

ENGROSSED SENATE AMENDMENT  
TO  
ENGROSSED HOUSE BILL NO. 1399

By: Lindley of the House  
and  
Monson of the Senate

( public health and safety - Oklahoma Managed Care  
Consumer Protection Act - codification -  
effective date )

AMENDMENT NO. 1. Page 1, strike the stricken title, enacting clause  
and entire bill and insert

"[ health maintenance organizations - legislative  
intent - health care plans - recodification -  
emergency ]

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

SECTION 1. AMENDATORY 63 O.S. 1991, Section 2501, as  
amended by Section 1, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998,  
Section 2501), is amended to read as follows:

Section 2501. A. 1. It is the purpose and intent of the  
Legislature to promote and protect the public health, to promote a  
wider distribution of health care services, and to maintain the  
standards and promote the progress of providing alternative delivery  
systems of prepaid health care, including comprehensive medically  
necessary managed care services and comprehensive health maintenance  
services in this state.

2. Further, it is the intent of the Legislature to ensure that  
citizens of this state have access to quality health care and  
adequate information for making informed decisions when choosing  
managed health care plans.

3. While it is the intent of Section 2501 et seq. of this act ~~title~~ to provide an opportunity for the development of managed health care plans that include, but are not limited to, prepaid health plans and health maintenance organizations, there is no ~~intention~~ intent to impair the present system of delivery of health services.

4. It shall be the policy of this state to eliminate legal barriers to the organization, ~~promoting~~ promotion and expansion of such alternative delivery systems of comprehensive prepaid health care.

B. The provisions of Section 2501 et seq. of this title shall not apply to certified workplace medical plans as defined in Section 3 of Title 85 of the Oklahoma Statutes.

SECTION 2. AMENDATORY 63 O.S. 1991, Section 2502, as amended by Section 2, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2502), is amended to read as follows:

Section 2502. Notwithstanding any law to the contrary, any person may, in compliance with the provisions of Section 2501 et seq. of this title, organize and operate a managed health care plan, including, but not limited to, a health maintenance organization or a prepaid health plan which provides comprehensive health services to ~~enrollees~~ an enrollee who ~~have become subscribers~~ subscribes to ~~said~~ such health maintenance organization or prepaid health plan pursuant to a contract entitling ~~each~~ such enrollee to comprehensive health services on a prepaid, capitated basis.

SECTION 3. AMENDATORY 63 O.S. 1991, Section 2503, as amended by Section 3, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2503), is amended to read as follows:

Section 2503. As used in Section 2501 et seq. of this title:

1. "Health maintenance organization" means any organization, subject to the provisions of Section 2501 et seq. of this title, organized pursuant to the laws of this state, or the laws of another

state or the District of Columbia, which provides, either directly or through arrangements with others, comprehensive health services to ~~members enrolled with the organization~~ an enrollee on a fixed prepayment basis;

2. "Enrollee" means a person who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a health maintenance organization or prepaid health plan for comprehensive health services or with other managed health care plans for covered health services;

3. "Person" includes, but is not limited to, individuals, partnerships, associations, corporations, or other public or private legal entities;

4. "Agent" means a person associated with a health maintenance organization and who engages in solicitation;

5. "Board" means the State Board of Health;

6. "Department" means the Oklahoma State Department of Health;

~~6.~~ 7. "Comprehensive health services" ~~includes~~ include, but ~~is~~ are not limited to, allopathic, osteopathic, chiropractic, podiatric, optometric, psychological, outpatient diagnostic and treatment, inpatient hospital, short-term rehabilitation and physical therapy, medically necessary emergency, short-term outpatient mental health, substance abuse diagnostic and medical treatment, home health, and preventive health services; and

~~7.~~ 8. a. "Prepaid health plan" means any organization, subject to the provisions of Section 2501 et seq. of this title, organized pursuant to the laws of this state, or the laws of another state or the District of Columbia, which provides, either directly, or through arrangements with others, or through reimbursement of claims, comprehensive health services to ~~members enrolled with the plan~~ an enrollee on a fixed prepayment basis.;

