

2020 -- H 7339

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LC003555
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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2020

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A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Edwards, Newberry, Canario, Vella-Wilkinson, and Kennedy

Date Introduced: January 29, 2020

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-76 of the General Laws in Chapter 27-18 entitled "Accident
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-76. Emergency services.**

4 (a) As used in this section:

5 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
6 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
7 possesses an average knowledge of health and medicine, could reasonably expect the absence of
8 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
9 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
10 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
11 part.

12 (2) "Emergency services" means, with respect to an emergency medical condition:

13 (A) A medical screening examination (as required under section 1867 of the Social
14 Security Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a
15 hospital, including ancillary services routinely available to the emergency department to evaluate
16 such emergency medical condition, and

17 (B) Such further medical examination and treatment, to the extent they are within the
18 capabilities of the staff and facilities available at the hospital, as are required under section 1867
19 of the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient.

1 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
2 § 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

3 (b) If a health insurance carrier offering health insurance coverage provides any benefits
4 with respect to services in an emergency department of a hospital, the carrier must cover
5 emergency services in compliance with this section.

6 (c) A health insurance carrier shall provide coverage for emergency services in the
7 following manner:

8 (1) Without the need for any prior authorization determination, even if the emergency
9 services are provided on an out-of-network basis;

10 (2) Without regard to whether the health care provider furnishing the emergency services
11 is a participating network provider with respect to the services;

12 (3) If the emergency services are provided out of network, without imposing any
13 administrative requirement or limitation on coverage that is more restrictive than the requirements
14 or limitations that apply to emergency services received from in-network providers;

15 (4) If the emergency services are provided out of network, by complying with the cost-
16 sharing requirements of subsection (d) of this section; and

17 (5) Without regard to any other term or condition of the coverage, other than:

18 (A) The exclusion of or coordination of benefits;

19 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
20 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

21 (C) Applicable cost-sharing.

22 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
23 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
24 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
25 the services were provided in-network; provided, however, that a participant or beneficiary ~~may~~
26 ~~be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-~~
27 ~~network provider charges over the amount the health insurance carrier is required to pay under~~
28 ~~subdivision (1) of this subsection~~ shall incur no greater out-of-pocket costs for the emergency
29 services than the participant or beneficiary would have incurred with an in-network provider
30 other than the in-network cost sharing. A health insurance carrier complies with the requirements
31 of this subsection if it provides benefits with respect to an emergency service in an amount equal
32 to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision
33 (1) (which are adjusted for in-network cost-sharing requirements).

34 (A) The amount negotiated with in-network providers for the emergency service

1 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
2 participant or beneficiary. If there is more than one amount negotiated with in-network providers
3 for the emergency service, the amount described under this subdivision (A) is the median of these
4 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
5 participant or beneficiary. In determining the median described in the preceding sentence, the
6 amount negotiated with each in-network provider is treated as a separate amount (even if the
7 same amount is paid to more than one provider). If there is no per-service amount negotiated with
8 in-network providers (such as under a capitation or other similar payment arrangement), the
9 amount under this subdivision (A) is disregarded.

10 (B) The amount for the emergency service shall be calculated using the same method the
11 plan generally uses to determine payments for out-of-network services (such as the usual,
12 customary, and reasonable amount), excluding any in-network copayment or coinsurance
13 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
14 determined without reduction for out-of-network cost-sharing that generally applies under the
15 plan or health insurance coverage with respect to out-of-network services.

16 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
17 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-
18 network copayment or coinsurance imposed with respect to the participant or beneficiary.

19 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
20 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
21 services provided out of network if the cost-sharing requirement generally applies to out-of-
22 network benefits. A deductible may be imposed with respect to out-of-network emergency
23 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
24 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
25 apply to out-of-network emergency services.

26 (e) The provisions of this section apply for plan years beginning on or after September
27 23, 2010.

28 (f) This section shall not apply to grandfathered health plans. This section shall not apply
29 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability
30 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit
31 health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both;
32 and (9) other limited benefit policies.

33 SECTION 2. Section 27-19-66 of the General Laws in Chapter 27-19 entitled "Nonprofit
34 Hospital Service Corporations" is hereby amended to read as follows:

1 **27-19-66. Emergency services.**

2 (a) As used in this section:

3 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
4 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
5 possesses an average knowledge of health and medicine, could reasonably expect the absence of
6 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
7 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
8 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
9 part.

