Rep. Lou Lang

Filed: 4/6/2018

AMENDMENT TO HOUSE BILL 68

AMENDMENT NO. ______. Amend House Bill 68, AS AMENDED, by inserting immediately below the enacting clause the following:

"Section 3. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, ~~and~~ 356z.25, and 356z.26 of the Illinois Insurance Code. The program of health benefits

1 must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c,
2 and 370c.1 of the Illinois Insurance Code. The Department of
3 Insurance shall enforce the requirements of this Section.
4 Rulemaking authority to implement Public Act 95-1045, if
5 any, is conditioned on the rules being adopted in accordance
6 with all provisions of the Illinois Administrative Procedure
7 Act and all rules and procedures of the Joint Committee on
8 Administrative Rules; any purported rule not so adopted, for
9 whatever reason, is unauthorized.
10 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
11 100-138, eff. 8-18-17; revised 10-3-17.)"; and

12 by inserting immediately below Section 5 the following:

13 "Section 6. The Counties Code is amended by changing
14 Section 5-1069.3 as follows:

15 (55 ILCS 5/5-1069.3)
16 Sec. 5-1069.3. Required health benefits. If a county,
17 including a home rule county, is a self-insurer for purposes of
18 providing health insurance coverage for its employees, the
19 coverage shall include coverage for the post-mastectomy care
20 benefits required to be covered by a policy of accident and
21 health insurance under Section 356t and the coverage required
22 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
23 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,

356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, and 356z.26 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

Section 7. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance

coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, and 356z.26 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

Section 8. The School Code is amended by changing Section

1 10-22.3f as follows:

2 (105 ILCS 5/10-22.3f)
3 Sec. 10-22.3f. Required health benefits. Insurance
4 protection and benefits for employees shall provide the
5 post-mastectomy care benefits required to be covered by a
6 policy of accident and health insurance under Section 356t and
7 the coverage required under Sections 356g, 356g.5, 356g.5-1,
8 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
9 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, and 356z.26 of
10 the Illinois Insurance Code. Insurance policies shall comply
11 with Section 356z.19 of the Illinois Insurance Code. The
12 coverage shall comply with Sections 155.22a, ~~and~~ 355b, and 370c
13 of the Illinois Insurance Code. The Department of Insurance
14 shall enforce the requirements of this Section.
15 Rulemaking authority to implement Public Act 95-1045, if
16 any, is conditioned on the rules being adopted in accordance
17 with all provisions of the Illinois Administrative Procedure
18 Act and all rules and procedures of the Joint Committee on
19 Administrative Rules; any purported rule not so adopted, for
20 whatever reason, is unauthorized.
21 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
22 revised 9-25-17.)"; and

23 in Section 10, by inserting immediately below paragraph (6) of
24 subsection (b) of Sec. 370c the following:

1 "(6.5) An individual or group health benefit plan amended,
2 delivered, issued, or renewed on or after the effective date of
3 this amendatory Act of the 100th General Assembly:
4 (A) shall not impose prior authorization requirements
5 on a prescription medication approved by the United States
6 Food and Drug Administration for the treatment of substance
7 use disorders;
8 (B) shall not impose any step therapy requirements
9 before authorizing coverage for a prescription medication
10 approved by the United States Food and Drug Administration
11 for the treatment of substance use disorders;
12 (C) shall place all prescription medications approved
13 by the United States Food and Drug Administration for the
14 treatment of substance use disorders on the lowest tier of
15 the drug formulary developed and maintained by the insurer;
16 and
17 (D) shall not exclude coverage for a prescription
18 medication approved by the United States Food and Drug
19 Administration for the treatment of substance use
20 disorders and any associated counseling or wraparound
21 services on the grounds that such medications and services
22 were court ordered."; and

23 in Section 10, by replacing subsection (d) of Sec. 370c with
24 the following:
25 "(d) With respect to a group or individual policy of

