HOUSE BILL 5

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(PRE-FILED)

By: **Delegates Taylor, Dewberry, Hurson, Arnick, Busch, Guns, Harrison, Hixson, Howard, Kopp, Menes, Montague, Owings, Rawlings, Rosenberg, Vallario, and Wood**

Requested: November 15, 1999
Introduced and read first time: January 12, 2000
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Health Maintenance Organizations - Responsibility for and Regulation of Downstream Risk Assumption Contracts - Member and Provider Protection

FOR the purpose of requiring health maintenance organizations and certain other entities that enter into administrative service provider contracts and downstream risk assumption contracts to meet certain requirements; specifying that certain requirements concerning administrative service provider contracts and downstream risk assumption contracts apply to managed care organizations under the Maryland Medical Assistance Program; authorizing the Maryland Insurance Commissioner to impose a certain additional penalty on a health maintenance organization; making the provisions of this Act applicable to certain provider sponsored organizations under certain circumstances; specifying that certain provisions of law apply to a licensed health services contractor and officers, directors, and trustees of a licensed health services contractor; requiring the Commissioner, in consultation with the Secretary of Health and Mental Hygiene, to adopt certain regulations for a certain methodology; prohibiting a health maintenance organization from entering into a downstream risk assumption contract with a person unless the person is a licensed health services contractor; prohibiting a licensed health services contractor from entering into a downstream risk assumption contract with another licensed health services contractor under certain circumstances; specifying the application content and requirements for an applicant for licensure as a health services contractor; specifying certain additional information to be submitted to the Commissioner by an applicant for licensure as a health services contractor; requiring an applicant for licensure as a health services contractor to satisfy the Commissioner that the applicant has a certain capacity and will meet certain requirements; requiring the Commissioner to establish and adopt by regulation certain minimum capital and surplus requirements for licensed health services contractors, certain requirements for an insolvency plan, and certain requirements for the creation of a segregated fund or availability of certain resources; authorizing the Commissioner to require that a health maintenance organization and a licensed health services

contractor file and receive approval of a certain plan; requiring a licensed health services contractor to meet certain requirements of law regarding payment and denial of claims; specifying that a health maintenance organization shall meet certain requirements regardless of the existence of a certain fund or certain contract provisions; clarifying that with certain exemptions, members and subscribers are not liable to a licensed health services contractor for certain services; requiring a licensed health services contractor to file certain reports with the Commissioner and certain health maintenance organizations by certain dates; authorizing the Commissioner to require certain quarterly reports; specifying certain provisions of law relating to financial impairment, liquidation, and rehabilitation of an insurer apply to a licensed health services contractor; prohibiting certain entities from entering into an administrative service contract unless a certain plan is filed and approved by the Commissioner; specifying the contents of a certain plan to be filed and approved by the Commissioner; requiring certain entities to follow a certain plan; requiring certain entities to monitor a contracting provider for compliance with a certain plan and to notify a contracting provider of failure to comply with the plan; specifying the responsibilities of certain entities upon a contracting provider's failure to comply with a certain plan; specifying the responsibility of a health maintenance organization upon the failure of a licensed health services contractor to meet certain requirements; specifying that a certain plan and certain documentation are confidential; providing for the expiration and renewal of a license for a health services contractor; prohibiting a licensed health services contractor from violating certain provisions of law or committing certain acts; establishing certain penalties; requiring the Commissioner to issue a certain notice to the Secretary; defining certain terms; and generally relating to health maintenance organizations, licensed health services contractors, contracting providers, and regulation of administrative service provider contracts and downstream risk assumption contracts.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-102.3
Annotated Code of Maryland
(1994 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-706(y), 19-729, 19-730, and 19-7A-03
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing
Article - Health - General
Section 19-713.2
Annotated Code of Maryland

(1996 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 9-231 and 15-605(a)
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

BY adding to
Article - Insurance
Section 15-10D-01 through 15-10D-11, inclusive, to be under the new subtitle "Subtitle 10D. Regulation of Administrative Service Provider Contracts and Downstream Risk Assumption Contracts"
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health - General

15-102.3.

(a) The provisions of § 15-112 of the Insurance Article (Provider panels) shall apply to managed care organizations in the same manner they apply to carriers.

(b) The provisions of § 15-1005 of the Insurance Article shall apply to managed care organizations in the same manner they apply to health maintenance organizations.

(c) THE PROVISIONS OF TITLE 15, SUBTITLE 10D OF THE INSURANCE ARTICLE SHALL APPLY TO MANAGED CARE ORGANIZATIONS IN THE SAME MANNER THEY APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

(D) (1) Except as otherwise provided in this subsection, the provisions of § 19-718 of this article (Financial affairs examination) shall apply to managed care organizations in the same manner they apply to health maintenance organizations.

(2) The Insurance Commissioner or an agent of the Commissioner shall examine the financial affairs and status of each managed care organization at least once every 5 years.

19-706.

(y) The provisions of Title 15, Subtitles 10A, [and] 10C, AND 10D of the Insurance Article shall apply to health maintenance organizations.

[19-713.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Administrative service provider contract" means a contract or capitation agreement between a health maintenance organization and a contracting provider which includes requirements that:

(i) The contracting provider accept payments from a health maintenance organization for health care services to be provided to members of the health maintenance organization that the contracting provider arranges to be provided by external providers; and

(ii) The contracting provider administer payments pursuant to the contract within the health maintenance organization for the health care services to the external providers.

(3) "Contracting provider" means a physician or other health care provider who enters into an administrative service provider contract with a health maintenance organization.

(4) "External provider" means a health care provider, including a physician or hospital, who is not:

(i) A contracting provider; or

(ii) An employee, shareholder, or partner of a contracting provider.

(b) A health maintenance organization may not enter into an administrative service provider contract unless:

(1) The health maintenance organization files with the Insurance Commissioner a plan that satisfies the requirements of subsection (c) of this section; and

(2) The Insurance Commissioner does not disapprove the filing within 30 days after the plan is filed.

