

South Carolina Department of Insurance

Capitol Center
1201 Main Street, Suite 1000
Columbia, South Carolina 29201

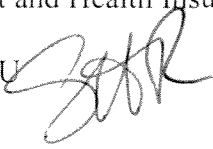
MARK SANFORD
Governor

SCOTT H. RICHARDSON
Director of Insurance

Mailing Address:
P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6160

BULLETIN NUMBER 2009-02

TO: All Insurers, Producers, Third Party Administrators and other Licensees
Transacting Life, Accident and Health Insurance Business

FROM: Scott H. Richardson, CPCU 
Director

SUBJECT: South Carolina Health Care Financial Recovery and Protection Act
(Prompt Pay)

DATE: April 15, 2009

I. PURPOSE

On June 11, 2009 the South Carolina Health Care Financial Recovery and Protection Act (Act) will go into effect.¹ Attached is a copy of the Act. The South Carolina Department of Insurance (Department) is charged with the responsibility of enforcing the provisions set forth in the Act. The purpose of this Bulletin is to provide a brief overview of the Act and to outline the complaint and hearing request procedures.

II. SUMMARY OF THE SOUTH CAROLINA HEALTH CARE FINANCIAL RECOVERY AND PROTECTION ACT

The Act establishes procedures for a health insurer to pay or reimburse a provider for health care services furnished by the provider, including, among other things: timeframes within which a claim for services rendered (which has no material defect or impropriety) must be paid by an insurer; the conditions which constitute a contested claim; interest rates and other fees that may be recovered for claims not paid or properly disputed within the timeframes provided; the applicability of unfair trade practices; timeframes within which an insurer seeking a refund of a payment made for health care services rendered must request the refund; and provisions limiting the number of services and supplies requiring preauthorization by an insurer, provisions relating to written notice which must

¹ See 2008 S.C. Act No. 356.

Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

be provided by insurers of claim policies and procedures, and the adoption of standardized claim forms, so as to revise certain claim form numbers. For purposes of this bulletin, the term “provider” includes, but is not limited to, physicians, hospitals, pharmacies and other persons providing medical services for which reimbursement may be sought from an insurer. The law is intended to apply to all plans and medical services not specifically exempted from the provisions of the Act.

What follows is a general summary of the more pertinent provisions of the Act. Also attached as Exhibit A, is the Department’s response to some specific implementation issues.

Claim Payment Procedures

Specifically, the Act requires insurers to pay clean claims received via paper within forty business days and clean electronic claims within twenty business days following the later of 1) the date the claim is received; or 2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a clean claim. Insurers must stamp paper claims with the date received or maintain an electronic system for determining when claims are submitted.

For purposes of this bulletin, the claim is considered received when it comes into the actual or constructive possession of the person. The document must be received at the last known physical or E-mail address of the person before it is considered received. Simply mailing the document is not sufficient.

Insurers must also acknowledge electronic claims and identify the date claims are received by the insurer. If there is any defect, error, or impropriety in a claim that prevents it from being adjudicated by the insurer, the insurer shall provide notice within twenty business days of receipt for electronic claims and forty business days of receipt for paper claims. Electronic claims cannot be converted to paper claims. Interest shall accrue on any clean claims paid after the twentieth and fortieth date of receipt and must be included either in the claim payment or a separate check with a report detailing the claim for which interest is being paid. Interest will not be due when: 1) a duplicate claim is submitted while the original claim is still being processed; 2) a provider balance bills a plan member in violation of the provider agreement; 3) a force majeure occurs which prevents the adjudication of the claim; or 4) when payment is made to a plan member.

Fee Schedules

Upon the request of the physician, each insurer shall provide electronically his fee schedule to any participating provider with whom the insurer has contracted for up to 100 CPT codes. This must be done within six months of the effective date of the Act. Each

Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department’s enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

physician may request the fee schedule twice annually. A physician may elect to receive a hard copy in lieu of the electronic version of the fee schedule. The insurer may charge a reasonable fee to cover the increased costs of providing the hard copy.

Physicians are required to keep the fee schedule confidential and only to disclose the information to employees who need to have this information in order to perform the responsibilities of their jobs. Those employees have a duty to maintain the confidentiality of this information. The failure of the physician or any member of his staff to protect the confidentiality of this information may constitute a breach of contract and will result in the forfeiture of the physician's right to receive fee schedule information.

