AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Prior Authorization Reform Act.

Section 5. Purpose. The General Assembly hereby finds and declares that:

(1) the health care professional-patient relationship is paramount and should not be subject to third-party intrusion;

(2) prior authorization programs shall be subject to member coverage agreements and medical policies but shall not hinder the independent medical judgment of a physician or health care provider; and

(3) prior authorization programs must be transparent to ensure a fair and consistent process for health care providers and patients.

Section 10. Applicability; scope. This Act applies to health insurance coverage as defined in the Illinois Health Insurance Portability and Accountability Act, and policies issued or delivered in this State to the Department of Healthcare and Family Services and providing coverage to

persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act, amended, delivered, issued, or renewed on or after the effective date of this Act, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974, health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act, and State, employee, unit of local government, or school district health plans. This Act does not diminish a health care plan's duties and responsibilities under other federal or State law or rules promulgated thereunder. This Act is not intended to alter or impede the provisions of any consent decree or judicial order to which the State or any of its agencies is a party.

Section 15. Definitions. As used in this Act:

"Adverse determination" has the meaning given to that term in Section 10 of the Health Carrier External Review Act.

"Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination.

"Approval" means a determination by a health insurance issuer or its contracted utilization review organization that a health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's or its contracted utilization review organization's requirements for medical necessity and appropriateness.

"Clinical review criteria" has the meaning given to that term in Section 10 of the Health Carrier External Review Act.

"Department" means the Department of Insurance.

"Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Emergency services" has the meaning given to that term in federal health insurance reform requirements for the group and individual health insurance markets, 45 CFR 147.138.

"Enrollee" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Health care professional" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Health care provider" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act, except that facilities licensed under the Nursing Home Care Act and long-term care facilities as defined in Section 1-113 of the Nursing Home Care Act are excluded from this Act.

"Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health, and

pharmaceutical services and products.

"Health insurance issuer" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party, but focused on what is best for the patient's health outcome.

"Physician" means a person licensed under the Medical Practice Act of 1987 or licensed under the laws of another state to practice medicine in all its branches.

"Prior authorization" means the process by which health insurance issuers or their contracted utilization review organizations determine the medical necessity and medical appropriateness of otherwise covered health care services before the rendering of such health care services. "Prior authorization" includes any health insurance issuer's or its contracted utilization review organization's requirement that

an enrollee, health care professional, or health care provider notify the health insurance issuer or its contracted utilization review organization before, at the time of, or concurrent to providing a health care service.

"Urgent health care service" means a health care service with respect to which the application of the time periods for making a non-expedited prior authorization that in the opinion of a health care professional with knowledge of the enrollee's medical condition:

(1) could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(2) could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

"Urgent health care service" does not include emergency services.

"Utilization review organization" has the meaning given to that term in 50 Ill. Adm. Code 4520.30.

Section 20. Disclosure and review of prior authorization requirements.

(a) A health insurance issuer shall maintain a complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the health

insurance issuer.

(b) A health insurance issuer shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals, and health care providers. Content published by a third party and licensed for use by a health insurance issuer or its contracted utilization review organization may be made available through the health insurance issuer's or its contracted utilization review organization's secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall indicate for each service subject to prior authorization:

(1) when prior authorization became required for policies issued or delivered in Illinois, including the effective date or dates and the termination date or dates, if applicable, in Illinois;

(2) the date the Illinois-specific requirement was listed on the health insurance issuer's or its contracted utilization review organization's website;

(3) where applicable, the date that prior authorization was removed for Illinois; and

(4) where applicable, access to a standardized electronic prior authorization request transaction process.

(c) The clinical review criteria must:

(1) be based on nationally recognized, generally accepted standards except where State law provides its own standard;

(2) be developed in accordance with the current standards of a national medical accreditation entity;

(3) ensure quality of care and access to needed health care services;

(4) be evidence-based;

(5) be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and

(6) be evaluated and updated, if necessary, at least annually.

(d) A health insurance issuer shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim.

