SYNOPSIS:

This bill would require that breast reconstruction be provided under all health insurance plans in the State of Alabama, including those covering public employees and the Medicaid program.

This bill would permit an insured individual to choose the type of breast reconstruction desired and a particular surgeon to perform the reconstruction, who may be outside of the health insurance benefit plan network.

For private health insurance, this bill would also set terms for cost-sharing obligations for enrollees and insurer payments to out-of-network providers.

This bill would provide that an insured individual or a health care professional may bring a civil action if the insurer fails to comply with this act, with enforcement powers given to the Attorney General and the Commissioner of the Department of Insurance.

A BILL

TO BE ENTITLED

AN ACT

Relating to health insurance; to add Chapter 50A, commencing with Section 27-50A-1, to Title 27, Code of Alabama 1975, to require health benefit plans to cover breast reconstruction; to define the scope of breast reconstruction benefits and provide requirements for payments to health care providers; to amend Section 10A-20-6.16, Code of Alabama 1975, to make conforming changes; to amend Section 27-21A-23, Code of Alabama 1975, to make conforming changes; to amend Section 16-25A-6, Code of Alabama 1975, to make conforming changes; to add Section 16-25A-6.1 to the Code of Alabama 1975, to require the Public Education Employees' Health Insurance Plan to cover breast reconstruction; to add Section 22-6-11.1 to the Code of Alabama 1975, to require Medicaid coverage for breast reconstruction; to add Section 36-29-4.1 to the Code of Alabama 1975, to require the State Employees' Health Insurance Plan to cover breast reconstruction; and to amend Section 36-29-5, Code of Alabama 1975, to make conforming changes.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Chapter 50A, commencing with Section 27-50A-1, is added to Title 27 of the Code of Alabama 1975, to read as follows:

§27-50A-1

The Legislature finds:

(1) Breast cancer affects thousands of Alabama women annually and access to comprehensive reconstruction surgery is essential to physical and psychological recovery.

(2) No woman residing in the State of Alabama should be

denied access to appropriate breast reconstruction surgery due to network limitations or excessive administrative requirements.

(3) The State of Alabama has a compelling public health interest in fostering as broad an access as possible to breast reconstruction services and by this act seeks to ensure flexibility and patient choice in accessing breast reconstruction care that is both appropriate for the individual and comprehensive.

§27-50A-2

For the purposes of this chapter, the following terms have the following meanings:

(1) BREAST RECONSTRUCTION. The medical repair of physical defects caused by the removal or treatment of breast tissue as a result of trauma, disease, lumpectomy, mastectomy, or prophylaxis against future disease, which has as its purpose the reconstruction of a new breast mound or a flat chest wall and the establishment of symmetry between two breasts, and which includes:

a. Augmentation or reduction;

b. All stages of preparatory, primary, and revision surgery to reconstruct a breast mound or to create a new breast mound;

c. All necessary procedures for a non-diseased, contralateral breast to create symmetry between two breasts;

d. Chest wall reconstruction, including, but not limited to, a flat closure that uses adjacent tissue transfer or complex repair to eliminate all redundancies of skin and

soft tissue;

e. Custom-fabricated breast prostheses, including, but not limited to, replacement of the breast prostheses;

f. Hybrid procedures that involve both autologous breast reconstruction and biologic or synthetic products or devices; and

g. Mechanical, medical, or surgical prophylaxis to prevent the physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

h. Mechanical, medical, and surgical treatment of physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

(2) COMMISSIONER. The Commissioner of the Department of Insurance of the State of Alabama.

(3) CORE-BASED STATISTICAL AREA. A metropolitan or micropolitan statistical area as defined by the U.S. Office of Management and Budget.

(4) COST-SHARING. An enrollee's payment obligation for a covered health care service, including a deductible, copayment, or coinsurance.

(5) ENROLLEE. A patient who is covered under a health benefit plan.

