ENROLLED HOUSE
BILL NO. 1346

By: Anthony, Cox, Pettigrew, Pope (Tim), Greenwood, Bryant, Vaughn and Maddux of the House

and

Hendrick, Monson and Campbell of the Senate

An Act relating to health insurance; providing short title; defining terms; requiring participation of health insurers and reinsurers in certain high risk pools; requiring availability of certain health insurance policies by certain date; specifying eligibility for benefit plans issued by pools; allowing certain employees of certain employer groups to obtain coverage under the Pool; stating exceptions to employee eligibility; creating Health Insurance High Risk Pool; requiring membership in Pool as condition of doing business; providing for Board of Directors, appointment of members, qualifications, terms of office, election of chairperson and reimbursement for expenses; requiring adoption and submission of benefit plans, articles, bylaws and operating rules to the Insurance Commissioner; granting the Insurance Commissioner certain authority; requiring Board to establish certain procedures, select administering insurer, collect certain assessments and develop certain forms and publicity program; granting Board certain optional powers and duties; requiring Board to select administering insurer through competitive bid and stating criteria for selection; providing for term of service and requiring administering insurer to perform certain duties; providing for payment of certain expenses; providing for assessment for operating losses, determination of assessment and use of excess assessment; providing for annual determination of insurers' participation in certain plans and for recoupment of deficit; authorizing Board to abate or defer certain assessments for certain reasons; requiring plans provide for coverage of certain persons and exceptions; providing for coverage and maximum limit of coverage; specifying covered and excluded expenses; requiring plan provide for certain deductibles and co-payments; requiring Board establish schedule of premiums and deductibles and certain rates; allowing exclusion of preexisting conditions for certain period under certain conditions; requiring conformity with certain freedom of choice provisions; stating certain acts constitute unfair practices; providing for

codification; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6531 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 14 of this act shall be known and may be cited as the "Health Insurance High Risk Pool Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6532 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in Sections 1 through 14 of the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

3. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, a limited benefit expense policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation;

4. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of this act;

5. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

6. "Pool" means the Health Insurance High Risk Pool;

7. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and maxiofacial surgery only, a doctor of dentistry, each duly licensed by this state;

8. "Plan" means the comprehensive health insurance benefit plan as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule; and

9. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6533 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every insurer and reinsurer providing health insurance or reinsurance shall participate in the Health Insurance High Risk Pool.

B. Health insurance policies provided in accordance with this act shall be available for sale no later than July 1, 1996.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6534 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as otherwise provided in this section, any resident of this state shall be eligible for coverage under the plan of the Health Insurance High Risk Pool including:

1. The spouse of the insured; and

2. Any dependent unmarried child of the insured, from the moment of birth. Such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of nineteen (19) years, whichever occurs first. However, if the child is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches the age of twenty-three (23) years.

B. 1. No person is eligible for coverage under the Pool plan unless such person has been rejected by at least two insurers for coverage substantially similar to the plan coverage. As used in this paragraph, rejection includes an offer of coverage with a material underwriting restriction or an offer of coverage at a rate equal to or greater than the Pool plan rate. No person is eligible for coverage under the plan if such person has, on the date of issue of coverage under the plan, equivalent coverage under another health insurance contract or policy.

2. No person who is currently receiving health care benefits under any federal or state program providing financial assistance or preventive and rehabilitative social services, except for Medicare, is eligible for coverage under the plan.

3. No person who is covered under the plan and who terminates coverage is again eligible for coverage unless twelve (12) months has elapsed since the coverage was terminated. The Board may waive the twelve-month waiting period under circumstances to be determined by the Board.

4. No person on whose behalf the plan has paid out Five Hundred Thousand Dollars ($500,000.00) in covered benefits is eligible for coverage under the plan.

5. No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment, and rehabilitation facility shall be eligible for coverage under the plan.

C. The Board may establish an annual enrollment cap if the Board determines it is necessary to limit costs to the plan.

D. The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6535 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created a nonprofit legal entity to be known as the "Health Insurance High Risk Pool". All insurers and reinsurers providing health insurance or reinsurance, as a condition of doing business in this state, shall be members of the Pool.

