SB 326

WEST VIRGINIA LEGISLATURE

SEVENTY-NINTH LEGISLATURE

REGULAR SESSION, 2009

ENROLLED

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 326

(SENATOR STOLLINGS, *original sponsor*)

[Passed April 11, 2009; in effect ninety days from passage.]

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AN ACT to amend and reenact §5-16-7 and §5-16-9 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §33-15-4j; to amend said code by adding thereto a new section, designated §33-16-3t; to amend said code by adding thereto a new section, designated §33-24-7j; to amend said code by adding thereto a new section, designated §33-25-8h; and to amend said code by adding thereto a new section, designated §33-25A-8i, all relating to mandating insurance coverage of dental anesthesia in certain circumstances.

Be it enacted by the Legislature of West Virginia:

That §5-16-7 and §5-16-9 of the Code of West Virginia, 1931, as amended, be amended and reenacted; that said code be amended by adding thereto a new section, designated §33-15-4j; that said code be amended by adding thereto a new section,

designated §33-16-3t; that said code be amended by adding thereto a new section, designated §33-24-7j; that said code be amended by adding thereto a new section, designated §33-25-8h; and that said code be amended by adding thereto a new section, designated §33-25A-8i, all to read as follows:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7. Authorization to establish group hospital and surgical insurance plan, group major medical insurance plan, group prescription drug plan and group life and accidental death insurance plan; rules for administration of plans; mandated benefits; what plans may provide; optional plans; separate rating for claims experience purposes.

(a) The agency shall establish a group hospital and surgical insurance plan or plans, a group prescription drug insurance plan or plans, a group major medical insurance plan or plans and a group life and accidental death insurance plan or plans for those employees herein made eligible, and to establish and promulgate rules for the administration of these plans, subject to the limitations contained in this article. Those plans shall include:

(1) Coverages and benefits for X ray and laboratory services in connection with mammograms when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College

of Obstetricians and Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age eighteen or over;

(2) Annual checkups for prostate cancer in men age fifty and over;

(3) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing as recommended by the National Kidney Foundation;

(4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed health care facility for a mother and her newly born infant for the length of time which the attending physician considers medically necessary for the mother or her newly born child: *Provided,* That no plan may deny payment for a mother or her newborn child prior to forty-eight hours following a vaginal delivery, or prior to ninety-six hours following a caesarean section delivery, if the attending physician considers discharge medically inappropriate;

(5) For plans which provide coverages for post-delivery care to a mother and her newly born child in the home, coverage for inpatient care following childbirth as provided in subdivision (4) of this subsection if inpatient care is determined to be medically necessary by the attending physician. Those plans may also include, among other things, medicines, medical equipment, prosthetic appliances and any other inpatient and outpatient services and expenses considered appropriate and desirable by the agency; and

(6) Coverage for treatment of serious mental illness.

(A) The coverage does not include custodial care, residential care or schooling. For purposes of this section, "serious mental illness" means an illness included in the American Psychiatric Association's diagnostic and statistical manual of mental disorders, as periodically revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia. With regard to any covered individual who has not yet attained the age of nineteen years, "serious mental illness" also includes attention deficit hyperactivity disorder, separation anxiety disorder and conduct disorder.

(B) Notwithstanding any other provision in this section to the contrary, in the event that the agency can demonstrate actuarially that its total anticipated costs for the treatment of mental illness for any plan will exceed or have exceeded two percent of the total costs for such plan in any experience period, then the agency may apply whatever cost-containment measures may be necessary, including, but not limited to, limitations on inpatient and outpatient benefits, to maintain costs below two percent of the total costs for the plan.

(C) The agency shall not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan. With regard to both medical-surgical and mental health benefits, it may make determinations of medical necessity and appropriateness, and it may use recognized health care quality and cost management tools, including, but not limited to, limitations on inpatient and outpatient benefits, utilization review, implementation of cost-containment measures,

preauthorization for certain treatments, setting coverage levels, setting maximum number of visits within certain time periods, using capitated benefit arrangements, using fee-for-service arrangements, using third-party administrators, using provider networks and using patient cost sharing in the form of copayments, deductibles and coinsurance.