(6) HEALTH BENEFIT PLAN. Any individual or group plan, employee welfare benefit plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state by a health care insurer, health

maintenance organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care service plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for insureds or beneficiaries in this state. The term includes, but is not limited to, entities created pursuant to Article 6 of Chapter 20 of Title 10A. A health benefit plan located or domiciled outside of the State of Alabama is deemed to be subject to this chapter if it receives, processes, adjudicates, pays, or denies claims for health care services submitted by or on behalf of patients, insureds, or beneficiaries who reside in Alabama. The term shall not include accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(7) HEALTH CARE PROFESSIONAL. A physician, physician assistant, or certified registered nurse practitioner licensed pursuant to Title 34, including, but not limited to, a physician who performs plastic and reconstructive surgery or who is a referring or consulting physician providing oncology treatment or breast surgery, or an employee acting under the direction of the same.

(8) HEALTH CARE SERVICES. The term includes, but is not limited to, all of the following:

a. Health care professional services, including, but not limited to, consultation, diagnosis, treatment, anesthesia, surgery, and therapy.

b. Prescription drugs.

c. Facilities, including a hospital or ambulatory surgical treatment center.

d. Prostheses and devices for breast reconstruction, including tissue expanders, customized implants, and nerve graft products, mesh, or repair products.

(9) INSURER. The term includes all of the following:

a. Any entity that issues, delivers, or renews a health benefit plan.

b. Any department or office of the entity described in paragraph a., or any individual employed by the entity, which performs utilization review or makes determinations of prior authorization or coverage.

c. Any separate entity or individual that is a contractor or agent of the entity described in paragraph a. which performs utilization review or makes determinations of prior authorization or coverage.

(10) MODALITY, TYPE, AND TECHNIQUE. A method of breast reconstruction surgery that employs a modality such as an implant, natural tissue, or fat, or some combination of the foregoing, and includes any of the following types and techniques:

a. Immediate implant-based, tissue-based, or combined reconstruction.

b. Delayed implant-based, tissue-based, or combined reconstruction.

c. Myocutaneous flap tissue-based reconstruction.

d. Microvascular free flap tissue-based reconstruction.

e. Structural fat grafting tissue-based breast reconstruction.

f. Combined implant-based and tissue-based breast reconstruction.

g. Any type of breast reconstruction that is developed subsequent to the effective date of this act that is recognized within Level I or Level II of the Healthcare Common Procedure Coding System (HCPCS) codes.

h. All techniques and procedural variations, iterations, or approaches associated with a type of breast reconstruction, as noted within the short descriptor or description for the Level I Healthcare Common Procedure Coding System code covering the type of breast reconstruction.

(11) NETWORK PROVIDER. A health care professional or facility that participates in the provider network of a health benefit plan to receive a contractually-established amount as payment in full for providing health care services.

(12) OUT-OF-NETWORK PROVIDER. A health care professional or facility located anywhere in the United States which does not receive a contractually-established amount from an insurer or health benefit plan as payment in full for providing health care services.

(13) PREVAILING MEDICAL STANDARD. The standards of care for breast reconstruction established by national specialty organizations, including the American Society of Plastic Surgeons, the American Society for Reconstructive Microsurgery, the American Society of Breast Surgeons, the National Comprehensive Cancer Network, and other

nationally-recognized medical specialty organizations, the members of which routinely perform breast reconstruction surgery.

§27-50A-3

(a) On and after January 1, 2027, a health benefit plan shall pay or reimburse for breast reconstruction, including all component health care services, subject to the requirements of this chapter.

(b) Coverage for breast reconstruction shall include any modality, type, and technique chosen by an enrollee in consultation with her health care professional based on personal factors such as the enrollee's anatomy, health status, preference, lifestyle, and reconstruction goals.

(c) Coverage shall include health care services for the breast reconstruction which are rendered by either a network or out-of-network provider as selected by an enrollee, provided that any surgeon shall be board certified or eligible for board certification in plastic and reconstructive surgery.

(d) The modality, type, and technique of breast reconstruction chosen by an enrollee in consultation with her surgeon who meets the requirement of subsection (c) shall be presumed by the insurer to meet both: (i) prevailing medical standards; and (ii) the requirement of medical necessity for purposes of a request for prior authorization.

