

# STATE OF NEW YORK

4828

2017-2018 Regular Sessions

## IN SENATE

March 2, 2017

Introduced by Sen. PERSAUD -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to providing health insurance protection to New Yorkers in the event that the federal Affordable Care Act is repealed

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. The insurance law is amended by adding a new section 3217-i  
2 to read as follows:

3 § 3217-i. Essential health benefits package. (a) Coverage required.  
4 No insurer subject to this article shall decline to provide an essential  
5 health benefits package as required by this section.

6 (b) Definition. The term "essential health benefits package" means,  
7 with respect to any health plan, coverage that provides for the essen-  
8 tial health benefits as defined by the superintendent under subsection  
9 (c) of this section; limits cost-sharing for such coverage in accordance  
10 with subsection (d) of this section; and subject to subsection (d) of  
11 this section, provides either bronze, silver, gold or platinum level of  
12 coverage as described in subsection (e) of this section.

13 (c) Superintendent's powers and duties with respect to essential  
14 health benefits. (1) Subject to paragraph two of this subsection, the  
15 superintendent shall define the essential health benefits, except that  
16 such benefits shall include at least the following general categories  
17 and the items and services covered within such categories: (i) ambulatory  
18 patient services, (ii) emergency services, (iii) hospitalization,  
19 (iv) maternity and newborn care, (v) mental health and substance use  
20 disorder services, including behavioral health treatment, (vi)  
21 prescription drugs, (vii) rehabilitative and habilitative services and  
22 devices, (viii) laboratory services, (ix) preventive and wellness  
23 services and chronic disease management, and (x) pediatric services,  
24 including oral and vision care.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets  
[-] is old law to be omitted.

LBD10208-02-7

1 (2) The superintendent shall ensure that the scope of the essential  
2 health benefits under paragraph one of this subsection is equal to the  
3 scope of benefits provided under a typical employer plan, as determined  
4 by the superintendent. In defining the essential health benefits under  
5 paragraph one of this subsection, the superintendent shall:

6 (A) ensure that such essential health benefits reflect an appropriate  
7 balance among the categories described in paragraph one of this  
8 subsection so that benefits are not unduly weighted toward any category;

9 (B) not make coverage decisions, determine reimbursement rates, estab-  
10 lish incentive programs, or design benefits in ways that discriminate  
11 against individuals because of their age, disability, or expected length  
12 of life;

13 (C) take into account the health care needs of diverse segments of the  
14 population, including women, children, persons with disabilities, and  
15 other groups;

16 (D) ensure that health benefits established as essential not be  
17 subject to denial to individuals against their wishes on the basis of  
18 the individuals' age or expected length of life or of the individuals'  
19 present or predicted disability, degree of medical dependency, or quali-  
20 ty of life;

21 (E) provide that a qualified health plan shall not be treated as  
22 providing coverage for the essential health benefits described in para-  
23 graph one of this subsection unless the plan provides that:

24 (i) coverage for emergency department services will be provided with-  
25 out imposing any requirement under the plan for prior authorization of  
26 services or any limitation on coverage where the provider of services  
27 does not have a contractual relationship with the plan for the providing  
28 of services that is more restrictive than the requirements or limita-  
29 tions that apply to emergency department services received from provid-  
30 ers who do have such a contractual relationship with the plan; and

31 (ii) if such services are provided out-of-network, the cost-sharing  
32 requirement, expressed as a copayment amount or coinsurance rate, is the  
33 same requirement that would apply if such services were provided in-net-  
34 work;

35 (F) provide that if a stand-alone dental benefits plan is offered  
36 through an exchange, another health plan offered through such exchange  
37 shall not fail to be treated as a qualified health plan solely because  
38 the plan does not offer coverage of benefits offered through the stand-  
39 alone plan that are otherwise required under subparagraph (G) of this  
40 paragraph; and

41 (G) periodically update the essential health benefits under paragraph  
42 one of this subsection to address any gaps in access to coverage.

43 (d) Cost-sharing requirements. (1) There shall be an annual limitation  
44 on cost-sharing. (A) The cost-sharing incurred under a health plan with  
45 respect to self-only coverage or coverage other than self-only coverage  
46 for a plan year beginning in two thousand fourteen shall not exceed the  
47 dollar amounts in effect for self-only and family coverage, respective-  
48 ly, for taxable years beginning in two thousand fourteen.

