By: Price H.B. No. 2096

A BILL TO BE ENTITLED

AN ACT

relating to access to and benefits for mental health conditions and substance use disorders.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02251 and 531.02252 to read as follows:

Sec. 531.02251. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE. (a) In this section, "ombudsman" means the individual designated as the ombudsman for behavioral health access to care.

(b) The executive commissioner shall designate an ombudsman for behavioral health access to care.

(c) The ombudsman is administratively attached to the office of the ombudsman for the commission.

(d) The ombudsman serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

(e) The ombudsman shall:

(1) interact with consumers and behavioral health care providers with concerns or complaints to help the consumers and providers resolve behavioral health care access issues;

(2) identify, track, and help report potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to nonquantitative treatment limitations;

(3) report concerns, complaints, and potential violations described by Subdivision (2) to the appropriate regulatory or oversight agency;

(3) provide appropriate referrals to help consumers obtain behavioral health care;

(4) develop appropriate points of contact for referrals to other state and federal agencies; and

(5) provide appropriate referrals and information to help consumers or providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies.

(f) The ombudsman shall participate on the mental health condition and substance use disorder parity work group established under Section 531.02252, and provide summary reports of concerns, complaints, and potential violations described by Subsection (e)(2) to the work group. This subsection expires September 1, 2021.

(g) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations described by Subsection (e)(2) from the ombudsman, consumers, or behavioral health care

providers.

Sec. 531.02252. MENTAL HEALTH CONDITION AND SUBSTANCE USE DISORDER PARITY WORK GROUP. (a) The commission shall establish and facilitate a mental health condition and substance use disorder parity work group at the office of mental health coordination to increase understanding of and compliance with state and federal rules, regulations, and statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions and substance use disorders.

(b) The work group may be a part of or a subcommittee of the behavioral health advisory committee.

(c) The work group is composed of:

(1) a representative of:

(A) Medicaid and the child health plan program;

(B) the office of mental health coordination;

(C) the Texas Department of Insurance;

(D) Medicaid managed care organizations;

(E) commercial health benefit plans;

(F) mental health provider organizations;

(G) substance use disorder providers;

(H) mental health consumer advocates;

(I) substance use disorder treatment consumers;

(J) family members of mental health or substance use disorder treatment consumers;

(K) physicians;

(L) hospitals;

(M) children's mental health providers;

(N) utilization review agents; and

(O) independent review organizations; and

(2) the ombudsman for behavioral health access to care.

(d) The work group shall meet at least quarterly.

(e) The work group shall study and make recommendations on:

(1) increasing compliance with the rules, regulations, and statutes described by Subsection (a);

(2) strengthening enforcement and oversight of these laws at state and federal agencies;

(3) improving the complaint processes relating to potential violations of these laws for consumers and providers;

(4) ensuring the commission and the Texas Department of Insurance can accept information concerns relating to these laws and investigate potential violations based on de-identified information and data submitted to providers in addition to individual complaints; and

(5) increasing public and provider education on these laws.

(f) The work group shall develop a strategic plan with metrics to serve as a road map to increase compliance with the rules, regulations, and statutes described by Subsection (a) in this state and to increase education and outreach relating to these laws.

(g) Not later than September 1 of each even-numbered year, the work group shall submit a report to the appropriate committees of the legislature and the appropriate state agencies on the

findings, recommendations, and strategic plan required by Subsections (e) and (f).

(h) The work group is abolished and this section expires September 1, 2021.

SECTION 2. The heading to Subchapter A, Chapter 1355, Insurance Code, is amended to read as follows:

SUBCHAPTER A. [~~GROUP~~] HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN SERIOUS MENTAL ILLNESSES AND OTHER DISORDERS

SECTION 3. Section 1355.001, Insurance Code, is amended by amending Subdivision (1) and adding Subdivisions (5), (6), and (7) to read as follows:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM), fifth edition, or a later edition adopted by the commissioner by rule:

(A) bipolar disorders (hypomanic, manic, depressive, and mixed);

(B) depression in childhood and adolescence;

(C) major depressive disorders (single episode or recurrent);

(D) obsessive-compulsive disorders;

(E) paranoid and other psychotic disorders;

(F) posttraumatic stress disorder;

(G) schizo-affective disorders (bipolar or depressive); and

(H) [~~(G)~~] schizophrenia.

(5) "Posttraumatic stress disorder" means a disorder that:

(A) meets the diagnostic criteria for posttraumatic stress disorder specified by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, or a later edition adopted by the commissioner by rule; and

(B) results in an impairment of a person's functioning in the person's community, employment, family, school, or social group.