(c) The plan required under subsection (b) of this section shall:

(1) Require the contracting provider to provide the health maintenance organization with regular reports, at least quarterly, that identify payments made or owed to external providers in sufficient detail to determine if the payments are being made in compliance with law;

(2) Require the contracting provider to provide to the health maintenance organization a current annual financial statement of the contracting provider each year;

(3) Require the creation by the contracting provider, or on the contracting provider's behalf, of a segregated fund (which may include withheld

funds, escrow accounts, letters of credit, or similar arrangements), or require the availability of other resources that are sufficient to satisfy the contracting provider's obligations to external providers for services rendered to members of the health maintenance organization;

(4) Require an explanation of how the fund or resources required under paragraph (3) of this subsection create funds or other resources sufficient to satisfy the contracting provider's obligations to external providers for services rendered to members of the health maintenance organization; and

(5) Permit the health maintenance organization, at mutually agreed upon times and upon reasonable prior notice, to audit and inspect the contracting provider's books, records, and operations relevant to the provider's contract for the purpose of determining the contracting provider's compliance with the plan.

(d) The health maintenance organization and the contracting provider shall comply with the plan.

(e) (1) The health maintenance organization shall monitor the contracting provider to assure compliance with the plan, and the health maintenance organization shall notify the contracting provider whenever a failure to comply with the plan occurs.

(2) Upon the failure of the contracting provider to comply with the plan following notice of noncompliance, or upon termination of the administrative service provider contract for any reason, the health maintenance organization shall assume the administration of any payments due from the contracting provider to external providers on behalf of the contracting provider.

(f) The plan and all supporting documentation submitted in connection with the plan shall be treated as confidential and proprietary, and may not be disclosed except as otherwise required by law.

(g) On July 1, 1991, any health maintenance organization which has existing contracts or arrangements subject to this section shall file a plan under this section within 120 days.]

19-729.

(a) A health maintenance organization may not:

(1) Violate any provision of this subtitle or any rule or regulation adopted under it;

(2) Fail to fulfill its obligations to provide the health care services specified in its contracts with subscribers;

(3) Make any false statement with respect to any report or statement required by this subtitle or by the Commissioner under this subtitle;

(4) Advertise, merchandise, or attempt to merchandise its services in a way that misrepresents its services or capacity for service;

(5) Engage in a deceptive, misleading, unfair, or unauthorized practice as to advertising or merchandising;

(6) Prevent or attempt to prevent the Commissioner or the Department from performing any duty imposed by this subtitle;

(7) Fraudulently obtain or fraudulently attempt to obtain any benefit under this subtitle;

(8) Fail to fulfill the basic requirements to operate as a health maintenance organization as provided in § 19-710 of this subtitle;

(9) Violate any applicable provision of Title 15, Subtitle 12 of the Insurance Article;

(10) Fail to provide services to a member in a timely manner as provided in § 19-705.1(b)(1) of this subtitle;

(11) Fail to comply with the provisions of Title 15, Subtitle 10A, 10B, [or] 10C, 10D, or § 2-112.2 of the Insurance Article; or

(12) Violate any provision of § 19-712.5 of this subtitle.

(b) If any health maintenance organization violates this section, the Commissioner may pursue any one or more of the courses of action described in § 19-730 of this subtitle.

19-730.

(a) If any person violates any provision of § 19-729 of this subtitle, the Commissioner may:

(1) Issue an administrative order that requires the health maintenance organization to:

(i) Cease inappropriate conduct or practices by it or any of the personnel employed or associated with it;

(ii) Fulfill its contractual obligations;

(iii) Provide a service that has been denied improperly;

(iv) Take appropriate steps to restore its ability to provide a service that is provided under a contract;

(v) Cease the enrollment of any additional enrollees except newborn children or other newly acquired dependents or existing enrollees; or

(vi) Cease any advertising or solicitation;

(2) [Impose] EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, IMPOSE a penalty of not more than $5,000 for each unlawful act committed;

(3) Impose any penalty that could be imposed on an insurer under § 4-113(d) of the Insurance Article;

(4) Suspend, revoke, or refuse to renew the certificate of authority to do business as a health maintenance organization;

(5) Suspend, revoke, or refuse to renew the certificate of a medical director of a health maintenance organization;

(6) Impose any penalty that could be imposed on an insurer under § 4-113(d) of the Insurance Article; or

(7) Apply to any court for legal or equitable relief considered appropriate by the Commissioner or the Department, in accordance with the joint internal procedures.

(b) IN ADDITION TO THE ACTIONS AVAILABLE TO THE COMMISSIONER IN SUBSECTION (A) OF THIS SECTION, IF A PERSON VIOLATES ANY PROVISION OF TITLE 15, SUBTITLE 10D OF THE INSURANCE ARTICLE, THE COMMISSIONER MAY IMPOSE A PENALTY OF NOT MORE THAN $125,000 FOR EACH VIOLATION.

(C) If the Commissioner issues an order or imposes any penalty under this section, the Commissioner immediately shall provide written notice of the order or penalty to the Secretary.

19-7A-03.

(a) (1) Before an entity may operate as a provider-sponsored organization under the federal Medicare+Choice Program, the entity must obtain a license from the Commissioner.

(2) The Commissioner shall issue a license under paragraph (1) of this subsection to any entity to operate as a provider-sponsored organization that meets the requirements of subsection (b) of this section.

(b) To operate as a provider-sponsored organization under the federal Medicare+Choice Program in this State, an entity shall:

(1) Meet the definition of a provider-sponsored organization under § 19-7A-01 of this subtitle; and

(2) Meet the requirements applicable to a health maintenance organization under Subtitle 7 of this title AND TITLE 15, SUBTITLE 10D OF THE INSURANCE ARTICLE to the extent those requirements are not preempted by federal law.

Article - Insurance

9-231.

(a) In this section, "chief executive officer" means a person charged by the board of directors or trustees of an insurer to administer and implement policies and procedures of the insurer.

