention: Appeals and Grievances within 90 days after the date of the notification of denial of benefits, denial of eligibility, or denial after review by the utilization review, pharmacy benefit or mental health contractors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1818 (October 1999), LR 27:

##### **§511. Subpoena of Witnesses; Production of Documents**

- A. - C. ...

C. No subpoena will be issued requiring the attendance and giving of testimony by witnesses unless a written request therefore is received in the office of the program, attention: appeals and grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoenas must contain the names of the witnesses and a statement of what is intended to be proved by each witness. No subpoenas will be issued until the party requesting the subpoena deposits with the program a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled.

D. No subpoena for the production of books, papers and other documentary evidence will be issued unless written request therefore is received in the office of the program, attention: Appeals and grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoena for books, papers, and other documentary evidence must contain a description of the items to be produced in sufficient detail for identification and must contain the name and street address of the person who is to be required to produce the items and a brief statement of what is intended to be proved by each item.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 27:

##### **§513. Appeals Decisions**

- A. ...
- B. Appeals Heard by Referee. At the conclusion of the hearing, the referee will take the matter under submission and, as soon as is reasonably possible thereafter, prepare a recommended decision in the case which will be based on the evidence adduced at the hearing or otherwise included in the hearing records. The decision will contain findings of fact and statement of reasons. The recommended decision will be submitted to the committee for review.

C. The committee may adopt or reject the recommended decision. In the case of adoption, the referee's decision becomes the decision of the committee. In the case of rejection, the committee will render its decision, which will include a statement of reasons for disagreement with the referee's decision. The decision of the committee will be final. A copy will be mailed by certified mail to the covered person and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 27:

##### **§515. Rehearing**

- A. - B. ...
- C. The request for rehearing must be filed with the program, attention: appeals and grievances on or before 30 calendar days after the mailing of the appeal decision of the Committee. The request will be deemed filed on the date it is received in the office of the Program.

D. ...

E. When the committee grants a rehearing, an order will be issued setting forth the grounds. A copy of the order will be sent, along with notice of the time and place fixed for the rehearing, to the appealing party and any representative by certified mail.

F. - G ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 27:

**Chapter 6. Definitions**

**§601. Definitions**

*Accidental Injury* Ca condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from and external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

*Acute or Non-maintenance Drug* Ca covered drug other than a maintenance drug as define herein.

\*\*\*

*Brand Drug* Cthe trademark name of a drug approved by the U.S. Food and Drug Administration.

\*\*\*

*Children* C

1. any legitimate, duly acknowledged, or legally adopted Children of the Employee and/or the Employee's legal spouse dependent upon the Employee for support;

2. - 4. ...

\*\*\*

*Generic Drug* Ca chemically equivalent copy of a brand name drug.

\*\*\*

*Maintenance Drug* Ccovered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition.

\*\*\*

*Non-Preferred Brand Drug* Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

\*\*\*

*Pharmacy and Therapeutic Committee* Ca committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a Preferred Brand Drug or a Non-Preferred Brand Drug. In making these determinations, the Pharmacy and Therapeutic Committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

\*\*\*

*Preferred Brand Drug* Ca brand name drug that has received a classification of Preferred Brand from the Pharmacy and Therapeutic Committee based on the following criteria:

1. clinical uniqueness of the medication;
2. positive efficacy profile;
3. good side effect, safety, and drug interaction profile;
4. positive quality of the implications;
5. clinical experience with the medication; and

6. cost (only considered when clinical parameters are equal to other products in its class).

\*\*\*

*Well-Baby Care* Croutine care to a well newborn infant from the date of birth until age one. This includes routine physical examinations, active immunizations, check-ups, and office visits to a physician and billed by that physician, except for the treatment and/or diagnosis of a specific illness. All other health services coded with wellness procedures and diagnosis codes are excluded.

*Well-Child Care* Croutine physical examinations, active immunizations, check-ups and office visits to a physician, and billed by a health care provider that has entered into a contract with the State Employees Benefits Program, except for the treatment and/or diagnosis of a specific illness, from age 1 to age 16. All other health services coded with wellness procedures and diagnosis codes are excluded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1820 (October 1999), LR 27:

**Chapter 7. Schedule of Benefits C EPO**

**§701 Comprehensive Medical Benefits**

A. ...

1. Deductibles:

	PPO/non participating provider	EPO
Inpatient deductible per day, maximum of 5 days per Admission (waived for admissions at PPO hospitals)	\$50	0
Emergency room charges for each visit unless The Covered person is hospitalized immediately Following emergency room treatment (prior to And in addition to Calendar Year deductible)	\$150	0
Professional and other eligible expenses, Employees and Dependents of Employees, Per person, per Calendar Year	\$500	0
Professional and other eligible expenses, Retirees and Dependents of Retirees, Per person, per Calendar Year	\$300	0
Family Unit maximum (3 individual deductibles)		
Prescription Drugs, Per person, per Calendar Year (separate from and in addition to all other deductibles)	\$150	\$150

2. - 3. ...

4. Prescription Drugs

50% non-Network in state
80% non-Network out of state
After deductible (\$150 per person, per calendar year), \$6 co-payment for generic drugs \$20 co-payment for preferred brand

name drugs, and  
\$30 co-payment for non-preferred  
brand name drugs purchased at a  
network pharmacy.

E. ...

F. Physical See % payable \$15 copay for  
/Occupational after deductible – outpatient services  
Therapy<sup>2</sup> Pg. 4  
Speech Therapy<sup>3</sup> See % payable \$15 copay for  
after deductible – outpatient services  
Pg. 4

G ...

AUTHORITY NOTE: Promulgated in accordance with R.S.  
42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the  
Governor, Board of Trustees of the State Employees Group  
Benefits Program, LR 25:1820 (October 1999), LR 26:488 (March  
2000), LR 27:

<sup>1</sup> ...

<sup>2</sup>Subject to Case Management Guideline if rendered in a home setting

<sup>3</sup>Subject to Outpatient Procedure Certification Guidelines

A. Kip Wall  
Interim Chief Executive Officer

0101#020

## DECLARATION OF EMERGENCY

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

Preferred Provider Organization (PPO) Plan of Benefits  
(LAC 32:III. Chapters 1-7)

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

The board finds that it is necessary to revise and amend  
provisions of the PPO Plan Document, including increasing  
the calendar year deductible for employees, imposing a  
calendar year deductible for prescription drugs, increasing  
the deductible applicable to emergency room services,  
imposing a pre-existing condition limitation on new  
employees and their dependents, eliminating benefits for  
glucometers, and providing for limited availability of a  
90-day supply of maintenance drugs.

Failure to adopt this rule on an emergency basis will  
adversely affect fiscal solvency of the State Employees  
Group Benefits Program and impact the availability of  
services necessary to maintain the health and welfare of the  
covered employees and their dependents, which is crucial to  
the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, revising and  
amending the PPO Plan of Benefits, is effective January 1,  
2001 and shall remain in effect for a maximum of 120 days,  
or until the final rule is promulgated, which ever occurs first.

## Title 32

### EMPLOYEE BENEFITS

#### Part III. Exclusive Provider (PPO) Plan of Benefits

##### Chapter 1. Eligibility

##### §101. Persons to be Covered

Eligibility requirements apply to all participants in the  
Program, whether in the PPO Plan, the EPO Plan or an  
HMO plan.

##### A. Employee Coverage

1. - 2. ...

3. Effective dates of coverage, New Employee,  
Transferring Employee. Coverage for each Employee who  
completes the applicable Enrollment Form and agrees to  
make the required payroll contributions to his Participant  
Employer is to be effective as follows.

a. - b. ...

c. Employee coverage will not become effective  
unless the employee completes an enrollment form within 30  
days following the date of employment. An employee who  
completes an enrollment form after 30 days following the  
date of employment will be considered an overdue applicant.

d. An employee that transfers employment to  
another participating employer must complete a transfer  
form within 30 days following the date of transfer in order to  
maintain coverage without interruption. An employee who  
completes a transfer form after 30 days following the date of  
transfer will be considered an overdue applicant.