- b. As used in this paragraph, "reimbursement of claims" means that a prepaid health plan may make provisions ~~for reimbursements to members~~ reimburse a member who ~~receive~~ receives covered services through a noncontracting ~~providers~~ provider and may make provisions ~~for payments to~~ pay a noncontracting ~~providers~~ provider for covered services rendered to ~~members~~ such member. A prepaid health plan may impose supplementary deductibles and copayments for covered services rendered through a noncontracting ~~providers~~ provider in order to cover the costs of such services and to encourage members to use contracting ~~providers-;~~

9. "Managed health care plan" means any organization or entity including, but not limited to, a health maintenance organization, prepaid health plan, preferred provider organization, or provider service network that offers to provide health care services or that contracts with a health care provider to provide health care services to an enrollee through a system of care that:

- a. integrates the financing and delivery of appropriate health care services to an enrollee through contracts or other arrangements with selected health care providers, to furnish a specified set of health services, which may be comprehensive health services, to such enrollee, or
- b. establishes significant financial incentives for an enrollee to use selected health care providers and specific procedures associated with the managed health care plan;

10. "Preferred provider organization" means any organization or entity that contracts to provide health care services to an enrollee from selected, participating providers; and

11. "Provider service network" means a provider-owned managed care entity including, but not limited to, physician-hospital organizations (PHOs) and integrated provider organizations (IPO), organized for the purpose of providing, financing, and managing the risk of health care services provided to enrollees.

SECTION 4. AMENDATORY 63 O.S. 1991, Section 2504, as last amended by Section 1, Chapter 62, O.S.L. 1998 (63 O.S. Supp. 1998, Section 2504), is amended to read as follows:

Section 2504. A. 1. ~~Upon compliance with the provisions of Section 2501 et seq. of this title, any organization, association, or corporation, public or private, may be licensed by the State Department of Health to organize, operate and maintain a health maintenance organization or a prepaid health plan for its duly enrolled members and their dependents in this state~~ No person may operate a health maintenance organization or prepaid health plan, or imply directly or indirectly that such person is authorized to operate a health maintenance organization or prepaid health plan, unless such person first applies for and is granted a license to do so by the State Department of Health pursuant to the provisions of Section 2501 et seq. of this title.

2. a. Prior to the issuance of any license to a health maintenance organization or a prepaid health plan, the State Department of Health shall forward one copy of the application to the Insurance Commissioner, who shall ~~be required,~~ within thirty (30) days ~~to,~~ review ~~said~~ such application with regard to the provisions in the application for fiscal responsibility and fiducial integrity, and make recommendations to the Department.
- b. If ~~a response is not received from~~ the Insurance Commissioner does not respond within thirty (30) days, the Department may proceed to make a determination based upon the application as submitted.

- c. The Insurance Commissioner, after notice and hearing, may promulgate such reasonable rules as are necessary to provide for the licensing of agents.

3. Notwithstanding the provisions of subsection A of Section 314 of Title 75 of the Oklahoma Statutes, prior to the issuance of a license to a health maintenance organization or prepaid health plan, the ~~State Health~~ Department shall conduct an individual proceeding pursuant to the Administrative Procedures Act and rules of the State Board of Health regarding the issuance of the license.

B. 1. The provisions of subsection A of Section 314 of Title 75 of the Oklahoma Statutes notwithstanding, the State Health Department shall annually conduct an individual proceeding to determine if each health maintenance organization or prepaid health plan has complied with all requirements set forth in this section and ~~in~~ any rules promulgated pursuant to Section 2501 et seq. of this title. Every health maintenance organization and prepaid health plan may be relicensed, annually, upon compliance with the provisions of Section 2501 et seq. of this title and any rules promulgated pursuant thereto.