(b) The provisions of this section that apply to insurers also apply to:

(1) a corporation that operates a nonprofit health service plan under Title 14, Subtitle 1 of this article;

(2) a dental plan organization, as defined in § 14-401 of this article;

(3) a surplus lines insurer; [and]

(4) a health maintenance organization; AND

(5) A LICENSED HEALTH SERVICES CONTRACTOR AS DEFINED IN § 15-10D-01 OF THIS ARTICLE.

(c) (1) A chief executive officer shall immediately provide the Commissioner and all members of the board of directors or the trustees of an insurer with written notice that the insurer is an impaired insurer, if the chief executive officer:

(i) knows that the insurer is an impaired insurer; and

(ii) for a period of 60 days, has been unable to remedy the impairment.

(2) A director, officer, or trustee of an insurer who knows that the insurer is an impaired insurer shall immediately notify the chief executive officer of the impairment.

(d) Notice provided to the Commissioner under this section has the confidentiality specified in § 7-106 of this article.

(e) If a person knows that the action will result in or contribute to an insurer becoming an impaired insurer, the person may not:

(1) conceal property that belongs to the insurer;

(2) transfer or conceal property of the person or property that belongs to the insurer in contemplation of a delinquency proceeding;

(3) conceal, destroy, mutilate, alter, or falsify a document that relates to the property of the insurer;

(4) withhold a document from a receiver, trustee, or other officer of the court entitled to its possession under this subtitle; or

(5) give, obtain, or receive anything of value for acting or forbearing to act in a delinquency proceeding.

(f) (1) In addition to any other applicable penalty provided in this article, a person that violates subsection (e) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50,000 or imprisonment not exceeding 3 years or both.

(2) In addition to any other applicable penalty provided in this article, a person that violates subsection (c) of this section is subject to a civil penalty not exceeding $50,000.

(g) THE REQUIREMENTS AND PENALTIES OF THIS SECTION THAT APPLY TO A CHIEF EXECUTIVE OFFICER OF AN INSURER APPLY IN THE SAME MANNER TO A DIRECTOR, OFFICER, OR TRUSTEE OF A LICENSED HEALTH SERVICES CONTRACTOR.

(H) The Commissioner may issue a cease and desist order in accordance with § 27-103 of this article against a person that violates subsection (c) or subsection (e) of this section.

15-605.

(a) (1) On or before March 1 of each year, an annual report that meets the specifications of paragraph (2) of this subsection shall be submitted to the Commissioner by:

(i) each authorized insurer that provides health insurance in the State;

(ii) each nonprofit health service plan that is authorized by the Commissioner to operate in the State;

(iii) each health maintenance organization that is authorized by the Commissioner to operate in the State; and

(iv) as applicable in accordance with regulations adopted by the Commissioner, each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health - General Article.

(2) The annual report required under this subsection shall:

(i) be submitted in a form required by the Commissioner; and

(ii) include for the preceding calendar year the following data for all health benefit plans specific to the State:

1. premiums written;

2. premiums earned;

3. total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;

4. total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, estimated if necessary;

5. loss ratio; and

6. expense ratio.

(3) The data required under paragraph (2) of this subsection shall be reported:

(i) by product delivery system for health benefit plans that are issued under Subtitle 12 of this title;

(ii) in the aggregate for health benefit plans that are issued to individuals;

(iii) in the aggregate for a managed care organization that operates under Title 15, Subtitle 1 of the Health - General Article; and

(iv) in a manner determined by the Commissioner in accordance with this subsection for all other health benefit plans.

(4) THE COMMISSIONER, IN CONSULTATION WITH THE SECRETARY OF HEALTH AND MENTAL HYGIENE, SHALL ESTABLISH AND ADOPT BY REGULATION A METHODOLOGY TO BE UTILIZED IN THE ANNUAL REPORT THAT ENSURES A CLEAR SEPARATION OF ALL MEDICAL AND ADMINISTRATIVE EXPENSES WHETHER INCURRED DIRECTLY OR THROUGH A SUBCONTRACTOR.

(5) The Commissioner may conduct an examination to ensure that an annual report submitted under this subsection is accurate.

[(5)] (6) Failure of an insurer, nonprofit health service plan, or health maintenance organization to submit the information required under this subsection in a timely manner shall result in a penalty of $500 for each day after March 1 that the information is not submitted.

SUBTITLE 10D. REGULATION OF ADMINISTRATIVE SERVICE PROVIDER CONTRACTS AND DOWNSTREAM RISK ASSUMPTION CONTRACTS.

15-10D-01.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "ADMINISTRATIVE SERVICE PROVIDER CONTRACT" MEANS A CONTRACT OR CAPITATION AGREEMENT BETWEEN A HEALTH MAINTENANCE ORGANIZATION AND A CONTRACTING PROVIDER OR BETWEEN A LICENSED HEALTH SERVICES

CONTRACTOR AND A CONTRACTING PROVIDER THAT INCLUDES REQUIREMENTS THAT:

(1) THE CONTRACTING PROVIDER ACCEPT PAYMENTS FROM A HEALTH MAINTENANCE ORGANIZATION FOR HEALTH CARE SERVICES TO BE PROVIDED TO MEMBERS OF A HEALTH MAINTENANCE ORGANIZATION THAT THE CONTRACTING PROVIDER ARRANGES TO BE PROVIDED BY EXTERNAL PROVIDERS; AND

(2) THE CONTRACTING PROVIDER ADMINISTER PAYMENTS PURSUANT TO THE CONTRACT WITHIN THE HEALTH MAINTENANCE ORGANIZATION FOR THE HEALTH CARE SERVICES TO THE EXTERNAL PROVIDERS.

(C) "CAPITATED BASIS" MEANS A FIXED MEMBER PER MONTH PAYMENT OR FIXED PERCENTAGE OF PREMIUM PAYMENT WHERE THE PROVIDER OR CONTRACTING PROVIDER ASSUMES THE RISK FOR THE COST OF THE CONTRACTED HEALTH CARE SERVICE.

(D) "CONTRACTING PROVIDER" MEANS A PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO ENTERS INTO AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION OR A LICENSED HEALTH SERVICES CONTRACTOR.