(e) A health insurance issuer or its contracted utilization review organization shall not deem as incidental or deny supplies or health care services that are routinely used as part of a health care service when:

(1) an associated health care service has received prior authorization; or

(2) prior authorization for the health care service is not required.

(f) If a health insurance issuer intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the health insurance issuer shall provide contracted health care professionals and contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. The written notice may be provided in an electronic format, including email or facsimile, if the health care professional or health care provider has agreed in advance to receive notices electronically. The health insurance issuer shall ensure that the new or amended requirement is not implemented unless the health insurance issuer's or its contracted utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

(g) Entities using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. The statistics must be updated annually and include all of the following information:

(1) a list of all health care services, including medications, that are subject to prior authorization;

(2) the total number of prior authorization requests

received;

(3) the number of prior authorization requests denied during the previous plan year by the health insurance issuer or its contracted utilization review organization with respect to each service described in paragraph (1) and the top 5 reasons for denial;

(4) the number of requests described in paragraph (3) that were appealed, the number of the appealed requests that upheld the adverse determination, and the number of appealed requests that reversed the adverse determination;

(5) the average time between submission and response; and

(6) any other information as the Director determines appropriate.

Section 25. Health insurance issuer's and its contracted utilization review organization's obligations with respect to prior authorizations in nonurgent circumstances. Notwithstanding any other provision of law, if a health insurance issuer requires prior authorization of a health care service, the health insurance issuer or its contracted utilization review organization must make an approval or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the approval or adverse determination as required by applicable law, but no later than 5 calendar days after

obtaining all necessary information to make the approval or adverse determination. As used in this Section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion, or other clinical information that is directly applicable to the requested service that may be required.

Section 30. Health insurance issuer's and its contracted utilization review organization's obligations with respect to prior authorizations concerning urgent health care services.

(a) Notwithstanding any other provision of law, a health insurance issuer or its contracted utilization review organization must render an approval or adverse determination concerning urgent care services and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of that approval or adverse determination as required by law, but not later than 48 hours after receiving all information needed to complete the review of the requested health care services.

(b) To facilitate the rendering of a prior authorization determination in conformance with this Section, a health insurance issuer or its contracted utilization review organization must establish a mechanism to ensure health care professionals have access to appropriately trained and licensed clinical personnel who have access to physicians for consultation, designated by the plan to make such

determinations for prior authorization concerning urgent care services.

Section 35. Personnel qualified to make adverse determinations of a prior authorization request. A health insurance issuer or its contracted utilization review organization must ensure that all adverse determinations are made by a physician when the request is by a physician or a representative of a physician. The physician must:

(1) possess a current and valid nonrestricted license in any United States jurisdiction; and

(2) have experience treating and managing patients with the medical condition or disease for which the health care service is being requested.

Notwithstanding the foregoing, a licensed health care professional who satisfies the requirements of this Section may make an adverse determination of a prior authorization request submitted by a health care professional licensed in the same profession.

Section 40. Requirements for adverse determination. If a health insurance issuer or its contracted utilization review organization makes an adverse determination, the health insurance issuer or its contracted utilization review organization shall include the following in the notification to the enrollee, the enrollee's health care professional, and

the enrollee's health care provider:

(1) the reasons for the adverse determination and related evidence-based criteria, including a description of any missing or insufficient documentation;

(2) the right to appeal the adverse determination;

(3) instructions on how to file the appeal; and

(4) additional documentation necessary to support the appeal.

Section 45. Requirements applicable to the personnel who can review appeals. A health insurance issuer or its contracted utilization review organization must ensure that all appeals are reviewed by a physician when the request is by a physician or a representative of a physician. The physician must:

(1) possess a current and valid nonrestricted license to practice medicine in any United States jurisdiction;

(2) be in the same or similar specialty as a physician who typically manages the medical condition or disease;

(3) be knowledgeable of, and have experience providing, the health care services under appeal;

(4) not have been directly involved in making the adverse determination; and

(5) consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the

health insurance issuer or its contracted utilization review organization by the enrollee's health care professional or health care provider and any medical literature provided to the health insurance issuer or its contracted utilization review organization by the health care professional or health care provider.

