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NCOIL ADOPTS THREE NEW HEALTH MODEL LAWS DURING ANNUAL MEETING IN SCOTTSDALE

Model Laws Include NCOIL Telemedicine Authorization and Reimbursement Model Act; NCOIL Accumulator Adjustment Program Model Act; and NCOIL Model Act Regarding Air Ambulance Patient Protections

Manasquan, NJ: - During the recently concluded 2021 National Council of Insurance Legislators (NCOIL) Annual National Meeting in Scottsdale, AZ, NCOIL, the nation's premier legislator-led insurance public policy organization, adopted three new NCOIL Model Laws. The Models were first passed via voice vote by the group's Health Insurance and Long-Term Care Issues Committee (Committee), Chaired by NY Asw. Pam Hunter, then adopted without dissent by the NCOIL Executive Committee.

The three new Model Laws are: the NCOIL Telemedicine Authorization and Reimbursement Model Act, sponsored by Asw. Hunter; the NCOIL Accumulator Adjustment Program Model Act, sponsored by AR Sen. Jason Rapert, NCOIL Immediate Past President, and co-sponsored by AR Rep. Deborah Ferguson, new NCOIL Secretary and Vice Chair of the Committee, ND Rep. George Keiser, former NCOIL President, and Asw. Hunter; and the NCOIL Model Act Regarding Air Ambulance Patient Protections, sponsored by WV Del. Steve Westfall and co-sponsored by IL Rep. Thaddeus Jones, KY Rep. Deanna Frazier, and TX Rep. Tom Oliverson, M.D., new NCOIL Treasurer.

Asw. Hunter stated "this Committee has worked very hard throughout the past year to make sure these Models were improved in response to the significant feedback received from the wide array of interested parties that were involved in this process. None of the Models adopted received unanimous Committee support, and that's ok. As we all know from our work in our respective state legislatures – everyone is not going to agree on everything, but it's important to always maintain a healthy and respective exchange of ideas when it comes to insurance public policy issues." Hunter continued "and of course, consistent with NCOIL's philosophy on model laws, states aren't bound by the provisions in our models. Rather, they are intended to serve as a framework so that states can add or remove things if desired."

"During my last meeting as NCOIL President, it was great to see the Committee take action on such important issues," said IN Representative and outgoing NCOIL President Matt Lehman. "I was very pleased to see the Committee be so productive, and I look forward to participating in the Committee's great work going forward."

The NCOIL Telemedicine Authorization and Reimbursement Act (TARA) encourages health insurers and health care providers to support the use of telemedicine, and also encourages state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services. Having been introduced during the height of the COVID-19 pandemic, TARA is an acknowledgement that access to telemedicine is vital to ensuring the continuity of physical, mental, and behavioral healthcare for consumers during the pandemic and responding to any future outbreaks of the virus.

Two issues in TARA that garnered significant attention were reimbursement levels for telemedicine services, and using telemedicine to satisfy network adequacy requirements. Ultimately, the Committee approved language in TARA that permits health insurers and healthcare providers to negotiate reimbursement levels, and permits health insurers to use telemedicine to satisfy network adequacy requirements with regard to healthcare services, but not exclusively.

Asw. Hunter said, "I am proud to have sponsored TARA as it deals with such an important issue. Telemedicine certainly didn't start with the COVID-19 pandemic, but I think it showed us all that it definitely will be more frequently utilized in the years to come. It is vital that people have the proper access to telemedicine, as it is crucial to ensuring the continuity of physical, mental, and behavioral health care of consumers, especially during health emergencies such as the COVID-19 pandemic."

"The level of discussion around 'payment parity' for telemedicine was perhaps unprecedented for any single phrase in a model law in my time at NCOIL," stated NCOIL General Counsel Will Melofchik. "However, Chair Hunter stated repeatedly and unambiguously that the reimbursement language does not mean dollar-for-dollar payment equality."