1 accident and health insurance or a qualified health plan
2 offered through the health insurance marketplace, the
3 Department and, with respect to medical assistance, the
4 Department of Healthcare and Family Services shall each enforce
5 the requirements of this Section and Sections 356z.23 and
6 370c.1 of this Code, the Paul Wellstone and Pete Domenici
7 Mental Health Parity and Addiction Equity Act of 2008, 42
8 U.S.C. 18031(j), and any amendments to, and federal guidance or
9 regulations issued under, those Acts, including, but not
10 limited to, final regulations issued under the Paul Wellstone
11 and Pete Domenici Mental Health Parity and Addiction Equity Act
12 of 2008 and final regulations applying the Paul Wellstone and
13 Pete Domenici Mental Health Parity and Addiction Equity Act of
14 2008 to Medicaid managed care organizations, the Children's
15 Health Insurance Program, and alternative benefit plans.
16 Specifically, the Department and the Department of Healthcare
17 and Family Services shall take action:
18 (1) proactively ensuring compliance by individual and
19 group policies;
20 (2) evaluating all consumer or provider complaints
21 regarding mental, emotional, nervous, or substance use
22 disorder or condition coverage for possible parity
23 violations;
24 (3) maintaining and regularly reviewing for possible
25 parity violations a publicly available consumer complaint
26 log regarding mental, emotional, nervous, or substance use

1 disorders or conditions coverage;
2 (4) requiring that insurers submit comparative
3 analyses during the form or contract review process
4 demonstrating how they design and apply nonquantitative
5 treatment limitations, both as written and in operation,
6 for mental, emotional, nervous, or substance use disorder
7 or condition benefits as compared to how they design and
8 apply nonquantitative treatment limitations, as written
9 and in operation, for medical and surgical benefits;
10 (5) performing parity compliance market conduct
11 examinations of individual and group plans and policies,
12 including, but not limited to, reviews of:
13 (A) nonquantitative treatment limitations,
14 including, but not limited to, prior authorization
15 requirements, concurrent review, retrospective review,
16 step therapy, network admission standards,
17 reimbursement rates, and geographic restrictions;
18 (B) denials of authorization, payment, and
19 coverage; and
20 (C) other specific criteria as set forth in rules
21 adopted by the Department.
22 The findings and the conclusions of the parity compliance
23 market conduct examinations shall be made public and shall be
24 reported to the General Assembly.
25 The Director shall adopt rules to effectuate any provisions
26 of the Paul Wellstone and Pete Domenici Mental Health Parity

1 and Addiction Equity Act of 2008 that relate to the business of
2 insurance.
3 ~~(d) The Department shall enforce the requirements of State~~
4 ~~and federal parity law, which includes ensuring compliance by~~
5 ~~individual and group policies; detecting violations of the law~~
6 ~~by individual and group policies proactively monitoring~~
7 ~~discriminatory practices; accepting, evaluating, and~~
8 ~~responding to complaints regarding such violations; and~~
9 ~~ensuring violations are appropriately remedied and deterred.~~";
10 and

11 in Section 10, by deleting paragraph (4) of subsection (h) of
12 Sec. 370c.1; and

13 in Section 10, by replacing paragraph (18) of subsection (j) of
14 Sec. 370c.1 with the following:
15 "(18) A description of the process used to develop or
16 select the medical necessity criteria for mental,
17 emotional, nervous, or substance use disorder or condition
18 benefits and the process used to develop or select the
19 medical necessity criteria for medical and surgical
20 benefits.
21 (19) Identification of all nonquantitative treatment
22 limitations that are applied to both mental, emotional,
23 nervous, or substance use disorder or condition benefits
24 and medical and surgical benefits within each

1 classification of benefits; there may be no separate
2 nonquantitative treatment limitations that apply to
3 mental, emotional, nervous, or substance use disorder or
4 condition benefits but do not apply to medical and surgical
5 benefits within any classification of benefits.
6 (20) The results of an analysis that demonstrates that
7 for the medical necessity criteria described in
8 subparagraph (A) and for each nonquantitative treatment
9 limitation identified in subparagraph (B), as written and
10 in operation, the processes, strategies, evidentiary
11 standards, or other factors used in applying the medical
12 necessity criteria and each nonquantitative treatment
13 limitation to mental, emotional, nervous, or substance use
14 disorder or condition benefits within each classification
15 of benefits are comparable to, and are applied no more
16 stringently than, the processes, strategies, evidentiary
17 standards, or other factors used in applying the medical
18 necessity criteria and each nonquantitative treatment
19 limitation to medical and surgical benefits within the
20 corresponding classification of benefits; at a minimum,
21 the results of the analysis shall:
22 (A) identify the factors used to determine that a
23 nonquantitative treatment limitation applies to a
24 benefit, including factors that were considered but
25 rejected;
26 (B) identify and define the specific evidentiary