(E) "DOWNSTREAM RISK ASSUMPTION CONTRACT" MEANS A CONTRACT OR AGREEMENT, INCLUDING AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT, FOR HEALTH CARE SERVICES TO BE PROVIDED TO A MEMBER OF A HEALTH MAINTENANCE ORGANIZATION WITH PAYMENT TO BE MADE ON A CAPITATED BASIS THAT INCLUDES REQUIREMENTS THAT:

(1) THE NUMBER OF MEMBERS TO RECEIVE HEALTH CARE SERVICES PER MONTH EXCEEDS 100 INDIVIDUALS; OR

(2) THE CAPITATION AMOUNT TO BE RECEIVED MEETS OR EXCEEDS $50,000 PER MONTH.

(F) "EXTERNAL PROVIDER" MEANS A HEALTH CARE PROVIDER, INCLUDING A PHYSICIAN OR HOSPITAL, WHO IS NOT:

(1) A CONTRACTING PROVIDER; OR

(2) AN EMPLOYEE, SHAREHOLDER, OR PARTNER OF A CONTRACTING PROVIDER.

(G) "HEALTH CARE SERVICES" HAS THE MEANING STATED IN § 19-701(E) OF THE HEALTH - GENERAL ARTICLE AND INCLUDES ANY HEALTH OR MEDICAL PROCEDURE OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

(1) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION; OR

(2) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

(H) "HEALTH MAINTENANCE ORGANIZATION" HAS THE MEANING STATED IN § 19-701(F) OF THE HEALTH - GENERAL ARTICLE.

(I) "LICENSED HEALTH SERVICES CONTRACTOR" MEANS AN ENTITY OR PROVIDER THAT IS LICENSED BY THE COMMISSIONER IN ACCORDANCE WITH THE REQUIREMENTS OF THIS SUBTITLE.

(J) "MEMBER" HAS THE MEANING STATED IN § 19-701(G) OF THE HEALTH - GENERAL ARTICLE.

(K) "PROVIDER" MEANS ANY PERSON, INCLUDING A PHYSICIAN OR HOSPITAL, THAT IS LICENSED OR OTHERWISE AUTHORIZED IN THIS STATE TO PROVIDE HEALTH CARE SERVICES.

15-10D-02.

(A) A HEALTH MAINTENANCE ORGANIZATION MAY NOT ENTER INTO A DOWNSTREAM RISK ASSUMPTION CONTRACT WITH A PERSON UNLESS THE PERSON IS A LICENSED HEALTH SERVICES CONTRACTOR IN ACCORDANCE WITH THIS SUBTITLE.

(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A LICENSED HEALTH SERVICES CONTRACTOR MAY NOT ENTER INTO A DOWNSTREAM RISK ASSUMPTION CONTRACT WITH ANOTHER LICENSED HEALTH SERVICES CONTRACTOR.

(2) A HEALTH MAINTENANCE ORGANIZATION THAT IS ALSO A LICENSED HEALTH SERVICES CONTRACTOR MAY ENTER INTO A DOWNSTREAM RISK ASSUMPTION CONTRACT WITH A LICENSED HEALTH SERVICES CONTRACTOR FOR HEALTH CARE SERVICES TO BE PROVIDED TO MEMBERS OF THE HEALTH MAINTENANCE ORGANIZATION.

15-10D-03.

(A) AN APPLICANT FOR LICENSURE AS A HEALTH SERVICES CONTRACTOR SHALL:

(1) SUBMIT AN APPLICATION TO THE COMMISSIONER ON THE FORM THAT THE COMMISSIONER REQUIRES; AND

(2) PAY TO THE COMMISSIONER THE APPLICATION FEE ESTABLISHED BY THE COMMISSIONER THROUGH REGULATION.

(B) THE APPLICATION SHALL:

(1) BE ON A FORM AND ACCOMPANIED BY ANY SUPPORTING DOCUMENTS THE COMMISSIONER REQUIRES; AND

(2) BE SIGNED AND VERIFIED BY THE APPLICANT.

(C) THE APPLICATION FEE REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL BE SUFFICIENT TO PAY FOR THE ADMINISTRATIVE COSTS OF THE LICENSURE PROGRAM AND ANY OTHER COSTS ASSOCIATED WITH CARRYING OUT THE PROVISIONS OF THIS SUBTITLE.

15-10D-04.

(A) IN CONJUNCTION WITH THE APPLICATION, AN APPLICANT FOR LICENSURE AS A HEALTH SERVICES CONTRACTOR SHALL SUBMIT ADDITIONAL INFORMATION TO THE COMMISSIONER, INCLUDING:

(1) A STATEMENT OF THE FINANCIAL CONDITION OF THE HEALTH SERVICES CONTRACTOR, INCLUDING:

(I) SOURCES OF FINANCIAL SUPPORT;

(II) A BALANCE SHEET SHOWING ASSETS, LIABILITIES, AND MINIMUM TANGIBLE NET WORTH; AND

(III) ANY OTHER FINANCIAL INFORMATION THE COMMISSIONER REQUIRES FOR ADEQUATE FINANCIAL EVALUATION;

(2) COPIES OF DOWNSTREAM RISK ASSUMPTION CONTRACTS PROPOSED TO BE MADE BETWEEN THE APPLICANT FOR LICENSURE AS A HEALTH SERVICES CONTRACTOR AND A HEALTH MAINTENANCE ORGANIZATION; AND

(3) COPIES OF ADMINISTRATIVE SERVICE PROVIDER CONTRACTS PROPOSED TO BE MADE BETWEEN THE APPLICANT FOR LICENSURE AS A HEALTH SERVICES CONTRACTOR AND A CONTRACTING PROVIDER.

(B) AN APPLICANT FOR LICENSURE AS A HEALTH SERVICES CONTRACTOR SHALL SATISFY TO THE COMMISSIONER THAT THE APPLICANT HAS A DEMONSTRATED CAPACITY TO ASSUME FINANCIAL RISK UNDER THE PROPOSED DOWNSTREAM RISK ASSUMPTION CONTRACT AND WILL MEET THE REQUIREMENTS OF THIS SUBTITLE.