III. QUESTIONS

Any questions regarding this Bulletin should be submitted in writing to the attention of David E. Belton, Sr. Associate General Counsel, at dbelton@doi.sc.gov. Complaints alleging a violation of the provisions of this Act may be submitted to the Office of Consumer Services via E-mail at consumers@doi.sc.gov or via telephone at 737-6180 (Columbia) or (800)768-3467 (South Carolina). Written complaints alleging violations of this Act may be mailed to the following address:

Attn: Office of Consumer Services
South Carolina Department of Insurance
Post Office Box 100105
Columbia, South Carolina 29202-3105

Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

FREQUENTLY ASKED QUESTIONS

What follows are the Department's responses to the preliminary questions we have received regarding the implementation of this legislation. The following questions have not been edited.

1. We assume in addition to our Medical plans that the prompt pay requirements must also be met by our Vision and Mental Health vendors. Correct?

RESPONSE: These requirements apply to health insurance plans that provide health insurance coverage as defined in Section 38-71-670(6).

2. Is there a dollar threshold for the interest payments? \$.01, \$1.00, etc.? or must the payment be for any amount even it is just a few cents?

RESPONSE: The statute does not limit the amount of interest payments. However, in lieu of cutting a check for \$.01, the insurer may credit the insured's account by that amount. Notice of the credit must be provided.

3. We assume the payment is for covered services for our members under a South Carolina issued policy. That is, the law is for South Carolina policies. In addition, the payment is for covered services received from South Carolina providers.

RESPONSE: This law applies to South Carolina policies and providers.

4. We assume the interest payments are paid to providers, not members.

RESPONSE: If interest applies, it should be provided to the provider. Section 38-59-340(B)(4) excludes interest payment when made to the plan member.

5. Will any interest rate changes be documented on the SCDOI website or do we need to check the law periodically?

RESPONSE: A copy of that provision will be put on the Department's website. Insurers need to periodically check the law. Refer to Section 34-31-20.

6. Is the definition of "electronic claim" considered as only an EDI 837 or is an electronic print image considered electronic?

RESPONSE: Electronic claims must meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Accordingly, an electronic claim for

Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

purposes of this legislation is the EDI 837 or equivalent format as specified in the HIPAA guidelines or regulations.

7. If a clearinghouse takes an EDI 837 and converts it to an electronic print image does that qualify as a conversion to hardcopy?

RESPONSE: Yes. Section 38-59-230(D) specifically prohibits a clearinghouse, billing services or any other vendor that contracts with a provider to deliver health care claims to an insurer on the provider's behalf from converting them from electronic to paper claims.

8. Are there exceptions to the "no conversion from electronic to hardcopy" rule, for example if a payer is not able to accept electronic claims?

RESPONSE: No. If they are a covered entity, insurers (payers) were required to comply with the administrative simplification requirements of HIPAA in 2002. If they are exempt from compliance with the HIPAA requirement, the Act requires that the claim be submitted on the CMS 1500 or UB 04 claim form.

9. SC stated that this law is effective June 11, 2009 – will there be any retroactive penalties for claims that were converted from electronic to hardcopy before June 11?

RESPONSE: No.

Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

South Carolina General Assembly
117th Session, 2007-2008

A356, R374, H3674

STATUS INFORMATION

General Bill

Sponsors: Reps. Cato, Perry, J.H. Neal, Chellis, Harvin, F.N. Smith, Bedingfield, Simrill, Crawford, Leach, W.D. Smith, Alexander, Bales, Bannister, Dantzler, Edge, Gambrell, Hamilton, Haskins, Kennedy, Lowe, Mitchell, Mulvaney, Ott, Pinson, Sandifer, Scarborough, Shoopman, G.R. Smith, Spires, Stewart, Thompson, Toole, White, Young, Brady, Talley, Clemmons, Owens, Hiott, Skelton and Rice
Document Path: l:\council\bill\nbd\11262ac07.doc