B. 1. The Pool shall operate under the supervision and approval of a nine-member Board of Directors appointed by the Insurance Commissioner. The Board shall consist of:

a. two representatives of domestic insurance companies licensed to do business in this state,
b. one representative of a not-for-profit hospital service and medical indemnity plan,
c. one representative of a health maintenance organization,
d. one member from a health-related profession,
e. one member from the general public, who is not associated with the medical profession, a hospital, or an insurer,
f. one member to represent a group considered to be "uninsurable",
g. one representative of reinsurers, and
h. one representative from the providers of small group plans licensed to do business in this state.

2. The original Board shall be appointed for the following terms:

a. three members for a term of one (1) year,
b. three members for a term of two (2) years, and
c. three members for a term of three (3) years.

3. All terms after the initial term shall be for three (3) years.

4. The Board shall elect one of its members as chairperson.

5. Members of the Board may be reimbursed from monies of the Pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board, but shall not otherwise be compensated for their services.

6. The Board shall adopt a plan pursuant to this act and submit its articles, bylaws, and operating rules to the Insurance Commissioner for approval. If the Board fails to adopt a plan and suitable articles, bylaws, and operating rules within one hundred eighty (180) days after the appointment of the Board, the Insurance Commissioner shall promulgate rules to effectuate the provisions of this act, and such rules shall remain in effect until superseded by a plan and articles, bylaws and operating rules submitted by the Board and approved by the Commissioner. The Board shall reimburse the Insurance Commissioner for any direct and actual administrative costs associated with administering the provisions of this act from monies collected by the Board.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6536 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Board of Directors of the Health Insurance High Risk Pool shall:

1. Establish administrative and accounting procedures for the operation of the Pool;

2. Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the Board;

3. Select an administering insurer in accordance with Section 8 of this act;

4. Levy and collect assessments from all insurers and reinsurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made. The level of assessments shall be established by the Board in accordance with Section 9 of this act. Assessment of the insurers shall occur at the end of each calendar year and shall be due and payable within thirty (30) days of receipt of the assessment notice by the insurer;

5. In addition to assessments required pursuant to paragraph 4 of this subsection, collect an organizational assessment or assessments from all insurers and reinsurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to the receipt of the first calendar year assessments. Organizational assessments shall be equal for all insurers and reinsurers, but shall not exceed One Hundred Dollars ($100.00) per insurer for all such assessments. Such assessments are due and payable within thirty (30) days of receipt of the assessment notice by the insurer;

6. Require that all policy forms issued by the Board conform to standard forms as approved by the Insurance Commissioner;

7. Develop a program to publicize the existence of the plan, the eligibility requirements of the plan, and the procedures for enrollment in the plan, and to maintain public awareness of the plan; and

8. Design and employ cost-containment measures and requirements which may include preadmission certification, home health care, hospice care, negotiated purchase of medical and pharmaceutical supplies and individual case management. The Board may employ a plan case manager or managers to supervise and manage the medical care or coordinate the supervision and management of the medical care with the administering insurer. The Board may employ other persons if the positions have been outlined in the Board's plan and approved by the Insurance Commissioner and are necessary to fulfill the duties and responsibilities of the Board.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6537 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Board of Directors of the Health Insurance High Risk Pool may:

1. Exercise powers granted to insurers under the laws of this state;

2. Sue or be sued;

3. In addition to imposing assessments under Section 6 of this act, levy interim assessments against insurers and reinsurers to ensure the financial ability of the plan to cover claims, expenses and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of a calendar year. Any interim assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice by the insurer. Interim assessments shall be credited against the insurer's and reinsurer's annual assessment; and

4. Request the Insurance Commissioner to check the reports, records, books and papers of the Insurance Department to determine the financial condition of an insurer for purposes of Section 10 of this act.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6538 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Board of Directors of the Health Insurance High Risk Pool shall select an administering insurer who shall be an insurer as defined in this act, through a competitive bidding process, to administer the plan. The Board shall evaluate the bids submitted under this subsection based on criteria established by the Board, which criteria shall include, but not be limited to, the following:

1. The administering insurer's proven ability to handle large group accident and health insurance policies and claims;

2. The efficiency of the administering insurer's claims-paying procedures; and

3. An estimate of total charges for administering the plan.

B. The administering insurer shall serve for a period of two (2) years. At least one (1) year prior to the expiration of each two-year period of service by an administering insurer, the Board shall invite all reasonably interested potential administering insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding two-year period. The selection of the administering insurer for the succeeding two-year period shall be made at least six (6) months prior to the end of the current two-year period.

C. The Board may select more than one administering insurer to perform the different functions involved in administering the plan.

