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HOUSE BILL 1562

State of Washington 66th Legislature 2019 Regular Session

By Representatives Stonier, DeBolt, Harris, Macri, Caldier, Robinson, Thai, Riccelli, Tharinger, Jinkins, Kloba, and Slatter

Read first time 01/24/19. Referred to Committee on Health Care & Wellness.

AN ACT Relating to health care benefit management; amending RCW 19.340.010, 48.02.120, 19.340.100, 19.340.020, 19.340.070, 19.340.080, 19.340.090, and 48.02.220; adding a new section to chapter 42.56 RCW; adding a new chapter to Title 48 RCW; creating new sections; recodifying RCW 19.340.010, 19.340.020, 19.340.040, 19.340.050, 19.340.060, 19.340.070, 19.340.080, 19.340.090, 19.340.100, and 19.340.110; repealing RCW 19.340.030 and 19.365.010; and providing an effective date.

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

NEW SECTION. **Sec. 1.** The legislature finds that growth in managed health care systems has shifted substantial authority over health care decisions from providers and patients to health carriers and benefit managers. Benefit managers acting as intermediaries between carriers, health care providers, and patients exercise broad discretion to affect health care services recommended and delivered by providers and the health care choices of patients. Regularly, these benefit managers are making care decisions on behalf of carriers and their decision makers routinely live outside of Washington and may not hold any Washington health care provider license. Benefit managers do not function as carriers. Therefore, it

is in the best interest of the public to create a separate chapter for benefit managers.

The legislature intends to protect and promote the health, safety, and welfare of Washington residents by establishing standards for regulatory oversight of benefit managers.

Sec. 2. RCW 19.340.010 and 2016 c 210 s 3 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Certification" has the same meaning as in RCW 48.43.005.

(2) "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or service.

((~~(2) "Commissioner" means the insurance commissioner established in chapter 48.02 RCW.~~))

(3) "Concurrent review" has the same meaning as in RCW 48.43.005.

(4) "Health care benefit manager" means any person or entity providing service to, or acting on behalf of, a health carrier, a public employee benefit program, or a school employee benefit program, including a pharmacy benefit manager or a radiology benefit manager, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies including, but not limited to:

(a) Prior authorization or preauthorization of benefits or care;

(b) Certification of benefits or care;

(c) Medical necessity determinations;

(d) Utilization review;

(e) Benefit determinations;

(f) Claims processing and repricing;

(g) Provider credentialing and recredentialing;

(h) Dispute resolution, grievances, or appeals relating to determinations; and

(i) Provider network management.

(5) "Health care provider" or "provider" has the same meaning as in RCW 48.43.005.

(6) "Health care service" has the same meaning as in RCW 48.43.005.

(7) "Health carrier" or "carrier" has the same meaning as in RCW 48.43.005.

(8) "Insurer" has the same meaning as in RCW 48.01.050.

((~~(4)~~)) (9) "Network" means the group of participating providers, pharmacies, and suppliers providing health care services, drugs, or supplies to beneficiaries of a particular carrier or program benefit plan.

(10) "Person" includes, as applicable, natural persons, licensed health care providers, carriers, corporations, companies, trusts, unincorporated associations, and partnerships.

(11) "Pharmacist" has the same meaning as in RCW 18.64.011.

((~~(5)~~)) (12) "Pharmacy" has the same meaning as in RCW 18.64.011.

((~~(6)~~)) (13)(a) "Pharmacy benefit manager" means a person ((~~that contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060 to~~)) providing service to, or acting on behalf of, a health carrier, a public employee benefit program, or a school employee benefit program, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, pharmacy benefits including but not limited to:

(i) ((~~Process~~)) Processing claims for prescription drugs or medical supplies or ((~~provide~~)) providing retail network management for pharmacies or pharmacists;

(ii) ((~~Pay~~)) Payment or payment authorization to pharmacies or pharmacists for prescription drugs or medical supplies; or

(iii) ((~~Negotiate~~)) Negotiation of rebates with manufacturers for drugs paid for or procured ((~~as described in this subsection~~)) directly or indirectly on behalf of a health carrier or a state agency.

(b) "Pharmacy benefit manager" does not include a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, or an issuer as defined in RCW 48.01.053.

((~~(7)~~)) (14)(a) "Radiology benefit manager" means any person or entity providing service to, or acting on behalf of, a health carrier, a public employee benefit program, or a school employee benefit program, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, the services of a licensed radiologist or to advanced diagnostic imaging services including but not limited to:

(i) Processing claims for services and procedures performed by a licensed radiologist or advanced diagnostic imaging service provider; or

(ii) Payment or payment authorization to radiology clinics, radiologists, or advanced diagnostic imaging service providers for services or procedures.