1 standards used to define the factors and any other
2 evidence relied upon in designing each nonquantitative
3 treatment limitation;
4 (C) provide the comparative analyses, including
5 the results of the analyses, performed to determine
6 that the processes and strategies used to design each
7 nonquantitative treatment limitation, as written, for
8 mental, emotional, nervous, or substance use disorder
9 or condition benefits are comparable to, and are
10 applied no more stringently than, the processes and
11 strategies used to design each nonquantitative
12 treatment limitation, as written, for medical and
13 surgical benefits;
14 (D) provide the comparative analyses, including
15 the results of the analyses, performed to determine
16 that the processes and strategies used to apply each
17 nonquantitative treatment limitation, in operation,
18 for mental, emotional, nervous, or substance use
19 disorder or condition benefits are comparable to, and
20 applied no more stringently than, the processes or
21 strategies used to apply each nonquantitative
22 treatment limitation, in operation, for medical and
23 surgical benefits; and
24 (E) disclose the specific findings and conclusions
25 reached by the insurer that the results of the analyses
26 described in subparagraphs (C) and (D) indicate that

1 the insurer is in compliance with this Section and the
2 Mental Health Parity and Addiction Equity Act of 2008
3 and its implementing regulations, which includes 42
4 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any
5 other related federal regulations found in the Code of
6 Federal Regulations."; and

7 in Section 10, in paragraph (19) of subsection (j) of Sec.
8 370c.1, by replacing "(19)" with "(21)"; and

9 in Section 10, in paragraph (20) of subsection (j) of Sec.
10 370c.1, by replacing "(20)" with "(22)"; and

11 in Section 10, by replacing subsection (k) of Sec. 370c.1 with
12 the following:
13 "(k) An insurer that amends, delivers, issues, or renews a
14 group or individual policy of accident and health insurance or
15 a qualified health plan offered through the health insurance
16 marketplace in this State providing coverage for hospital or
17 medical treatment and for the treatment of mental, emotional,
18 nervous, or substance use disorders or conditions on or after
19 the effective date of this amendatory Act of the 100th General
20 Assembly shall, in advance of the plan year, make available to
21 the Department or, with respect to medical assistance, the
22 Department of Healthcare and Family Services and to all plan
23 participants and beneficiaries the information required in

1 subparagraphs (C) through (E) of paragraph (20) of subsection
2 (j). For plan participants and medical assistance
3 beneficiaries, the information required in subparagraphs (C)
4 through (E) of paragraph (20) of subsection (j) shall be made
5 available on a publicly-available website whose web address is
6 prominently displayed in plan and managed care organization
7 informational and marketing materials.

8 (l) In accordance with the Illinois State Auditing Act, the
9 Auditor General shall undertake a review of compliance by the
10 Department and the Department of Healthcare and Family Services
11 with the provisions set forth in Section 370c and this Section
12 and report to the General Assembly within 6 months after the
13 effective date of this amendatory Act of the 100th General
14 Assembly and annually thereafter."; and

15 by inserting immediately below Section 10 the following:

16 "Section 15. The Illinois Public Aid Code is amended by
17 changing Section 5-30.1 as follows:

18 (305 ILCS 5/5-30.1)

19 Sec. 5-30.1. Managed care protections.

20 (a) As used in this Section:

21 "Managed care organization" or "MCO" means any entity which
22 contracts with the Department to provide services where payment
23 for medical services is made on a capitated basis.