D. The administering insurer shall:

1. Perform all eligibility and administrative claims-payment functions relating to the plan;

2. Pay an agent's referral fee as established by the Board to each agent who refers an applicant to the plan, if the applicant is accepted. The selling or marketing of the plan shall not be limited to the administering insurer or its agents. The referral fees shall be paid by the administering insurer from moneys received as premiums for the plan;

3. Establish a premium billing procedure for collection of premiums from persons insured under the plan;

4. Perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including, but not limited to, the following:

a. making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made,

b. evaluating the eligibility of each claim for payment under the plan, and

c. notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised;

5. Submit regular reports to the Board regarding the operation of the plan. The frequency, content, and form of the reports shall be determined by the Board;

6. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expenses allowance, the expense of administration pertaining to the reinsurance operations of the Pool, and the incurred losses for the year, and report this information to the Board and to the Insurance Commissioner; and

7. Pay claims expenses from the premium payments received from, or on behalf of, covered persons under the plan. If the payments by the administering insurer for claims expenses exceed the portion of premiums allocated by the Board for the payment of claims expenses, the Board shall provide through assessment the additional funds necessary for payment of claims expenses.

E. 1. The administering insurer shall be paid, as provided in the contract of the Pool, for direct and indirect expenses incurred in administering the Pool.

2. As used in this subsection, the term "direct and indirect expenses" includes the portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the administering insurer which are

approved by the Board as allocable to the administration of the plan and included in the bid specifications.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6539 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Each participating insurer and each participating reinsurer shall be assessed by the Board of Directors of the Health Insurance High Risk Pool a portion of the operating losses of the plan; such portion being determined by multiplying the operating losses by a fraction, the numerator of which equals the insurer's total health insurance premiums or subscriber's contract charges pertaining to the direct writing of health insurance written in this state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums and all subscriber contract charges written by all health insurers in this state during the preceding calendar year. The computation of assessments shall be made with a reasonable degree of accuracy, with the recognition that exact determinations may not always be possible.

B. 1. If assessments and other receipts by the Pool exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce premiums.

2. As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.

C. 1. Each participant's proportion of participation in the plan shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.

2. Any deficit incurred under the plan shall be recouped by assessments apportioned among the participants by the Board in the manner set forth in subsection A of this section, and the participants may recover the net loss, if any, in the normal course of their respective businesses without time limitation.

3. An insurer which has paid an assessment levied pursuant to this section shall not take a credit on the premium tax return for that insurer but may include the assessment amount in the insurer's claims cost calculation for the purpose of determining the insurer's rates for premiums charged for insurance policies to which the act applies. The rates shall not be deemed excessive for the sole reason of including in the calculation an amount reasonably calculated to recoup the assessment amount paid by the participating insurer or reinsurer.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6540 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Board may abate or defer, in whole or in part, the assessment of any participant if, in the opinion of the Board, payment of the assessment would endanger the ability of the participant to fulfill the contractual obligations of the participant.

B. In the event that an assessment against a participant is abated or deferred, in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other participants in a manner consistent with the basis for assessments set forth in subsection A of Section 9 of this act, and the participant receiving the abatement or deferment shall remain liable to the Pool for the deficiency for four (4) years.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6541 of Title 36, unless there is created a duplication in numbering, reads as follows:

The coverage provided by the plan shall be directly insured by the Health Insurance High Risk Pool and the policies administered through the administering insurer.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6542 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. The plan shall offer as one basic option an annually renewable policy with coverage as specified in this section for each eligible person, except, that if an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

2. Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within sixty (60) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

3. The plan shall provide that, upon the death, annulment of marriage or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty (60) days to continue coverage under a continuation or conversion policy.

4. No coverage provided to a person who is eligible for Medicare benefits shall be issued as a Medicare supplement policy.

B. 1. The plan shall offer as a minimum major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection E of this section up to a lifetime limit of Five Hundred Thousand Dollars ($500,000.00) per covered individual. The maximum limit under this paragraph shall not be altered by the Board of Directors of the Health Insurance High Risk Pool, and no actuarially equivalent benefit may be substituted by the Board.

2. The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experiences reasonably expected to occur as a result of Medicare payments.

