WEST VIRGINIA LEGISLATURE
SECOND REGULAR SESSION, 2012

ENROLLED
COMMITTEE SUBSTITUTE
FOR
House Bill No. 4260

(By Delegates Fleischauer, Miley, Brown, Caputo, Hunt, Longstreth, Pino, Overington and Sobonya)

Passed March 10, 2012
To Take Effect Ninety Days From Passage
AN ACT to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended; to amend and reenact §5-16B-6e of said code; to amend and reenact §33-16-3v of said code; to amend and reenact §33-24-7k of said code; and to amend and reenact §33-25A-8j of said code, all relating to insurance coverage for autism spectrum disorders; specifying application of benefit caps; clarifying time frames; adding evaluation of autism spectrum disorder to included coverage; clarifying diagnosis, evaluation and treatment requirements; clarifying reporting requirements; and making technical corrections.

Be it enacted by the Legislature of West Virginia:

That §5-16-7 of the Code of West Virginia, 1931, as amended, be amended and reenacted; that §5-16B-6e of said code be amended and reenacted; that §33-16-3v of said code be amended and reenacted; that §33-24-7k of said code be amended and reenacted; and that §33-25A-8j of said code be amended and reenacted, all to read as follows:
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 that its total costs for the treatment of mental illness for any plan exceeded two percent of the total costs for such plan in any experience period, then the agency may apply whatever additional 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 for the next experience period.

(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.

(8)(A) Any plan issued or renewed on or after January 1,
2012, shall include coverage for diagnosis, evaluation and
treatment of autism spectrum disorder in individuals ages
eighteen months to eighteen years. To be eligible for
coverage and benefits under this subdivision, the individual
must be diagnosed with autism spectrum disorder at age eight
or younger. Such policy shall provide coverage for
treatments that are medically necessary and ordered or
prescribed by a licensed physician or licensed psychologist
and in accordance with a treatment plan developed from a
comprehensive evaluation by a certified behavior analyst for
an individual diagnosed with autism spectrum disorder.

(B) The coverage shall include, but not be limited to,
applied behavior analysis. Applied behavior analysis shall be
provided or supervised by a certified behavior analyst. The
annual maximum benefit for applied behavior analysis
required by this subdivision shall be in an amount not to
exceed $30,000 per individual, for three consecutive years
from the date treatment commences. At the conclusion of the
third year, coverage for applied behavior analysis required by
this subdivision shall be in an amount not to exceed $2,000
per month, until the individual reaches eighteen years of age,
as long as the treatment is medically necessary and in
accordance with a treatment plan developed by a certified
behavior analyst pursuant to a comprehensive evaluation or
reevaluation of the individual. This subdivision shall not be
construed as limiting, replacing or affecting any obligation to
provide services to an individual under the Individuals with
Disabilities Education Act, 20 U.S.C. 1400 et seq., as
amended from time to time or other publicly funded
programs. Nothing in this subdivision shall be construed as
requiring reimbursement for services provided by public
school personnel.

(C) The certified behavior analyst shall file progress
reports with the agency semiannually. In order for treatment
to continue, the agency must receive objective evidence or a
clinically supportable statement of expectation that:
(i) The individual’s condition is improving in response to treatment; and

(ii) A maximum improvement is yet to be attained; and

(iii) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(D) On or before January 1 each year, the agency shall file an annual report with the Joint Committee on Government and Finance describing its implementation of the coverage provided pursuant to this subdivision. The report shall include, but shall not be limited to, the number of individuals in the plan utilizing the coverage required by this subdivision, the fiscal and administrative impact of the implementation, and any recommendations the agency may have as to changes in law or policy related to the coverage provided under this subdivision. In addition, the agency shall provide such other information as may be required by the Joint Committee on Government and Finance as it may from time to time request.

(E) For purposes of this subdivision, the term:

(i) “Applied Behavior Analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(ii) “Autism spectrum disorder” means any pervasive developmental disorder, including autistic disorder, Asperger’s Syndrome, Rett Syndrome, childhood
disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(iii) "Certified behavior analyst" means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

(iv) "Objective evidence" means standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required, but their use will enhance the justification for continued treatment.