2. A health maintenance organization or prepaid health plan ~~shall~~ that is determined to be deemed in noncompliance ~~and~~, after thirty (30) days' notice and failure to take corrective action, shall not be relicensed by the Department if its:

- a. application for license renewal,
- b. evidence of coverage,
- c. standards and procedures for the selection of providers, or
- d. any other documents filed with the Department,

contain definitions of words or terms that are contrary to or inconsistent with the definitions of words or terms appearing in Section 2503 of this title or appearing in the rules promulgated pursuant to Section 2501 et seq. of this title.

C. Enrollment in any such organization or plan shall be voluntary only.

D. A license from the Department shall not be required for any prepaid health plan duly licensed as an insurer by the Insurance Commissioner pursuant to Title 36 of the Oklahoma Statutes. Nothing in this subsection shall be construed to prevent a person from electing to apply for and obtain separate licenses as an insurer under Title 36 of the Oklahoma Statutes and as a prepaid health plan under Section 2501 et seq. of this title.

E. Each application or reapplication for a license or annual license renewal pursuant to the provisions of this section shall be accompanied by ~~an application~~ a nonrefundable fee of Five Thousand Dollars (\$5,000.00).

SECTION 5. AMENDATORY Section 6, Chapter 349, O.S.L. 1996, as amended by Section 1, Chapter 116, O.S.L. 1998 (63 O.S. Supp. 1998, Section 2513), is amended to read as follows:

Section 2513. A. 1. Beginning July 1, 1999, no person may operate a preferred provider organization or provider service network or imply directly or indirectly that such person is authorized to operate a preferred provider organization or provider service network, unless that person first applies for and is granted a license by the State Department of Health as provided herein.

2. A preferred provider organization or provider service network which assumes full risk shall be licensed pursuant to the provisions of Section 2504 of this title and shall be subject to similar standards for solvency, network capacity to deliver contracted services, quality assurance, accreditation, grievance procedures, and other such standards, as are applied to health maintenance organizations.

3. a. A preferred provider organization or provider service network which assumes partial risk shall be licensed by the State Department of Health and shall be subject

to standards for solvency, network capacity to deliver contracted services, quality assurance, accreditation, grievance procedures, and other such standards, as are appropriate to the risk assumed and the scope of services to be provided, as determined by rules promulgated by the State Board of Health.

b. Each application or reapplication for a license or annual license renewal made pursuant to the provisions of this paragraph shall be accompanied by a nonrefundable fee of Two Thousand Dollars (\$2,000.00).

4. a. A preferred provider organization or provider service network which assumes no risk shall be licensed by the Department and shall be subject to standards for network capacity to deliver contracted services, quality assurance, accreditation, grievance procedures, and other such standards, as are appropriate to the scope of services to be provided, as determined by rules promulgated by the Board.

b. Each application or reapplication for a license or annual license renewal made pursuant to the provisions of this paragraph shall be accompanied by a nonrefundable fee of Five Hundred Dollars (\$500.00).

B. The State Board of Health shall promulgate rules regarding the establishment, licensure and operation of preferred provider organizations and provider service networks ~~(PSNs)~~ which shall address, at a minimum, the following:

1. Procedures to allow health care providers within a service area to enter into voluntary agreements to improve access to and the quality or affordability of health care;

2. Procedures for reviewing the plan of operation of a preferred provider organization and a provider service network and standards for approval or disapproval of such plan; and



3. Financial solvency and network capacity standards to ensure a preferred provider organization's and a provider service network's ability to deliver ~~promised~~ contracted services; provided, however, the Board shall exempt from such standards a provider service network serving solely Medicare beneficiaries which is in compliance with federal solvency standards, pursuant to the provisions of the federal Balanced Budget Act of 1997, and as certified by the Secretary of the U.S. Department of Health and Human Services.