1 "Emergency services" include:
2 (1) emergency services, as defined by Section 10 of the
3 Managed Care Reform and Patient Rights Act;
4 (2) emergency medical screening examinations, as
5 defined by Section 10 of the Managed Care Reform and
6 Patient Rights Act;
7 (3) post-stabilization medical services, as defined by
8 Section 10 of the Managed Care Reform and Patient Rights
9 Act; and
10 (4) emergency medical conditions, as defined by
11 Section 10 of the Managed Care Reform and Patient Rights
12 Act.
13 (b) As provided by Section 5-16.12, managed care
14 organizations are subject to the provisions of the Managed Care
15 Reform and Patient Rights Act.
16 (c) An MCO shall pay any provider of emergency services
17 that does not have in effect a contract with the contracted
18 Medicaid MCO. The default rate of reimbursement shall be the
19 rate paid under Illinois Medicaid fee-for-service program
20 methodology, including all policy adjusters, including but not
21 limited to Medicaid High Volume Adjustments, Medicaid
22 Percentage Adjustments, Outpatient High Volume Adjustments,
23 and all outlier add-on adjustments to the extent such
24 adjustments are incorporated in the development of the
25 applicable MCO capitated rates.
26 (d) An MCO shall pay for all post-stabilization services as

1 a covered service in any of the following situations:
2 (1) the MCO authorized such services;
3 (2) such services were administered to maintain the
4 enrollee's stabilized condition within one hour after a
5 request to the MCO for authorization of further
6 post-stabilization services;
7 (3) the MCO did not respond to a request to authorize
8 such services within one hour;
9 (4) the MCO could not be contacted; or
10 (5) the MCO and the treating provider, if the treating
11 provider is a non-affiliated provider, could not reach an
12 agreement concerning the enrollee's care and an affiliated
13 provider was unavailable for a consultation, in which case
14 the MCO must pay for such services rendered by the treating
15 non-affiliated provider until an affiliated provider was
16 reached and either concurred with the treating
17 non-affiliated provider's plan of care or assumed
18 responsibility for the enrollee's care. Such payment shall
19 be made at the default rate of reimbursement paid under
20 Illinois Medicaid fee-for-service program methodology,
21 including all policy adjusters, including but not limited
22 to Medicaid High Volume Adjustments, Medicaid Percentage
23 Adjustments, Outpatient High Volume Adjustments and all
24 outlier add-on adjustments to the extent that such
25 adjustments are incorporated in the development of the
26 applicable MCO capitated rates.

1 (e) The following requirements apply to MCOs in determining
2 payment for all emergency services:
3 (1) MCOs shall not impose any requirements for prior
4 approval of emergency services.
5 (2) The MCO shall cover emergency services provided to
6 enrollees who are temporarily away from their residence and
7 outside the contracting area to the extent that the
8 enrollees would be entitled to the emergency services if
9 they still were within the contracting area.
10 (3) The MCO shall have no obligation to cover medical
11 services provided on an emergency basis that are not
12 covered services under the contract.
13 (4) The MCO shall not condition coverage for emergency
14 services on the treating provider notifying the MCO of the
15 enrollee's screening and treatment within 10 days after
16 presentation for emergency services.
17 (5) The determination of the attending emergency
18 physician, or the provider actually treating the enrollee,
19 of whether an enrollee is sufficiently stabilized for
20 discharge or transfer to another facility, shall be binding
21 on the MCO. The MCO shall cover emergency services for all
22 enrollees whether the emergency services are provided by an
23 affiliated or non-affiliated provider.
24 (6) The MCO's financial responsibility for
25 post-stabilization care services it has not pre-approved
26 ends when:

1 (A) a plan physician with privileges at the
2 treating hospital assumes responsibility for the
3 enrollee's care;
4 (B) a plan physician assumes responsibility for
5 the enrollee's care through transfer;
6 (C) a contracting entity representative and the
7 treating physician reach an agreement concerning the
8 enrollee's care; or
9 (D) the enrollee is discharged.
10 (f) Network adequacy and transparency.
11 (1) The Department shall:
12 (A) ensure that an adequate provider network is in
13 place, taking into consideration health professional
14 shortage areas and medically underserved areas;
15 (B) publicly release an explanation of its process
16 for analyzing network adequacy;
17 (C) periodically ensure that an MCO continues to
18 have an adequate network in place; and
19 (D) require MCOs, including Medicaid Managed Care
20 Entities as defined in Section 5-30.2, to meet provider
21 directory requirements under Section 5-30.3.
22 (2) Each MCO shall confirm its receipt of information
23 submitted specific to physician additions or physician
24 deletions from the MCO's provider network within 3 days
25 after receiving all required information from contracted
26 physicians, and electronic physician directories must be