(F) To the extent that the application of this subdivision for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year the agency may apply additional cost containment measures.

(G) To the extent that the provisions of this subdivision require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of insurance plans offered by the Public Employees Insurance Agency.

(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.
provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from time to time, or other publicly funded programs. Nothing in this section shall be construed as requiring reimbursement for services provided by public school personnel.

(c) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:

1. The individual’s condition is improving in response to treatment; and

2. A maximum improvement is yet to be attained; and

3. There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(d) On or before January 1 each year, the agency shall file an annual report with the Joint Committee on Government and Finance describing its implementation of the coverage provided pursuant to this section. The report shall include, but shall not be limited to, the number of individuals in the plan utilizing the coverage required by this section, the fiscal and administrative impact of the implementation, and any recommendations the agency may have as to changes in law or policy related to the coverage provided under this section. In addition, the agency shall provide such other information as may be requested by the Joint Committee on Government and Finance as it may from time to time request.

(e) For purposes of this section, the term:
(1) “Applied Behavior Analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) “Autism spectrum disorder” means any pervasive developmental disorder, including autistic disorder, Asperger’s Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(3) “Certified behavior analyst” means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

(4) “Objective evidence” means standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required, but their use will enhance the justification for continued treatment.

(f) To the extent that the application of this section for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year the agency may apply additional cost containment measures.

(g) To the extent that the provisions of this section require benefits that exceed the essential health benefits
specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of the West Virginia Children's Health Insurance Program.

CHAPTER 33. INSURANCE.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3v. Required coverage for treatment of autism spectrum disorders.

(a) Any insurer who, on or after January 1, 2012, delivers, renews or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall include coverage for diagnosis, evaluation and treatment of autism spectrum disorder in individuals ages eighteen months to eighteen years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age eight or younger. Such policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(b) Coverage shall include, but not be limited to, applied behavior analysis. Applied behavior analysis shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subsection shall be in an amount not to exceed $30,000 per individual, for three consecutive years from the date treatment commences. At the conclusion of the
third year, required coverage shall be in an amount not to exceed $2,000 per month, until the individual reaches eighteen years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This section shall not be construed as limiting, replacing or affecting any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from time to time or other publicly funded programs. Nothing in this section shall be construed as requiring reimbursement for services provided by public school personnel.

(c) The certified behavior analyst shall file progress reports with the insurer semiannually. In order for treatment to continue, the insurer must receive objective evidence or a clinically supportable statement of expectation that:

1. The individual’s condition is improving in response to treatment; and

2. A maximum improvement is yet to be attained; and

3. There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(d) For purposes of this section, the term:

1. “Applied Behavior Analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and
(2) "Autism spectrum disorder" means any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(3) "Certified behavior analyst" means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

(4) "Objective evidence" means standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required, but their use will enhance the justification for continued treatment.

(e) The provisions of this section do not apply to small employers. For purposes of this section a small employer means any person, firm, corporation, partnership or association actively engaged in business in the State of West Virginia who, during the preceding calendar year, employed an average of no more than twenty-five eligible employees.

(f) To the extent that the application of this section for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year the insurer may apply additional cost containment measures.
(g) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered by a health care insurer in this state.

ARTICLE 24. HOSPITAL MEDICAL AND DENTAL CORPORATIONS.

§33-24-7k. Coverage for diagnosis and treatment of autism spectrum disorders.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article, for policies issued or renewed on or after January 1, 2012, which delivers, renews or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall include coverage for diagnosis and treatment of autism spectrum disorder in individuals ages eighteen months to eighteen years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age eight or younger. The policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

(b) Coverage shall include, but not be limited to, applied behavior analysis. Applied behavior analysis shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis
required by this subsection shall be in an amount not to exceed $30,000 per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required by this subsection shall be in an amount not to exceed $2,000 per month, until the individual reaches eighteen years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This section shall not be construed as limiting, replacing or affecting any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from time to time or other publicly funded programs. Nothing in this section shall be construed as requiring reimbursement for services provided by public school personnel.