15-10D-05.

(A) THE COMMISSIONER SHALL ESTABLISH AND ADOPT BY REGULATION:

(1) MINIMUM CAPITAL AND SURPLUS REQUIREMENTS FOR LICENSED HEALTH SERVICES CONTRACTORS; AND

(2) REQUIREMENTS THAT A LICENSED HEALTH SERVICES CONTRACTOR MAINTAIN AN INSOLVENCY PLAN APPROVED BY THE COMMISSIONER.

(B) (1) THE COMMISSIONER SHALL ESTABLISH AND ADOPT BY REGULATION REQUIREMENTS FOR THE CREATION AND MAINTENANCE, BY THE LICENSED HEALTH

SERVICES CONTRACTOR OR ON THE LICENSED HEALTH SERVICES CONTRACTOR'S BEHALF, OF A SEGREGATED FUND OR THE AVAILABILITY OF OTHER RESOURCES.

(2) THE REGULATIONS SHALL:

(I) REQUIRE A SUFFICIENT AMOUNT TO BE HELD IN THE SEGREGATED FUND TO SATISFY THE OBLIGATIONS OF THE LICENSED HEALTH SERVICES CONTRACTOR TO EXTERNAL PROVIDERS FOR SERVICES RENDERED TO MEMBERS OF THE HEALTH MAINTENANCE ORGANIZATION;

(II) SPECIFY THE METHODOLOGY FOR DETERMINING A SUFFICIENT AMOUNT TO BE HELD IN THE SEGREGATED FUND;

(III) PROVIDE THAT THE SEGREGATED FUND MAY INCLUDE WITHHELD FUNDS, ESCROW ACCOUNTS, LETTERS OF CREDIT, OR SIMILAR ARRANGEMENTS;

(IV) REQUIRE AN ANNUAL REPORTING OF THE STATUS OF THE SEGREGATED FUND; AND

(V) REQUIRE THAT ANY CHANGES MADE TO A DOWNSTREAM RISK ASSUMPTION CONTRACT SHALL BE REVIEWED BY THE COMMISSIONER TO DETERMINE THE SUFFICIENCY OF THE SEGREGATED FUND BASED ON THE CHANGES MADE TO THE DOWNSTREAM RISK ASSUMPTION CONTRACT.

(C) UPON THE BANKRUPTCY OR INSOLVENCY OF A LICENSED HEALTH SERVICES CONTRACTOR, THE SEGREGATED FUND CREATED UNDER THE REGULATIONS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE THE RESPONSIBILITY OF THE HEALTH MAINTENANCE ORGANIZATION AND SHALL BE USED FOR PAYMENTS OWED BY THE LICENSED HEALTH SERVICES CONTRACTOR TO EXTERNAL PROVIDERS AND MAY NOT BE CONSIDERED TO BE AN ASSET OR ACCOUNT OF THE LICENSED HEALTH SERVICES CONTRACTOR.

(D) THE COMMISSIONER MAY REQUIRE THAT A HEALTH MAINTENANCE ORGANIZATION AND A LICENSED HEALTH SERVICES CONTRACTOR, PRIOR TO ENTERING INTO A DOWNSTREAM RISK ASSUMPTION CONTRACT, FILE AND RECEIVE APPROVAL FROM THE COMMISSIONER OF A PLAN THAT SATISFIES ANY OF THE REQUIREMENTS OF A PLAN TO BE FILED UNDER § 15-10D-08 OF THIS SUBTITLE.

(E) A LICENSED HEALTH SERVICES CONTRACTOR SHALL COMPLY WITH THE PROVISIONS OF §§ 15-1005 AND 15-1008 OF THIS TITLE AS TO THE CLAIMS OF EXTERNAL PROVIDERS.

(F) (1) UPON THE FAILURE OF A LICENSED HEALTH SERVICES CONTRACTOR TO COMPLY WITH THE REQUIREMENTS OF THIS SUBTITLE OR UPON THE TERMINATION OF THE DOWNSTREAM RISK ASSUMPTION CONTRACT FOR ANY REASON, THE HEALTH MAINTENANCE ORGANIZATION SHALL:

(I) BE FINANCIALLY AND ADMINISTRATIVELY RESPONSIBLE FOR PAYMENT DUE FROM THE LICENSED HEALTH CARE SERVICES CONTRACTOR TO

EXTERNAL PROVIDERS ON BEHALF OF THE LICENSED HEALTH CARE SERVICES CONTRACTOR; AND

(II) MAKE ALL PAYMENTS TO EXTERNAL PROVIDERS IN ACCORDANCE WITH THE REQUIREMENTS OF § 15-1005 OF THIS TITLE.

(2) A HEALTH MAINTENANCE ORGANIZATION SHALL MEET THE REQUIREMENTS OF THIS SUBSECTION, REGARDLESS OF THE EXISTENCE OF THE SEGREGATED FUND OR A CONTRARY PROVISION IN A DOWNSTREAM RISK ASSUMPTION CONTRACT.

(3) NOTHING IN PARAGRAPH (1) OR (2) OF THIS SUBSECTION MAY BE CONSTRUED TO PROHIBIT A HEALTH MAINTENANCE ORGANIZATION FROM SEEKING PAYMENT FROM A LICENSED HEALTH SERVICES CONTRACTOR OR FROM AMOUNTS HELD IN THE SEGREGATED FUND FOR PAYMENTS MADE TO EXTERNAL PROVIDERS ON BEHALF OF THE LICENSED HEALTH SERVICES CONTRACTOR.

(G) EXCEPT AS OTHERWISE PROVIDED BY LAW, INDIVIDUAL MEMBERS AND SUBSCRIBERS OF HEALTH MAINTENANCE ORGANIZATIONS SHALL NOT BE LIABLE TO A LICENSED HEALTH SERVICES CONTRACTOR FOR ANY COVERED SERVICES PROVIDED TO THE ENROLLEE OR SUBSCRIBER.

15-10D-06.