(b) "Radiology benefit manager" does not include a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, or an issuer as defined in RCW 48.01.053.

(15) "Third-party payor" means a person licensed under RCW 48.39.005.

(16) "Utilization review" has the same meaning as in RCW 48.43.005.

NEW SECTION. **Sec. 3.** (1) A person may not act in the capacity of a health care benefit manager with respect to benefits for Washington residents, unless that person obtains and maintains a license issued by the commissioner.

(2) To obtain a license, a health care benefit manager must:

(a) Submit an application on forms and in a manner prescribed by the commissioner and verified by the applicant by affidavit, or certificate under RCW 9A.72.085. Applications must contain at least the following information:

(i) The identity of the health care benefit manager and of persons with any ownership or controlling interest in the applicant including relevant business licenses and tax identification numbers, and the identity of any entity that the health care benefit manager has a controlling interest in;

(ii) The business name, address, phone number, and contact person for the manager;

(iii) Whether the person does business as a pharmacy benefit manager, a radiology benefit manager, a health care benefit manager other than a pharmacy benefit manager or radiology benefit manager, or a combination of different types of health care benefit managers; and

(iv) Any other information as the commissioner may reasonably require.

(b) Pay an initial license fee and annual renewal license fee established in rule by the commissioner for each license. The fees

for each license must be set by the commissioner in an amount that ensures the licensing, renewal, and oversight activities are self-supporting. If one licensee has a contract with more than one carrier, the licensee shall complete only one application providing the detail necessary for each contract.

(3) All receipts from fees collected by the commissioner under this section must be deposited into the commissioner's regulatory account created in RCW 48.02.190.

(4) Before approving an application for or renewal of a license, the commissioner must find that the health care benefit manager:

(a) Has not committed any act that resulted in denial, suspension, or revocation of a license;

(b) Has paid the required fees; and

(c) Has the capacity to comply with and has designated a person responsible for compliance with state and federal laws.

(5) Any material change in information provided to obtain or renew a license must be filed with the commissioner within fifteen days of the change.

(6) Every licensee shall retain a record of all transactions completed under the license for a period of not less than seven years from the date of their creation. All such records as to any particular transaction must be kept available and open to inspection by the commissioner during the seven years after the date of completion of such transaction.

NEW SECTION. **Sec. 4.** (1) A licensee must file with the commissioner in the form and manner prescribed by the commissioner, every benefit management contract and contract amendment, and every contract and contract amendment between the licensee and any other person entered into directly or indirectly in support of such licensee contract, at least thirty days prior to use of the contract or amendment.

(2) Licensee contracts must be available for public inspection and posted on the commissioner's web site. Contract compensation provisions filed with the commissioner are confidential and are not subject to public disclosure under RCW 48.02.120(2) or chapter 42.56 RCW, if filed in accordance with commissioner procedures for submitting confidential filings, except for contract compensation provisions that a reasonable person would believe encourages managers

to deny, delay, or limit benefits, and the method or formula for compensation.

NEW SECTION. **Sec. 5.** (1) A licensee has a fiduciary duty to patients and beneficiaries to perform services in accordance with state and federal law.

(2) A licensee may not penalize, require, or provide financial incentives including variations in premiums, deductibles, copayments, or coinsurance, to beneficiaries as an incentive to use a specific provider or a retail, mail order, or other network pharmacy, in which a carrier, program, or a benefit manager has an ownership interest, except for and only to the limited extent the commissioner adopts by rule an exception for use of the financial incentive as necessary to the operation of a health care benefit plan or program such as a staff model health maintenance organization that depends upon patient use of owned facilities.

(3) A licensee may not deny a benefit or impose a cost or limitation upon a beneficiary of any health insurance policy, plan, or contract providing benefits for health care services, drugs, or supplies and no person may collect or attempt to collect a debt for the delivery of health care services, drugs, or supplies from a patient if such denial, limitation, cost, or debt is attributable to a violation of this chapter or rules adopted under this chapter.

(4) For purposes of authorization for services, whether prior, concurrent, or postservice, a medical necessity determination made by the primary care provider, or portal of entry provider, is sufficient for access to the initial six visits of care under RCW 48.43.016 and may not require additional referrals or medical necessity determinations by the licensee or carrier.

Sec. 6. RCW 48.02.120 and 2011 c 312 s 1 are each amended to read as follows:

(1) The commissioner shall preserve in permanent form records of his or her proceedings, hearings, investigations, and examinations, and shall file such records in his or her office.