49 (B) In the case of any plan year beginning in a calendar year after  
50 two thousand fourteen, the limitation under this paragraph shall:

51 (i) in the case of self-only coverage, be equal to the dollar amount  
52 under subparagraph (A) of this paragraph for self-only coverage for plan  
53 years beginning in two thousand fourteen, increased by an amount equal  
54 to the product of that amount and the premium adjustment percentage  
55 under paragraph three of this subsection for the calendar year; and

1 (ii) in the case of other coverage, twice the amount in effect under  
2 clause (i) of this subparagraph. If the amount of any increase under  
3 clause (i) of this subparagraph is not a multiple of fifty dollars, such  
4 increase shall be rounded to the next lowest multiple of fifty dollars.

5 (2) (A) The term "cost-sharing" shall include:

6 (i) deductibles, coinsurance, copayments, or similar charges; and

7 (ii) any other expenditure required of an insured individual which is  
8 a qualified medical expense with respect to essential health benefits  
9 covered under the plan.

10 (B) Such term does not include premiums, balance billing amounts for  
11 non-network providers, or spending for non-covered services.

12 (3) For purposes of clause (i) of subparagraph (B) of paragraph one of  
13 this subsection, the premium adjustment percentage for any calendar year  
14 is the percentage, if any, by which the average per capita premium for  
15 health insurance coverage in the United States for the preceding calen-  
16 dar year exceeds such average per capita premium for the year two thou-  
17 sand thirteen.

18 (e) Levels of coverage. (1) Levels of coverage described in this  
19 subsection are as follows:

20 (A) Bronze level. A plan in the bronze level shall provide a level of  
21 coverage that is designed to provide benefits that are actuarially  
22 equivalent to sixty percent of the full actuarial value of the benefits  
23 provided under the plan.

24 (B) Silver level. A plan in the silver level shall provide a level of  
25 coverage that is designed to provide benefits that are actuarially  
26 equivalent to seventy percent of the full actuarial value of the bene-  
27 fits provided under the plan.

28 (C) Gold level. A plan in the gold level shall provide a level of  
29 coverage that is designed to provide benefits that are actuarially  
30 equivalent to eighty percent of the full actuarial value of the benefits  
31 provided under the plan.

32 (D) Platinum level. A plan in the platinum level shall provide a level  
33 of coverage that is designed to provide benefits that are actuarially  
34 equivalent to ninety percent of the full actuarial value of the benefits  
35 provided under the plan.

36 (2) (A) Actuarial value. Under regulations issued by the superinten-  
37 dent, the level of coverage of a plan shall be determined on the basis  
38 that the essential health benefits described in subsection (c) of this  
39 section shall be provided to a standard population and without regard to  
40 the population the plan may actually provide benefits to.

41 (B) Employer contributions. The superintendent shall issue regulations  
42 under which employer contributions to a health savings account may be  
43 taken into account.

44 § 2. The insurance law is amended by adding a new section 4306-h to  
45 read as follows:

46 § 4306-h. Essential health benefits package. (a) Coverage required. No  
47 corporation subject to this article shall decline to provide an essen-  
48 tial health benefits package as required by this section.

49 (b) Definition. The term "essential health benefits package" means,  
50 with respect to any health plan, coverage that provides for the essen-  
51 tial health benefits as defined by the superintendent under subsection  
52 (c) of this section; limits cost-sharing for such coverage in accordance  
53 with subsection (d) of this section; and subject to subsection (d) of  
54 this section, provides either bronze, silver, gold or platinum level of  
55 coverage as described in subsection (e) of this section.

1 (c) Superintendent's powers and duties with respect to essential  
2 health benefits. (1) Subject to paragraph two of this subsection, the  
3 superintendent shall define the essential health benefits, except that  
4 such benefits shall include at least the following general categories  
5 and the items and services covered within such categories: (i) ambulatory  
6 patient services, (ii) emergency services, (iii) hospitalization,  
7 (iv) maternity and newborn care, (v) mental health and substance use  
8 disorder services, including behavioral health treatment, (vi)  
9 prescription drugs, (vii) rehabilitative and habilitative services and  
10 devices, (viii) laboratory services, (ix) preventive and wellness  
11 services and chronic disease management, and (x) pediatric services,  
12 including oral and vision care.