(7) Coverage for general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care if the covered person is:

(A) Seven years of age or younger or is developmentally disabled, and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia;

(B) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(b) The agency shall make available to each eligible employee, at full cost to the employee, the opportunity to purchase optional group life and accidental death insurance as established under the rules of the agency. In addition, each employee is entitled to have his or her spouse and dependents, as defined by the rules of the

agency, included in the optional coverage, at full cost to the employee, for each eligible dependent; and with full authorization to the agency to make the optional coverage available and provide an opportunity of purchase to each employee.

(c) The finance board may cause to be separately rated for claims experience purposes:

(1) All employees of the State of West Virginia;

(2) All teaching and professional employees of state public institutions of higher education and county boards of education;

(3) All nonteaching employees of the Higher Education Policy Commission, West Virginia Council for Community and Technical College Education and county boards of education; or

(4) Any other categorization which would ensure the stability of the overall program.

(d) The agency shall maintain the medical and prescription drug coverage for Medicare-eligible retirees by providing coverage through one of the existing plans or by enrolling the Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the Medicare/Advantage Prescription Drug Plan. In the event that a Medicare-specific plan would no longer be available or advantageous for the agency and the retirees, the retirees shall remain eligible for coverage through the agency.

§5-16-9. Authorization to execute contracts for group hospital and surgical insurance, group major medical insurance, group prescription drug insurance, group life and accidental death insurance and other accidental death insurance; mandated benefits; limitations; awarding of contracts;

reinsurance; certificates for covered employees; discontinuance of contracts.

(a) The director is hereby given exclusive authorization to execute such contract or contracts as are necessary to carry out the provisions of this article and to provide the plan or plans of group hospital and surgical insurance coverage, group major medical insurance coverage, group prescription drug insurance coverage and group life and accidental death insurance coverage selected in accordance with the provisions of this article, such contract or contracts to be executed with one or more agencies, corporations, insurance companies or service organizations licensed to sell group hospital and surgical insurance, group major medical insurance, group prescription drug insurance and group life and accidental death insurance in this state.

(b) The group hospital or surgical insurance coverage and group major medical insurance coverage herein provided shall include coverages and benefits for X ray and laboratory services in connection with mammogram and pap smears when performed for cancer screening or diagnostic services and annual checkups for prostate cancer in men age fifty and over. Such benefits shall include, but not be limited to, the following:

(1) Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force;

(2) A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from the United States Preventative Services Task Force or The American College of Obstetricians and Gynecologists, for women age eighteen and over;

(3) A test for the human papilloma virus (HPV) for women age eighteen or over, when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age eighteen and over;

(4) A checkup for prostate cancer annually for men age fifty or over; and

(5) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing as recommended by the National Kidney Foundation.

(6) Coverage for general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed healthcare individuals in conjunction with dental care if the covered person is:

(A) Seven years of age or younger or is developmentally disabled and is either an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia; or

(B) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such

condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) The group life and accidental death insurance herein provided shall be in the amount of $10,000 for every employee. The amount of the group life and accidental death insurance to which an employee would otherwise be entitled shall be reduced to $5,000 upon such employee attaining age sixty-five.

(d) All of the insurance coverage to be provided for under this article may be included in one or more similar contracts issued by the same or different carriers.