(e) Coverage for breast reconstruction shall extend to all health care services that are necessary to achieve the breast reconstruction outcome determined appropriate by the the enrollee and her health care professional, including the

initial and all subsequent surgeries required by the modality, type, and technique and not limited with respect to any revision surgery, symmetry procedure, nipple reconstruction, lymphovenous bypass, tattooing, nerve grafting, scar revision, fat grafting, or treatment for a complication.

§27-50A-4

(a) An insurer shall respond to a request for prior authorization for breast reconstruction no later than three business days after the date and time of the submission of the request.

(b)(1) An insurer may deny a request for prior authorization of a specific modality, type, and technique of breast reconstruction chosen by an enrollee in consultation with her health care professional if the conditions in this subsection are met.

(2) Any determination of denial shall be made upon review of the request and all relevant clinical information by a health care professional who: (i) is board certified or eligible for board certification in plastic surgery and reconstructive surgery; and (ii) has specific training in the modality, type, and technique at issue.

(3) The reviewing health care professional shall rebut the presumption of medical necessity recognized under Section 27-50A-3(d) by providing to the enrollee and her health care professional articulable reasons in writing that support a conclusion that: (i) the modality, type, and technique proposed fails to comport with prevailing medical standards; or (ii) clinical considerations unique to the enrollee make

the enrollee a poor candidate for the modality, type, and technique requested.

(4) An enrollee or health care professional whose request for prior authorization is denied may appeal the denial in the internal appeal process afforded by the insurer, provided the appeal is determined by a health care professional who did not perform the initial review but who otherwise meets the requirements of subdivision (2).

(5) A health care professional acting on behalf of an insurer, who meets the requirements of subdivision (2), while a denial of prior authorization is under consideration, or pursuant to an appeal of a denial of prior authorization under subdivision (4), shall provide a direct telephone number to the enrollee's health care professional, and may request or shall consider additional clinical information concerning the enrollee for purposes of review.

(c) An insurer may not deny a request for prior authorization of the modality, type, and technique of breast reconstruction chosen by the enrollee in consultation with her health care professional on any of the following grounds:

(1) A different modality, type, and technique of breast reconstruction is also appropriate for the enrollee, in absence of articulable reasons required under subdivision (b)(3).

(2) The health care services required in providing coverage, including the plastic surgeon or facility, are out-of-network, unless the individual or facility proposed to render the health care service is outside of the United States

or does not hold the necessary professional or other license under the law of the state where the individual or facility is located.

(3) The modality, type, and technique of breast reconstruction requested by the enrollee or her health care professional is more expensive than the modality, type, and technique or the related health care services proposed by the insurer.

§27-50A-5

(a) An enrollee's cost-sharing obligations for breast reconstruction shall not exceed the health benefit plan's rates that apply to network providers for comparable coverages under the plan, and an enrollee who receives health care services for breast reconstruction from health care professionals, facilities, or other services that are out-of-network shall pay in-network cost-sharing rates.

(b) Other coverages provided under the health benefit plan may not be limited or reduced as a result of including in the plan the coverage described in this chapter.

(c) If an enrollee receives coverage for breast reconstruction, the enrollee's contractual right to other coverages or benefits available under the health benefit plan may not in any way be reduced or limited, nor may receiving coverage for breast reconstruction render an enrollee ineligible to renew coverage under the plan.

(d) The requirements of this chapter apply regardless of whether the health benefit plan otherwise provides coverage for out-of-network services or contains any provision that

purports to limit or exclude out-of-network coverage.

§27-50A-6

(a)(1) A health benefit plan may not impose a requirement that an enrollee receive breast reconstruction health care services from a network provider as a condition for coverage.

(2) An insurer shall approve the choice of an enrollee to receive health care services from a health care professional who is an out-of-network provider, unless the individual proposed to render the service does not hold the necessary professional license under the law of the state where the entity or individual is located.