13 (2) The superintendent shall ensure that the scope of the essential  
14 health benefits under paragraph one of this subsection is equal to the  
15 scope of benefits provided under a typical employer plan, as determined  
16 by the superintendent. In defining the essential health benefits under  
17 paragraph one of this subsection, the superintendent shall:

18 (A) ensure that such essential health benefits reflect an appropriate  
19 balance among the categories described in paragraph one of this  
20 subsection so that benefits are not unduly weighted toward any category;

21 (B) not make coverage decisions, determine reimbursement rates, estab-  
22 lish incentive programs, or design benefits in ways that discriminate  
23 against individuals because of their age, disability, or expected length  
24 of life;

25 (C) take into account the health care needs of diverse segments of the  
26 population, including women, children, persons with disabilities, and  
27 other groups;

28 (D) ensure that health benefits established as essential not be  
29 subject to denial to individuals against their wishes on the basis of  
30 the individuals' age or expected length of life or of the individuals'  
31 present or predicted disability, degree of medical dependency, or quali-  
32 ty of life;

33 (E) provide that a qualified health plan shall not be treated as  
34 providing coverage for the essential health benefits described in para-  
35 graph one of this subsection unless the plan provides that:

36 (i) coverage for emergency department services will be provided with-  
37 out imposing any requirement under the plan for prior authorization of  
38 services or any limitation on coverage where the provider of services  
39 does not have a contractual relationship with the plan for the providing  
40 of services that is more restrictive than the requirements or limita-  
41 tions that apply to emergency department services received from provid-  
42 ers who do have such a contractual relationship with the plan; and

43 (ii) if such services are provided out-of-network, the cost-sharing  
44 requirement, expressed as a copayment amount or coinsurance rate, is the  
45 same requirement that would apply if such services were provided in-net-  
46 work;

47 (F) provide that if a stand-alone dental benefits plan is offered  
48 through an exchange, another health plan offered through such exchange  
49 shall not fail to be treated as a qualified health plan solely because  
50 the plan does not offer coverage of benefits offered through the stand-  
51 alone plan that are otherwise required under subparagraph (G) of this  
52 paragraph; and

53 (G) periodically update the essential health benefits under paragraph  
54 one of this subsection to address any gaps in access to coverage.

55 (d) Cost-sharing requirements. (1) There shall be an annual limitation  
56 on cost-sharing. (A) The cost-sharing incurred under a health plan with

1 respect to self-only coverage or coverage other than self-only coverage  
2 for a plan year beginning in two thousand fourteen shall not exceed the  
3 dollar amounts in effect for self-only and family coverage, respective-  
4 ly, for taxable years beginning in two thousand fourteen.

5 (B) In the case of any plan year beginning in a calendar year after  
6 two thousand fourteen, the limitation under this paragraph shall:

7 (i) in the case of self-only coverage, be equal to the dollar amount  
8 under subparagraph (A) of this paragraph for self-only coverage for plan  
9 years beginning in two thousand fourteen, increased by an amount equal  
10 to the product of that amount and the premium adjustment percentage  
11 under paragraph three of this subsection for the calendar year; and

12 (ii) in the case of other coverage, twice the amount in effect under  
13 clause (i) of this subparagraph. If the amount of any increase under  
14 clause (i) of this subparagraph is not a multiple of fifty dollars, such  
15 increase shall be rounded to the next lowest multiple of fifty dollars.

16 (2) (A) The term "cost-sharing" shall include:

17 (i) deductibles, coinsurance, copayments, or similar charges; and

18 (ii) any other expenditure required of an insured individual which is  
19 a qualified medical expense with respect to essential health benefits  
20 covered under the plan.

21 (B) Such term does not include premiums, balance billing amounts for  
22 non-network providers, or spending for non-covered services.

23 (3) For purposes of clause (i) of subparagraph (B) of paragraph one of  
24 this subsection, the premium adjustment percentage for any calendar year  
25 is the percentage, if any, by which the average per capita premium for  
26 health insurance coverage in the United States for the preceding calen-  
27 dar year exceeds such average per capita premium for the year two thou-  
28 sand thirteen.

29 (e) Levels of coverage. (1) Levels of coverage described in this  
30 subsection are as follows:

31 (A) Bronze level. A plan in the bronze level shall provide a level of  
32 coverage that is designed to provide benefits that are actuarially  
33 equivalent to sixty percent of the full actuarial value of the benefits  
34 provided under the plan.