(A) UNLESS, FOR GOOD CAUSE SHOWN, THE COMMISSIONER EXTENDS THE TIME FOR A REASONABLE PERIOD:

(1) ON OR BEFORE MARCH 1 OF EACH YEAR, EACH LICENSED HEALTH SERVICES CONTRACTOR SHALL FILE WITH THE COMMISSIONER A REPORT THAT SHOWS THE FINANCIAL CONDITION OF THE LICENSED HEALTH SERVICES CONTRACTOR ON THE LAST DAY OF THE PRECEDING CALENDAR YEAR AND ANY OTHER INFORMATION THAT THE COMMISSIONER REQUIRES BY RULE OR REGULATION; AND

(2) ON OR BEFORE JUNE 1 OF EACH YEAR, EACH LICENSED HEALTH SERVICES CONTRACTOR SHALL FILE, WITH THE COMMISSIONER AND ANY HEALTH MAINTENANCE ORGANIZATIONS WITH WHICH THE LICENSED HEALTH SERVICES CONTRACTOR HAS ENTERED INTO ONE OR MORE DOWNSTREAM RISK ASSUMPTION CONTRACTS, AN AUDITED FINANCIAL REPORT FOR THE PRECEDING CALENDAR YEAR.

(B) THE ANNUAL REPORT SHALL:

(1) BE ON THE FORMS THAT THE COMMISSIONER REQUIRES; AND

(2) INCLUDE A DESCRIPTION OF ANY CHANGES IN THE INFORMATION SUBMITTED UNDER THIS SUBTITLE.

(C) THE AUDITED FINANCIAL REPORT SHALL:

(1) BE ON THE FORMS THAT THE COMMISSIONER REQUIRES;

(2) DEMONSTRATE EXISTENCE OF THE REQUIRED MINIMUM CAPITAL AND SURPLUS REQUIREMENTS; AND

(3) BE CERTIFIED BY AN AUDIT OF A CERTIFIED PUBLIC ACCOUNTING FIRM.

(D) EACH FINANCIAL REPORT FILED UNDER THIS SECTION IS A PUBLIC RECORD.

(E) THE COMMISSIONER MAY REQUIRE A LICENSED HEALTH SERVICES CONTRACTOR TO PROVIDE QUARTERLY CLAIMS PAYMENT REPORTS ON THE STATUS OF PAYMENTS MADE OR OWED TO PROVIDERS IN SUFFICIENT DETAIL TO DETERMINE IF THE PAYMENTS ARE BEING MADE IN COMPLIANCE WITH THE LAW.

15-10D-07.

(A) SUBJECT TO THIS SECTION, THE PROVISIONS OF TITLE 9, SUBTITLE 2 OF THIS ARTICLE REGARDING THE REHABILITATION AND LIQUIDATION OF INSURERS ARE APPLICABLE TO LICENSED HEALTH SERVICES CONTRACTORS.

(B) THE REHABILITATION OR LIQUIDATION OF A LICENSED HEALTH SERVICES CONTRACTOR SHALL BE SUBJECT TO § 19-706.1 OF THE HEALTH - GENERAL ARTICLE AND SHALL BE CONDUCTED BY THE COMMISSIONER IN THE SAME MANNER AS REHABILITATION OR LIQUIDATION OF A HEALTH MAINTENANCE ORGANIZATION.

(C) THE FOLLOWING PROVISIONS SHALL APPLY TO LICENSED HEALTH SERVICES CONTRACTORS IN THE SAME MANNER THAT THEY APPLY TO INSURERS:

(1) § 9-231 OF THIS ARTICLE REGARDING NOTICE OF IMPAIRMENT OF AN INSURER AND PROHIBITION ON CONTRIBUTION TO IMPAIRMENT OF AN INSURER; AND

(2) TITLE 9, SUBTITLE 1 OF THIS ARTICLE REGARDING IMPAIRED ENTITIES.

15-10D-08.

(A) A HEALTH MAINTENANCE ORGANIZATION OR A LICENSED HEALTH SERVICES CONTRACTOR MAY NOT ENTER INTO AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT WITH A CONTRACTING PROVIDER UNLESS:

(1) THE HEALTH MAINTENANCE ORGANIZATION OR THE LICENSED HEALTH SERVICES CONTRACTOR FILES WITH THE COMMISSIONER A PLAN THAT SATISFIES THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION; AND

(2) THE COMMISSIONER DOES NOT DISAPPROVE THE FILING WITHIN 30 DAYS AFTER THE PLAN IS FILED.

(B) THE PLAN REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL:

(1) REQUIRE THE CONTRACTING PROVIDER TO PROVIDE THE HEALTH MAINTENANCE ORGANIZATION OR THE LICENSED HEALTH SERVICES CONTRACTOR WITH REGULAR REPORTS, AT LEAST QUARTERLY, THAT IDENTIFY PAYMENTS MADE OR OWED TO EXTERNAL PROVIDERS IN SUFFICIENT DETAIL TO DETERMINE IF THE PAYMENTS ARE BEING MADE IN COMPLIANCE WITH LAW;

(2) REQUIRE THE CONTRACTING PROVIDER TO PROVIDE TO THE HEALTH MAINTENANCE ORGANIZATION OR THE LICENSED HEALTH SERVICES CONTRACTOR A CURRENT ANNUAL FINANCIAL STATEMENT OF THE CONTRACTING PROVIDER EACH YEAR;

(3) REQUIRE THE CREATION AND MAINTENANCE BY THE CONTRACTING PROVIDER, OR ON THE CONTRACTING PROVIDER'S BEHALF, OF A SEGREGATED FUND IN COMPLIANCE WITH THE REGULATIONS ADOPTED BY THE COMMISSIONER;

(4) REQUIRE AN EXPLANATION OF HOW THE FUND OR RESOURCES REQUIRED UNDER ITEM (3) OF THIS SUBSECTION CREATE FUNDS OR OTHER RESOURCES SUFFICIENT TO SATISFY THE CONTRACTING PROVIDER'S OBLIGATIONS TO EXTERNAL PROVIDERS FOR SERVICES RENDERED TO MEMBERS OF THE HEALTH MAINTENANCE ORGANIZATION;

(5) REQUIRE THE CONTRACTING PROVIDER TO COMPLY WITH THE PROVISIONS OF §§ 15-1005 AND 15-1008 OF THIS TITLE; AND

(6) PERMIT THE HEALTH MAINTENANCE ORGANIZATION OR LICENSED HEALTH SERVICES CONTRACTOR, AT MUTUALLY AGREED UPON TIMES AND UPON REASONABLE PRIOR NOTICE, TO AUDIT AND INSPECT THE CONTRACTING PROVIDER'S BOOKS, RECORDS, AND OPERATIONS RELEVANT TO THE PROVIDER'S CONTRACT FOR THE PURPOSE OF DETERMINING THE CONTRACTING PROVIDER'S COMPLIANCE WITH THE PLAN.