Introduced in the House on March 8, 2007

Introduced in the Senate on March 4, 2008

Last Amended on May 28, 2008

Passed by the General Assembly on June 4, 2008

Governor's Action: June 11, 2008. Signed

Summary: Health Care Financial Recovery and Protection Act

HISTORY OF LEGISLATIVE ACTIONS

Date	Body	Action Description with journal page number
3/8/2007	House	Introduced and read first time HJ-10
3/8/2007	House	Referred to Committee on Labor, Commerce and Industry HJ-11
2/27/2008	House	Member(s) request name added as sponsor: Brady
2/27/2008	House	Committee report: Favorable with amendment Labor, Commerce and Industry HJ-3
2/28/2008	House	Member(s) request name added as sponsor: Talley, Clemmons, Owens, Hiott, Skelton, Rice
2/28/2008	House	Amended HJ-14
2/28/2008	House	Read second time HJ-21
2/28/2008	House	Unanimous consent for third reading on next legislative day HJ-21
2/29/2008	House	Read third time and sent to Senate HJ-1
2/29/2008		Scrivener's error corrected
3/4/2008	Senate	Introduced and read first time SJ-7
3/4/2008	Senate	Referred to Committee on Banking and Insurance SJ-7
3/12/2008	Senate	Committee report: Favorable Banking and Insurance SJ-18
3/13/2008		Scrivener's error corrected
5/14/2008	Senate	Amended SJ-18
5/14/2008	Senate	Read second time SJ-18
5/15/2008		Scrivener's error corrected
5/15/2008	Senate	Read third time and returned to House with amendments SJ-10
5/28/2008	House	Senate amendment amended HJ-188
5/28/2008	House	Returned to Senate with amendments HJ-196
6/4/2008	Senate	Concurred in House amendment and enrolled SJ-308
6/5/2008		Ratified R 374
6/11/2008		Signed By Governor
7/10/2008		Copies available
7/10/2008		Effective date 06/11/09
7/14/2008		Act No. 356

View the latest [legislative information](#) at the LPITS web site

VERSIONS OF THIS BILL

[3/8/2007](#)

[2/27/2008](#)

[2/28/2008](#)

[2/29/2008](#)

[3/12/2008](#)

[3/13/2008](#)

[5/14/2008](#)

[5/15/2008](#)

[5/28/2008](#)

(A356, R374, H3674)

AN ACT TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING ARTICLE 2 TO CHAPTER 59, TITLE 38 SO AS TO ENACT THE "SOUTH CAROLINA HEALTH CARE FINANCIAL RECOVERY AND PROTECTION ACT"; TO REQUIRE AN INSURER, UPON REQUEST, TO PROVIDE THE FEE SCHEDULE THAT IS CONTRACTED WITH THE REQUESTING PHYSICIAN AND TO PROVIDE THAT THE FEE SCHEDULE MUST BE KEPT CONFIDENTIAL; TO PROVIDE THAT CLEAN CLAIMS SUBMITTED BY PAPER MUST BE PAID WITHIN FORTY BUSINESS DAYS OF RECEIPT OR OF THE DATE ALL NECESSARY INFORMATION HAS BEEN RECEIVED AND TWENTY BUSINESS DAYS FOR CLAIMS SUBMITTED ELECTRONICALLY; TO REQUIRE INSURERS TO MAINTAIN A SYSTEM FOR TRACKING RECEIPT AND DISPOSITION OF CLAIMS, TO PROVIDE ACKNOWLEDGEMENT OF CLAIMS RECEIVED AND NOTICE OF DEFECT OR ERRORS IN CLAIMS, AND TO ESTABLISH TIMEFRAMES FOR PROVIDING SUCH INFORMATION; TO PROVIDE THAT CLAIMS THAT ARE NOT TIMELY PAID IN ACCORDANCE WITH THIS ARTICLE ACCRUE INTEREST AT THE LEGAL RATE OF INTEREST, AS PROVIDED FOR IN LAW; TO SPECIFY CIRCUMSTANCES UNDER WHICH INTEREST PAYMENTS ARE NOT REQUIRED; TO ESTABLISH PROCEDURES AND TIMEFRAMES FOR CONDUCTING OVERPAYMENT RECOVERY EFFORTS; TO PROVIDE THAT THIS ARTICLE DOES NOT APPLY TO CLAIMS PROCESSED UNDER ANY NATIONAL ACCOUNT DELIVERY PROGRAM; AND TO PROVIDE THAT THE DEPARTMENT OF INSURANCE SHALL ENFORCE THE PROVISIONS OF THIS ARTICLE AND TO FURTHER SPECIFY SANCTIONS THE DEPARTMENT MAY IMPOSE FOR VIOLATIONS; AND TO AMEND SECTION 38-71-230, RELATING TO WRITTEN NOTICE OF HEALTH INSURANCE CLAIMS POLICIES AND PROCEDURES AND THE ADOPTION OF STANDARDIZED CLAIM FORMS, SO AS TO MAKE TECHNICAL CORRECTIONS.

Be it enacted by the General Assembly of the State of South Carolina:

South Carolina Health Care Financial Recovery and Protection Act

SECTION 1. Chapter 59, Title 38, of the 1976 Code is amended by adding:

“Article 2

South Carolina Health Care Financial Recovery and Protection Act

Section 38-59-200. This article may be cited as the ‘South Carolina Health Care Financial Recovery and Protection Act’.