35 (B) Silver level. A plan in the silver level shall provide a level of  
36 coverage that is designed to provide benefits that are actuarially  
37 equivalent to seventy percent of the full actuarial value of the bene-  
38 fits provided under the plan.

39 (C) Gold level. A plan in the gold level shall provide a level of  
40 coverage that is designed to provide benefits that are actuarially  
41 equivalent to eighty percent of the full actuarial value of the benefits  
42 provided under the plan.

43 (D) Platinum level. A plan in the platinum level shall provide a level  
44 of coverage that is designed to provide benefits that are actuarially  
45 equivalent to ninety percent of the full actuarial value of the benefits  
46 provided under the plan.

47 (2) (A) Actuarial value. Under regulations issued by the superinten-  
48 dent, the level of coverage of a plan shall be determined on the basis  
49 that the essential health benefits described in subsection (c) of this  
50 section shall be provided to a standard population and without regard to  
51 the population the plan may actually provide benefits to.

52 (B) Employer contributions. The superintendent shall issue regulations  
53 under which employer contributions to a health savings account may be  
54 taken into account.

55 § 3. Subsection (e) of section 3217-f of the insurance law, as added  
56 by chapter 219 of the laws of 2011, is amended to read as follows:

1 (e) For purposes of this section, "essential health benefits" shall  
2 have the same meaning [~~ascribed by section 1302(b) of the Affordable~~  
3 ~~Care Act, 42 U.S.C. § 18022(b)~~] as subsection (c) of section three thou-  
4 sand two hundred seventeen-i of this article.

5 § 4. Subsection (h) and paragraph 19 of subsection (k) of section 3221  
6 of the insurance law, subsection (h) as added by section 54 of part D of  
7 chapter 56 of the laws of 2013 and paragraph 19 of subsection (k) as  
8 amended by chapter 377 of the laws of 2014, are amended to read as  
9 follows:

10 (h) Every small group policy or association group policy delivered or  
11 issued for delivery in this state that provides coverage for hospital,  
12 medical or surgical expense insurance and is not a grandfathered health  
13 plan shall provide coverage for the essential health benefit package as  
14 required in section [~~2707(a) of the public health service act, 42 U.S.C.~~  
15 ~~§ 300gg-6(a)~~] three thousand two hundred seventeen-i of this article.

16 For purposes of this subsection:

17 (1) "essential health benefits package" shall have the meaning set  
18 forth in [~~section 1302(a) of the affordable care act, 42 U.S.C. §~~  
19 ~~18022(a)~~] subsection (c) of section three thousand two hundred seven-  
20 teen-i of this article;

21 (2) "grandfathered health plan" means coverage provided by an insurer  
22 in which an individual was enrolled on March twenty-third, two thousand  
23 ten for as long as the coverage maintains grandfathered status [~~in~~  
24 ~~accordance with section 1251(e) of the affordable care act, 42 U.S.C. §~~  
25 ~~18011(e)~~];

26 (3) "small group" means a group of fifty or fewer employees or members  
27 exclusive of spouses and dependents; provided, however, that beginning  
28 January first, two thousand sixteen, "small group" means a group of one  
29 hundred or fewer employees or members exclusive of spouses and depen-  
30 dents; and

31 (4) "association group" means a group defined in subparagraphs (B),  
32 (D), (H), (K), (L) or (M) of paragraph one of subsection (c) of section  
33 four thousand two hundred thirty-five of this chapter, provided that:

34 (A) the group includes one or more individual members; or

35 (B) the group includes one or more member employers or other member  
36 groups that are small groups.

37 (19) Every group or blanket accident and health insurance policy  
38 delivered or issued for delivery in this state which provides medical  
39 coverage that includes coverage for physician services in a physician's  
40 office and every policy which provides major medical or similar compre-  
41 hensive-type coverage shall include coverage for equipment and supplies  
42 used for the treatment of ostomies, if prescribed by a physician or  
43 other licensed health care provider legally authorized to prescribe  
44 under title eight of the education law. Such coverage shall be subject  
45 to annual deductibles and coinsurance as deemed appropriate by the  
46 superintendent. The coverage required by this paragraph shall be identi-  
47 cal to, and shall not enhance or increase the coverage required as part  
48 of essential health benefits [~~as required pursuant to section 2707 (a)~~  
49 ~~of the public health services act 42 U.S.C. 300 gg-6(a)~~] set forth in  
50 section three thousand two hundred seventeen-i of this article.