(3) The requirement of subdivision (2) applies to an out-of-network hospital or facility in which surgery is to be performed if the hospital or facility complies with the applicable licensure or certification requirements under federal law and the law of the state where the hospital or facility is located.

(b) With respect to a surgeon who is an out-of-network provider chosen by an enrollee, an insurer may not do any of the following:

(1) Undertake any communication or action, or impose any provision, that has the effect of discouraging the enrollee from choosing the surgeon, including any incentive, disincentive, or penalty related to the enrollee's health benefit plan coverage.

(2) Require the enrollee to first consult with or consider a surgeon who is a network provider.

(3) Undertake any communication or action, or impose any provision, that has the effect of steering the enrollee to choose a surgeon who is a network provider, including any incentive, disincentive, or penalty related to the enrollee's health benefit plan coverage.

(4) Impose additional administrative, licensure, certification, or qualification requirements, including documentation, in excess of what is required for out-of-network providers for other coverages under the health benefit plan.

(c) An insurer may not use any indirect means to prevent, disincentivize, or discourage an enrollee from receiving a health care service from an out-of-network provider, including influencing, inducing, or pressuring a hospital or other facility to require a surgeon to be a network provider of the insurer as a condition for obtaining or maintaining medical staff privileges to perform breast reconstruction.

§27-50A-7

An insurer may not withdraw an approval of prior authorization for breast reconstruction communicated to a health care professional or enrollee, nor may an insurer refuse or fail to reimburse a health care professional for a health care service after it has communicated the approval of prior authorization, unless an enrollee or health care provider made a misrepresentation by statement or omission to the insurer which was material to the approval of prior authorization.

§27-50A-8

(a) If a health care service included in breast reconstruction is rendered by an out-of-network provider, this section shall govern the rate of reimbursement.

(b) If an enrollee selects an out-of-network provider, the insurer shall initiate single case agreement negotiations with the provider according to all of the following conditions:

(1) The insurer shall initiate negotiations with the provider within five business days of receiving notice of the enrollee's selection.

(2) The insurer and the provider shall have 10 business days from initiation of negotiations to agree on reimbursement terms.

(3) If the insurer and provider reach agreement, the agreed terms shall govern reimbursement for the health care services covered by the single case agreement.

(4) If the insurer fails to initiate negotiations within the time required, fails to negotiate in good faith, or the insurer and provider do not reach agreement within 10 business days, the payment provisions of subsection (c) shall govern the rate of reimbursement.

(5) An insurer's failure to respond to a provider's communication within two business days during the negotiating period shall be deemed a failure to negotiate in good faith.

(c) If the conditions provided in subsection (b) are not met, the health benefit plan shall reimburse the provider an amount that is the lesser of:

(1) The provider's billed charges; or

(2) The 80th percentile of all charges for the same provider service in the same core-based statistical area in which the provider service is performed, as reported in a database that is maintained by a nonprofit organization that is unaffiliated or not otherwise financially supported by any insurer.

(d) If the health benefit plan fails to reimburse an out-of-network provider as required under subsection (a), in addition to making the required payment, the health benefit plan shall pay the out-of-network provider an amount that is treble the difference between:

(1) The initial reimbursement, or in the case of denial of payment, zero dollars ($0); and

(2) The reimbursement rate required under subsection (c) less any cost-sharing amount to be paid by the insured.

(e) The payment required under subsection (d) shall be subject to interest at a rate to be specified by rule adopted by the department.

§27-50A-9

If an enrollee who has received prior authorization for breast reconstruction subsequently enrolls in a different health benefit plan offered by the same insurer, or in a health benefit plan offered by a different insurer, any health care service necessary to achieve the breast reconstruction outcome determined appropriate by the enrollee and her health care professional, including any health care service for revision or to treat a complication, shall be covered.

§27-50A-10

(a) An enrollee or health care professional who is injured as a result of an insurer's failure to comply with this chapter may bring a civil action against the insurer in the Circuit Court of Montgomery County or in the circuit court of the county where the enrollee resides.