C. Except for a health maintenance organization and prepaid health plan or preferred provider organization utilized by the Board or a covered person, the usual customary charges for the following services and articles, when prescribed by a physician, shall be covered expenses:

1. Hospital services;

2. Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at the direction of a physician;

3. Drugs requiring a physician's prescription;

4. Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the services are the type which would qualify as reimbursable services under Medicare;

5. Services of a home health agency, if the services are of a type which would qualify as reimbursable services under Medicare;

6. Use of radium or other radioactive materials;

7. Oxygen;

8. Anesthetics;

9. Prosthesis, other than dental prosthesis;

10. Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

11. Diagnostic x-rays and laboratory tests;

12. Oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;

13. Services of a physical therapist;

14. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

15. Processing of blood, including, but not limited to, collecting, testing, fractioning, and distributing blood; and

16. Services for the treatment of alcohol and drug abuse, but the plan shall be required to make a fifty percent (50%) co-payment and the payment of the plan shall not exceed Four Thousand Dollars ($4,000.00).

Usual and customary charges shall not exceed the reimbursement rate for charges as set by the State and Education Employees Group Insurance Board.

D. 1. Covered expenses shall not include the following:

a. any charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions,

b. any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid,

c. any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician,

d. that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary,

e. any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the service or articles,

f. any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred,

g. any charge for routine physical examinations in excess of one every twenty-four (24) months,

h. any charge for the services of blood donors and any fee for the failure to replace the first three (3) pints of blood provided to an eligible person annually, and

i. any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

2. The plan may provide an option for a person to have coverage for the expenses set out in paragraph 1 of this subsection or any benefits payable under any other health insurance policy or plan, commensurate with the deductible and coinsurance selected.

E. 1. The plan shall provide for a choice of annual deductibles per person covered for major medical expenses in the

amounts of Five Hundred Dollars ($500.00), One Thousand Dollars ($1,000.00), One Thousand Five Hundred Dollars ($1,500.00), Two Thousand Dollars ($2,000.00), Five Thousand Dollars ($5,000.00) and Seven Thousand Five Hundred Dollars ($7,500.00), plus the additional benefits payable at each level of deductible; provided, if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calender year.

2. The schedule of premiums and deductibles shall be established by the Board.

3. Rates for coverage issued by the Pool may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing coverage.

4. Separate schedules of premium rates based on age may apply for individual risks.

5. Rates are subject to approval by the Insurance Commissioner.

6. Standard risk rates for coverages issued by the Pool shall be established by the Board, subject to the approval of the Insurance Commissioner, using reasonable actuarial techniques, and shall reflect anticipated experiences and expenses of such coverage for standard risks.

7. a. The rating plan established by the Board shall initially provide for rates equal to one hundred twenty-five percent (125%) of the average standard risk rates of the five largest insurers doing business in the state.

   b. Any change to the initial rates shall be based on experience of the plan and shall reflect reasonably anticipated losses and expenses. The rates shall not increase more than five percent (5%) annually with a maximum rate not to exceed one hundred fifty percent (150%) of the average standard risk rates.

8. a. A Pool policy may contain provisions under which coverage is excluded during a period of twelve (12) months following the effective date of coverage with respect to a given covered person's preexisting condition, as long as:

      (1) the condition manifested itself within a period of six (6) months before the effective date of coverage, or

      (2) medical advice or treatment for the condition was recommended or received within a period of six (6) months before the effective date of coverage.

   b. The Board shall waive the twelve-month period if the person had continuous coverage under another policy with respect to the given condition within a period of six (6) months before the effective date of coverage under the Pool plan.

9. a. No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums, or to reduce the limits of benefits available, and

   b. The Board shall have a cause of action against a covered person for any benefits paid to a covered person which should not have been claimed or recognized as claims because of the provisions of this paragraph, or because otherwise not covered.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6543 of Title 36, unless there is created a duplication in numbering, reads as follows:

The plan shall conform with and be subject to the provisions of Sections 6054 through 6057 of Title 36 of the Oklahoma Statutes in the same manner as if it were a group policy issued by an insurer.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6544 of Title 36, unless there is created a duplication in numbering, reads as follows:

It shall constitute an unfair practice for the purposes of Section 1201 et seq. of Title 36 of the Oklahoma Statutes for an insurer, insurance agent, insurance broker or third party administrator to refer an individual employee to the plan or arrange for an individual employee to apply for the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

SECTION 15. This act shall become effective July 1, 1995.

SECTION 16. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 17th day of May, 1995.

Speaker of the House of Representatives

Passed the Senate the 18th day of May, 1995.

President of the Senate