The NCOIL Accumulator Adjustment Program Model Act (Accumulator Model) seeks to prohibit accumulator adjustment programs which prevent copayment assistance that helps patients pay for high-cost prescription drugs from counting towards their annual deductible or maximum out-of-pocket costs. The Accumulator Model, and the similar laws across the country, state that no matter who is contributing towards prescription drug costs, whether its pharmaceutical manufacturers, copay systems, a go fund me page, or aunt or uncle, those funds and third party payments should be counted towards a patient's cost-sharing requirements.

"As legislators, we need to make sure that our constituents are being fairly treated by health insurers and are not receiving any unexpected charges," said Arkansas Senator Jason Rapert, NCOIL Immediate Past President and Prime Sponsor of the Accumulator Model. "When patients are faced with unexpected charges, they are oftentimes less likely to adhere to their medical regimen, which can lead to various health consequences, such as unexpected visits to the

emergency room. I sponsored a similar law in my home state of Arkansas and I am proud that NCOIL has now offered guidance to other states on this important issue."

The NCOIL Model Act Regarding Air Ambulance Patient Protections (Air Ambulance Model), aims to amend state insurance laws to include certain air ambulance membership subscriptions as insurance products. The Air Ambulance Model also requires any entity operating such an air ambulance membership program to: implement a patient advocacy program that shall include, among other things, a dedicated patient hotline number and dedicated patient resource e-mail address to process patient billing and claims, and to address patient questions, complaints and concerns; and make other consumer disclosures on any advertisement, marketing material, brochure or contract terms and conditions made available to prospective members or the public, including noting that if eligible and covered by Medicaid or Medicaid managed care, the prospective member is already covered with no out of pocket cost liability for air ambulance services.

West Virginia Delegate Steve Westfall, Prime Sponsor of the Air Ambulance Model said, "It is important that products acting as insurance are categorized and regulated as such so that the proper consumer protections are in place. The old saying 'If it walks like a duck and quacks like a duck…' rings true with air ambulance membership subscriptions. I sponsored similar legislation in my home state of West Virginia and I am confident that states will look to this tightly crafted NCOIL Model and take action." Westfall continued "The legal challenges surrounding these types of laws are well known, but I believe the NCOIL Model has been drafted in such a way that affirms the ability of states to regulate the business of insurance without threat of Federal obstruction."

"Kudos to Chair Hunter, the sponsors, and everyone else involved, for the successful passage of three significant NCOIL Model Laws," said Commissioner Tom Considine, NCOIL CEO. "These issues have clearly struck a chord with the Committee and interested parties given the level of rigorous debate these Models have had over the past several months. It is encouraging to see how much time and effort goes into the passage of our Model Laws – in these cases over many meetings of vigorous discussion - it shows how much people care which is one of the many reasons why NCOIL is such a great organization."

Full copies of the Models appear below.

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NCOIL is a national legislative organization with the nation's 50 states as members, represented principally by legislators serving on their states' insurance and financial institutions committees. NCOIL writes Model Laws in insurance and financial services, works to preserve the State jurisdiction over insurance as established by the McCarran-Ferguson Act over seventy years ago, and to serve as an educational forum for public policymakers and interested parties. Founded in 1969, NCOIL works to assert the prerogative of legislators in making State policy when it comes to insurance and educate State legislators on current and longstanding insurance issues.

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National Council of Insurance Legislators (NCOIL

Telemedicine Authorization and Reimbursement Act (TARA)

Sponsored by Asw. Pam Hunter (NY)

Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee meeting on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021.

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Section 1. Title.

This act shall be known as and may be cited as the Telemedicine Authorization and Reimbursement Act.

Section 2. Purpose

The Legislature hereby finds and declares that:

(A) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine.

(B) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, including behavioral health care, and one way to provide, ensure, or enhance access to care given these barriers is through the appropriate use of technology to allow health care consumers access to qualified health care providers.

(C) There is a need in this state to embrace efforts that will encourage health insurers and health care providers to support the use of telemedicine and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services.