4. - 7. ...

8. Pre-Existing Condition (PEC) New employees (on  
and after January 1, 2001)

a. The terms of the following paragraphs apply to  
all eligible employees whose employment with a participant  
employer commences on or after January 1, 2001, and to the  
dependents of such employees.

b. The program may require that such applicants  
complete a Statement of Physical Condition and an  
Acknowledgement of Pre-existing Condition form.

c. Medical expenses incurred during the first 12  
months that coverage for the employee and/or dependent is  
in force under the plan will not be considered as covered  
medical expenses if they are in connection with a disease,  
illness, accident or injury for which medical advice,  
diagnosis, care, or treatment was recommended or received  
during the 6-month period immediately prior to the effective  
date of coverage. The provisions of this section do not apply  
to pregnancy.

d. If the covered person was previously covered  
under a Group Health Plan, Medicare, Medicaid or other  
creditable coverage as defined in the Health Insurance  
Portability and Accountability Act of 1996 (HIPAA), credit  
will be given for previous coverage that occurred without a  
break of 63 days or more for the duration of prior coverage  
against the initial 12-month period. Any coverage occurring  
prior to a break in coverage 63 days or more will not be  
credited against a pre-existing condition exclusion period.

B. - G ...

H. Medicare Risk HMO Option for Retirees (Effective  
July 1, 1999) who are eligible to participate in a Medicare

Risk HMO plan who cancel coverage with the program upon enrollment in a Medicare Risk HMO plan may re-enroll in the program upon withdrawal from or termination of coverage in the Medicare Risk HMO plan, at the earlier of the following:

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1825 (October 1999), LR 27:

### §103. Continued Coverage

A. - B.2. ...

C. Surviving Dependents/Spouse. The provisions of this section are applicable to surviving dependents who elect to continue coverage following the death of an employee or retiree. On or after July 1, 1999, eligibility ceases for a covered person who becomes eligible for coverage in a group health plan other than Medicare. Coverage under the Group Health Plan may be subject to HIPAA.

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the employee's or retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

a. ...

b. The surviving unmarried (never married) Children of an Employee or Retiree may continue coverage until they are eligible for coverage under a Group Health Plan other than Medicare, or until attainment of the termination age for Children, whichever occurs first;

1.c. - D.3. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer shall pay the employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1827 (October 1999), LR 27:

### §107. Change of Classification

A. Adding or Deleting Dependents. The plan member must notify the program whenever a dependent is added to, or deleted from, the plan member's coverage that would result in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1829 (October 1999), LR 27:

## Chapter 3. Medical Benefits

### §301. Medical Benefits Apply when Eligible Expenses are Incurred by a Covered Person

A. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable deductibles, limits of the Fee Schedule, Schedule of Benefits, exclusions and other

provisions of the Plan. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. - 8.l. ...

9. Services of licensed speech therapist when prescribed by a physician and pre-approved through Outpatient Procedure Certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease;

10. - 11.c. ...

d. Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

12. Durable Medical Equipment, subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits;

[The Program will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of Durable Medical Equipment will be considered an eligible expense only upon showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of Durable Medical Equipment exceed the purchase price of such item.]

13. - 18. ...

19. Acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;

20.- 20.d. ...

21. Services of a Physical Therapist and Occupational Therapist licensed by the state in which the services are rendered when:

a. - e. ...

f. approved through case management when rendered in the home;

23. - 23.c.iii. ...

24. Not subject to the annual deductible:

a. ...

b. Mammographic examinations performed according to the following schedule:

i. One mammogram during the five-year period a person is 35-39 years of age;

24.b.ii - 26.iii. ...

27. Services rendered by the following, when billed by the supervising physician:

a. Perfusionists and registered nurse assistants assisting in the operating room;

b. Physician's Assistants and Registered Nurse Practitioners;

28. - 32. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), LR 27:

### §307. Utilization Review/Pre-Admission Certification, Continued Stay Review

A. - A.2. ...

B. For a routine vaginal delivery, PAC is not required for a stay of two days or less. If the mother's stay exceeds or is expected to exceed two days, PAC is required within 24

hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate pre-certification number must be obtained for the baby. In the case of a caesarean section, PAC is required if the mother's stay exceeds or is expected to exceed 4 days;

C. No benefits will be paid under the Plan:

1. ...

2. Unless PAC is requested within two business days following admission in the case of an emergency;

C.3. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), LR 27:

### §309. Outpatient Procedure Certification

A. ...

B. OPC is required on the following procedures:

1. - 6. ...

7. Speech Therapy.

C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

C.1. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), LR 27:

### §311. Case Management

A. - E.8. ...

9. Physical and occupational therapy rendered in a home setting.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 27:

### §313. Dental Surgical Benefits

A. ...

B. Eligible expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the deductible, co-insurance and the maximum benefit provisions of the Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 27:

### §315. Medicare Reduction

A. ...

B. Retiree 100-Medicare COBC Upon enrollment and payment of the additional monthly premium, a plan member and dependents who are covered under Medicare, both Parts A and B, may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare or within 30 days of retirement if already eligible for Medicare and at the annual open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 27:

### §317. Exceptions and Exclusions for All Medical Benefits

A. No benefits are provided under this Plan for:

1. - 24. ...

[Note: Paragraph 25 is being repealed.]

26. - 40. ...

41. Glucometers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1834 (October 1999), LR 26:488 (March 2000), LR 27:

### §323. Prescription Drug Benefits

A. This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor, requiring a prescription, and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a covered person as an inpatient hospital patient or an outpatient hospital patient, including insulin, retin-A dispensed for covered persons under the age of 26, vitamin B12 injections, prescription potassium chloride, and over-the-counter diabetic supplies including, but not limited to, strips, lancets and swabs.

B. The following drugs, medicines, and related services are not covered:

1. - 10. ...

11. Drugs for treatment of impotence, except following surgical removal of the prostate gland; and glucometers.

C. ...

1. Upon presentation of the Group Benefits Program Health Benefits Identification Card at a network pharmacy, and after satisfying the Prescription Drug Deductible set forth in the Schedule of Benefits, the Plan Member will be responsible for copayment of \$8 per prescription when a generic drug is dispensed, \$25 per prescription when a preferred brand name drug is dispensed, and \$40 per prescription when a non-preferred brand name drug is dispensed. The copayment cannot exceed the actual charge by the pharmacy for the drug.

2. - 4. ...

5. Prescription drug dispensing and refills will be limited in accordance with protocols established by the prescription benefits manager, including the following limitations:

a. up to a 34-day supply of acute drugs may be dispensed at one time;

b. up to a 90-day supply of maintenance drugs may be dispensed at one time only at pharmacies identified as participating in the 90-day Maintenance Drug Plan administered by the prescription benefits manager; up to a 34-day supply of maintenance drugs may be dispensed at one time at any other network pharmacy; and

c. refills will be available only after 75 percent of drugs previously dispensed should have been consumed.

6. *Acute or Non-maintenance Drug* Ca covered drug other than a maintenance drug as define herein.

7. *Brand Drug* the trademark name of a drug approved by the U.S. Food and Drug Administration.

8. *Generic Drug* a chemically equivalent copy of a brand name drug.

9. *Maintenance Drug* covered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition

10. *Non-Preferred Brand Drug* a brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

11. *Pharmacy and Therapeutic Committee* a committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a *preferred brand drug* or a non-preferred brand drug. In making these determinations, the Pharmacy and Therapeutic Committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

12. *Preferred Brand Drug* a brand name drug that has received a classification of preferred brand from the Pharmacy and Therapeutic Committee based on the following criteria:

- a. clinical uniqueness of the medication;
- b. positive efficacy profile;
- c. good side effect, safety, and drug interaction profile;
- d. positive quality of the implications;
- e. clinical experience with the medication; and
- f. cost (only considered when clinical parameters are equal to other products in its class).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1835 (October 1999), LR 27:

#### **Chapter 4. Uniform Provisions**

##### **§403. Properly Submitted Claim Form**

- A. For Plan reimbursements, all bills must show:
1. employee's name;
  2. name of patient;
  3. name, address, and telephone number of the provider of care;
  4. diagnosis;
  5. type of services rendered, with diagnosis and/or procedure codes;
  6. date of service;
  7. charges;
  8. employee's member number;
  9. provider tax identification number;
  10. Medicare explanation of benefits, if applicable.