10 (2) "Emergency services" means, with respect to an emergency medical condition:

11 (A) A medical screening examination (as required under section 1867 of the Social
12 Security Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a
13 hospital, including ancillary services routinely available to the emergency department to evaluate
14 such emergency medical condition, and

15 (B) Such further medical examination and treatment, to the extent they are within the
16 capabilities of the staff and facilities available at the hospital, as are required under section 1867
17 of the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient.

18 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
19 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

20 (b) If a nonprofit hospital service corporation provides any benefits to subscribers with
21 respect to services in an emergency department of a hospital, the plan must cover emergency
22 services consistent with the rules of this section.

23 (c) A nonprofit hospital service corporation shall provide coverage for emergency
24 services in the following manner:

25 (1) Without the need for any prior authorization determination, even if the emergency
26 services are provided on an out-of-network basis;

27 (2) Without regard to whether the health-care provider furnishing the emergency services
28 is a participating network provider with respect to the services;

29 (3) If the emergency services are provided out of network, without imposing any
30 administrative requirement or limitation on coverage that is more restrictive than the requirements
31 or limitations that apply to emergency services received from in-network providers;

32 (4) If the emergency services are provided out of network, by complying with the cost-
33 sharing requirements of subsection (d) of this section; and

34 (5) Without regard to any other term or condition of the coverage, other than:

1 (A) The exclusion of or coordination of benefits;

2 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
3 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

4 (C) Applicable cost sharing.

5 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
6 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
7 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
8 the services were provided in-network. However, a participant or beneficiary ~~may be required to~~
9 ~~pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network~~
10 ~~provider charges over the amount the health insurance carrier is required to pay under subdivision~~
11 ~~(1) of this subsection~~ shall incur no greater out-of-pocket costs for the emergency services than
12 the participant or beneficiary would have incurred with an in-network provider other than the in-
13 network cost sharing. A group health plan or health insurance carrier complies with the
14 requirements of this subsection if it provides benefits with respect to an emergency service in an
15 amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
16 this subdivision (1) (which are adjusted for in-network cost-sharing requirements).

17 (A) The amount negotiated with in-network providers for the emergency service
18 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
19 participant or beneficiary. If there is more than one amount negotiated with in-network providers
20 for the emergency service, the amount described under this subdivision (A) is the median of these
21 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
22 participant or beneficiary. In determining the median described in the preceding sentence, the
23 amount negotiated with each in-network provider is treated as a separate amount (even if the
24 same amount is paid to more than one provider). If there is no per-service amount negotiated with
25 in-network providers (such as under a capitation or other similar payment arrangement), the
26 amount under this subdivision (A) is disregarded.

27 (B) The amount for the emergency service shall be calculated using the same method the
28 plan generally uses to determine payments for out-of-network services (such as the usual,
29 customary, and reasonable amount), excluding any in-network copayment or coinsurance
30 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
31 determined without reduction for out-of-network cost sharing that generally applies under the
32 plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a
33 plan generally pays seventy percent (70%) of the usual, customary, and reasonable amount for
34 out-of-network services, the amount in this subdivision (B) for an emergency service is the total,

1 that is, one hundred percent (100%), of the usual, customary, and reasonable amount for the
2 service, not reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-
3 network services (but reduced by the in-network copayment or coinsurance that the individual
4 would be responsible for if the emergency service had been provided in-network).

5 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
6 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-
7 network copayment or coinsurance imposed with respect to the participant or beneficiary.

8 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
9 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
10 services provided out of network if the cost-sharing requirement generally applies to out-of-
11 network benefits. A deductible may be imposed with respect to out-of-network emergency
12 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
13 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
14 apply to out-of-network emergency services.

15 (e) The provisions of this section apply for plan years beginning on or after September
16 23, 2010.

17 (f) This section shall not apply to insurance coverage providing benefits for: (1) Hospital
18 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
19 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
20 bodily injury or death by accident or both; and (9) Other limited benefit policies.