(D) The need to access health care services is compounded by the challenges associated with COVID-19, as consumers are experiencing the negative effects the pandemic has on physical, mental, and emotional health that will extend into future years.

(E) Access to telemedicine is vital to ensuring the continuity of physical, mental, and behavioral health care for consumers during the COVID-19 pandemic and responding to any future outbreaks of the virus.

Section 3. Definitions

(A) "Telemedicine" means the delivery of clinical health care services by means of real time audio only telephonic conversation, two-way electronic audio visual communications, including the application of secure video conferencing or store and forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while such patient is at an originating site and the health care provider is at a distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(B) "Telehealth" means delivering health care services by means of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(C) "Store and forward" transfer means the transmission of a patient's medical information from an originating site to the provider at the distant site without the patient being present.

(D) "Distant site" means a site at which a health care provider is located while providing health care services by means of telemedicine or telehealth; unless the term is otherwise defined with respect to the provision in which it is used.

(E) "Originating site" means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

Section 4. Coverage of Telemedicine Services

(A) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

(B) An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(C) An insurer, corporation, or health maintenance organization shall not require a covered person to have a previously established patient-provider relationship with a specific provider in order for the covered person to receive health care services provided through telemedicine services; however, the establishment of a patient-provider relationship shall not occur via an audio-only telephonic conversation..

(D) An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact.

(E) An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services;, however, such deductible, copayment, or coinsurance shall be combined with the deductible, copayment, or coinsurance applicable to the same services provided through in-person diagnosis, consultation, or treatment.

(F) No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(G) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in [State] on and after January 1, 20__, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(H) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to

persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

(I) Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require prior authorization of emergent telemedicine services.

Section 5. Limited Telemedicine License

An applicant who has an unrestricted license in good standing in another state and maintains an unencumbered certification in a recognized specialty area; or is eligible for such certification and indicates a residence and a practice outside [State] but proposes to practice telemedicine only across state lines on patients within the physical boundaries of [State], shall be issued a license limited to telemedicine by the [State] Medical Board. The holder of such limited license shall be subject to the disciplinary jurisdiction of the [State] Medical board in the same manner as if (s)he held a full license to practice medicine.

Section 6. Network Adequacy and Limitation

(a) An insurer shall not solely use telemedicine or telehealth to satisfy network adequacy requirements with regard to a health care service.

(b) An insurer shall not limit coverage only to services delivered by select third party telemedicine or telehealth organizations.

Section 7. Rules

The [chief State insurance regulator and the chief medical licensing regulator] may adopt rules regulating that are consistent with this Act.

Section 8. Effective Date

This Act shall become effective immediately upon being enacted into law.

Section 9. Severability

If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

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National Council of Insurance Legislators (NCOIL)

Accumulator Adjustment Program Model Act

***Sponsored by Sen. Jason Rapert (AR)**
***Rep. Deborah Ferguson (AR); Rep. George Keiser (ND); Asw. Pam Hunter (NY) – Co-Sponsors**

***Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021.**

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Section 1. Title

This Act shall be known and may be cited as the "[State] Accumulator Adjustment Program Act."

Section 2. Legislative Purpose

(A) The legislature finds that cost sharing assistance is indispensable to help many patients with rare, serious, and chronic diseases afford out-of-pocket costs for their essential, often lifesaving, medications.

(B) The legislature further finds that patients need cost sharing assistance because of the high out-of-pocket cost of medications.

(C) The legislature further finds that when patients face unexpected charges during the plan year, they are less likely to adhere to their medication regimen.

(D) The legislature further finds that lack of patient adherence to needed medicines leads to potential negative health consequences for the patients, such as unnecessary emergency room visits, doctors' visits, surgeries, and other interventions.

(E) The legislature further finds that patients are only able to use cost sharing assistance after they have met requirement(s) for coverage of their medication. Requirements for coverage can include the medication's inclusion on the patient's formulary and utilization management protocols, such as prior authorization and step therapy.