(2) The records of the commissioner and insurance filings in his or her office shall be open to public inspection, except as otherwise provided by section 4 of this act and this code.

(3) Except as provided in subsection (4) of this section, actuarial formulas, statistics, and assumptions submitted in support

of a rate or form filing by an insurer, health care service contractor, or health maintenance organization or submitted to the commissioner upon his or her request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

(4) For individual and small group health benefit plan rate filings submitted on or after July 1, 2011, subsection (3) of this section applies only to the numeric values of each small group rating factor used by a health carrier as authorized by RCW 48.21.045(3)(a), 48.44.023(3)(a), and 48.46.066(3)(a). Subsection (3) of this section may continue to apply for a period of one year from the date a new individual or small group product filing is submitted or until the next rate filing for the product, whichever occurs earlier, if the commissioner determines that the proposed rate filing is for a new product that is distinct and unique from any of the carrier's currently or previously offered health benefit plans. Carriers must make a written request for a product classification as a new product under this subsection and must receive subsequent written approval by the commissioner for this subsection to apply.

(5) Unless the commissioner has determined that a filing is for a new product pursuant to subsection (4) of this section, for all individual or small group health benefit rate filings submitted on or after July 1, 2011, the health carrier must submit part I rate increase summary and part II written explanation of the rate increase as set forth by the department of health and human services at the time of filing, and the commissioner must:

(a) Make each filing and the part I rate increase summary and part II written explanation of the rate increase available for public inspection on the tenth calendar day after the commissioner determines that the rate filing is complete and accepts the filing for review through the electronic rate and form filing system; and

(b) Prepare a standardized rate summary form, to explain his or her findings after the rate review process is completed. The commissioner's summary form must be included as part of the rate filing documentation and available to the public electronically.

NEW SECTION. **Sec. 7.** A new section is added to chapter 42.56 RCW to read as follows:

Contract compensation provisions filed with the insurance commissioner under section 4 of this act are exempt from disclosure

under this chapter if filed in accordance with commissioner procedures for submitting confidential filings, except for contract compensation provisions that a reasonable person would believe encourages managers to deny, delay, or limit benefits, and the method or formula for compensation.

Sec. 8. RCW 19.340.100 and 2016 c 210 s 4 are each amended to read as follows:

(1) As used in this section:

(a) "Critical access pharmacy" means:

(i) A pharmacy in Washington that is outside a ten-mile radius of any other pharmacy; or

(ii) A pharmacy in Washington that is within a ten-mile radius of another pharmacy if closure of either pharmacy could result in impaired access for a rural area, in which case both pharmacies must be considered critical access pharmacies.

(b) "List" means the list of drugs for which predetermined reimbursement costs have been established, such as a maximum allowable cost or maximum allowable cost list or any other benchmark prices utilized by ((~~the~~)) a health care benefit manager doing business as a pharmacy benefit manager and must include the basis of the methodology and sources utilized to determine multisource generic drug reimbursement amounts.

((~~(b)~~)) (c) "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers.

((~~(c)~~)) (d) "Multisource generic drug" means any covered outpatient prescription drug for which there is at least one other drug product that is rated as therapeutically equivalent under the food and drug administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations;" is pharmaceutically equivalent or bioequivalent, as determined by the food and drug administration; and is sold or marketed in the state during the period.

((~~(d)~~)) (e) "Network pharmacy" means a retail drug outlet licensed as a pharmacy under RCW 18.64.043 that contracts with a health care benefit manager doing business as a pharmacy benefit manager.

((~~(e)~~)) (f) "Therapeutically equivalent" has the same meaning as in RCW 69.41.110.

(2) A health care benefit manager doing business as a pharmacy benefit manager:

(a) May not place a drug on a list unless there are at least two therapeutically equivalent multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers;

(b) Shall ensure that all drugs on a list are readily available for purchase by pharmacies in this state from national or regional wholesalers that serve pharmacies in Washington;

(c) Shall ensure that all drugs on a list are not obsolete;

(d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the predetermined reimbursement costs for multisource generic drugs of the health care benefit manager doing business as a pharmacy benefit manager;

(e) Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy;

(f) Shall update each list maintained by the health care benefit manager doing business as a pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format;

(g) Shall ensure that dispensing fees are not included in the calculation of the predetermined reimbursement costs for multisource generic drugs;

(h) May not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;

(i) May not charge a pharmacist or pharmacy a fee related to the adjudication of a claim including, but not limited to, a fee for the receipt and processing of a pharmacy claim, for the development or management of claims processing services in a pharmacy benefit manager network, or for participation in a pharmacy benefit manager network;