21 SECTION 3. Section 27-20-62 of the General Laws in Chapter 27-20 entitled "Nonprofit
22 Medical Service Corporations" is hereby amended to read as follows:

23 **27-20-62. Emergency services.**

24 (a) As used in this section:

25 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
26 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
27 possesses an average knowledge of health and medicine, could reasonably expect the absence of
28 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
29 with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious
30 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
31 part.

32 (2) "Emergency services" means, with respect to an emergency medical condition:

33 (A) A medical screening examination (as required under section 1867 of the Social
34 Security Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a

1 hospital, including ancillary services routinely available to the emergency department to evaluate
2 such emergency medical condition, and

3 (B) Such further medical examination and treatment, to the extent they are within the
4 capabilities of the staff and facilities available at the hospital, as are required under section 1867
5 of the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient.

6 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
7 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

8 (b) If a nonprofit medical service corporation offering health insurance coverage provides
9 any benefits with respect to services in an emergency department of a hospital, it must cover
10 emergency services consistent with the rules of this section.

11 (c) A nonprofit medical service corporation shall provide coverage for emergency
12 services in the following manner:

13 (1) Without the need for any prior authorization determination, even if the emergency
14 services are provided on an out-of-network basis;

15 (2) Without regard to whether the health care provider furnishing the emergency services
16 is a participating network provider with respect to the services;

17 (3) If the emergency services are provided out of network, without imposing any
18 administrative requirement or limitation on coverage that is more restrictive than the requirements
19 or limitations that apply to emergency services received from in-network providers;

20 (4) If the emergency services are provided out of network, by complying with the cost-
21 sharing requirements of subsection (d) of this section; and

22 (5) Without regard to any other term or condition of the coverage, other than:

23 (A) The exclusion of or coordination of benefits;

24 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
25 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

26 (C) Applicable cost-sharing.

27 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
28 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
29 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
30 the services were provided in-network. However, a participant or beneficiary ~~may be required to~~
31 ~~pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network~~
32 ~~provider charges over the amount the health insurance carrier is required to pay under subdivision~~
33 ~~(1) of this subsection~~ shall incur no greater out-of-pocket costs for the emergency services than
34 the participant or beneficiary would have incurred with an in-network provider other than the in-

1 [network cost sharing](#). A group health plan or health insurance carrier complies with the
2 requirements of this subsection if it provides benefits with respect to an emergency service in an
3 amount equal to the greatest of the three amounts specified in subdivisions (A), (B), and (C) of
4 this subdivision (1) (which are adjusted for in-network cost-sharing requirements).

5 (A) The amount negotiated with in-network providers for the emergency service
6 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
7 participant or beneficiary. If there is more than one amount negotiated with in-network providers
8 for the emergency service, the amount described under this subdivision (A) is the median of these
9 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
10 participant or beneficiary. In determining the median described in the preceding sentence, the
11 amount negotiated with each in-network provider is treated as a separate amount (even if the
12 same amount is paid to more than one provider). If there is no per-service amount negotiated with
13 in-network providers (such as under a capitation or other similar payment arrangement), the
14 amount under this subdivision (A) is disregarded.

15 (B) The amount for the emergency service shall be calculated using the same method the
16 plan generally uses to determine payments for out-of-network services (such as the usual,
17 customary, and reasonable amount), excluding any in-network copayment or coinsurance
18 imposed with respect to the participant or beneficiary. The amount in this subdivision (B) is
19 determined without reduction for out-of-network cost-sharing that generally applies under the
20 plan or health insurance coverage with respect to out-of-network services.

21 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
22 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-
23 network copayment or coinsurance imposed with respect to the participant or beneficiary.

24 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
25 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
26 services provided out of network if the cost-sharing requirement generally applies to out-of-
27 network benefits. A deductible may be imposed with respect to out-of-network emergency
28 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
29 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
30 apply to out-of-network emergency services.

31 (f) The provisions of this section shall apply to grandfathered health plans. This section
32 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
33 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
34 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by

1 accident or both; and (9) Other limited benefit policies.

