Sixty-third Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 8, 2013

SENATE BILL NO. 2337
(Senators Sinner, Carlisle, Klein)
(Representatives Keiser, Porter)

AN ACT to amend and reenact subsection 4 of section 14-09-08.20, section 26.1-36.3-01, subsection 4 of section 26.1-36.3-04, and sections 26.1-36.3-06 and 26.1-36.3-11 of the North Dakota Century Code, relating to basic health benefit plans and standard health benefit plans; to repeal sections 26.1-36-09.4, 26.1-36.3-08, 26.1-36.3-10, and 26.1-36.4-07 of the North Dakota Century Code, relating to basic health benefit plans and standard health benefit plans; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 4 of section 14-09-08.20 of the North Dakota Century Code is amended and reenacted as follows:

4. For purposes of this section:

   a. "Basic coverage" means~~:~~

      ~~(1)~~ ~~Health~~ health insurance that includes coverage for the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital care, physician services whether provided within or outside a hospital setting, diagnostic laboratory, and diagnostic and therapeutic radiological services; ~~or~~

      ~~(2) A basic group health benefit plan approved under section 26.1-36.3-08;~~

   b. "Employer" means an entity or individual who would be determined to be an employer under section 3401(d) of the Internal Revenue Code of 1986, as amended [26 U.S.C. 3401(d)], and includes any governmental entity and any labor organization;

   c. "Insurer" has the meaning provided in section 26.1-36.5-01;

   d. "National medical support notice" means the notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 [Pub. L. 105-200; 112 Stat. 645] and regulations adopted thereunder; and

   e. "Title IV-D" has the meaning provided in section 50-09-01.

SECTION 2. AMENDMENT. Section 26.1-36.3-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-01. Definitions.

As used in this chapter and section 26.1-36-37.2, unless the context otherwise requires:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the insurance commissioner, that a small employer carrier is in compliance with section 26.1-36.3-04, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

3. "Association" means, with respect to health insurance coverage offered in this state, an association that:

   a. Has been actively in existence for at least five years;

   b. Has been formed and maintained in good faith for purposes other than obtaining insurance;

   c. Does not condition membership in the association on any health status-related factor relating to an individual, including an employee or dependent of an employee;

   d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members, or individuals eligible for coverage through a member; and

   e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

4. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

5. ~~"Basic health benefit plan" means a lower cost health benefit plan developed under section 26.1-36.3-08.~~

~~6.~~ "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer; however, claim experience, health status, and duration of coverage are not case characteristics.

~~7.~~6. "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

~~8.~~7. "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.

~~9. "Committee" means the health benefit plan committee created under section 26.1-36.3-08.~~

~~10.~~8. "Control" is as defined in section 26.1-10-01.

~~11.~~9. "Dependent" means a spouse, an unmarried child, including a dependent of an unmarried child, under the age of twenty-two, an unmarried child who is a full-time student under the age of twenty-six and who is financially dependent upon the enrollee, and an unmarried child, including a dependent of an unmarried child, of any age who is medically certified as disabled and dependent upon the enrollee as set forth in section 26.1-36-22.

~~12.~~10. "Eligible employee" means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

~~13.~~11. "Enrollee" means a person covered under a small employer health benefit plan.

~~14.~~ 12. "Established geographic service area" means a geographic area, as approved by the insurance commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

~~15.~~ 13. "Governmental plan" means an employee welfare benefit plan as defined in section 3(32) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] or any federal government plan.

~~16.~~ 14. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] to the extent that the plan provides medical care as defined in this section and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of this chapter:

a. A plan, fund, or program that would not be, but for this section, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, must be treated as an employee welfare benefit plan which is a group health benefit plan;

b. In the case of a group health benefit plan, the term "employer" also includes the partnership in relationship to any partner; and

c. In the case of a group health benefit plan, the term "participant" also includes:

(1) In connection with a group health benefit plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(2) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual, if the individual is, or may become, eligible to receive benefits under the plan or the beneficiaries may be eligible to receive any benefit.