B. The program can require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish the requested information within 90 days of the request will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), LR 27:

##### **§501. Claims Review Procedures and Appeals**

A. ...

B. The request for review must be directed to Attention: Appeals and Grievances within 90 days after the date of the notification of denial of benefits, denial of eligibility, or denial after review by the utilization review, pharmacy benefit or mental health contractors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1838 (October 1999), LR 27:

##### **§511. Subpoena of Witnesses; Production of Documents**

A. - C. ...

C. No subpoena will be issued requiring the attendance and giving of testimony by witnesses unless a written request therefore is received in the office of the program, attention: appeals and grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoenas must contain the names of the witnesses and a statement of what is intended to be proved by each witness. No subpoenas will be issued until the party requesting the subpoena deposits with the program a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled.

D. No subpoena for the production of books, papers and other documentary evidence will be issued unless written request therefore is received in the office of the Program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoena for books, papers, and other documentary evidence must contain a description of the items to be produced in sufficient detail for identification and must contain the name and street address of the person who is to be required to produce the items and a brief statement of what is intended to be proved by each item.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1839 (October 1999), LR 27:

##### **§513. Appeals Decisions**

A. ...

B. Appeals Heard by Referee. At the conclusion of the hearing, the referee will take the matter under submission and, as soon as is reasonably possible thereafter, prepare a recommended decision in the case which will be based on the evidence adduced at the hearing or otherwise included in the hearing records. The decision will contain findings of fact and statement of reasons. The recommended decision will be submitted to the committee for review.

C. The Committee may adopt or reject the recommended decision. In the case of adoption, the referee's decision becomes the decision of the committee. In the case of rejection, the committee will render its decision, which will include a statement of reasons for disagreement with the referee's decision. The decision of the committee will be final. A copy will be mailed by certified mail to the covered person and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1839 (October 1999), LR 27:

**§515. Rehearing**

A. - B. ...

C. The request for rehearing must be filed with the program, attention: appeals and grievances on or before 30 calendar days after the mailing of the appeal decision of the Committee. The request will be deemed filed on the date it is received in the office of the program.

D. ...

E. When the committee grants a rehearing, an order will be issued setting forth the grounds. A copy of the order will be sent, along with notice of the time and place fixed for the rehearing, to the appealing party and any representative by certified mail.

F. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), LR 27:

**Chapter 6. Definitions**

**Accidental Injury**Ca condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from and external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

**Acute or Non-maintenance Drug**Ca covered drug other than a maintenance drug as define herein.

\*\*\*

**Brand Drug**Ca the trademark name of a drug approved by the U. S. Food and Drug Adminis tration.

\*\*\*

**Children**Ca

1. any legitimate, duly acknowledged, or legally adopted children of the employee and/or the employee's legal spouse dependent upon the Employee for support;

2. - 4. ...

\*\*\*

**Generic Drug**Ca chemically equivalent copy of a brand name drug.

\*\*\*

**Maintenance Drug**Ca covered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition.

\*\*\*

**Non-Preferred Brand Drug**Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the Pharmacy and Therapeutic Committee.

\*\*\*

**Pharmacy and Therapeutic Committee**Ca committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as

a preferred brand drug or a non-preferred brand drug. In making these determinations, the pharmacy and therapeutic committee relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

\*\*\*

**Preferred Brand Drug**Ca brand name drug that has received a classification of Preferred Brand from the Pharmacy and Therapeutic Committee based on the following criteria:

1. clinical uniqueness of the medication;
2. positive efficacy profile;
3. good side effect, safety, and drug interaction profile;
4. positive quality of the implications;
5. clinical experience with the medication; and
6. cost (only considered when clinical parameters are equal to other products in its class).

\*\*\*

**Well-Baby Care**Croutine care to a well newborn infant from the date of birth until age one. This includes routine physical examinations, active immunizations, check-ups, and office visits to a physician and billed by that physician, except for the Treatment and/or diagnosis of a specific illness. All other health services coded with wellness procedures and diagnosis codes are excluded.

**Well-Child Care**Croutine physical examinations, active immunizations, check-ups and office vis its to a physician, and billed by a health care provider that has entered into a contract with the State Employees Benefits Program, except for the Treatment and/or diagnosis of a specific illness, from age 1 to age 16. All other health services coded with wellness procedures and diagnosis codes are excluded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), LR 27:

**Chapter 7. Schedule of Benefits**CPPO

**§701. Comprehensive Medical Benefits**

A. ...

1. Deductibles:

Inpatient deductible per day, maximum of 5 \$ 50  
days per admission (waived for admissions at PPO hospitals)

Emergency room charges for each visit unless \$ 150  
the covered person is hospitalized  
immediatly following emergency room  
treatment (prior to and in addition to calendar  
year deductible)

Professional and other eligible expenses, \$ 500  
employees and dependents of employees, per \$ 300  
person, per calendar year

Professional and other eligible expenses,  
retirees and dependents of retirees, per person,  
per calendar year

Family unit maximum (3 individual  
deductibles)

Prescription drugs, per person, per calendar \$ 150  
year (separate from and in addition to all other  
deductibles)

2. - 3. ...

4. Prescription Drugs 50% Non-Network in state

After Deductible (\$150 Per person, per Calendar Year), \$8 copayment for generic drugs, 80% non-Network \$25 copayment for preferred brand name drugs, and out of state

\$40 copayment for non-preferred brand name drugs

purchased at a network pharmacy

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1843 (October 1999), LR 26:488 (March 2000), LR 27:

A. Kip Wall  
Interim Chief Executive Officer

0101#019

**DECLARATION OF EMERGENCY**

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

**Adult Denture Program Reimbursement Fee Increase**

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)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage under the Medicaid Program for dentures and denture related services rendered to recipients age 21 years and older. As a result of the allocation of additional funds by the Legislature during the 2000 Second Extraordinary Session, the bureau has determined it is necessary to increase the reimbursement fees for certain designated procedure codes. In addition, the bureau proposes to establish requirements for unique identification information to be processed into all new removable dental prosthetics reimbursed under the Medicaid program. The bureau proposes that Adult Denture Program providers process into the acrylic base of each new removable dental prosthesis, the recipient's last name and first initial, the month and year, and the Medicaid provider number. This criteria would apply to the following services: upper full denture, lower full denture, immediate full upper denture, immediate full lower denture, upper acrylic partial w/clasp and lower acrylic partial w/clasp.

This action is being taken to protect the health and welfare of recipients by encouraging the participation of more dental providers in the Medicaid Program. It is estimated that implementation of this Emergency Rule will increase expenditures for Adult Denture services by approximately \$704,294.00 for state fiscal year 2000-2001.

**Emergency Rule**

Effective January 21, 2001, the Department of Health and Hospitals, Bureau of Health Services Financing increases the reimbursement fees for certain designated procedure codes to the following rates.

Procedure Code	Procedure Name	New Rate
05110	Full Upper Denture	\$470.00
05120	Full Lower Denture	\$470.00
05130	Immediate Full Upper Denture	\$470.00
05140	Immediate Full Lower Denture	\$470.00
05211	Upper Acrylic Partial w/Clasp	\$425.00
05212	Lower Acrylic Partial w/Clasp	\$425.00
05750	Reline Full Upper Denture-Lab Reline	\$200.00
05751	Reline Full Lower Denture-Lab Reline	\$200.00
05760	Reline Upper Partial Denture-Lab Reline	\$175.00
05761	Reline Lower Partial Denture-Lab Reline	\$175.00

In addition, the bureau establishes requirements for unique identification information to be processed into all new removable dental prosthetics reimbursed under the Medicaid program. Adult Denture Program providers shall process into the acrylic base of each new removable dental prosthesis, the recipient's last name and first initial, the month and year, and the Medicaid provider number. This criteria applies to the following services: upper full denture, lower full denture, immediate full upper denture, immediate full lower denture, upper acrylic partial w/clasp and lower acrylic partial w/clasp.