2 SECTION 4. Section 27-41-79 of the General Laws in Chapter 27-41 entitled "Health
3 Maintenance Organizations" is hereby amended to read as follows:

4 **27-41-79. Emergency services.**

5 (a) As used in this section:

6 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
7 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who
8 possesses an average knowledge of health and medicine, could reasonably expect the absence of
9 immediate medical attention to result in a condition: (i) Placing the health of the individual, or
10 with respect to a pregnant woman her unborn child in serious jeopardy; (ii) Constituting a serious
11 impairment to bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or
12 part.

13 (2) "Emergency services" means, with respect to an emergency medical condition:

14 (A) A medical screening examination (as required under section 1867 of the Social
15 Security Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a
16 hospital, including ancillary services routinely available to the emergency department to evaluate
17 such emergency medical condition, and

18 (B) Such further medical examination and treatment, to the extent they are within the
19 capabilities of the staff and facilities available at the hospital, as are required under section 1867
20 of the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient.

21 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
22 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

23 (b) If a health maintenance organization offering group health insurance coverage
24 provides any benefits with respect to services in an emergency department of a hospital, it must
25 cover emergency services consistent with the rules of this section.

26 (c) A health maintenance organization shall provide coverage for emergency services in
27 the following manner:

28 (1) Without the need for any prior authorization determination, even if the emergency
29 services are provided on an out-of-network basis;

30 (2) Without regard to whether the health care provider furnishing the emergency services
31 is a participating network provider with respect to the services;

32 (3) If the emergency services are provided out of network, without imposing any
33 administrative requirement or limitation on coverage that is more restrictive than the requirements
34 or limitations that apply to emergency services received from in-network providers;

1 (4) If the emergency services are provided out of network, by complying with the cost-
2 sharing requirements of subsection (d) of this section; and

3 (5) Without regard to any other term or condition of the coverage, other than:

4 (A) The exclusion of or coordination of benefits;

5 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
6 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

7 (C) Applicable cost sharing.

8 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance
9 rate imposed with respect to a participant or beneficiary for out-of-network emergency services
10 cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if
11 the services were provided in-network; provided, however, that a participant or ~~may be required~~
12 ~~to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network~~
13 ~~provider charges over the amount the health insurance carrier is required to pay under subdivision~~
14 ~~(1) of this subsection~~ shall incur no greater out-of-pocket costs for the emergency services than
15 the participant or beneficiary would have incurred with an in-network provider other than the in-
16 network cost sharing. A health maintenance organization complies with the requirements of this
17 subsection if it provides benefits with respect to an emergency service in an amount equal to the
18 greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)
19 (which are adjusted for in-network cost-sharing requirements).

20 (A) The amount negotiated with in-network providers for the emergency service
21 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
22 participant or beneficiary. If there is more than one amount negotiated with in-network providers
23 for the emergency service, the amount described under this subdivision (A) is the median of these
24 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
25 participant or beneficiary. In determining the median described in the preceding sentence, the
26 amount negotiated with each in-network provider is treated as a separate amount (even if the
27 same amount is paid to more than one provider). If there is no per-service amount negotiated with
28 in-network providers (such as under a capitation or other similar payment arrangement), the
29 amount under this subdivision (A) is disregarded.

30 (B) The amount for the emergency service calculated using the same method the plan
31 generally uses to determine payments for out-of-network services (such as the usual, customary,
32 and reasonable amount), excluding any in-network copayment or coinsurance imposed with
33 respect to the participant or beneficiary. The amount in this subdivision (B) is determined without
34 reduction for out-of-network cost sharing that generally applies under the plan or health insurance

1 coverage with respect to out-of-network services.

2 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
3 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-
4 network copayment or coinsurance imposed with respect to the participant or beneficiary.

5 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement
6 (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency
7 services provided out of network if the cost-sharing requirement generally applies to out-of-
8 network benefits. A deductible may be imposed with respect to out-of-network emergency
9 services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-
10 pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must
11 apply to out-of-network emergency services.

12 (e) The provisions of this section apply for plan years beginning on or after September
13 23, 2010.

14 (f) The provisions of this section shall apply to grandfathered health plans. This section
15 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
16 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6)
17 Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by
18 accident or both; and (9) Other limited benefit policies.

19 SECTION 5. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

1 This act would require that a participant or beneficiary incur no greater out-of-pocket
2 costs for emergency services than they would have incurred with an in-network provider other
3 than in-network cost sharing.

4 This act would take effect upon passage.

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