1 updated consistent with current rules as published by the
2 Centers for Medicare and Medicaid Services or its successor
3 agency.
4 (g) Timely payment of claims.
5 (1) The MCO shall pay a claim within 30 days of
6 receiving a claim that contains all the essential
7 information needed to adjudicate the claim.
8 (2) The MCO shall notify the billing party of its
9 inability to adjudicate a claim within 30 days of receiving
10 that claim.
11 (3) The MCO shall pay a penalty that is at least equal
12 to the penalty imposed under the Illinois Insurance Code
13 for any claims not timely paid.
14 (4) The Department may establish a process for MCOs to
15 expedite payments to providers based on criteria
16 established by the Department.
17 (g-5) Recognizing that the rapid transformation of the
18 Illinois Medicaid program may have unintended operational
19 challenges for both payers and providers:
20 (1) in no instance shall a medically necessary covered
21 service rendered in good faith, based upon eligibility
22 information documented by the provider, be denied coverage
23 or diminished in payment amount if the eligibility or
24 coverage information available at the time the service was
25 rendered is later found to be inaccurate; and
26 (2) the Department shall, by December 31, 2016, adopt

1 rules establishing policies that shall be included in the
2 Medicaid managed care policy and procedures manual
3 addressing payment resolutions in situations in which a
4 provider renders services based upon information obtained
5 after verifying a patient's eligibility and coverage plan
6 through either the Department's current enrollment system
7 or a system operated by the coverage plan identified by the
8 patient presenting for services:

9 (A) such medically necessary covered services
10 shall be considered rendered in good faith;

11 (B) such policies and procedures shall be
12 developed in consultation with industry
13 representatives of the Medicaid managed care health
14 plans and representatives of provider associations
15 representing the majority of providers within the
16 identified provider industry; and

17 (C) such rules shall be published for a review and
18 comment period of no less than 30 days on the
19 Department's website with final rules remaining
20 available on the Department's website.

21 (3) The rules on payment resolutions shall include, but
22 not be limited to:

23 (A) the extension of the timely filing period;

24 (B) retroactive prior authorizations; and

25 (C) guaranteed minimum payment rate of no less than
26 the current, as of the date of service, fee-for-service

1 rate, plus all applicable add-ons, when the resulting
2 service relationship is out of network.
3 (4) The rules shall be applicable for both MCO coverage
4 and fee-for-service coverage.
5 (g-6) MCO Performance Metrics Report.
6 (1) The Department shall publish, on at least a
7 quarterly basis, each MCO's operational performance,
8 including, but not limited to, the following categories of
9 metrics:
10 (A) claims payment, including timeliness and
11 accuracy;
12 (B) prior authorizations;
13 (C) grievance and appeals;
14 (D) utilization statistics;
15 (E) provider disputes;
16 (F) provider credentialing; and
17 (G) member and provider customer service.
18 (2) The Department shall collect and report on the
19 metrics identified in subparagraphs (A), (B), (D), (E), and
20 (F) of paragraph (1) by behavioral health providers and
21 non-behavioral health providers. The Department shall
22 specifically report data on the following provider types
23 independent of each other, but within the same behavioral
24 health umbrella:
25 (A) community mental health centers; and
26 (B) alcohol and substance abuse providers.

(3) ~~(2)~~ The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(4) ~~(3)~~ The metrics shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(5) ~~(4)~~ Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(g-8) An MCO shall enter into a contract with any willing

1 and qualified alcohol and substance abuse provider or certified
2 community health center so long as the alcohol and substance
3 abuse provider or certified community health center agrees to
4 the MCO's rate and adheres to the MCO's requirements.
5 (h) The Department shall not expand mandatory MCO
6 enrollment into new counties beyond those counties already
7 designated by the Department as of June 1, 2014 for the
8 individuals whose eligibility for medical assistance is not the
9 seniors or people with disabilities population until the
10 Department provides an opportunity for accountable care
11 entities and MCOs to participate in such newly designated
12 counties.
13 (i) The requirements of this Section apply to contracts
14 with accountable care entities and MCOs entered into, amended,
15 or renewed after June 16, 2014 (the effective date of Public
16 Act 98-651).
17 (Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16;
18 100-201, eff. 8-18-17; 100-580, eff. 3-12-18.)

19 Section 99. Effective date. This Act takes effect upon
20 becoming law.".