(c) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the insurer must receive objective evidence or a clinically supportable statement of expectation that:

(1) The individual's condition is improving in response to treatment; and

(2) A maximum improvement is yet to be attained; and

(3) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

(d) For purposes of this section, the term:

(1) “Applied Behavior Analysis” means the design, implementation, and evaluation of environmental
modifications using behavioral stimuli and consequences, to
produce socially significant improvement in human behavior,
including the use of direct observation, measurement, and
functional analysis of the relationship between environment
and behavior.

(2) "Autism spectrum disorder" means any pervasive
developmental disorder, including autistic disorder,
Asperger's Syndrome, Rett Syndrome, childhood
disintegrative disorder, or Pervasive Development Disorder
as defined in the most recent edition of the Diagnostic and
Statistical Manual of Mental Disorders of the American
Psychiatric Association.

(3) "Certified behavior analyst" means an individual who
is certified by the Behavior Analyst Certification Board or
certified by a similar nationally recognized organization.

(4) "Objective evidence" means standardized patient
assessment instruments, outcome measurements tools or
measurable assessments of functional outcome. Use of
objective measures at the beginning of treatment, during and
after treatment is recommended to quantify progress and
support justifications for continued treatment. The tools are
not required, but their use will enhance the justification for
continued treatment.

(e) The provisions of this section do not apply to small
employers. For purposes of this section a small employer
means any person, firm, corporation, partnership or
association actively engaged in business in the State of West
Virginia who, during the preceding calendar year, employed
an average of no more than twenty-five eligible employees.

(f) To the extent that the application of this section for
autism spectrum disorder causes an increase of at least one
percent of actual total costs of coverage for the plan year the corporation may apply additional cost containment measures.

(g) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered by a corporation in this state.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.


(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article for policies issued or renewed on or after January 1, 2012, which delivers, renews or issues a policy of group accident and sickness insurance in this state under the provisions of this article shall include coverage for diagnosis, evaluation and treatment of autism spectrum disorder in individuals ages eighteen months to eighteen years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age eight or younger. The policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.
(b) Coverage shall include, but not be limited to, applied behavior analysis. Applied behavior analysis shall be provided or supervised by a certified behavior analyst. The annual maximum benefit for applied behavior analysis required by this subsection shall be in amount not to exceed $30,000 per individual, for three consecutive years from the date treatment commences. At the conclusion of the third year, coverage for applied behavior analysis required by this subsection shall be in an amount not to exceed $2,000 per month, until the individual reaches eighteen years of age, as long as the treatment is medically necessary and in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual. This section shall not be construed as limiting, replacing or affecting any obligation to provide services to an individual under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from time to time or other publicly funded programs. Nothing in this section shall be construed as requiring reimbursement for services provided by public school personnel.

(c) The certified behavior analyst shall file progress reports with the agency semiannually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:

1. The individual's condition is improving in response to treatment; and
2. A maximum improvement is yet to be attained; and
3. There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
(d) For purposes of this section, the term:

1. "Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

2. "Autism spectrum disorder" means any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

3. "Certified behavior analyst" means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

4. "Objective evidence" means standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and after treatment is recommended to quantify progress and support justifications for continued treatment. The tools are not required, but their use will enhance the justification for continued treatment.

(e) The provisions of this section do not apply to small employers. For purposes of this section a small employer means any person, firm, corporation, partnership or association actively engaged in business in the State of West
Virginia who, during the preceding calendar year, employed an average of no more than twenty-five eligible employees.

(f) To the extent that the application of this section for autism spectrum disorder causes an increase of at least one percent of actual total costs of coverage for the plan year the health maintenance organization may apply additional cost containment measures.

(g) To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered by a health maintenance organization in this state.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman, House Committee

Chairman, Senate Committee

Originating in the House.

To take effect ninety days from passage.

Clerk of the House of Delegates

Clerk of the Senate

Speaker of the House of Delegates

President of the Senate

The within is approved this the 2nd day of April, 2012.

Earl Ray Tomblin
PRESENTED TO THE GOVERNOR

MAR 26 2012

Time 10:00 am