51 § 5. Subsection (d) of section 3240 of the insurance law, as added by  
52 section 41 of part D of chapter 56 of the laws of 2013, is amended to  
53 read as follows:

54 (d) A student accident and health insurance policy or contract shall  
55 provide coverage for essential health benefits as defined in [~~section~~

1 ~~1302(b) of the affordable care act, 42 U.S.C. § 18022(b)]~~ subsection (c)  
2 of section three thousand two hundred seventeen-i of this article.

3 § 6. Subsection (u-1) of section 4303 of the insurance law, as amended  
4 by chapter 377 of the laws of 2014, is amended to read as follows:

5 (u-1) A medical expense indemnity corporation or a health service  
6 corporation which provides medical coverage that includes coverage for  
7 physician services in a physician's office and every policy which  
8 provides major medical or similar comprehensive-type coverage shall  
9 include coverage for equipment and supplies used for the treatment of  
10 ostomies, if prescribed by a physician or other licensed health care  
11 provider legally authorized to prescribe under title eight of the educa-  
12 tion law. Such coverage shall be subject to annual deductibles and coin-  
13 surance as deemed appropriate by the superintendent. The coverage  
14 required by this subsection shall be identical to, and shall not enhance  
15 or increase the coverage required as part of essential health benefits  
16 as required pursuant to section [~~2707(a) of the public health services~~  
17 ~~act 42 U.S.C. 300gg-6(a)]~~ four thousand three hundred six-h of this  
18 article.

19 § 7. Subsection (e) of section 4306-e of the insurance law, as added  
20 by chapter 219 of the laws of 2011, is amended to read as follows:

21 (e) For purposes of this section, "essential health benefits" shall  
22 have the meaning ascribed by [~~section 1302(b) of the Affordable Care~~  
23 ~~Act, 42 U.S.C. § 18022(b)]~~ subsection (c) of section four thousand three  
24 hundred six-h of this article.

25 § 8. Subsections (d) and (e) of section 4326 of the insurance law, as  
26 amended by section 56 of part D of chapter 56 of the laws of 2013, are  
27 amended to read as follows:

28 (d) A qualifying group health insurance contract shall provide cover-  
29 age for the essential health benefit package as required [~~in section~~  
30 ~~2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)]~~ by  
31 section four thousand three hundred six-h of this article. For purposes  
32 of this subsection "essential health benefits package" shall have the  
33 meaning set forth in [~~section 1302(a) of the affordable care act, 42~~  
34 ~~U.S.C. § 18022(a)]~~ subsection (c) of section four thousand three hundred  
35 six-h of this article.

36 (e) A qualifying group health insurance contract issued to a qualify-  
37 ing small employer prior to January first, two thousand fourteen that  
38 does not include all essential health benefits required pursuant to  
39 section [~~2707(a) of the public health service act, 42 U.S.C. §~~  
40 ~~300gg-6(a)]~~ four thousand three hundred six-h of this article, shall be  
41 discontinued, including grandfathered health plans. For the purposes of  
42 this paragraph, "grandfathered health plans" means coverage provided by  
43 a corporation to individuals who were enrolled on March twenty-third,  
44 two thousand ten for as long as the coverage maintains grandfathered  
45 status [~~in accordance with section 1251(e) of the affordable care act,~~  
46 ~~42 U.S.C. § 18011(e)].~~ A qualifying small employer shall be transitioned  
47 to a plan that provides: (1) a level of coverage that is designed to  
48 provide benefits that are actuarially equivalent to eighty percent of  
49 the full actuarial value of the benefits provided under the plan; and  
50 (2) coverage for the essential health benefit package as required in  
51 section [~~2707(a) of the public health service act, 42 U.S.C. §~~  
52 ~~300gg-6(a)]~~ four thousand three hundred six-h of this article. The  
53 superintendent shall standardize the benefit package and cost sharing  
54 requirements of qualified group health insurance contracts consistent  
55 with coverage offered through the health benefit exchange [~~established~~  
56 ~~pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031].~~