~~B. The rules promulgated by the Board shall provide that provider service networks shall be subject to the same quality assurance standards established by law or by rules promulgated by the Board for health maintenance organizations.~~

C. As used in this section, ~~"provider service network" means a provider-based managed care entity, including physician-hospital organizations (PHOs), organized for the purpose of providing, financing, and managing the risk of health care services to subscribers:~~

1. "Full risk" means the financial risk assumed by a preferred provider organization or a provider service network which contracts directly with an employer, a representative of an employer, or an insurer and which is paid on a prepaid, capitated basis for all health care services;

2. "Partial risk" means the financial risk assumed by a preferred provider organization or a provider service network which contracts directly with an employer, a representative of an employer, or an insurer, which is paid a budgeted amount for services provided for a set period of time. Such organization or network may be liable for a portion of additional expenses above the budgeted amount, or may be eligible for a share of any savings achieved pursuant to the terms of the contract; and

3. "No risk" means the absence of financial risk which occurs when a preferred provider organization or a provider service network

contracts directly with an employer, a representative of an employer, or an insurer to provide health care services on a fee-for-service basis, and the employer or insurer retains the full risk for the cost of employee health care services.

SECTION 6. AMENDATORY 63 O.S. 1991, Section 2506, as amended by Section 6, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2506), is amended to read as follows:

Section 2506. ~~Health maintenance organizations and prepaid health plans~~ Managed health care plans may provide any services included in state or federal health care programs, such as state employees benefits, the state basic health benefits program, "Medicare", "Medicaid", "Champus" and Veterans Administrations and other health programs provided in whole or in part by state or federal funds, in accordance with the laws governing such programs.

SECTION 7. AMENDATORY 63 O.S. 1991, Section 2507, as amended by Section 7, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2507), is amended to read as follows:

Section 2507. A. Comprehensive health services as herein provided may be furnished to ~~enrollees~~ an enrollee of a health maintenance ~~organizations~~ organization outside this state only in accordance with the laws of ~~the~~ this state or of the United States which govern the provisions of such services in the state or place concerned; provided, that an enrollee may be reimbursed directly for emergency health care expenses incurred by ~~him~~ the enrollee while temporarily outside the state, when such expenses would have been provided under the enrollee's program had ~~he~~ the enrollee been within the state. Such reimbursement made by a health maintenance organization shall not be construed as an indemnity ~~and no.~~ No health maintenance organization shall be an insurer or make any contract of insurance of any kind whatsoever.

B. 1. The State Board of Health shall provide by rule the requirements for claims reimbursements by a prepaid health plan for

health care services rendered by professionals or facilities not covered under an agreement with the managed care organization, whether those providers are located inside or outside the state.

2. The State Board of Health also shall provide by rule for geographic service area variations which ~~remit~~ permit prepaid health plans to enroll persons who desire to become members but who do not reside in an area where contracting primary and emergency care providers are available and accessible within reasonable promptness.

3. Prepaid health plans may reimburse out-of-state providers for services received by Title XIX enrollees at the medicaid fee-for-service rates in effect in this state or the rates in effect in the state in which care was rendered, whichever are lower.

SECTION 8. AMENDATORY 63 O.S. 1991, Section 2508, as amended by Section 8, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2508), is amended to read as follows:

Section 2508. A. The State Department of Health shall:

1. ~~Fix~~ Issue and renew licenses and collect license fees for the operation of ~~health maintenance organizations and prepaid health managed health care~~ plans pursuant to the provisions of Section 2504 of this title and Section 5 of this act;

2. Enforce the provisions of ~~this act~~ Section 2501 et seq. of this title;

3. ~~Promulgate~~ Enact procedures pursuant to rules and regulations promulgated by the State Board of Health as necessary to effectuate the purposes of ~~this act~~ Section 2501 et seq. of this title, to protect the public and ensure access to quality health care, and to ensure the sound, proper and efficient operation of ~~health maintenance organizations and prepaid health managed health care~~ plans in this state; and

4. Have authority to suspend, revoke or not renew any license for violation of any of the rules or any violation of law or for other good cause.