(6) "Eating disorder" means:

(A) any eating disorder described by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, or a later edition adopted by the commissioner by rule, including:

(i) anorexia nervosa;

(ii) bulimia nervosa;

(iii) binge eating disorder;

(iv) rumination disorder;

(v) avoidant/restrictive food intake disorder; or

(vi) any eating disorder not otherwise specified; or

(B) any eating disorder contained in a subsequent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and adopted by the commissioner by rule.

(7) "Serious emotional disturbance of a child" means an emotional or behavioral disorder or a neuropsychiatric condition that causes a person's functioning to be impaired in thought, perception, affect, or behavior and that:

(A) has been diagnosed, by a physician licensed to practice medicine in this state, a psychologist licensed to practice in this state, or a licensed professional counselor licensed to practice in this state, in a person who is at least 3 years of age and younger than 17 years of age; and

(B) meets at least one of the following criteria:

(i) the disorder substantially impairs the person's ability in at least two of the following activities or tasks:

(a) self-care;

(b) engaging in family relationships;

(c) functioning in school; or

(d) functioning in the community;

(ii) the disorder creates a risk that the person will be removed from the person's home and placed in a more restrictive environment, including in a facility or program operated by the Department of Family and Protective Services or an agency that is part of the juvenile justice system;

(iii) the disorder causes the person to:

(a) display psychotic features or violent behavior; or

(b) pose a danger to the person's self or others; or

(iv) the disorder results in the person meeting state special education eligibility requirements for serious emotional disturbance.

SECTION 4. Section 1355.002, Insurance Code, is amended by amending Subsection (a) and adding Subsections (c) and (d) to read as follows:

(a) This subchapter applies only to a [~~group~~] health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, [~~a~~] group, blanket, or franchise insurance policy or [~~, group~~] insurance agreement, a group hospital service contract, [~~or~~] an individual or group evidence of coverage, or a similar coverage document, that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; [~~or~~]

(E) a health maintenance organization operating under Chapter 843; [~~and~~]

(F) a reciprocal exchange operating under Chapter 942;

(G) a Lloyd's plan operating under Chapter 941;

(H) an approved nonprofit health corporation

that holds a certificate of authority under Chapter 844; or

(I) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; and

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement.

(c) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(d) This subchapter applies to a standard health benefit plan issued under Chapter 1507.

SECTION 5. The heading to Section 1355.003, Insurance Code, is amended to read as follows:

Sec. 1355.003. EXCEPTIONS [~~EXCEPTION~~].

SECTION 6. Section 1355.003, Insurance Code, is amended by amending Subsection (a) and adding Subsection (c) to read as follows:

(a) This subchapter does not apply to coverage under:

(1) [~~a blanket accident and health insurance policy, as described by Chapter 1251;~~

[~~(2)~~] a short-term travel policy;

(2) [~~(3)~~] an accident-only policy;

(3) [~~(4)~~] a limited or specified-disease policy that does not provide benefits for mental health care or similar

services;

(4) [~~(5)~~] except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601;

(5) [~~(6)~~] a plan offered in accordance with Section 1355.151; or

(6) [~~(7)~~] a Medicare supplement benefit plan, as defined by Section 1652.002.

(c) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this subchapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

SECTION 7. Section 1355.004, Insurance Code, is amended to read as follows:

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS EMOTIONAL DISTURBANCE OF A CHILD AND SERIOUS MENTAL ILLNESS. (a) A [~~group~~] health benefit plan:

(1) must provide coverage for serious emotional disturbance of a child diagnosed as described by Section 1355.001 and coverage, based on medical necessity, for serious mental illness for not less than the following treatments [~~of serious mental illness~~] in each calendar year:

(A) 45 days of inpatient treatment; and

(B) 60 visits for outpatient treatment, including group and individual outpatient treatment;

(2) may not include a lifetime limitation on the

number of days of inpatient treatment or the number of visits for outpatient treatment covered under the plan; and

(3) must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious emotional disturbance of a child and serious mental illness as the plan includes for physical illness.

(b) A [~~group~~] health benefit plan issuer:

(1) may not count an outpatient visit for medication management against the number of outpatient visits required to be covered under Subsection (a)(1)(B); and

(2) must provide coverage for an outpatient visit described by Subsection (a)(1)(B) under the same terms as the coverage the issuer provides for an outpatient visit for the treatment of physical illness.

SECTION 8. Section 1355.005, Insurance Code, is amended to read as follows:

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A [~~group~~] health benefit plan issuer may provide or offer coverage required by Section 1355.004 through a managed care plan.

SECTION 9. Section 1355.006(b), Insurance Code, is amended to read as follows:

(b) This subchapter does not require a [~~group~~] health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law.

SECTION 10. Subchapter A, Chapter 1355, Insurance Code, is amended by adding Section 1355.008 to read as follows:

Sec. 1355.008. REQUIRED COVERAGE FOR EATING DISORDERS. (a) A health benefit plan must provide coverage, based on medical necessity, for the diagnosis and treatment of an eating disorder.