Notwithstanding the foregoing, a licensed health care professional who satisfies the requirements in this Section may review appeal requests submitted by a health care professional licensed in the same profession.

Section 50. Review of prior authorization requirements. A health insurance issuer shall periodically review its prior authorization requirements and consider removal of prior authorization requirements:

(1) where a medication or procedure prescribed is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications; or

(2) for patients currently managed with an established treatment regimen.

Section 55. Denial.

(a) The health insurance issuer or its contracted utilization review organization may not revoke or further limit, condition, or restrict a previously issued prior

authorization approval while it remains valid under this Act.

(b) Notwithstanding any other provision of law, if a claim is properly coded and submitted timely to a health insurance issuer, the health insurance issuer shall make payment according to the terms of coverage on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one of the following occurs:

(1) it is timely determined that the enrollee's health care professional or health care provider knowingly provided health care services that required prior authorization from the health insurance issuer or its contracted utilization review organization without first obtaining prior authorization for those health care services;

(2) it is timely determined that the health care services claimed were not performed;

(3) it is timely determined that the health care services rendered were contrary to the instructions of the health insurance issuer or its contracted utilization review organization or delegated reviewer if contact was made between those parties before the service being rendered;

(4) it is timely determined that the enrollee receiving such health care services was not an enrollee of the health care plan; or

(5) the approval was based upon a material misrepresentation by the enrollee, health care professional, or health care provider; as used in this paragraph (5), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(c) Nothing in this Section shall preclude a utilization review organization or a health insurance issuer from performing post-service reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse.

Section 60. Length of prior authorization approval. A prior authorization approval shall be valid for the lesser of 6 months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care professional or the renewal of the plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. All dosage increases must be based on established evidentiary standards and nothing in this Section shall prohibit a health insurance issuer from having safety edits in place. This Section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids. Except to the extent required by medical

exceptions processes for prescription drugs set forth in Section 45.1 of the Managed Care Reform and Patient Rights Act, nothing in this Section shall require a policy to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Section 65. Length of prior authorization approval for treatment for chronic or long-term conditions. If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, the approval shall remain valid for the lesser of 12 months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional. This Section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids. Except to the extent required by medical exceptions processes for prescription drugs set forth in Section 45.1 of the Managed Care Reform and Patient Rights Act, nothing in this Section shall require a policy to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care,

treatment, or services are medically necessary.

Section 70. Continuity of care for enrollees.

(a) On receipt of information documenting a prior authorization approval from the enrollee or from the enrollee's health care professional or health care provider, a health insurance issuer shall honor a prior authorization granted to an enrollee from a previous health insurance issuer or its contracted utilization review organization for at least the initial 90 days of an enrollee's coverage under a new health plan, subject to the terms of the member's coverage agreement.

(b) During the time period described in subsection (a), a health insurance issuer or its contracted utilization review organization may perform its own review to grant a prior authorization approval subject to the terms of the member's coverage agreement.

(c) If there is a change in coverage of or approval criteria for a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization approval before the effective date of the change for the remainder of the enrollee's plan year.

(d) Except to the extent required by medical exceptions processes for prescription drugs, nothing in this Section shall require a policy to cover any care, treatment, or

services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Section 75. Health care services deemed authorized if a health insurance issuer or its contracted utilization review organization fails to comply with the requirements of this Act. A failure by a health insurance issuer or its contracted utilization review organization to comply with the deadlines and other requirements specified in this Act shall result in any health care services subject to review to be automatically deemed authorized by the health insurance issuer or its contracted utilization review organization.

Section 80. Severability. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

Section 85. Administration and enforcement.