(C) THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(1) REQUIRE THE SEGREGATED FUND TO CONTAIN A SUFFICIENT AMOUNT TO SATISFY THE OBLIGATIONS OF THE CONTRACTING PROVIDER TO EXTERNAL PROVIDERS FOR SERVICES RENDERED TO MEMBERS OF THE HEALTH MAINTENANCE ORGANIZATION;

(2) SPECIFY THE METHODOLOGY FOR DETERMINING A SUFFICIENT AMOUNT TO BE HELD IN THE SEGREGATED FUND;

(3) PROVIDE THAT THE SEGREGATED FUND MAY INCLUDE WITHHELD FUNDS, ESCROW ACCOUNTS, LETTERS OF CREDIT, OR SIMILAR ARRANGEMENTS;

(4) REQUIRE AN ANNUAL REPORTING OF THE STATUS OF THE SEGREGATED FUND; AND

(5) REQUIRE THAT ANY CHANGES MADE TO AN ADMINISTRATIVE SERVICES PROVIDER CONTRACT SHALL BE REVIEWED BY THE COMMISSIONER TO DETERMINE THE SUFFICIENCY OF THE SEGREGATED FUND BASED ON THE CHANGES MADE TO THE ADMINISTRATIVE SERVICES PROVIDER CONTRACT.

(D) UPON THE BANKRUPTCY OR INSOLVENCY OF A CONTRACTING PROVIDER, THE SEGREGATED FUND CREATED UNDER THE REGULATIONS REQUIRED UNDER SUBSECTION (C) OF THIS SECTION SHALL BE THE RESPONSIBILITY OF THE HEALTH MAINTENANCE ORGANIZATION OR THE LICENSED HEALTH SERVICES CONTRACTOR AND SHALL BE USED FOR PAYMENTS OWED BY THE CONTRACTING PROVIDER TO EXTERNAL PROVIDERS AND MAY NOT BE CONSIDERED TO BE AN ASSET OR ACCOUNT OF THE CONTRACTING PROVIDER.

(E) THE HEALTH MAINTENANCE ORGANIZATION OR THE LICENSED HEALTH SERVICES CONTRACTOR AND THE CONTRACTING PROVIDER SHALL COMPLY WITH THE PLAN.

(F) THE HEALTH MAINTENANCE ORGANIZATION OR THE LICENSED HEALTH SERVICES CONTRACTOR SHALL MONITOR THE CONTRACTING PROVIDER TO ASSURE COMPLIANCE WITH THE PLAN, AND THE HEALTH MAINTENANCE ORGANIZATION OR THE LICENSED HEALTH SERVICES CONTRACTOR SHALL NOTIFY THE CONTRACTING PROVIDER WHENEVER A FAILURE TO COMPLY WITH THE PLAN OCCURS.

(G) (1) UPON THE FAILURE OF A CONTRACTING PROVIDER TO COMPLY WITH THE PLAN FOLLOWING A NOTICE OF NONCOMPLIANCE, OR UPON A TERMINATION OF THE ADMINISTRATIVE SERVICE PROVIDER CONTRACT FOR ANY REASON, THE HEALTH MAINTENANCE ORGANIZATION OR LICENSED HEALTH SERVICES CONTRACTOR SHALL:

(I) BE FINANCIALLY AND ADMINISTRATIVELY RESPONSIBLE FOR PAYMENT DUE FROM THE CONTRACTING PROVIDER TO EXTERNAL PROVIDERS ON BEHALF OF THE CONTRACTING PROVIDER; AND

(II) MAKE ALL PAYMENTS TO EXTERNAL PROVIDERS IN ACCORDANCE WITH THE REQUIREMENTS OF § 15-1005 OF THIS TITLE.

(2) A HEALTH MAINTENANCE ORGANIZATION OR LICENSED HEALTH SERVICES CONTRACTOR SHALL MEET THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, REGARDLESS OF THE EXISTENCE OF THE SEGREGATED FUND OR A CONTRARY PROVISION IN AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT.

(3) NOTHING IN PARAGRAPH (1) OR PARAGRAPH (2) OF THIS SUBSECTION MAY BE CONSTRUED TO PROHIBIT A HEALTH MAINTENANCE ORGANIZATION OR LICENSED HEALTH SERVICES CONTRACTOR FROM SEEKING PAYMENT FROM THE CONTRACTING PROVIDER OR FROM AMOUNTS HELD IN THE SEGREGATED FUND IN ACCORDANCE WITH THIS SECTION FOR PAYMENTS MADE TO EXTERNAL PROVIDERS ON BEHALF OF THE CONTRACTING PROVIDER.

(4) UPON THE FAILURE OF THE LICENSED HEALTH SERVICES CONTRACTOR TO ACCEPT FINANCIAL AND ADMINISTRATIVE RESPONSIBILITY FOR

PAYMENT DUE TO EXTERNAL PROVIDERS ON BEHALF OF THE CONTRACTING PROVIDER IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION, THE HEALTH MAINTENANCE ORGANIZATION THAT HAS ENTERED INTO A DOWNSTREAM RISK CONTRACT WITH THE LICENSED HEALTH CARE PROVIDER SHALL:

(I) BE FINANCIALLY AND ADMINISTRATIVELY RESPONSIBLE FOR PAYMENT DUE FROM THE CONTRACTING PROVIDER TO EXTERNAL PROVIDERS ON BEHALF OF THE CONTRACTING PROVIDER; AND

(II) MAKE ALL PAYMENTS TO EXTERNAL PROVIDERS IN ACCORDANCE WITH THE REQUIREMENTS OF § 15-1005 OF THIS TITLE.