(j) Unless approved by the pharmacy quality assurance commission, may not require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the pharmacy quality assurance commission;

(k) May not reimburse a pharmacy or pharmacist in the state an amount less than the amount the pharmacy benefit manager reimburses an affiliate for providing the same pharmacist services; and

(l) May not retroactively deny or reduce a pharmacist for services after adjudication of the claim, unless:

(i) The original claim was submitted fraudulently;

(ii) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist's services; or

(iii) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

(3) A health care benefit manager doing business as a pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to predetermined reimbursement costs for multisource generic drugs. A network pharmacy may appeal a predetermined reimbursement cost for a multisource generic drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section must be completed within thirty calendar days of the pharmacy submitting the appeal. If after thirty days the network pharmacy has not received the decision on the appeal from the health care benefit manager doing business as a pharmacy benefit manager, then the appeal is considered denied.

The health care benefit manager doing business as a pharmacy benefit manager shall uphold the appeal of a pharmacy with fewer than fifteen retail outlets, within the state of Washington, under its corporate umbrella if the pharmacy or pharmacist can demonstrate that it is unable to purchase a therapeutically equivalent interchangeable product from a supplier doing business in Washington at the health care benefit manager doing business as a pharmacy benefit manager's list price.

(4) A health care benefit manager doing business as a pharmacy benefit manager must provide as part of the appeals process established under subsection (3) of this section:

(a) A telephone number at which a network pharmacy may contact the health care benefit manager doing business as a pharmacy benefit manager and speak with an individual who is responsible for processing appeals; and

(b) If the appeal is denied, the reason for the denial and the national drug code of a drug that has been purchased by other network

pharmacies located in Washington at a price that is equal to or less than the predetermined reimbursement cost for the multisource generic drug. A pharmacy with fifteen or more retail outlets, within the state of Washington, under its corporate umbrella may submit information to the commissioner about an appeal under subsection (3) of this section for purposes of information collection and analysis.

(5)(a) If an appeal is upheld under this section, the health care benefit manager doing business as a pharmacy benefit manager shall make a reasonable adjustment on a date no later than one day after the date of determination.

(b) If the request for an adjustment has come from a critical access pharmacy, ((~~as defined by the state health care authority by rule for purposes related to the prescription drug purchasing consortium established under RCW 70.14.060,~~)) the adjustment approved under (a) of this subsection shall apply only to critical access pharmacies.

(6) Beginning July 1, 2017, if a network pharmacy appeal to the health care benefit manager doing business as a pharmacy benefit manager is denied, or if the network pharmacy is unsatisfied with the outcome of the appeal, the pharmacy or pharmacist may dispute the decision and request review by the commissioner within thirty calendar days of receiving the decision.

(a) All relevant information from the parties may be presented to the commissioner, and the commissioner may enter an order directing the health care benefit manager doing business as a pharmacy benefit manager to make an adjustment to the disputed claim, deny the pharmacy appeal, or take other actions deemed fair and equitable. An appeal requested under this section must be completed within thirty calendar days of the request.

(b) Upon resolution of the dispute, the commissioner shall provide a copy of the decision to both parties within seven calendar days.

(c) The commissioner may authorize the office of administrative hearings, as provided in chapter 34.12 RCW, to conduct appeals under this subsection (6).

(d) A health care benefit manager doing business as a pharmacy benefit manager may not retaliate against a pharmacy for pursuing an appeal under this subsection (6).

(e) This subsection (6) applies only to a pharmacy with fewer than fifteen retail outlets, within the state of Washington, under its corporate umbrella.

(7) This section does not apply to the state medical assistance program.

((~~(8) A pharmacy benefit manager shall comply with any requests for information from the commissioner for purposes of the study of the pharmacy chain of supply conducted under section 7, chapter 210, Laws of 2016.~~))

NEW SECTION. **Sec. 9.** Sections 3, 4, and 5 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 10.** RCW 19.340.010, 19.340.020, and 19.340.040 through 19.340.110 are each recodified as sections in the new chapter created in section 9 of this act.

Sec. 11. RCW 19.340.020 and 2014 c 213 s 3 are each amended to read as follows:

As used in this section and RCW 19.340.040 through 19.340.090 (as recodified by this act):

(1) "Audit" means an on-site or remote review of the records of a pharmacy by or on behalf of an entity.

(2) "Clerical error" means a minor error:

(a) In the keeping, recording, or transcribing of records or documents or in the handling of electronic or hard copies of correspondence;

(b) That does not result in financial harm to an entity; and

(c) That does not involve dispensing an incorrect dose, amount, or type of medication, or dispensing a prescription drug to the wrong person.