(b) Coverage required under Subsection (a) is limited to a service or medication, to the extent the service or medication is covered by the health benefit plan, ordered by a licensed physician, psychiatrist, psychologist, or therapist within the scope of the practitioner's license and in accordance with a treatment plan.

(c) On request from the health benefit plan issuer, an eating disorder treatment plan must include all elements necessary for the issuer to pay a claim under the health benefit plan, which may include a diagnosis, goals, and proposed treatment by type, frequency, and duration.

(d) Coverage required under Subsection (a) is not subject to a limit on the number of days of medically necessary treatment except as provided by the treatment plan.

(e) A health benefit plan issuer may conduct a utilization review of an eating disorder treatment plan not more than once each six months unless the physician, psychiatrist, psychologist, or therapist treating the enrollee under the treatment plan agrees that a more frequent review is necessary. An agreement to conduct more frequent review under this subsection applies only to the enrollee who is the subject of the agreement.

(f) A health benefit plan issuer shall pay any costs of

conducting a utilization review of coverage required under Subsection (a) or obtaining a treatment plan.

(g) In conducting a utilization review of treatment for an eating disorder, including review of medical necessity or the treatment plan, a utilization review agent shall consider:

(1) the overall medical and mental health needs of the individual with the eating disorder;

(2) factors in addition to weight; and

(3) the most recent Practice Guideline for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association.

SECTION 11. Section 1355.054(a), Insurance Code, is amended to read as follows:

(a) Benefits of coverage provided under this subchapter may be used only in a situation in which:

(1) the covered individual has a serious mental illness or serious emotional disturbance of a child that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and

(2) the covered individual's mental illness or emotional disturbance:

(A) substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or

(B) as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.

SECTION 12. Chapter 1355, Insurance Code, is amended by

adding Subchapter F to read as follows:

SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

Sec. 1355.251. DEFINITIONS. In this subchapter:

(1) "Financial requirement" includes a requirement relating to a deductible, copayment, coinsurance, or other out-of-pocket expense or an annual or lifetime limit.

(2) "Mental health benefit" means a benefit relating to an item or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(3) "Nonquantitative treatment limitation" includes:

(A) a medical management standard limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether a treatment is experimental or investigational;

(B) formulary design for prescription drugs;

(C) network tier design;

(D) a standard for provider participation in a network, including reimbursement rates;

(E) a method used by a health benefit plan to determine usual, customary, and reasonable charges;

(F) a step therapy protocol;

(G) an exclusion based on failure to complete a course of treatment; and

(H) a restriction based on geographic location, facility type, provider specialty, and other criteria that limit

the scope or duration of a benefit.

(4) "Substance use disorder benefit" means a benefit relating to an item or service for a substance use disorder, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(5) "Treatment limitation" includes a limit on the frequency of treatment, number of visits, days of coverage, or other similar limit on the scope or duration of treatment. The term includes a nonquantitative treatment limitation.

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an individual or group evidence of coverage, or a similar coverage document, that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a health maintenance organization operating under Chapter 843;

(6) a reciprocal exchange operating under Chapter 942;

(7) a Lloyd's plan operating under Chapter 941;

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(b) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(c) This subchapter applies to a standard health benefit plan issued under Chapter 1507.

Sec. 1355.253. EXCEPTIONS. (a) This subchapter does not apply to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss(g)(1));

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under

a motor vehicle insurance policy; or

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1355.252.

(b) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this subchapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Sec. 1355.254. REQUIRED COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS. (a) A health benefit plan must provide benefits for mental health conditions and substance use disorders under the same terms and conditions applicable to benefits for medical or surgical expenses.

(b) Coverage under Subsection (a) may not impose treatment limitations or financial requirements on benefits for a mental health condition or substance use disorder that are generally more restrictive than treatment limitations or financial requirements imposed on coverage of benefits for medical or surgical expenses.

Sec. 1355.255. DEFINITIONS UNDER PLAN. (a) A health benefit plan must define a condition to be a mental health condition or not a mental health condition in a manner consistent with generally recognized independent standards of medical practice.

(b) A health benefit plan must define a condition to be a substance use disorder or not a substance use disorder in a manner

consistent with generally recognized independent standards of medical practice.

Sec. 1355.256. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE. This subchapter supplements Subchapters A and B of this chapter and Chapter 1368 and the department rules adopted under those statutes. It is the intent of the legislature that Subchapter A or B of this chapter or Chapter 1368 or the department rules adopted under those statutes controls in any circumstance in which that other law requires:

(1) a benefit that is not required by this subchapter; or

(2) a more extensive benefit than is required by this subchapter.