(F) The legislature further finds that health insurers and pharmacy benefit managers (PBMs) have implemented programs, such as accumulator adjustment programs, to restrict cost sharing assistance from counting towards a patient's deductible or annual out-of-pocket limit.

(G) The legislature further finds that as a result of an accumulator adjustment program, a patient is required to continue to make payments even if the patient has already hit an out-of-pocket limit when including cost sharing assistance. As such, the cost sharing assistance depletes leaving the patient responsible for paying the full deductible and meeting the annual out-of-pocket limit for a second time. This means accumulator adjustment programs limit the benefit patients receive from copay assistance programs.

(H) The legislature further finds that patients often are not aware of the inclusion of accumulator adjustment programs in their health plan contracts. Patients tend to learn about these types of programs when they attempt to obtain their medication after their cost sharing assistance has run out, whether at the pharmacy, infusion center, or at home through the mail.

(I) Therefore, the legislature declares it a matter of public interest that health insurers and PBMs must count any amount paid by the patient or on behalf of the patient by another person towards a patient's annual out-of-pocket limit and any cost sharing requirement, such as deductibles.

Section 3. Definitions

(A) "Cost sharing" means any copayment, coinsurance, deductible, or annual limitation on cost sharing (including but not limited to a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan, whether covered under the medical or pharmacy benefit.

(B) "Carrier" OR "Insurer" OR "Issuer" means [cross-reference state insurance statutes and use their existing definitions], and shall include, but not be limited to any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded

health benefit plan offered by public and private entities. For the purposes of this section, "insurer" does not include self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Pub.L. 93–406, 88 Stat. 829, as amended).

(C) "Commissioner" means the state insurance commissioner.

(D) "Generic Equivalent":

(i) means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States Pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects.

(ii) does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the Administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

(E) "Health Plan" means a policy, contract, certificate, or subscriber agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(F) "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

(G) "Pharmacy Benefit Manager" means any person or business who administers the prescription drug or device program of one or more health plans on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

Drafting Note: Use existing statutory definitions of "health plan" and "pharmacy benefit manager" when possible.

Drafting Note: If "person" is already in the state's definition, that includes corporation. Otherwise, can remove "by another person."

Section 4. Cost-Sharing Requirements

(A) When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [CARRIER/INSURER/ISSUER] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person for a prescription drug that is either:

(1) without a generic equivalent; or

(2) with a generic equivalent where the enrollee has obtained access to the prescription drug through any of the following:

(a) prior authorization

(b) a step therapy protocol

(c) the health care insurer's exceptions and appeals process.

(B) A person that pays any amount on behalf of an enrollee for a covered prescription drug:

(1) must notify the enrollee prior to the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available; and

(2) may not condition the assistance on enrollment in a specific health plan or type of health plan, to the extent permitted under federal law.

(C) If under federal law, application of subsection (A) would result in Health Savings Account ineligibility under section 223 of the federal Internal Revenue Code, this requirement shall apply only, for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of subsection (A) shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

Section 5. Rules

The commissioner shall promulgate rules necessary to carry out this Act.

Section 6. Enactment

This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 202##.

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National Council of Insurance Legislators (NCOIL)

Model Act Regarding Air Ambulance Patient Protections

***Sponsored by Del. Steve Westfall (WV)**
***Rep. Thaddeus Jones (IL); Rep. Deanna Frazier (KY); Rep. Tom Oliverson, M.D. (TX) – Co-Sponsors**
***Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021**

AN ACT to amend the insurance law, in relation to private air ambulance services and consumer protections

Section 1. Short Title

This Act may be cited as the Air Ambulance Patient Protection Act.

Section 2. Purpose

This Act is intended to help preserve the long-standing jurisdiction that states have over the regulation of the business of insurance as expressly established by the McCarran-Ferguson Act (15 U.S.C. 1011 et seq., 1945), and to affirm the ability of states to regulate the business of insurance without threat of Federal obstruction.