(3) "Entity" includes:

(a) A health care benefit manager doing business as a pharmacy benefit manager;

(b) An insurer;

(c) A third-party payor;

(d) A state agency; or

(e) A person that represents or is employed by one of the entities described in this subsection.

(4) "Fraud" means knowingly and willfully executing or attempting to execute a scheme, in connection with the delivery of or payment for health care benefits, items, or services, that uses false or misleading pretenses, representations, or promises to obtain any money or property owned by or under the custody or control of any person.

Sec. 12. RCW 19.340.070 and 2014 c 213 s 7 are each amended to read as follows:

For purposes of RCW 19.340.020 and 19.340.040 through 19.340.090 (as recodified by this act), an entity, or an independent third party that contracts with an entity to conduct audits, must allow as evidence of validation of a claim:

(1) An electronic or physical copy of a valid prescription if the prescribed drug was, within fourteen days of the dispensing date:

(a) Picked up by the patient or the patient's designee;

(b) Delivered by the pharmacy to the patient; or

(c) Sent by the pharmacy to the patient using the United States postal service or other common carrier;

(2) Point of sale electronic register data showing purchase of the prescribed drug, medical supply, or service by the patient or the patient's designee; or

(3) Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy's central operations, and any other reasonably clear and accurate electronic documentation that corresponds to a claim.

Sec. 13. RCW 19.340.080 and 2014 c 213 s 8 are each amended to read as follows:

(1)(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than forty-five days after the date on which the audit was completed and must be sent:

(i) By mail or common carrier with a return receipt requested; or

(ii) Electronically with electronic receipt confirmation.

(b) An entity shall provide a pharmacy receiving a preliminary report under this subsection no fewer than forty-five days after receiving the report to contest the report or any findings in the

report in accordance with the appeals procedure established under RCW 19.340.040(1) (as recodified by this act) and ((~~to provide~~)) must allow the submission of additional documentation in support of the claim. The entity shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.

(2) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including facsimile, mail, or ((~~electronic mail~~)) email.

(3) An entity must provide a pharmacy that is the subject of an audit with a final report of the audit no later than sixty days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure established under RCW 19.340.040(1) (as recodified by this act). The final report must include a final accounting of all moneys to be recovered by the entity.

(4) Recoupment of disputed funds from a pharmacy by an entity or repayment of funds to an entity by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under RCW 19.340.040(1) (as recodified by this act) are final. If the identified discrepancy for an individual audit exceeds forty thousand dollars, any future payments to the pharmacy may be withheld by the entity until the audit and the appeals procedure established under RCW 19.340.040(1) (as recodified by this act) are final.

Sec. 14. RCW 19.340.090 and 2014 c 213 s 9 are each amended to read as follows:

RCW 19.340.020 and 19.340.040 through 19.340.090 (as recodified by this act) do not:

(1) Preclude an entity from instituting an action for fraud against a pharmacy;

(2) Apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is indicated by physical review, review of claims data or statements, or other investigative methods; or

(3) Apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of pharmacy

records for prescription drugs paid for by the state medical assistance program.

Sec. 15. RCW 48.02.220 and 2016 c 210 s 5 are each amended to read as follows:

(1) The commissioner shall accept ((~~registration~~)) licensing of ((~~pharmacy~~)) health care benefit managers as established in ((~~RCW 19.340.030~~)) section 3 of this act and receipts shall be deposited in the insurance commissioner's regulatory account.

(2) The commissioner shall have enforcement authority over chapter ((~~19.340~~)) 48.--- RCW (the new chapter created in section 9 of this act) consistent with requirements established in RCW 19.340.110 (as recodified by this act).

(3) The commissioner may adopt rules to implement chapter ((~~19.340~~)) 48.--- RCW (the new chapter created in section 9 of this act) and to establish ((~~registration~~)) licensing and renewal fees that ensure the ((~~registration~~)) licensing, renewal, and oversight activities are self-supporting.

NEW SECTION. **Sec. 16.** The following acts or parts of acts are each repealed:

(1) RCW 19.340.030 (Pharmacy benefit managers—Registration—Renewal) and 2016 c 210 s 1 & 2014 c 213 s 2; and

(2) RCW 19.365.010 (Registration required—Requirements) and 2015 c 166 s 1.

NEW SECTION. **Sec. 17.** The insurance commissioner shall adopt any rules necessary to implement this act.

NEW SECTION. **Sec. 18.** Sections 1 through 16 of this act take effect January 1, 2021.

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