(5) A HEALTH MAINTENANCE ORGANIZATION SHALL MEET THE REQUIREMENTS OF PARAGRAPH (4) OF THIS SUBSECTION, REGARDLESS OF THE EXISTENCE OF THE SEGREGATED FUND OR A CONTRARY PROVISION IN A DOWNSTREAM RISK ASSUMPTION CONTRACT OR AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT.

(6) NOTHING IN PARAGRAPH (4) OR PARAGRAPH (5) OF THIS SUBSECTION MAY BE CONSTRUED TO PROHIBIT A HEALTH MAINTENANCE ORGANIZATION FROM SEEKING PAYMENT FROM THE CONTRACTING PROVIDER, THE LICENSED HEALTH SERVICES CONTRACTOR, OR FROM AMOUNTS HELD IN THE SEGREGATED FUND IN ACCORDANCE WITH THIS SUBTITLE FOR PAYMENTS MADE TO EXTERNAL PROVIDERS ON BEHALF OF THE CONTRACTING PROVIDER.

(H) THE PLAN AND ALL SUPPORTING DOCUMENTATION SUBMITTED IN CONNECTION WITH THE PLAN SHALL BE TREATED AS CONFIDENTIAL AND PROPRIETARY, AND MAY NOT BE DISCLOSED EXCEPT AS OTHERWISE REQUIRED BY LAW.

15-10D-09.

(A) THE LICENSE OF A LICENSED HEALTH SERVICES PROVIDER EXPIRES ON THE SECOND ANNIVERSARY OF ITS EFFECTIVE DATE UNLESS THE LICENSE IS RENEWED FOR A 2-YEAR TERM AS PROVIDED IN THIS SECTION.

(B) BEFORE THE LICENSE EXPIRES, A LICENSE MAY BE RENEWED FOR AN ADDITIONAL 2-YEAR TERM IF THE APPLICANT:

(1) OTHERWISE IS ENTITLED TO THE LICENSE;

(2) PAYS TO THE COMMISSIONER THE RENEWAL FEE SET BY THE COMMISSIONER THROUGH REGULATION; AND

(3) SUBMITS TO THE COMMISSIONER:

(I) A RENEWAL APPLICATION ON THE FORM THAT THE COMMISSIONER REQUIRES; AND

(II) SATISFACTORY EVIDENCE OF COMPLIANCE WITH ANY REQUIREMENT UNDER THIS SUBTITLE FOR LICENSE RENEWAL.

(C) IF THE REQUIREMENTS OF THIS SECTION ARE MET, THE COMMISSIONER SHALL RENEW A LICENSE.

15-10D-10.

(A) A LICENSED HEALTH SERVICES CONTRACTOR MAY NOT:

(1) VIOLATE ANY PROVISION OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER IT;

(2) FAIL TO FULFILL ITS OBLIGATIONS TO PROVIDE THE HEALTH CARE SERVICES SPECIFIED IN ITS CONTRACTS WITH HEALTH MAINTENANCE ORGANIZATIONS OR LICENSED HEALTH SERVICES CONTRACTORS;

(3) MAKE ANY FALSE STATEMENT WITH RESPECT TO ANY REPORT OR STATEMENT REQUIRED BY THIS SUBTITLE OR BY THE COMMISSIONER UNDER THIS SUBTITLE;

(4) PREVENT OR ATTEMPT TO PREVENT THE COMMISSIONER OR SECRETARY OF HEALTH AND MENTAL HYGIENE FROM PERFORMING ANY DUTY IMPOSED BY THIS SUBTITLE; OR

(5) VIOLATE ANY APPLICABLE PROVISION OF § 9-231 OF THIS ARTICLE.

(B) IF A LICENSED HEALTH SERVICES CONTRACTOR VIOLATES THIS SECTION, THE COMMISSIONER MAY PURSUE ANY ONE OR MORE OF THE COURSES OF ACTION DESCRIBED IN § 15-10D-11 OF THIS SUBTITLE.

15-10D-11.

(A) IF ANY PERSON VIOLATES ANY PROVISION OF § 15-10D-10 OF THIS SUBTITLE, THE COMMISSIONER MAY:

(1) ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES THE LICENSED HEALTH SERVICES CONTRACTOR TO:

(I) CEASE INAPPROPRIATE CONDUCT OR PRACTICES BY IT OR ANY OF THE PERSONNEL EMPLOYED OR ASSOCIATED WITH IT;

(II) FULFILL ITS CONTRACTUAL OBLIGATIONS;

(III) PROVIDE A SERVICE THAT HAS BEEN DENIED IMPROPERLY;

(IV) TAKE APPROPRIATE STEPS TO RESTORE ITS ABILITY TO PROVIDE A SERVICE THAT IS PROVIDED UNDER A CONTRACT;

(2) IMPOSE A PENALTY OF NOT MORE THAN $125,000 FOR EACH VIOLATION;

(3) SUSPEND, REVOKE, OR REFUSE TO RENEW THE LICENSE OF A LICENSED HEALTH SERVICES CONTRACTOR; OR

(4) APPLY TO ANY COURT FOR LEGAL OR EQUITABLE RELIEF CONSIDERED APPROPRIATE BY THE COMMISSIONER.

(B) IF THE COMMISSIONER ISSUES AN ORDER OR IMPOSES ANY PENALTY UNDER THIS SECTION, THE COMMISSIONER IMMEDIATELY SHALL PROVIDE WRITTEN NOTICE OF THE ORDER OR PENALTY TO THE SECRETARY OF HEALTH AND MENTAL HYGIENE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2000.