B. All actions of the Department shall be subject to the provisions of the Oklahoma Administrative Procedures Act.

C. License fees collected shall be deposited in the Public Health Special Fund of the State Treasury.

SECTION 9. AMENDATORY Section 2, Chapter 95, O.S.L. 1995, as renumbered by Section 9, Chapter 204, O.S.L. 1995 (63 O.S. Supp. 1998, Section 2508.1), is amended to read as follows:

Section 2508.1 The ~~Oklahoma~~ State Board of Health shall promulgate rules which will authorize health maintenance organizations, prepaid health plans and other managed health care entities plans, as a consideration and valuation of their net worth with regard to requirements for protection against insolvency required by the Board, to include real property and improvements thereon and any other capital or fixed assets owned by the managed health care entity plan which are unencumbered with any financial obligations of the managed health care entity plan.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2508.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Health shall promulgate rules or take other appropriate action to address, commensurate with risk assumed and scope of services to be provided, the following:

1. Information to be provided by managed health care plans which will enable consumers to make informed choices about enrolling in or accepting coverage offered by a plan. Such information shall include, but not be limited to:

- a. information regarding coverage provisions, benefits, limitations, and any exclusions by category of service, provider or physician, and, if applicable, by specific service,
- b. prior authorization or other utilization review requirements, and

c. the financial responsibility of the enrollee with regard to coinsurance or noncovered or out-of-plan services, and, as applicable, other areas of financial responsibility of the enrollee;

2. Criteria designed to ensure that managed health care plans which seek to expand into delivery of services to special needs populations have the requisite capabilities to meet those needs and an appropriate avenue for dialogue between the plan and advocates for such special needs populations;

3. The definition of emergency care to ensure that conditions which reasonably appear to constitute an emergency are covered under managed health care plans;

4. Standardization and centralization of information and forms used in the credentialing process;

5. Minimum standards for the administration and operation of managed health care plans. Such standards shall:

a. hold comparable managed health care plans to comparable standards which may include nationally recognized minimum standards for quality assurance and accreditation, and

b. require regular quality assessment for managed health care plans which addresses, at a minimum, the following:

- (1) quality improvement,
- (2) credentialing,
- (3) member rights and responsibilities,
- (4) preventive health services,
- (5) utilization management, and
- (6) medical records; and

6. An appeal process for plans which provides:

a. timely notice to a patient when:

- (1) the plan makes an adverse coverage recommendation or decision affecting the patient, or
  - (2) the patient has notified the plan of his or her disagreement with the provider treatment recommendation,
- b. an easily understood description of the patient's appeal rights and the time frame for an appeal,
  - c. an expedited appeal process for situations in which the normal time frame could jeopardize a patient's life or health, and
  - d. a method for ensuring that decisions are rendered as rapidly as warranted by the patient's condition and coverage issue.

B. Beginning July 1, 1999, rules promulgated and actions taken by the Board pursuant to this section shall apply to managed health care plans required to be licensed pursuant to the provisions of Section 2513 of Title 63 of the Oklahoma Statutes.

SECTION 11. AMENDATORY 63 O.S. 1991, Section 2509, as amended by Section 9, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2509), is amended to read as follows:

Section 2509. ~~Each health maintenance organization and prepaid health~~ A. Except as provided in subsection B of this section, each managed health care plan shall furnish, commensurate with risk assumed and scope of services to be provided, a surety bond in an amount satisfactory to the State Department of Health, or deposit with the Department, cash or securities acceptable to the Department in at least the same amount as a guarantee that the obligations to the enrollees will be performed. The Department may waive this requirement whenever satisfied that the assets of the organization or plan, or its contracts with insurers, governments or other entities are sufficient to reasonably assure the performance of its obligations.