Interested persons may submit written comments to Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

David W. Hood  
Secretary

0101#054

**DECLARATION OF EMERGENCY**

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

**Early Periodic Screening Diagnosis and Treatment (EPSDT) Dental Program Reimbursement Fee Increase**

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)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) dental services under the Medicaid Program. Reimbursement for these services is a flat fee established by the bureau

minus the amount that any third party coverage would pay. As a result of the allocation of additional funds by the Legislature during the 2000 Second Extraordinary Session, the seven percent reduction to the reimbursement rates for EPSDT dental services was restored and the reimbursement fees for certain designated procedure codes were increased (*Louisiana Register*, Volume 26, Number 7). The bureau has subsequently determined that it is necessary to make additional increases to the fees for certain designated procedure codes in order to be in compliance with Act 11 of the 2000 Second Extraordinary Session of the Louisiana Legislature. In addition, the bureau proposes to establish requirements for unique identification information to be processed into all new removable dental prosthetics reimbursed under the Medicaid program. The bureau proposes that EPSDT Dental Program providers process into the acrylic base of each new removable dental prosthesis, the recipient's last name and first initial, the month and year, and the Medicaid provider number. This criteria would apply to the following services: upper full denture, lower full denture, immediate full upper denture, immediate full lower denture, upper acrylic partial w/clasp, lower acrylic partial w/clasp, upper cast partial/acrylic and lower cast partial/acrylic.

This action is being taken to protect the health and welfare of recipients by encouraging the participation of more dental providers in the Medicaid Program. It is estimated that implementation of this Emergency Rule will increase expenditures for EPSDT Dental services by approximately \$66,337 for state fiscal year 2000-2001.

**Emergency Rule**

Effective January 21, 2001, the Department of Health and Hospitals, Bureau of Health Services Financing increases the reimbursement fees for certain designated procedure codes to the following rates.

Procedure Code	Procedure Name	New Rate
02930	Stainless Steel Crown-Primary	\$78.00
02931	Stainless Steel Crown-Permanent	\$78.00
05110	Full Upper Denture	\$470.00
05120	Full Lower Denture	\$470.00
05130	Immediate Full Upper Denture	\$470.00
05140	Immediate Full Lower Denture	\$470.00
05211	Upper Acrylic Partial w/Clasp	\$425.00
05212	Lower Acrylic Partial w/Clasp	\$425.00
05750	Reline Full Upper Denture-Lab Reline	\$200.00
05751	Reline Full Lower Denture-Lab Reline	\$200.00
05760	Reline Upper Partial Denture-Lab Reline	\$175.00
05761	Reline Lower Partial Denture-Lab Reline	\$175.00

In addition, the bureau establishes requirements for unique identification information to be processed into all new removable dental prosthetics reimbursed under the Medicaid program. EPSDT Dental Program providers shall process into the acrylic base of each new removable dental prosthesis, the recipient's last name and first initial, the month and year, and the Medicaid provider number. This criteria applies to the following services: upper full denture, lower full denture, immediate full upper denture, immediate full lower denture, upper acrylic partial w/clasp, lower acrylic partial w/clasp, upper cast partial/acrylic and lower cast partial/acrylic.

Interested persons may submit written comments to Ben A. Bearden, Bureau of Health Services Financing, P.O. Box

91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

David W. Hood  
Secretary

0101#055

**DECLARATION OF EMERGENCY**

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

Home Health Services CRehabilitation Services

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)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides coverage under the Medicaid Program for skilled nursing visits, home health aide visits and physical therapy services provided by home health agencies. Reimbursement for these services is made at a prospective rate established by the Bureau (*Louisiana Register*, Volume 22, Number 3). As a result of a court order, the bureau expanded the Home Health Program to include coverage of occupational therapy and speech therapy. In addition, the bureau amended the March 20, 1996 Rule to establish new rates for home health rehabilitation services that are the same as the rates paid for outpatient hospital rehabilitation services. The bureau also amended the February 1, 2000 Emergency Rule to discontinue the separate reimbursement rate established for physical therapy services when the services are provided by a physical therapy assistant. Home health rehabilitation services include physical, occupational and speech therapies. All home health rehabilitation services must be prior authorized through the fiscal intermediary's Prior Authorization Unit in order to receive payment. This Emergency Rule is being adopted to continue the provisions of the September 20, 2000 Rule.

**Emergency Rule**

Effective January 20, 2001, the Department of Health and Hospitals, Bureau of Health Services Financing expands home health services under the Medicaid Program to include coverage of occupational therapy and speech therapy. In addition, the Bureau amends the March 20, 1996 rule governing reimbursement for home health services to establish new reduced rates for home health rehabilitation services that are the same as the rates paid for outpatient hospital rehabilitation services. The Bureau also amends the February 1, 2000 rule to discontinue the separate reimbursement rate established for physical therapy services when the services are provided by a physical therapy

assistant. Home health rehabilitation services include physical, occupational and speech therapies. All home health rehabilitation services must be prior authorized through the fiscal intermediary's Prior Authorization Unit in order to receive payment.

Interested persons may submit written comments to Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

David W. Hood  
Secretary

0101#058

**DECLARATION OF EMERGENCY**

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

Home Health Services  
Skilled Nursing Services  
Reduction Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following Emergency Rule under the Medical Assistance Program as authorized by R.S. 46:153 and 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 1999-2000 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 of 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 reimbursement for skilled nursing services provided by home health agencies. Reimbursement is made at a prospective rate established by the bureau. As a result of a budgetary shortfall, the bureau determined it was necessary to create a separate reimbursement rate of 80 percent of the current skilled nursing rate when services are performed by a licensed practical nurse (LPN) (*Louisiana Register*, Volume 26, Number 9). However, the current fee on file will continue to be paid when a registered nurse (RN) provides the skilled nursing service. This Emergency Rule is being adopted to continue the provisions of the September 30, 2000 Rule.

**Emergency Rule**

Effective for dates of service January 29, 2001, and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing establishes a separate reimbursement rate of 80 percent of the current Home Health skilled nursing rate when the skilled nursing

service is provided by a licensed practical nurse (LPN). However, the current fee on file will continue to be paid when a licensed registered nurse (RN) provides the skilled nursing service.

Interested persons may submit written comments to Ben A. Bearden, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule. A copy of this emergency rule is available at the parish Medicaid office for review by interested parties.

David W. Hood  
Secretary

0101#057

**DECLARATION OF EMERGENCY**

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

Public Nursing Facilities  
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 Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage under the Medicaid Program for nursing facility services. Payments for nursing facility services are made in accordance with the prospective reimbursement methodology adopted effective August 1, 1984 (*Louisiana Register*, Volume 10, Number 6). This Rule was subsequently amended by a rule adopted to discontinue the practice of automatically applying an inflation adjustment to the reimbursement rates in those years when the rates are not rebased (*Louisiana Register*, Volume 25, Number 6). As a result of a budgetary shortfall, an emergency rule was adopted to reduce the prospective per diem rates for private nursing facilities by seven percent (*Louisiana Register*, Volume 26, Number 2). The March 1, 2000 Emergency Rule was later replaced by an emergency rule to restore the seven percent reduction previously made to the prospective per diem rates for private nursing facilities (*Louisiana Register*, Volume 26, Number 8).

In compliance with the provisions of Act 143 of 2000 First Extraordinary Session of the Louisiana Legislature, the bureau amended the reimbursement methodology for parish-owned nursing facilities in order to increase reimbursement to these facilities in proportion to their share of Medicaid days provided during the reporting period used to set rates. This Emergency Rule is being adopted to continue the provisions of the November 20, 2000 Rule.