Sec. 1355.257. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

SECTION 13. Section 1368.002, Insurance Code, is amended to read as follows:

Sec. 1368.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a [~~group~~] health benefit plan that provides hospital and medical coverage or services on an expense incurred, service, or prepaid basis, including an individual, [~~a~~] group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an individual or group evidence of coverage, or a similar coverage document, or self-funded or self-insured plan or arrangement, that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating

under Chapter 842;

(3) a health maintenance organization operating under Chapter 843; [~~or~~]

(4) an employer, trustee, or other self-funded or self-insured plan or arrangement;

(5) a fraternal benefit society operating under Chapter 885;

(6) a stipulated premium company operating under Chapter 884;

(7) a reciprocal exchange operating under Chapter 942;

(8) a Lloyd's plan operating under Chapter 941;

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(10) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(b) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(c) This chapter applies to a standard health benefit plan issued under Chapter 1507.

SECTION 14. Section 1368.003, Insurance Code, is amended to read as follows:

Sec. 1368.003. EXCEPTIONS [~~EXCEPTION~~]. (a) This chapter does not apply to:

(1) an employer, trustee, or other self-funded or self-insured plan or arrangement with 250 or fewer employees or members;

(2) [~~an individual insurance policy;~~

[~~(3) an individual evidence of coverage issued by a health maintenance organization;~~

[~~(4)~~] a health insurance policy that provides only:

(A) cash indemnity for hospital or other confinement benefits;

(B) supplemental or limited benefit coverage;

(C) coverage for specified diseases or accidents;

(D) disability income coverage; or

(E) any combination of those benefits or coverages;

(3) [~~(5) a blanket insurance policy;~~

[~~(6)~~] a short-term travel insurance policy;

(4) [~~(7)~~] an accident-only insurance policy;

(5) [~~(8)~~] a limited or specified disease insurance policy;

(6) [~~(9) an individual conversion insurance policy or contract;~~

[~~(10)~~] a policy or contract designed for issuance to a person eligible for Medicare coverage or other similar coverage under a state or federal government plan; or

(7) [~~(11)~~] an evidence of coverage provided by a health maintenance organization if the plan holder is the subject of a collective bargaining agreement that was in effect on January 1, 1982, and that has not expired since that date.

(b) To the extent that this section would otherwise require

this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this chapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

SECTION 15. Section 1368.004, Insurance Code, is amended to read as follows:

Sec. 1368.004. COVERAGE REQUIRED. (a) A [~~group~~] health benefit plan shall provide coverage for the necessary care and treatment of chemical dependency.

(b) Coverage required under this section may be provided:

(1) directly by the [~~group~~] health benefit plan issuer; or

(2) by another entity, including a single service health maintenance organization, under contract with the [~~group~~] health benefit plan issuer.

SECTION 16. Section 1368.005(b), Insurance Code, is amended to read as follows:

(b) A [~~group~~] health benefit plan may set dollar or durational limits for coverage required under this chapter that are less favorable than for coverage provided for physical illness generally under the plan if those limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Section 1368.007. If guidelines and standards adopted under Section 1368.007 are not in effect, the dollar and durational limits may not be less favorable than for physical illness generally.

SECTION 17. Section 1355.007, Insurance Code, is repealed.

SECTION 18. (a) The Texas Department of Insurance shall conduct a study and prepare a report on benefits for medical or surgical expenses and for mental health conditions and substance use disorders.

(b) In conducting the study, the department must collect and compare data from health benefit plan issuers subject to Subchapter F, Chapter 1355, Insurance Code, as added by this Act, on medical or surgical benefits and mental health condition or substance use disorder benefits that are:

(1) subject to prior authorization or utilization review;

(2) denied as not medically necessary or experimental or investigational;

(3) internally appealed, including data that indicates whether the appeal was denied; or

(4) subject to an independent external review, including data that indicates whether the denial was upheld.

(c) Not later than September 1, 2018, the department shall report the results of the study and the department's findings.

SECTION 19. (a) The Health and Human Services Commission shall conduct a study and prepare a report on benefits for medical or surgical expenses and for mental health conditions and substance use disorders provided by Medicaid managed care organizations.

(b) In conducting the study, the commission must collect and compare data from Medicaid managed care organizations on medical or surgical benefits and mental health condition or substance use

disorder benefits that are:

(1) subject to prior authorization or utilization review;

(2) denied as not medically necessary or experimental or investigational;

(3) internally appealed, including data that indicates whether the appeal was denied; or

(4) subject to an independent external review, including data that indicates whether the denial was upheld.

(c) Not later than September 1, 2018, the commission shall report the results of the study and the commission's findings.

SECTION 20. The changes in law made by this Act to Chapters 1355 and 1368, Insurance Code, apply only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2018. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2018, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 21. This Act takes effect September 1, 2017.