1 § 9. Paragraph 1 of subsection (b) of section 4328 of the insurance  
2 law, as added by section 46 of part D of chapter 56 of the laws of 2013,  
3 is amended to read as follows:

4 (1) The individual enrollee direct payment contract offered pursuant  
5 to this section shall provide coverage for the essential health benefit  
6 package as required in section [~~2707(a) of the public health service~~  
7 ~~act, 42 U.S.C. § 300gg-6(a)~~] four thousand three hundred six-h of this  
8 article. For purposes of this paragraph, "essential health benefits  
9 package" shall have the meaning set forth in [~~section 1302(a) of the~~  
10 ~~affordable care act, 42 U.S.C. § 18022(a)~~] subsection (c) of section  
11 four thousand three hundred six-h of this article.

12 § 10. Paragraphs (f) and (g) of section 3232 of the insurance law, as  
13 added by chapter 219 of the laws of 2011, are amended and a new para-  
14 graph (j) is added to read as follows:

15 (f) With respect to an individual under age nineteen, an insurer may  
16 not impose any pre-existing condition exclusion in an individual or  
17 group policy of hospital, medical, surgical or prescription drug expense  
18 insurance [~~pursuant to the requirements of section 2704 of the Public~~  
19 ~~Health Service Act, 42 U.S.C. § 300gg-3, as made effective by section~~  
20 ~~1255(2) of the Affordable Care Act,~~] except for an individual under age  
21 nineteen covered under an individual policy of hospital, medical, surgi-  
22 cal or prescription drug expense insurance that is a grandfathered  
23 health plan.

24 (g) Beginning January first, two thousand fourteen[, ~~pursuant to~~  
25 ~~section 2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3,~~] an  
26 insurer may not impose any pre-existing condition exclusion in an indi-  
27 vidual or group policy of hospital, medical, surgical or prescription  
28 drug expense insurance except in an individual policy that is a grandfa-  
29 thered health plan.

30 (j) For purposes of subsections (f) and (g) of this section, "pre-ex-  
31 isting condition" shall mean a limitation or exclusion of benefits  
32 relating to a condition based on the fact that the condition was present  
33 before the date of enrollment for such coverage, whether or not any  
34 medical advice, diagnosis, care, or treatment was recommended or  
35 received before such date.

36 § 11. Subsections (f) and (g) of section 4318 of the insurance law, as  
37 added by chapter 219 of the laws of 2011, are amended and a new  
38 subsection (j) is added to read as follows:

39 (f) With respect to an individual under age nineteen, a corporation  
40 may not impose any pre-existing condition exclusion in an individual or  
41 group contract of hospital, medical, surgical or prescription drug  
42 expense insurance pursuant to the requirements of section [~~2704 of the~~  
43 ~~Public Health Service Act, 42 U.S.C. § 300gg-3, as made effective by~~  
44 ~~section 1255(2) of the Affordable Care Act~~] four thousand three hundred  
45 six-h of this article, except for an individual under age nineteen  
46 covered under an individual contract of hospital, medical, surgical or  
47 prescription drug expense insurance that is a grandfathered health plan.

48 (g) Beginning January first, two thousand fourteen, pursuant to  
49 section [~~2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3~~]  
50 four thousand three hundred six-h of this article, a corporation may not  
51 impose any pre-existing condition exclusion in an individual or group  
52 contract of hospital, medical, surgical or prescription drug expense  
53 insurance except in an individual contract that is a grandfathered  
54 health plan.

55 (j) For purposes of subsections (f) and (g) of this section, "pre-ex-  
56 isting exclusion" shall mean a limitation or exclusion of benefits



1 relating to a condition based on the fact that the condition was present  
2 before the date of enrollment for such coverage, whether or not any  
3 medical advice, diagnosis, care, or treatment was recommended or  
4 received before such date.

5 § 12. This act shall take effect on such date as the affordable care  
6 act is fully repealed and at such time as the provisions of such act are  
7 no longer in force and effect; provided that the superintendent of  
8 financial services shall notify the legislative bill drafting commission  
9 upon the occurrence of the repeal of the federal Affordable Care Act in  
10 order that the commission may maintain an accurate and timely effective  
11 data base of the official text of the laws of the state of New York in  
12 furtherance of effectuating the provisions of section 44 of the legisla-  
13 tive law and section 70-b of the public officers law.