(b) In an action brought under this section, the court may award to the plaintiff any of the following:

(1) Injunctive relief.

(2) Compensatory damages.

(3) Treble damages upon a finding that failure of an insurer to comply with this chapter was knowing or in reckless disregard of the provisions of this chapter.

(4) Reasonable costs and attorney fees.

(c) An action brought under this section may be predicated upon any common law or statutory cause of action, including breach of contract or any applicable tort, including fraud or bad faith, or a deceptive trade practice under Chapter 19 of Title 8.

§27-50A-11

The commissioner and the Attorney General have concurrent jurisdiction to enforce this chapter, to include any of the following measures:

(1) The commissioner may investigate complaints or conduct compliance audits pursuant to Article 1 of Chapter 2.

(2) The Attorney General may investigate complaints pursuant to Section 8-19-9 and cooperate with the department in conducting investigations.

(3) The commissioner or the Attorney General may bring a civil action against an insurer in the Circuit Court of Montgomery County for injunctive relief to enforce compliance with this chapter, or in a representative capacity on behalf of aggrieved enrollees to include recovery of compensatory damages.

(4) The commissioner or the Attorney General may intervene as a plaintiff in any private action brought under Section 27-50A-10 if the issues raised are broad or significant enough in application to be in the public interest.

§27-50A-12

(a) An insurer shall provide a written notice to an enrollee which contains a summary of the enrollee's rights under this chapter when any of the following occurs:

(1) Upon initial enrollment in a health benefit plan.

(2) Upon annual renewal of a health benefit plan.

(3) Within five business days of the insurer receiving notice that an enrollee has been diagnosed with breast cancer or has undergone a mastectomy or lumpectomy.

(b)(1) The notice required under subsection (a) shall include, at a minimum, a plain-language summary of the enrollee's right: (i) to choose any qualified plastic surgeon for breast reconstruction; (ii) to receive coverage for health care services from out-of-network providers at in-network cost-sharing rates; and (iii) to appeal any denial of coverage.

(2) The commissioner shall develop a model notice for

use by an insurer to comply with this section.

§27-50A-13

The commissioner shall adopt rules to implement and administer this chapter.

Section 2. Sections 10A-20-6.16 and 27-21A-23, Code of Alabama 1975, are amended to read as follows:

"§10A-20-6.16

(a) No statute of this state applying to insurance companies shall be applicable to any corporation organized under this article and amendments thereto or to any contract made by the corporation; except the corporation shall be subject to the following:

(1) The provisions regarding annual premium tax to be paid by insurers on insurance premiums.

(2) Chapter 55 of Title 27.

(3) Article 2 and Article 3 of Chapter 19 of Title 27.

(4) Section 27-1-17.

(5) Chapter 56 of Title 27.

(6) Rules adopted by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

(7) Chapter 54 of Title 27.

(8) Chapter 57 of Title 27.

(9) Chapter 58 of Title 27.

(10) Chapter 59 of Title 27.

(11) Chapter 54A of Title 27.

(12) Chapter 12A of Title 27.

(13) Chapter 2B of Title 27.

(14) Chapter 29 of Title 27.

(15) Chapter 62 of Title 27.

(16) Chapter 63 of Title 27.

(17) Chapter 45A of Title 27.

(18) Chapter 50A of Title 27.

(b) The provisions in subsection (a) that require specific types of coverage to be offered or provided shall not apply when the corporation is administering a self-funded benefit plan or similar plan, fund, or program that it does not insure."

"§27-21A-23

(a) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of health care service plan laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer or health care service plan licensed and regulated pursuant to the insurance law or the health care service plan laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provisions of Section 34-24-310, et seq., relating to the practice of medicine.

(d) No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance, or malpractice in connection with the furnishing of such services and supplies.

(e) Nothing in this chapter shall be construed in any way to repeal or conflict with any provision of the certificate of need law.

(f) Notwithstanding the provisions of subsection (a), a health maintenance organization shall be subject to all of the following:

(1) Section 27-1-17.