(e) The provisions of article three, chapter five-a of this code, relating to the Division of Purchasing of the Department of Finance and Administration, shall not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this article, the director shall invite competent bids from all qualified and licensed insurance companies or carriers, who may wish to offer plans for the insurance coverage desired: *Provided,* That the director shall negotiate and contract directly with health care providers and other entities, organizations and vendors in order to secure competitive premiums, prices and other financial advantages. The director shall deal directly with insurers or health care providers and other entities, organizations and vendors in presenting specifications and receiving quotations for bid purposes. No commission or finder's fee, or any combination thereof, shall be paid to any individual or agent; but this shall not preclude an underwriting insurance company or companies, at their own expense, from appointing a licensed resident agent, within this state, to service the companies' contracts awarded under the provisions of this article. Commissions reasonably related to actual service rendered

for the agent or agents may be paid by the underwriting company or companies: *Provided, however,* That in no event shall payment be made to any agent or agents when no actual services are rendered or performed. The director shall award the contract or contracts on a competitive basis. In awarding the contract or contracts the director shall take into account the experience of the offering agency, corporation, insurance company or service organization in the group hospital and surgical insurance field, group major medical insurance field, group prescription drug field and group life and accidental death insurance field, and its facilities for the handling of claims. In evaluating these factors, the director may employ the services of impartial, professional insurance analysts or actuaries or both. Any contract executed by the director with a selected carrier shall be a contract to govern all eligible employees subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance carrier from soliciting employees covered hereunder to purchase additional hospital and surgical, major medical or life and accidental death insurance coverage.

(f) The director may authorize the carrier with whom a primary contract is executed to reinsure portions of the contract with other carriers which elect to be a reinsurer and who are legally qualified to enter into a reinsurance agreement under the laws of this state.

(g) Each employee who is covered under any contract or contracts shall receive a statement of benefits to which the employee, his or her spouse and his or her dependents are entitled under the contract, setting forth the information as to whom the benefits are payable, to whom claims shall be submitted and a summary of the provisions of the contract or contracts as they affect the employee, his or her spouse and his or her dependents.

(h) The director may at the end of any contract period discontinue any contract or contracts it has executed with any carrier and replace the same with a contract or contracts with any other carrier or carriers meeting the requirements of this article.

(i) The director shall provide by contract or contracts entered into under the provisions of this article the cost for coverage of children's immunization services from birth through age sixteen years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles, rubella, tetanus, hepatitis-b, haemophilus influenzae-b and whooping cough. Additional immunizations may be required by the Commissioner of the Bureau for Public Health for public health purposes. Any contract entered into to cover these services shall require that all costs associated with immunization, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration be exempt from any deductible, per visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4j. Required coverage for dental anesthesia services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is:

(A) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or

(B) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) *Prior authorization.* – An entity subject to this section may require prior authorization for general anesthesia and associated out patient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated out patient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry;

(2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) *Dental care coverage not required.* – The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) *Temporal mandibular joint disorders.* – The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3t. Required coverage for dental anesthesia services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated out patient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is:

(1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or

(2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) *Prior authorization.* – An entity subject to this section may require prior authorization for general anesthesia and associated out patient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated out patient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry;

(2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) *Dental care coverage not required.* – The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) *Temporal mandibular joint disorders.* – The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7j. Required coverage for dental anesthesia services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated out patient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is:

(1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or

insured and for whom a superior result can be expected from dental care provided under general anesthesia; or

(2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) *Prior authorization.* – An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry;

(2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) *Dental care coverage not required.* – The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) *Temporal mandibular joint disorders.* – The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8h. Required coverage for dental anesthesia services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is:

(1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or

(2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of

treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) *Prior authorization.* – An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry;

(2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) *Dental care coverage not required.* – The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) *Temporal mandibular joint disorders.* – The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8i. Third-party reimbursement for dental anesthesia services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to a subscriber or member if the subscriber or member is:

(1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the subscriber or member and for whom a superior result can be expected from dental care provided under general anesthesia; or

(2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) *Prior authorization.* – An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital, ambulatory facility or similar charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry;

(2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) *Dental care coverage not required.* – The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) *Temporal mandibular joint disorders.* – The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

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Chairman Senate Committee

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Chairman House Committee

Originated in the Senate.

In effect ninety days from passage.

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Clerk of the Senate

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Clerk of the House of Delegates

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President of the Senate

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Speaker House of Delegates

The within ..... this the .....

Day of ....., 2009.

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Governor

PRESENTED TO THE
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