**Emergency Rule**

Effective February 11, 2001, the Department of Health and Hospitals, Bureau of Health Services Financing creates

an enhanced payment pool for qualifying nursing facilities, subject to the availability of funds and to the payment limits as set forth in 42 CFR 447.272.

Qualifying nursing facilities are parish-owned nursing facilities that meet the following criteria:

1. have an annual Medicaid occupancy level at or above 60 percent;
2. provide 12,000 or more Medicaid days of care annually; and
3. have entered into, or be part of a parish government that has entered into, a transfer agreement with the department to provide for an intergovernmental transfer of funds.

The nursing facility payment differential for any year shall be the difference between the upper limit of aggregate payments to nursing facilities as defined in 42 CFR §447.272 and the aggregate Medicaid per diem reimbursement paid to nursing facilities for the year. This is determined for all nursing facilities participating in the state's Medicaid Program, or for a subset of these facilities that includes parish-owned nursing facilities for which a separate upper payment limit calculation is in effect in that year as required by 42 CFR §447.272.

Total payments from the pool in any year shall not exceed a percentage of the nursing facility payment differential that will be determined by the department for each payment year. The enhancement pool payment amount shall be distributed to qualifying parish-owned nursing facilities based on their pro-rata share of the total annual Medicaid days of care of all qualifying parish-owned nursing facilities. Determination of annual Medicaid occupancy level and Medicaid days of care shall be based on the most recently filed cost reports on file with the Department. Implementation of this emergency rule is subject to approval by the United States Department of Health and Human Services, Health Care Financing Administration.

Interested persons may submit written comments to Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

David W. Hood  
Secretary

0101#056

## DECLARATION OF EMERGENCY

### Department of Revenue Office of the Secretary

#### Payment of Taxes by Electronic Funds Transfer (LAC 61:III.7501)

Under the authority of R.S. 47:1519(C) and in accordance with the provisions for adopting an emergency rule under the Administrative Procedures Act, R.S. 49:953(B), the Department of Revenue, Office of the Secretary, adopts this emergency rule to provide for the payment of taxes by electronic funds transfer, credit or debit cards, or bank drafts.

The Secretary of Revenue is mandated by R.S. 47:1519(C) to adopt rules and regulations necessary to allow for the payment of all taxes, penalties, interest, fees, and payments due under any state law for which the authority to collect has been delegated to the secretary, by electronic funds transfer, credit or debit cards, or bank drafts. This emergency rule is adopted to address the payment alternatives and the procedures for returning erroneous payments and duplicate payments.

Revised Statute 47:1519 was passed to allow for the payment of taxes by alternative means, including the use of electronic systems. With the advances in modern technology, a taxpayer can file and remit his taxes almost exclusively through machines. The absence of personal contact has many advantages; however, the potential for human error is still present. To alleviate this concern for human error and to protect taxpayers making payments by electronic funds transfer, credit or debit cards, or bank drafts, the department is adopting this emergency rule in accordance with 15 U.S.C.A. §1693 et seq., 12 C.F.R. §205.1 et seq., and R.S. 10:3-101 et seq., which establish the rights, liabilities, and responsibilities of participants in electronic fund transfers and the collection of checks.

The existing statutes and procedures governing the department's collection of taxes do not provide adequate protections to taxpayers making payments by electronic funds transfer, credit or debit cards, or bank drafts. In the absence of rules defining when a payment by electronic funds transfer, credit or debit cards, or bank draft is made erroneously, the department is required to treat all amounts paid in excess of the tax due as overpayments. Currently, if a taxpayer makes an erroneous payment using any of the aforementioned payment alternatives, the taxpayer is required to file a Claim Against the State in accordance with R.S. 47:1481 to recover the amount paid in error. The time involved in recovering the amount paid in error under this provision creates an undue economic hardship on taxpayers. This emergency rule will allow the department to immediately identify those payments by electronic funds transfer, credit or debit cards, or bank drafts that are made in error, and to return those erroneous payments in the most expedient manner.

This declaration of emergency is effective January 2, 2001, and shall remain in effect for 120 days or until promulgation of the final Rule, whichever occurs first.

### Title 61

### REVENUE AND TAXATION

### Part III. Department of Revenue; Administrative Provisions and Miscellaneous

### Chapter 75. Return of Funds

### §7501. Payment of Taxes by Electronic Funds Transfer; Credit or Debit Cards; Other

A. Payments Accepted. As authorized by R.S. 47:1519, the secretary will accept cash, bank draft, cashier's check, teller's check, certified check, personal check, money order, electronic funds transfer, or credit or debit card from a nationally recognized institution for the payment of taxes, penalties, interest, fees, and payments due under any state law which the authority to collect has been delegated to the secretary.

B. Definitions. For the purposes of this Section, the following terms are defined.

*Duplicate Payment*—a payment remitted by cash, bank draft, cashier's check, teller's check, certified check, personal check, money order, electronic funds transfer, or credit or debit card from a nationally recognized institution for the same tax type and the same tax period.

*Erroneous Payment*—a payment remitted by bank draft, cashier's check, teller's check, certified check, personal check, money order, electronic funds transfer, or credit or debit card from a nationally recognized institution, in which the amount remitted differs from the amount shown to be due on the face of the tax return, report, bill, or assessment submitted at the time of payment.

*Payment*—any amount paid to the Department of Revenue representing a tax, fee, interest, penalty, or other amount.

C. Return of Funds. The secretary is authorized to return funds to a taxpayer when the taxpayer has remitted an erroneous payment or a duplicate payment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:1519.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Revenue, Office of the Secretary, LR 27:

Cynthia Bridges  
Secretary

0101#017

## DECLARATION OF EMERGENCY

### Department of Social Services Office of Community Services

#### Reimbursement Rates for Residential Facilities (LAC 67:V.3503)

The Department of Social Services, Office of Community Services adopts the following Emergency Rule in the Foster Care Program as authorized by R.S. 46:153. This Emergency Rule supersedes the Notice of Intent published in the *Louisiana Register*, Vol. 26, No. 11, November 20, 2000, and shall be in effect for 120 days beginning February 1, 2001.

The Department of Social Services, Office of Community Services previously published a Notice of Intent to freeze residential rates at the 1999/2000 amount. The department has not received additional funding to increase the residential rates. After consultation and feedback from residential providers for foster children, the department recognizes the technical difficulties in the rate setting methodology especially with a capped budget expenditure. The department is required by R.S. 15:1084 to establish rates for the residential care of foster children. Also, continuing the freeze on residential rates may cause a fiscal emergency for some residential providers which would adversely affect their ability to continue caring for foster children in residential placements. In order to meet the various requirements, the department decided to set residential rates through a competitive solicitation process as published in *Louisiana Register*, Vol. 22, No. 9. An emergency rule is needed to change the rate setting process immediately in

order to allow the department and private residential providers adequate process and response time in order to implement rates by September 1, 2001. The rate setting process is a critical component in continued quality residential services to foster children. Therefore, the department amends LAC 67:V.3503, continuing the frozen residential rates issued for the 2000/2001 rate year at the 1999/2000 amount while changing the rate setting process for the 2001/2002 rate year.

The Department of Social Services, Office of Community Services amends LAC 67:V.3503.

### Title 67

### SOCIAL SERVICES

### Part V. Office of Community Services

### Subpart 5. Foster Care

### Chapter 35. Payments, Reimbursables and Expenditures

### §3503. Reimbursement Rates for Residential Facilities

A. OCS will implement a competitive solicitation process as a means to select all private residential facility - based programs to serve foster children and to establish per diem rates for that residential service. The department's published Prospective Provider Procedure will be followed.

B. Individuals and/or agencies currently providing residential services to OCS foster children and those that contact the Department of Social Services, Office of Community Services (OCS) wishing to provide residential services to foster children funded by OCS are placed on a prospective provider list. All persons and agencies on the list will be notified at the time that the office seeks to develop residential services for foster children in a specific geographic area. The current and prospective residential providers will be mailed a full description of the type and scope of programs sought in geographic areas along with an invitation to submit to OCS a proposal for that service. The notification will include a list of other materials that providers may request/need to assist proposers in preparation of their proposals. The name and telephone number of an OCS representative will be given to prospective providers to contact for more information.