Section 38-59-210. As used in this article:

(1) ‘Insurer’ means an insurance company, a health maintenance organization, and any other entity providing health insurance coverage, as defined in Section 38-71-670(6), which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

(2) ‘Health care services’ means services included in furnishing an individual medical care or hospitalization, or services incident to the furnishing of medical care or hospitalization, and other services to prevent, alleviate, cure, or heal human illness, injury, or physical disability.

(3) ‘Health maintenance organization’ means an organization as defined in Section 38-33-20(8).

(4) ‘Health insurance plan’ means a health insurance policy or health benefit plan offered by a health insurer or a health maintenance organization that provides health insurance coverage, as defined in Section 38-71-670(6).

(5) ‘Physician’ means a doctor of medicine or doctor of osteopathic medicine licensed by the South Carolina Board of Medical Examiners.

(6) ‘Provider’ means a physician, hospital, or other person properly licensed, certified, or permitted, where required, to furnish health care services.

(7) ‘Participating provider’ means a provider who provides covered health care services to an insured or a member pursuant to a contract with an insurer or health insurance plan.

(8) ‘Clean claim’ means an eligible electronic or paper claim for reimbursement that:

(a) is received by the insurer within one hundred twenty business days of the date the health care services at issue were performed;

(b)(i) when submitted via paper has all the elements of the standardized CMS 1500 or UB 04 claim form, or the successor of each as either may be amended from time to time; or

(ii) when submitted via an electronic transaction, uses only permitted standard code sets and has all the elements of the standard electronic formats as required by the Health Insurance Portability and Accountability Act of 1996 and other federal and state regulatory authority;

(c) is for health care services covered by the health insurance plan and rendered to an insured person by a provider eligible for reimbursement under the health insurance plan;

(d) has any corresponding referral that may be required for the applicable claim;

(e) is a claim for which the insurer is the primary payor, or for which the insurer's responsibility as a secondary payor has been clearly established;

(f) has no material defect, error, or impropriety that would affect the adjudication of the claim;

(g) includes all required substantiating documentation or coding;

(h) is not subject to any particular circumstance that the insurer reasonably believes, subject to review by the Department of Insurance, would prevent accurate or timely payment from being made on the claim under the terms of the health insurance plan, the participating provider agreement, or the insurer's published filing requirements; and

(i) is under a health insurance plan for which the insurer has been timely paid all applicable premiums.

(9) 'Force majeure' means any act of God, governmental act, act of terrorism, war, fire, flood, earthquake, hurricane, or other natural disaster, explosion or civil commotion.

Section 38-59-220. (A) Within six months of the effective date of this article, each insurer, upon written request from a physician who is also a participating provider will provide, by CD-ROM, or electronically at the insurer's option, the fee schedule that is contracted with that physician for up to 100 CPT(r) Codes customarily and routinely used by the specialty type of such physician. Each physician may request from an insurer an updated fee schedule no more than two times annually.

(B) A physician requesting a fee schedule pursuant to subsection (A) may elect to receive a hard copy of the fee schedule in lieu of the foregoing; however, the insurer may charge the physician a reasonable fee to cover the increased administrative costs of providing the hard copy.

(C) The physician shall keep all fee schedule information provided pursuant to this section confidential. The physician shall disclose fee schedule information only to those employees of the physician who have a reasonable need to access this information in order to perform their duties for the physician and who have been placed under an obligation to keep this information confidential. Any failure of a physician's office to abide by this subsection shall result in the physician's forfeiture of the right to receive fee schedules pursuant to this section and at the option of the insurer may constitute a breach of contract by the physician.

(D) Nothing in this section prohibits an insurer from basing actual compensation to the physician on the insurer's maximum allowable amount or other contract adjustments, including those stated in the patient's plan of benefits, or both.

Section 38-59-230. (A) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted via paper within forty business days following the later of the insurer's receipt of the claim or the date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer:

(1) to determine that such claim does not contain any material defect, error, or impropriety; or

(2) to make a payment determination.

(B) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted electronically within twenty business days following the later of the insurer's receipt of the claim or the date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer:

(1) to determine that such claim does not contain any material defect, error, or impropriety; or

(2) to make a payment determination.