~~17.~~ 15. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract.

b. "Health benefit plan" does not include one or more, or any combination of, the following:

(1) Coverage only for accident, or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workforce safety and insurance or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance.

c. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Such other similar, limited benefits as are specified in federal regulations.

d. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits, and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

e. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and

(3) Similar supplemental coverage provided under a group health plan.

f. A carrier offering a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance shall comply with the following:

(1) File with the insurance commissioner on or before March first of each year a certification that contains:

(a) A statement from the carrier certifying that the policy or certificate is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(b) A summary description of the policy or certificate, including the average annual premium rates, or range of premium rates in cases when premiums vary by age, gender, or other factors, charged for the policy and certificate in this state.

(2) When the policy or certificate is offered for the first time in this state on or after August 1, 1993, file with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

~~18.~~16. "Health carrier" or "carrier" means any entity that provides health insurance in this state. For purposes of this chapter, health carrier includes an insurance company, a prepaid limited health service corporation, a fraternal benefit society, a health maintenance organization, nonprofit health service corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

~~19.~~17. "Health status-related factor" means any of the following factors:

a. Health status;

b. Medical condition, including both physical and mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including condition arising out of acts of domestic violence; or

h. Disability.

~~20.~~18. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

~~21.~~19. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty days. An eligible employee or dependent may not be considered a late enrollee, however, if:

a. The individual:

(1) Was covered under qualifying previous coverage at the time of the initial enrollment;

(2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and

(3) Requests enrollment within thirty days after termination of the qualifying previous coverage.

b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

d. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.

~~22.~~20. "Medical care" means amounts paid for:

a. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in subdivision a; and

c. Insurance covering medical care referred to in subdivisions a and b.

~~23.~~21. "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

~~24.~~22. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

~~25.~~23. "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

~~26.~~24. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~27.~~25. "Producer" means insurance producer.

~~28.~~26. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under any of the following:

a. A group health benefit plan;

b. A health benefit plan;

c. Medicare;

d. Medicaid;

e. Civilian health and medical program for uniformed services;

f. A medical care program of the Indian health service or of a tribal organization;

g. A state health benefit risk pool, including coverage issued under chapter 26.1-08;

h. A health plan offered under 5 U.S.C. 89;

i. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government;

j. A health benefit plan under section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and

k. A state's children's health insurance program funded through title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].

The term "qualifying previous coverage" does not include coverage of benefits excepted from the definition of a "health benefit plan" ~~under subsection 17~~.

~~29.~~27. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~30.~~28. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.

~~31.~~29. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered

into a contractual arrangement with the carrier under chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered individuals.

~~32.~~30. "Small employer" means, in connection with a group health plan with respect to a calendar and a plan year, an employer who employed an average of at least two but not more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

~~33.~~31. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

~~34. "Standard health benefit plan" means a health benefit plan developed under section 26.1-36.3-08.~~

SECTION 3. AMENDMENT. Subsection 4 of section 26.1-36.3-04 of the North Dakota Century Code is amended and reenacted as follows:

4. The commissioner may suspend for a specified period the application of subdivision a of subsection 2 as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the small employer carrier or~~, with the prior approval of the committee established pursuant to section 26.1-36.3-08,~~ that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

SECTION 4. AMENDMENT. Section 26.1-36.3-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-06. Availability of coverage.

1. a. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer small employers all health benefit plans it actively markets to small employers in this state~~, including a basic health benefit plan and a standard health benefit plan~~.

   b. (1) Subject to subdivision a of subsection 1, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter and section 26.1-36-37.2. However, a carrier may not be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

   (2) In the case of a small employer carrier that establishes more than one class of business pursuant to section 26.1-36.3-03, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans it actively markets to small employers~~, including at least one basic health benefit plan and at least one standard health benefit plan in each established class of business~~. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan, are not related to a health status-related factor of the small employer, and are applied consistently to all small employers applying for coverage in the class of business. The small employer carrier shall provide for the acceptance of all eligible small employers into one or more classes of business. This paragraph does not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

2. ~~a. A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed under this subdivision may be used by a small employer carrier beginning sixty days after it is filed unless the commissioner disapproves its use.~~

   ~~b. The commissioner after providing notice and an opportunity for a hearing to the small employer carrier may disapprove, at any time, the continued use by a small employer carrier of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter and section 26.1-36-37.2.~~

~~3.~~ Health benefit plans covering small employers must comply with the following:

   a. A health benefit plan may impose a preexisting condition exclusion only if:

      (1) The exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage;

      (2) The exclusion extends for a period of not more than twelve months after the effective date of coverage;