1. A committee of professionals from OCS will evaluate the proposals according to criteria included in the packet of materials. The committee will select the program(s) most fitting the needs of the foster care program.

C. Each proposal will include a submitted per diem cost bid with a budget in accordance with the instructions for the solicitation. This competitive process, resulting selections and final negotiations constitutes OCS' rate setting process as rates will be based on market economy and proposer's fiscal projections for programs. The final rate for each provider can be negotiated down from the bid rate, but in no case will be higher than the bid rate. The use of the residential beds at the rate set through this process will be done on a case-by-case basis by the OCS case worker(s) as the need arises. There are no guarantees of specific sums of monthly or annual payments or referrals of clientele.

D. The department reserves the right to cancel the solicitation if the expenditures for the aggregately selected proposals would result in OCS exceeding available funds. In the event the department cancels the solicitation process, the department will freeze the rates for the current programs at the current amount. For rates issued for the 2000/2001 rate

year, the department continues freezing the rates at the 1999/2000 amount.

AUTHORITY NOTE: Promulgated in accordance with R.S.15:1084.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 14:542 (August 1988), amended LR 20:898 (August 1994), LR 25:1144 (June 1999), LR 25:1609 (September, 1999), LR26:24 (January 2000), LR 26:1342 (June 2000), LR 26:2665 (November 2000), LR 27:

J. Renea Austin-Duffin  
Secretary

0101#043

## DECLARATION OF EMERGENCY

### Department of Social Services Office of Family Support

#### Wrap-Around Child Care Program (LAC 67:III.Chapter 52)

The Department of Social Services, Office of Family Support, has exercised the emergency provision of R.S. 49:953(B), the Administrative Procedure Act, to adopt the following Emergency Rule to continue the Wrap-Around Child Care Program effective January 26, 2001. This declaration is necessary to extend the original Emergency Rule of June 1, 2000 since it is effective for a maximum of 120 days and will expire before a final Rule takes effect. The agency published the Notice of Intent in November; it was delayed while eligibility factors and other aspects of the program were being finalized.

The purpose of this program is to provide very low-income working families with quality, full-day/full-year child care services.

### Title 67 SOCIAL SERVICES

#### Subpart 12. Child Care Assistance

#### Chapter 52. Wrap-Around Child Care Program

##### §5201. Authority

A. The Wrap-Around Child Care Program is established effective June 1, 2000 and is administered under the authority of state and federal laws.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 27:

##### §5202. Definitions

*Head of Household* the individual who may apply for Wrap-Around Child Care services for a child who customarily resides more than half the time with him/her, that is, the child's parent or the adult with primary responsibility for the child's care and financial support if the child's parent is not living in the home or is living in the home but under age 18 and not emancipated by law.

*Household* a group of individuals who live together consisting of the head of household, the spouse of the head of household, and all children under the age of 18, including the minor unmarried parent of any dependent children who need child care services (unless the minor unmarried parent has been emancipated by law).

*Training and Employment Mandatory Participant* a household member who is required to be employed, or in a combination of employment and attendance at a job training or educational program, including the head of household, spouse of head of household, and the minor unmarried parent of a child who needs Wrap-Around Child Care services.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 27:

##### §5203. Conditions of Eligibility

A. A household must meet all of the following eligibility criteria:

1. all children receiving services must reside with their parent or adult head of household;

2. any child receiving Wrap-Around Child Care Program services must not be receiving assistance from the Family Independence Temporary Assistance Program (FITAP) or the Child Care Assistance Program (CCAP) to ensure that Wrap-Around services are not considered assistance according to 45 CFR 260.31 and that there will be no duplication of services;

3. the head of household, that person's spouse, or nonlegal spouse (if the parent of a child in the household), including any minor unmarried parent who is not legally emancipated and whose child(ren) are in need of Wrap-Around Child Care services, must be:

a. employed a minimum average of 20 hours per week and all countable work hours must be paid at the federal minimum hourly wage; or

b. engaged in a combination of employment, which is paid at least at the federal minimum hourly wage, and job training or an educational program, for a combined average of at least 20 hours per week;

4. each parent and/or adult household member must be working, or engaged in a combination of working and attending a job training or educational program, during the hours that child care is needed, that is, child care will only be provided during hours that parents and/or adult household members are actually at work, a job training, an educational program, or commuting to, or from, these activities;

5. the household must include at least one child with a need for Wrap-Around Child Care services defined as full-day/full-year child care, that is, full time (30 or more hours per week) or part-time (less than 30 hours per week) and holiday care provided in conjunction with part-time care during the school year, who is:

a. under age 13; or

b. age 13 to under age 18, with a physical, mental, or emotional disability rendering him incapable of caring for himself, as verified by a physician or licensed psychologist;

6. the child needing care must customarily reside more than half of the time with the head of household who is applying for child care services, ensuring that only one household can receive child care service for that child;

7. the head of household or another adult household member must be responsible for the payment of child care costs for a child who lives in the household. A need for child care services does not exist if child care costs will be paid by a third party who is not a household member. However, this will not apply if a third party, not legally obligated to make

child care payments, is temporarily doing so until payments begin; and

8. there must be a current need for child care at the time of application.

B. The household must qualify under the income guidelines set forth in §5205, based on the following income sources:

1. gross earnings from all sources of employment and the profit from self-employment; and

2. any unearned income, such as child support, alimony, retirement and disability benefits, Social Security, SSI, unemployment compensation benefits, or veteran's benefits, that is received by any household member.

C. A slot must be available with the selected Head Start grantee.

D. The child in need of care must be either a citizen or a qualified alien. Program policy on qualified aliens is the same as policy defined in LAC 67:III.1223.

E. The household must provide the information and verification necessary for determining eligibility and payment amount. Required verification includes:

1. proof of social security numbers for all household members;

2. birth or baptismal certificates for all children in need of care;

3. proof of all countable household income; and

4. proof of the hours of all employment.

F. Eligible cases may be assigned a certification period of up to 12 months.

G. The household is required to report any changes that could affect eligibility or payment amount within 10 days of the change. Failure to report a change that affects eligibility or payment amount may result in action to recover any ineligible payment.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 27:

**§5205. Income Limits**

A. A household must have total countable income no greater than the monthly maximum amount for the appropriate household size as follows, based on 130 percent of poverty level:

Household Size	Monthly Maximum	Household Size	Monthly Maximum
		11	\$4049
2	\$1219	12	\$4364
3	\$1533	13	\$4679
4	\$1848	14	\$4994
5	\$2162	15	\$5309
6	\$2476	16	\$5624
7	\$2790	17	\$5939
8	\$3104	18	\$6254
9	\$3419	19	\$6569
10	\$3734	20	\$6884

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 27:

**§5207. Rights and Responsibilities**

A. The head of the household applying for, or receiving, Wrap-Around Child Care services shall have certain rights and responsibilities.

1. Information provided by the household will not be released without written consent, except to agencies and officials as allowed by law (LAC 67:III.101-103).

2. The household is entitled to receive timely, written notification of action taken on applications or reported changes in household circumstances.

3. The head of household is responsible for reporting the following within 10 days of the change:

a. termination of employment or attendance at a job training or educational program;

b. reduction to less than an average of 20 hours per week of employment or a combination of employment and job training or educational program;

c. an eligible child moves out of the home;

d. household composition;

e. earned and unearned income; and

f. number of days or hours that a child is in care.

4. Any applicant or recipient who has been denied services under the program may appeal the denial by filing a written request within 10 days of receipt of the written notice of denial. The request must contain a copy of the notice of denial and must state the reason(s) the applicant believes services were wrongfully denied. Notice of denial is deemed received on the seventh calendar day after it is mailed to the applicant or recipient with correct postage paid at the address listed on his most recent application.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 27:

**§5209. Head Start Grantees**

A. The agency will provide services to eligible individuals through contracts with some Head Start Program grantees for a designated number of slots. Available slots will be filled on a first-come, first-served basis.