(2) Chapter 56.

(3) Chapter 54.

(4) Chapter 57.

(5) Chapter 58.

(6) Chapter 59.

(7) Rules adopted by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

(8) Chapter 12A.

(9) Chapter 54A.

(10) Chapter 2B.

(11) Chapter 29.

(12) Chapter 62.

(13) Chapter 63.

(14) Chapter 45A.

(15) Chapter 50A."

Section 3. Sections 16-25A-6 and 36-29-5, Code of Alabama 1975, are amended to read as follows:

"§16-25A-6

~~Such health insurance~~The Public Education Employees' Health Insurance Plan shall not include coverage for any of the following:

(1) Expenses incurred by or on account of an individual prior to the effective date of the plan ~~as to him;~~.

(2) Hearing aids and examinations for the prescription or fitting thereof~~;~~-.

(3) Cosmetic surgery or treatment, except to the extent necessary for correction of damage caused by accidental injury or for breast reconstruction as required pursuant to Section 16-25A-6.1 ~~while covered by the plan~~, or as a direct result of disease covered by the plan~~;~~.

(4) Services received in a hospital owned or operated by the United States government for which no charge is made~~;~~.

(5) Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan~~;~~.

(6) Expenses for which the individual is not required to make payment~~;~~.

(7) Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state participates in the cost thereof~~;~~.

(8) Such other expenses as may be excluded by ~~regulations~~rule of the board~~; and~~.

(9) Coordination of benefit of basic hospital/medical coverage provided herein and any supplemental hospital indemnity, cancer or dental coverage provided herein under the provisions of this article or as may privately be purchased by any employee."

"§36-29-5

(a) ~~Such health insurance~~The State Employees' Health Insurance Plan shall not include coverage for any of the following:

(1) Expenses incurred by or on account of an individual prior to the effective date of the plan.

(2) Cosmetic surgery or treatment, except to the extent necessary for correction of damages caused by accidental injury or for breast reconstruction as required pursuant to Section 36-29-4.1~~while covered by the plan~~, or as a direct result of disease covered by the plan.

(3) Services received in a hospital owned or operated by the United States government for which no charge is made.

(4) Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan.

(5) Expenses for which the individual is not required to make payment.

(6) Expenses to the extent of benefits provided under any employer group plan other than the plan in which the state participates in the cost thereof.

(7) Such other expenses as may be excluded by

~~regulations~~rule of the board.

(b) This section shall not mandate the coverage of hearing assistance devices except that the State Employees' Health Insurance Board may determine by a majority vote of the board to cover such expenses in part or in whole on or after April 11, 2000."

Section 4. Sections 16-25A-6.1, 22-6-11.1, and 36-29-4.1 are added to the Code of Alabama 1975, to read as follows:

§16-25A-6.1

(a) On and after January 1, 2027, the Public Education Employees' Health Insurance Plan shall provide coverage for breast reconstruction subject to the same terms and conditions as those provided in Chapter 50A of Title 27.

(b) If there is a conflict between this chapter and Chapter 50A of Title 27, this chapter shall be given effect.

§22-6-11.1

(a) The Alabama Medicaid Agency shall provide coverage for breast reconstruction as defined in Section 27-50A-2 to any woman who is accepted for participation in a Medicaid program for delivery of medical services which exists on the effective date of this act.

(b) Breast reconstruction benefits shall commence on and after January 1, 2027, and to the degree consistent with this chapter, Medicaid rules, and policies, including those governing Medicaid-approved providers, shall be according to the same coverage provided in Chapter 50A of Title 27.

(c) The Alabama Medicaid Agency may adopt rules to

implement this section.

§36-29-4.1

(a) On and after January 1, 2027, the State Employees' Health Insurance Plan shall provide coverage for breast reconstruction subject to the same terms and conditions as those provided in Chapter 50A of Title 27.

(b) If there is a conflict between this chapter and Chapter 50A of Title 27, this chapter shall be given effect.

Section 5. This act shall become effective on October 1, 2026.