      (3) The exclusion does not relate to pregnancy as a preexisting condition; and

      (4) The exclusion does not treat genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

   b. A small employer carrier shall reduce any time period applicable to a preexisting condition exclusion or limitation period by the aggregate of periods the individual was covered by qualifying previous coverage, if any, if the qualifying previous coverage was continuous until at least sixty-three days prior to the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a group health benefit plan may not be taken into account in determining the period of continuous coverage. This subdivision does not preclude application of an employer waiting period applicable to all new enrollees under the health benefit plan. Small employer carriers shall credit coverage by either a standard method or an alternative method. The commissioner shall adopt rules for crediting coverage under the standard and alternative method. These rules must be consistent with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and any federal rules adopted pursuant thereto.

   c. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.

   d. (1) Except as provided in this subdivision, a small employer carrier shall apply requirements used to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, uniformly among all small employers with the same number of eligible employees who are applying for coverage or receiving coverage from the small employer carrier.

      (2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) (a) Except as provided in subparagraph b, a small employer carrier, in applying minimum participation requirements with respect to a small employer, may not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met. For purposes of determining the applicable percentage of participation under this subparagraph only, individual health benefit plans are not included in the definition of "qualifying existing coverage" under section 26.1-36.3-01.

(b) With respect to a small employer, with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer in applying minimum participation requirements.

(4) A small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

(2) Except as permitted under subsection 1 and this subsection, a small employer carrier may not modify a health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

~~4.~~3. a. A small employer carrier offering coverage through a network plan is not required to offer coverage or accept applications under subsection 1 to a small employer if:

(1) The small employer does not have eligible individuals who live, work, or reside in the service area for such network plan; or

(2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier has demonstrated, if required, to the commissioner that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contractholders and enrollees, and that it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

b. A small employer carrier, upon denying health insurance coverage in any service area in accordance with paragraph 2 of subdivision a, may not offer coverage in the small employer market within the service area for a period of one hundred eighty days after the date the coverage is denied.

~~5.~~4. A small employer carrier is not required to provide coverage to small employers pursuant to subsection 1 for any period of time for which the commissioner determines that the carrier does not have the financial reserves to underwrite additional coverage and is applying this section uniformly without regard to the claims experience of small employers or any health status-related factor relating to employees and their dependents. A small employer carrier denying coverage in accordance with this section may not offer coverage in connection with a group health benefit plan in the small group market for a period of one hundred eighty days

after the health coverage is denied or until the carrier has demonstrated to the commissioner sufficient financial reserves to underwrite financial coverage, whichever is later.

~~6.~~5. Subsection 1 does not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more associations.

SECTION 5. AMENDMENT. Section 26.1-36.3-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-11. Standards to assure fair marketing.

1. Each small employer carrier shall actively market health benefit plan coverage~~, including the basic and standard health benefit plans,~~ to eligible small employers in the state.

2. a. A small employer carrier or producer may not engage in the following activities, directly or indirectly:

   (1) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

   (2) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

   b. Subdivision a does not apply to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. a. A small employer carrier may not enter into any contract, agreement, or arrangement, directly or indirectly, with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

   b. Subdivision a does not apply to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided the percentage does not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

4. ~~A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.~~

~~5.~~ No small employer carrier may terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

~~6.~~5. No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

~~7.~~6. Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

~~8.~~7. A violation of this section by a small employer carrier or a producer is an unfair trade practice under section 26.1-04-03.

~~9.~~ 8. If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator is subject to this section as if it were a small employer carrier.

SECTION 6. REPEAL. Sections 26.1-36-09.4, 26.1-36.3-08, 26.1-36.3-10, and 26.1-36.4-07 of the North Dakota Century Code are repealed.

SECTION 7. EFFECTIVE DATE. This Act becomes effective on January 1, 2014.

President of the Senate	Speaker of the House
Secretary of the Senate	Chief Clerk of the House

This certifies that the within bill originated in the Senate of the Sixty-third Legislative Assembly of North Dakota and is known on the records of that body as Senate Bill No. 2337.

Senate Vote:	Yeas 46	Nays 0	Absent 1
House Vote:	Yeas 65	Nays 29	Absent 0

Secretary of the Senate

Received by the Governor at _____M. on _____, 2013.

Approved at _____M. on _____, 2013.

Governor

Filed in this office this _____day of _____, 2013,

at _____ o'clock _____M.

Secretary of State