B. The contracted Head Start grantee will establish a child care program that consists of full-day/full-year child care, that is, full time (30 or more hours per week) or part time (less than 30 hours per week) and holiday care provided in conjunction with part-time care during the school year.

C. The center shall maintain the following child/staff ratios:

1. 4:1 up to age 12 months;

2. 6:1 from age 12 months to age 24 months;

3. 8:1 from age 24 months to age 36 months;

4. 10:1 from age 36 months to age 60 months;

5. 16:1 from age 5 years to age 12 years;

6. children with disabilities will have a child/staff ratio sufficient to provide adequate care but under no circumstances shall the child/staff ratio exceed 16:1.

D. Each group/class shall consist of two staff members for the appropriate number of children. In mixed-age groups, the ratio and group size for the youngest child shall be used.

E. Each group/class shall be supervised by one teacher and one aide, or by two teachers. All teachers at each facility must have at least a CDA (Child Development Associate credential) for the appropriate age of children.

F. The grantee shall ensure that procedures are in place to prevent, identify, and report suspected abuse or neglect of children as required by Children's Code Articles 601-610 and 45 CFR 1301.31.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 27:

**§5211. Payment**

A. The Head Start grantee will be paid a weekly rate of \$85 per week (\$17 per day) per child for full-day, full-time child care.

B. The Head Start grantee will be paid \$2.12 per hour per child for part-time care.

C. The Head Start grantee will be paid \$2.12 per hour for up to a maximum of eight hours per child (\$17 per day) for allowable, holiday care provided in conjunction with part-time care during the school year.

D. Payment will not be made for a child who is absent from day care more than five days in a calendar month or for an extended closure by a provider of more than five consecutive days in a calendar month.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 27:

J. Renea Austin-Duffin  
Secretary

0101#039

**DECLARATION OF EMERGENCY**

**Department of Treasury**

**Credit Card Acceptance by State Agencies  
(LAC 71:I.Chapter 9)**

Pursuant to the authority granted by R.S. 49:316.1, the treasurer is directed to establish procedures and guidelines for the approval and operation of any cards or devices accepted by state agencies, boards or commissions for the payment of any obligations of such state entities.

The procedures provide the guidance and requirements state entities must adhere to in order to correctly and in a timely manner receive credit for such receipts. These procedures fulfill the requirements of the state's cash management practices for making deposit within 24 hours.

Failure to adopt this rule on an emergency basis will adversely affect the fiscal stability of state agencies currently accepting payment of obligations by credit card. Those state agencies would be required to discontinue acceptance of credit cards for such payments.

Accordingly, the following Emergency Rule, is effective February 1, 2001, and shall remain in effect for a maximum of 120 days, or until the final rule is promulgated, which ever occurs first.

**Title 71  
TREASURY**

**Part I. Treasurer**

**Chapter 9. Credit Card Acceptance by State Agencies**

**§901. Purpose**

A. It is the intent of the state to accept payment of any obligation including, but not limited to, taxes, fees, charges, licenses, service fees or charges, fines, penalties, interest, sanctions, stamps, surcharges, assessments, obligations or any other similar charges by credit cards, debit cards or similar payment devices approved by the treasurer. The state recognizes the expanding role of electronic commerce (e-

commerce) in conducting business and the state is taking steps to become an active participant with the development of the EMail, the state's one-stop shopping internet web site. Electronic payment methods, including credit cards, debit cards and similar devices is a vital link in e-commerce. In order to incorporate these payment methods, Treasury must develop and promulgate guidelines in accordance with R.S. 49:316.1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:316.1.

HISTORICAL NOTE: Promulgated by the Department of Treasury, LR 27:

**§903. Definitions**

**Card Holder**—the person a credit card, debit card or similar device has been issued or an authorized user of a payment card.

**Card Provider**—the issuer of a credit card, debit card or similar device who has contracted with Treasury for acceptance of their payment card or a financial institution which has contracted with Treasury for processing of card payments.

**Merchant Account Number**—the account number assigned by the Card Provider to the state entity.

**Obligation**—taxes, fees, charges, licenses, service fees or charges, fines, penalties, interest, sanctions, stamps, surcharges, assessments, obligations and any other similar charges or obligations.

**Payment Card**—a valid credit or debit card or similar payment device which is designated by the treasurer as acceptable by any state entity to make payment for any state obligations.

**Provider Billings**—the manner in which the card providers will bill the state for the settled card payment transactions.

**State Charge**—a fee established by the treasurer in the form of a uniform dollar amount or percentage assessed for all types of cards or devices accepted by state entities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:316.1.

HISTORICAL NOTE: Promulgated by the Department of Treasury, LR 27:

**§905. Application for Credit Card or Similar Devices**

A. The treasurer will negotiate and enter into contracts, with card provider(s) not to exceed five years, for acceptance of credit card, debit card and similar payment devices. The treasurer will seek to achieve uniform implementation and standard terms and provisions with respect to the acceptance of payments by state entities. A state entity may recommend that the treasurer consider a specific credit or debit card for approval. Annually, the treasurer will publish on the treasurer's website a list of approved credit card, debit card or similar devices by which any state entity will be authorized to accept for payment of any obligation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:316.1.

HISTORICAL NOTE: Promulgated by the Department of Treasury, LR 27:

**§907. Acceptance of Cards by the State Entities**

A. The state, through any department, agency, board or commission or other state entity, may accept payment of any obligation by credit card, debit card and similar payment devices approved by the treasurer. Each entity will apply for participation by completing a merchant service agreement.

The original completed application must be delivered to Treasury. Treasury will review the application for correctness and forward the application to the card provider for processing.

B. The agency may not set a per order minimum and/or maximum dollar transaction amount that an agency may accept payment by a payment card in compliance with card service agreements. State entities shall not institute or adopt any practice that discriminates or provides unequal treatment for any payment card versus any other payment card.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:316.1.

HISTORICAL NOTE: Promulgated by the Department of Treasury, LR 27:

### **§909. Operating Procedures**

A. Treasury will determine procedures that state entities must comply with to accept payment by payment card(s). These procedures, may be modified from time to time, to accommodate the state's accounting policies or Treasury contract(s) for acceptance of payment card(s). Treasury will provide written procedures to participating state entities. These procedures will provide uniform implementation and standard terms and conditions for acceptance of payments by state entities. These procedures will determine:

1. the manner in which authorization is obtained by state agencies prior to making the card sales;
2. preparation of sales slips;
3. handling of card member refunds and credits;
4. settlement of transactions;
5. charge back rights;
6. card member disputes;
7. billing inquires;
8. retention of records; and
9. any other contract matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:316.1.

HISTORICAL NOTE: Promulgated by the Department of Treasury, LR 27:

### **§911. State Charge**

A. Treasury, from time to time, will negotiate with card providers for a fee for processing payment card transactions with state entities. Treasury will seek to achieve a reasonable fee that reflects the economies of scale achieved by negotiation for a statewide fee applicable to all state entities. The fee may be composed of a percentage and/or a specific dollar amount as determined by Treasury and the card provider.

B. The state charge shall encompass these various fees charged by card providers and include other applicable fees including fees by third party processors, or fees assessed by providers of Internet payment processing services. The state charge shall be a uniform dollar amount and/or percentage designated by the treasurer for all card types. The state charge will be revised from time to time and the state treasurer shall notify state entities of the revised state charge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:316.1.

HISTORICAL NOTE: Promulgated by the Department of Treasury, LR 27:

### **§913. Fees**

A. Each state entity shall assess a state charge for each payment transaction a payment card is accepted.

B. The state charge will be classified by the state entity into a fund designated by the treasurer. Each card issuer will provide to the treasurer and the entity a monthly billing detailing the amount of charges by merchant name and merchant account number. The entity will review the monthly billing and pay the invoice from the fund pursuant to an appropriation for this purpose by the legislature.