(a) The Department shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law. To enforce the provisions of this Act, the Director is hereby

granted specific authority to issue a cease and desist order or require a utilization review organization or health insurance issuer to submit a plan of correction for violations of this Act, or both, in accordance with the requirements and authority set forth in Section 85 of the Managed Care Reform and Patient Rights Act. Subject to the provisions of the Illinois Administrative Procedure Act, the Director may, pursuant to Section 403A of the Illinois Insurance Code, impose upon a utilization review organization or health insurance issuer an administrative fine not to exceed $250,000 for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this Act.

(b) Any person who believes that his or her utilization review organization or health insurance issuer is in violation of the provisions of this Act may file a complaint with the Department. The Department shall review all complaints received and investigate all complaints that it deems to state a potential violation. The Department shall fairly, efficiently, and timely review and investigate complaints. Health insurance issuers and utilization review organizations found to be in violation of this Act shall be penalized in accordance with this Section.

(c) The Department of Healthcare and Family Services shall enforce the provisions of this Act as it applies to persons enrolled under Article V of the Illinois Public Aid Code or

under the Children's Health Insurance Program Act.

Section 900. The Illinois Insurance Code is amended by changing Sections 155.36 and 370g as follows:

(215 ILCS 5/155.36)

Sec. 155.36. Managed Care Reform and Patient Rights Act. Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code shall comply with Sections 45, 45.1, 45.2, 65, 70, and 85, subsection (d) of Section 30, and the definition of the term "emergency medical condition" in Section 10 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 101-608, eff. 1-1-20.)

(215 ILCS 5/370g) (from Ch. 73, par. 982g)

Sec. 370g. Definitions. As used in this Article, the following definitions apply:

(a) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision and pharmaceutical services or products.

(b) "Insurer" means an insurance company or a health service corporation authorized in this State to issue policies or subscriber contracts which reimburse for expenses of health

care services.

(c) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

(d) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

(e) "Noninstitutional provider" means any person licensed under the Medical Practice Act of 1987, as now or hereafter amended.

(f) "Beneficiary" means an individual entitled to reimbursement for expenses of or the discount of provider fees for health care services under a program where the beneficiary has an incentive to utilize the services of a provider which has entered into an agreement or arrangement with an administrator.

(g) "Administrator" means any person, partnership or corporation, other than an insurer or health maintenance organization holding a certificate of authority under the "Health Maintenance Organization Act", as now or hereafter amended, that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.

(h) "Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act. ~~means a medical condition manifesting itself by~~

~~acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:~~

~~(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;~~

~~(2) serious impairment to bodily functions; or~~

~~(3) serious dysfunction of any bodily organ or part.~~

(Source: P.A. 91-617, eff. 1-1-00.)

Section 905. The Managed Care Reform and Patient Rights Act is amended by changing Section 10 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions.

"Adverse determination" means a determination by a health care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary.

"Clinical peer" means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition

manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to another hospital before delivery; or

(B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches, or to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Emergency services" means, with respect to an enrollee of

a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

"Health care plan" means a plan, including, but not limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services, that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall

not include the following:

(1) indemnity health insurance policies including those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health care professional" means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing

in this Act shall be construed to define Independent Practice Associations or Physician-Hospital Organizations as health care providers.

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including behavioral health, mental health, home health, and pharmaceutical services and products.

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Physician" means a person licensed under the Medical Practice Act of 1987.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

"Stabilization" means, with respect to an emergency

medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

"Utilization review" means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review program" means a program established by a person to perform utilization review.

(Source: P.A. 101-452, eff. 1-1-20.)

Section 910. The Illinois Public Aid Code is amended by adding Section 5-5.12d as follows:

(305 ILCS 5/5-5.12d new)

Sec. 5-5.12d. Managed care organization prior authorization of health care services.

(a) As used in this Section, "health care service" has the meaning given to that term in the Prior Authorization Reform Act.

(b) Notwithstanding any other provision of law to the contrary, all managed care organizations shall comply with the requirements of the Prior Authorization Reform Act.

Section 999. Effective date. This Act takes effect January 1, 2022.