B. Beginning July 1, 1999, the provisions of this section shall apply to managed health care plans required to be licensed pursuant to the provisions of Section 2513 of this title.

SECTION 12. AMENDATORY 63 O.S. 1991, Section 2510, as last amended by Section 1, Chapter 139, O.S.L. 1996 (63 O.S. Supp. 1998, Section 2510), is amended to read as follows:

Section 2510. A. No ~~health maintenance organization or prepaid health~~ managed health care plan, or representative thereof, shall cause or knowingly permit the use of advertising which is untrue or misleading, or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive.

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a managed health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does in fact exist;

3. An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges or other advantages which

evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

B. An enrollment may not be canceled or nonrenewed except for the failure to pay the charge for such coverage or, in the case of a Title XIX enrollees enrollee, for loss of eligibility for medical assistance, or for such other reasons as may be promulgated by the Department.

C. No ~~health maintenance organization or prepaid health~~ managed health care plan, unless licensed as an insurer, may use in its name, contracts or literature, any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

D. When contracting with educational entities within the meaning of Section 1303 of Title 74 of the Oklahoma Statutes, effective for the plan year beginning July 1, 1997, and for each year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, health maintenance organizations, self-insured plans ~~and~~, prepaid plans, and other managed health care plans shall set the monthly premium for active employees at a maximum of Ninety Dollars (\$90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

E. No managed health care plan shall engage in the practice of medicine or any other profession except as provided by law, nor shall such plan include any provision in a provider contract which precludes or discourages a plan's providers from:

1. Informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's plan; or



2. Advocating on behalf of a patient before the managed health care plan.

SECTION 13. AMENDATORY Section 11, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2511), is amended to read as follows:

Section 2511. A. No person may proceed to operate a ~~health maintenance organization or prepaid health~~ managed health care plan or imply directly or indirectly that ~~it~~ such person is authorized to operate a ~~health maintenance organization or prepaid health~~ managed health care plan, unless that person first applies for and is granted a license by the State Department of Health under Section 2501 et seq. of this title. Any person who operates a ~~health maintenance organization or prepaid health~~ managed health care plan without first having obtained a license as required herein, shall be deemed guilty of a misdemeanor, and, upon conviction, shall be punishable by payment ~~or~~ of a fine of not less than One Hundred Dollars (\$100.00), nor more than Five Hundred Dollars (\$500.00).

B. If the ~~State Department of Health~~, through one of its agents or representatives, notifies in writing, through certified mail, the person who has unlawfully commenced the operation of a ~~health maintenance organization or prepaid health~~ managed health care plan to cease and desist, ~~then~~ each day that such person continues such offering or development shall be a separate offense. If any person continues to operate a ~~health maintenance organization or prepaid~~ health managed health care plan after the issuance of a cease and desist order, the Department shall seek an injunction to prohibit the continued offering or development.

SECTION 14. AMENDATORY Section 12, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1998, Section 2512), is amended to read as follows:

Section 2512. Any person who, after notice and hearing, has been determined by the State Department of Health to have violated

any provision of Section 2501 et seq. of this title, or any rule promulgated or order issued pursuant to the provisions of ~~said~~ such sections, may be liable for an administrative penalty of not more than One Hundred Dollars (\$100.00) for each day that ~~said~~ the violation continues. The maximum administrative penalty shall not exceed Twenty Thousand Dollars (\$20,000.00) for any related series of violations.

SECTION 15. RECODIFICATION Section 6, Chapter 349, O.S.L. 1996, as last amended by Section 5 of this act, shall be recodified as Section 2504.1 of Title 63 of the Oklahoma Statutes, unless there is created a duplication in numbering.

SECTION 16. This act shall become effective July 1, 1999.

SECTION 17. 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 Senate the 5th day of April, 1999.

\_\_\_\_\_  
President of the Senate

Passed the House of Representatives the \_\_\_\_ day of \_\_\_\_\_,  
1999.

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Speaker of the House of  
Representatives