(C) An insurer shall affix to or on paper claims, or otherwise maintain a system for determining, the date claims are received by the insurer. An insurer shall send an electronic acknowledgement of claims submitted electronically either to the provider or the provider's designated vendor for the exchange of electronic health care transactions. The acknowledgement must identify the date claims are

received by the insurer. If an insurer determines that there is any defect, error, or impropriety in a claim that prevents the claim from entering the insurer's adjudication system, the insurer shall provide notice of the defect or error either to the provider or the provider's designated vendor for the exchange of electronic health care transactions within twenty business days of the submission of the claim if it was submitted electronically or within forty business days of the claim if it was submitted via paper. Nothing contained in this section is intended or may be construed to alter an insurer's ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

(D) A clearinghouse, billing service, or any other vendor that contracts with a provider to deliver health care claims to an insurer on the provider's behalf is prohibited from converting electronic claims received from the provider into paper claims for submission to the insurer. A violation of this subsection constitutes an unfair trade practice under Chapter 5, Title 39, and individual providers and insurers injured by violations of this subsection have an action for damages as set forth in Section 39-5-140.

Section 38-59-240. (A) For each clean claim with respect to which an insurer has directed the issuance of a check or the electronic funds transfer later than the applicable period specified in Section 38-59-230, the insurer shall pay interest in the same manner and at the same rate set forth in Section 34-31-20(A) on the balance due on each claim computed from the twenty-first or the forty-first business day, as appropriate, based on the circumstances described in Section 38-59-230, up to the date on which the insurer directs the issuance of the check or the electronic funds transfer for payment of the clean claim. At the insurer's election, interest paid pursuant to this section must be included in the claim payment check or wire transfer or must be remitted periodically, but at least quarterly, in a separate check or wire transfer along with a report detailing the claims for which interest is being paid.

(B) No insurer has an obligation to make any interest payment pursuant to subsection (A):

(1) with respect to any clean claim if within twenty business days of the submission of an original claim submitted electronically or within forty business days of an original claim submitted via paper, a duplicate claim is submitted while the adjudication of the original claim is still in process;

(2) to any participating provider who balance bills a plan member in violation of the participating provider's agreement with the insurer;

(3) with respect to any time period during which a force majeure prevents the adjudication of claims; or

(4) when payment is made to a plan member.

Section 38-59-250. (A)(1) An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least thirty business days prior to engaging in the overpayment recovery efforts, other than for recovery of duplicate payments or other similar adjustments relating to:

(a) claims where a provider has received payment for the same services from another payor whose obligation is primary; or

(b) timing or sequence of claims for the same insured that are received by the insurer out of chronological order in which the services were performed.

(2) The written notice required by this section shall include:

(a) the patient's name;

(b) the service date;

(c) the payment amount received by the provider; and

(d) a reasonably specific explanation of the change in payment.

(B) An insurer may not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by the provider; however, this time limit does not apply to the initiation of overpayment recovery efforts:

(1) based upon a reasonable belief of fraud or other intentional misconduct;

(2) required by a self-insured plan; or

(3) required by a state or federal government program.

Section 38-59-260. The requirements of this article do not apply to claims that are processed under any national account delivery program in which an insurer participates but is not solely responsible for the processing and payment of the claims, or claims for services under a program offered or sponsored by any state or federal governmental entity other than in its capacity as an employer, or both.

Section 38-59-270. The Department of Insurance shall enforce the provisions of this article. If, after due notice and hearing, the director of the Department of Insurance or his designee determines that an insurer has failed to meet the obligations imposed by this article, he shall order

the insurer to cease and desist from the practice, to correct any errant business practices, and to make any payments due, including applicable interest. If an insurer does not comply with the order within thirty days, the director or his designee may then impose a penalty as provided in Section 38-2-10. Nothing in this article may be construed to create a private right of action to enforce the specific provisions of this article.”

Standardized forms

SECTION 2. Section 38-71-230 (B) and (C) of the 1976 Code is amended to read:

“(B) An organization providing payment or reimbursement for diagnosis and treatment of a condition or a complaint by a licensed physician in South Carolina must accept the standardized CMS 1500 claim form, or its successor as it may be amended from time to time. An organization providing payment or reimbursement for diagnosis and treatment of a condition or a complaint by a hospital licensed in South Carolina shall accept the standardized UB 04 claim form, or its successor as it may be amended from time to time.

(C) The CMS 1500 or the UB 04 claim form or the successor of each or as either may be amended from time to time may be altered only with a customized logo which must appear in the top portion of the claim form one inch vertical from the top.”

Severability clause

SECTION 3. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

Time effective

SECTION 4. This act takes effect one year after approval by the Governor.

Ratified the 5th day of June, 2008.

Approved the 11th day of June, 2008.