This Act does so consistent with McCarran-Ferguson Act standards by defining and regulating the particular practice of risk transferring and spreading air ambulance subscription memberships. Legislating protection from consumer harm in these insurance contracts is an appropriate and necessary measure fulfilling the states' responsibility and authority under McCarran-Ferguson to exercise broad regulatory authority over the business of insurance.

Section 3. Section (X) of the insurance law is amended by adding a new subsection (X) to read as follows:

(a) An air ambulance service provider or any affiliated entity who solicits air ambulance membership subscriptions, accepts membership applications, or charges membership fees, is deemed to be engaged in the business of insurance to the extent that it contracts, promises, guarantees, or in any other way claims to pay, reimburse, or indemnify the copayments, deductibles or other cost-sharing amounts of a patient relating to the air ambulance transport as

determined or set by the patient's health insurance provider, health care provider or other third parties or, any post-service payments of costs to third parties relating to the transport.

(b) To the extent that an air ambulance membership subscription falls within the business of insurance described in paragraph (a) of this section, it shall be considered insurance and an insurance product and may be considered secondary insurance coverage or a supplement to any insurance coverage and shall be regulated accordingly by the State Department of Insurance.

Section 4. Air Ambulance Patient Billing Consumer Protections

(a) An entity operating an air ambulance membership program pursuant to Section 3(a) of this Act shall, within one year of enactment of this Act, implement a patient advocacy program, which shall include, at a minimum, the following components:

(1) A dedicated patient hotline number and dedicated patient resource email address to process patient billing and claims, and to address patient questions, complaints and concerns;

(2) A dedicated patient advocacy page on the air medical provider's website that is clearly marked as the "patient portal" or "patient advocacy" page, which is easily navigated to and contains clearly-written and comprehensive resources for patients, including:

(A) A layperson's explanation of what to expect during the claims process,

(B) Frequently asked questions and answers,

(C) Frequently used forms,

(D) Information regarding the air ambulance provider's financial assistance or charity care program, and

(E) Additional resources for patients, including but not limited to contact information for the DOT Consumer Affairs Division, state and federal health and insurance regulatory agencies and departments, and other health consumer informational resources;

(3) Dedicated individuals assigned to review patient complaints and disputes about air ambulance billing and to respond to patients, governmental agencies and any other concerned parties no later than 3 months from the date the complaint is received;

(4) The inclusion of the patient hotline number and email address required by paragraph (1) and patient advocacy webpage address required by paragraph (2) on all patient communication materials, including but not limited to websites, brochures, letters, invoices or billing statements that are sent to or made available to patients;

(5) Mandatory yearly patient advocacy training for all air medical provider personnel who have direct interaction with patients and/or their family members via written, verbal or electronic communications; and

(6) A financial assistance or charity care program to assist patients suffering financial hardship with resolving any unpaid balance owed to the air medical provider.

(b) This provision shall not be enforced in a manner that conflicts with federal law, including the federal preemption of state regulation of air carriers.

Section 5. Consumer disclosures.

(a) An entity selling air ambulance membership products pursuant to Section 3(a) of this Act shall make the following general disclosures in writing in bold type and not less than twelve (12) point font on any advertisement, marketing material, brochure or contract terms and conditions made available to prospective members or the public:

(1) if eligible and covered by Medicaid or Medicaid managed care, the prospective member is already covered with no out of pocket cost liability for air ambulance services; and

(2) if eligible and covered under Medicare and/or a Medicare supplemental plan, the prospective member might already be covered for air ambulance services and should consult with a representative of the Medicare program or a representative of their Medicare Advantage or Medicare Supplemental Plan to determine the level of existing coverage they have for air ambulance and out of pocket costs and whether their plan provider recommends additional supplemental insurance coverage.

Section 6. Severability

If any provision, part or clause of this Act is declared invalid or unconstitutional by a court of competent jurisdiction, such decision shall not affect the validity of the remaining sections or provisions of this article or the article in its entirety.

Section 7. This Act shall take effect one year after enactment.