C. Each state entity will review the monthly billings and resolve discrepancies directly with the card provider(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:316.1.

HISTORICAL NOTE: Promulgated by the Department of Treasury, LR 27:

Ron Henson  
First Assistant

0101#027

## **DECLARATION OF EMERGENCY**

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

#### **2001 Commercial King Mackerel Season**

In accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, R.S. 49:967 which allows the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons and all rules and regulations pursuant thereto by emergency rule, and R.S. 56:6(25)(a) and 56:326.3 which provide that the Wildlife and Fisheries Commission may set seasons for saltwater finfish; the Wildlife and Fisheries Commission hereby sets the following season and trip limit for the commercial harvest of king mackerel in Louisiana state waters.

The commercial season for king mackerel in Louisiana state waters will open at 12:01 a.m., July 1, 2001 and remain open until the allotted portion of the commercial king mackerel quota for the Western Gulf of Mexico has been harvested or projected to be harvested.

The commission grants authority to the secretary of the Department of Wildlife and Fisheries to close the commercial king mackerel season in Louisiana state waters when he is informed by the National Marine Fisheries Service (NMFS) that the commercial king mackerel quota for the Western Gulf of Mexico has been harvested or is projected to be harvested, such closure order shall close the season until 12:01 a.m., July 1, 2002, which is the date expected to be set for the re-opening of the 2002 commercial king mackerel season in federal waters.

The commission also authorizes the secretary to open an additional commercial king mackerel season in Louisiana state waters if he is informed that NMFS has opened an additional season and to close such season when he is informed that the commercial king mackerel quota for the western Gulf of Mexico has been filled, or is projected to be filled.

Nothing herein shall preclude the legal harvest of king mackerel by legally licensed recreational fishermen. Effective with any closure, no person shall commercially harvest, transport, purchase, barter, trade, sell or attempt to purchase, barter, trade or sell king mackerel. Effective with the closure, no person shall possess king mackerel in excess

of a daily bag limit. Provided however that fish in excess of the daily bag limit which were legally taken prior to the closure may be purchased, possessed, transported, and sold by a licensed wholesale/retail dealer if appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6 are properly maintained. Those other than wholesale/retail dealers may purchase such fish in excess of the daily bag limit from wholesale/retail dealers for their own use or for sale by a restaurant as prepared fish.

Dr. H. Jerry Stone  
Chairman

0101#026

## **DECLARATION OF EMERGENCY**

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

#### **2001 Commercial Red Snapper Seasons**

The red snapper fishery in the Gulf of Mexico is cooperatively managed by the Louisiana Department of Wildlife and Fisheries (LDWF) and the National Marine Fisheries Services (NMFS) with advice from the Gulf of Mexico Fishery Management Council (Gulf Council). Regulations promulgated by NMFS are applicable in waters of the Exclusive Economic Zone (EEZ) of the U.S., generally three miles offshore. NMFS will provide rules for commercial harvest seasons for red snapper in the EEZ off of Louisiana. NMFS and the Gulf Council typically request consistent regulations in order to enhance the effectiveness and enforceability of regulations for EEZ waters.

In accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, R.S. 49:967, which allows the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, and R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish; the Wildlife and Fisheries Commission hereby sets the following season for commercial harvest of red snapper in Louisiana state waters.

The season for the commercial fishery for red snapper in Louisiana state waters will open at 12 noon February 1, 2001. The commercial fishery for red snapper in Louisiana waters will close at 12 noon February 10, 2001, and thereafter open at 12 noon on the first of each month and close at 12 noon on the tenth of each month, for each month of 2001 until two-thirds (2/3) of the 2001 commercial red snapper quota for the Gulf of Mexico has been harvested or projected to be harvested.

The commission grants authority to the secretary of the Department of Wildlife and Fisheries to change the closing dates for the commercial red snapper season in Louisiana state waters when he is informed that two-thirds (2/3) of the commercial red snapper quota for the Gulf of Mexico has been harvested or projected to be harvested, such closure order shall close the season until 12 noon October 1, 2001, which is the date expected to be set for the re-opening of the 2001 commercial red snapper season in federal waters.

The season for the commercial fishery for red snapper in Louisiana state waters will re-open at 12 noon October 1,

2001. The commercial fishery for red snapper in Louisiana waters will close at 12 noon October 10, 2001, and thereafter open at 12 noon on the first of each month and close at 12 noon on the tenth of each month for each month of 2001, until the remainder of the 2001 commercial quota is harvested.

The commission grants authority to the secretary of the Department of Wildlife and Fisheries to change the closing dates for the commercial red snapper season in Louisiana state waters when he is informed that the commercial red snapper quota for the Gulf of Mexico has been harvested or projected to be harvested; such closure order shall close the season until the date set for the opening of the year 2002 commercial red snapper season in federal waters.

The commission also grants authority to the secretary of the Department of Wildlife and Fisheries to change the opening dates for the commercial red snapper season in Louisiana state waters if he is informed by the Regional Administrator of NMFS that the season dates for the commercial harvest of red snapper in the federal waters of the Gulf of Mexico as set out herein have been modified, and that the Regional Administrator of NMFS requests that the season be modified in Louisiana state waters.

Nothing herein shall preclude the legal harvest of red snapper by legally licensed recreational fishermen. Effective with any commercial closure, no person shall commercially harvest, transport, purchase, barter, trade, sell or attempt to purchase, barter, trade or sell red snapper. Effective with the closure, no person shall possess red snapper in excess of a daily bag limit. Provided however that fish in excess of the daily bag limit which were legally taken prior to the closure may be purchased, possessed, transported, and sold by a licensed wholesale/retail dealer if appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6 are properly maintained, and those other than wholesale/retail dealers may purchase such fish in excess of the daily bag limit from wholesale/retail dealers for their own use or for sale by a restaurant as prepared fish.

Dr. H. Jerry Stone  
Chairman

0101#025

## **DECLARATION OF EMERGENCY**

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

#### **2001 Recreational Red Snapper Season**

The red snapper fishery in the Gulf of Mexico is cooperatively managed by the Louisiana Department of Wildlife and Fisheries (LDWF), the Wildlife and Fisheries Commission (LWFC) and the National Marine Fisheries Service (NMFS) with advice from the Gulf of Mexico Fishery Management Council (Gulf Council). Regulations promulgated by NMFS are applicable in waters of the Exclusive Economic Zone (EEZ) of the U.S., which in Louisiana is generally three miles offshore. Rules were established by NMFS to close recreational harvest season in the EEZ off of Louisiana effective midnight October 31, 2000 through April 20, 2001 by reducing the bag limit to

zero, and NMFS requested that consistent regulations be established in Louisiana waters. NMFS typically requests consistent regulations in order to enhance the effectiveness and enforceability of regulations for EEZ waters.

In order to enact regulations in a timely manner so as to have compatible regulations in place in Louisiana waters for the 2001 recreational red snapper season, it is necessary that emergency rules be enacted.

In accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, R.S. 49:967 which allows the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, and R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons and size limits for saltwater finfish; the Wildlife and Fisheries Commission hereby sets the following seasons for recreational harvest of red snapper in Louisiana state waters.

The season for the recreational fishery for red snapper in Louisiana state waters will remain closed through April 20,

2001 by reducing the bag limit to zero for that time period. The season will open at 12:01 a.m., April 21, 2001 and continue through October 31, 2001. If the secretary is notified that the opening and closing of Federal seasons is changed, he is hereby authorized to change the opening and closing dates for state waters accordingly.

Effective with the recreational red snapper season closure, any person, except those who possess a Class 1 or Class 2 commercial red snapper license issued by the National Marine Fisheries Service under the Federal Fishery Management Plan for the Gulf of Mexico Reef Fish and who are legally taking red snapper during an open commercial season, shall not possess any red snapper whether taken from within or without Louisiana territorial waters.

Dr. H. Jerry Stone  
Chairman

0101#024