CHAPTER 470
FORMERLY
SENATE BILL NO. 228
AS AMENDED BY
SENATE AMENDMENT NOS. 1 & 2 and
HOUSE AMENDMENT 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE FOR PURPOSES OF REGULATING DISCOUNT MEDICAL PLANS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE (Three-fifths of all members elected to each house thereof concurring therein):

WHEREAS, discount medical plan programs, whereby consumers pay a fee in order to receive reduced fees from particular health care providers, have become increasingly prevalent in Delaware; and

WHEREAS, some consumers have been misled into believing that they are purchasing health insurance when they purchase medical discount plans, and other consumers have complained that the benefits they received from purchasing their medical discount plans were not what they were promised at the time of purchase; and

WHEREAS medical discount plan programs currently operate in Delaware without any specific statutes or regulations targeted at the unique regulatory and enforcement challenge they present; and

WHEREAS it is desirable to offer consumers the opportunity to purchase medical discount plans as an alternative to health insurance, but only when the terms of purchase are fully and fairly disclosed and the plan companies are subject to strict oversight by the State in order to protect consumers.

NOW, THEREFORE:

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE (Three-fifths of all members elected to each house thereof concurring therein):

Section 1. Add a new Chapter 83 to Title 18 of the Delaware Code, which shall read as follows:

“CHAPTER 83: DISCOUNT MEDICAL PLANS

§ 8301 Definitions

For purposes of this Chapter:

(1) The terms “affiliate”, “control”, and “subsidiary” shall have the meanings ascribed to them in Section 5001 of this Title.

(2) “Ancillary services” includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic and podiatry services. Ancillary Services do not include services which are unrelated to medical care, and do not include the sale of eyeglasses or hearing aids if such sale does not involve, respectively, a vision or hearing examination or other medical treatment.

(3) “Commissioner” means the Insurance Commissioner of this State.

(4) a)“Discount medical plan” means a business arrangement or contract in which a person, in exchange for consideration paid by members, offers access for its members to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount medical plan from those providers.

b) “Discount medical plan” does not include:

1. A plan that does not charge consideration from a member to use the plan’s discount medical card; or

2. Any product already expressly authorized as insurance by the Commissioner pursuant to this Title; or

3. Any physician or group of physicians or contracts regulated by the Board of Medical Practice.

(5) “Discount medical plan organization” means an entity that, in exchange for consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It is the organization that contracts with providers, provider networks or other discount medical plan organizations to offer access to medical or ancillary services at a discount and determines the charge to discount medical plan members.

(6) a) “Facility” means an institution providing medical or ancillary services in a health care setting.

b) “Facility” includes, but is not limited to:

1. A hospital or other licensed inpatient center;

2. An ambulatory surgical or treatment center;

3. A skilled nursing center;

4. A residential treatment center;

5. A rehabilitation center; and

6. A diagnostic laboratory or imaging center.

(7) “Health care professional” means a physician, pharmacist or other health care practitioner who is licensed, accredited or certified to perform specified medical or ancillary services within the scope of his or her license, accreditation, certification or other appropriate authority and consistent with state law.

(8) “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including but not limited to an insurance company, health service corporation, health maintenance organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Health carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health benefit plans.

(9) "Marketer" means a person or entity that markets, promotes, sells or distributes a discount medical plan, including a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a marketing agreement with a discount medical plan organization.

(10) a) "Medical services" means any maintenance care of, or preventive care for, the human body or care, service or treatment of an illness or dysfunction of, or injury to, the human body.

b) "Medical services" includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services and medical equipment and supplies.

(c) "Medical services" does not include pharmacy services, and does not include the sale of eyeglasses or hearing aids if such sale does not involve, respectively, a vision or hearing examination or other medical treatment.

(11) "Member" means any individual who pays consideration for the right to receive the benefits of a discount medical plan.

(12) "Provider" means any health care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to provide medical or ancillary services to members.

(13) "Provider network" means an entity that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider to provide medical or ancillary services to members.

§ 8302 Applicability and Scope

(a) This Act applies to all discount medical plan organizations doing business in Delaware.

(b) A discount medical plan organization that is a health carrier licensed pursuant to Chapter 5 of this Title, a health service corporation subject to Chapter 63 of this Title, or managed care organization subject to Chapter 64 of this Title:

(1) Is not required to obtain a license under Section 8303 of this Chapter, except that any of its affiliates that operate as a discount medical plan organization in this state shall obtain a license under Section 8303 and comply with all other provisions of this Act; but

(2) Is required to comply with Sections 8306, 8307, 8308, 8309, and 8310 of this Act and report any of the information described in Section 8312 of this Act in the form and manner as the Commissioner may require.

§ 8303 Licensing Requirements

(a) Before doing business in this State as a discount medical plan organization, a person shall obtain a license from the Commissioner to operate as a discount medical plan organization.

(b) Each application for a license to operate as a discount medical plan organization:

(1) Shall be in a form prescribed by the Commissioner and verified by an officer or authorized representative of the applicant; and

(2) Shall demonstrate, set forth or be accompanied by the following, if applicable:

a. The applicable fees required under Chapter 7 of this Title;

b. A copy of the organization documents of the applicant, such as the articles of incorporation, including all amendments;

c. A copy of the applicant's bylaws or other enabling documents that establish organizational structure;

d. The applicant's federal identification number, business address and mailing address;

e. (i) A list of names, addresses, official positions and biographical information of the individuals who are responsible for conducting the applicant's affairs, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the officers, contracted management company personnel and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant; and

(ii) A disclosure of the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest;

f. A complete biographical statement, on forms prescribed by the Commissioner, with respect to each individual identified under Subparagraph e. of this paragraph;

g. A statement generally describing the applicant, its facilities and personnel and the medical or ancillary services for which a discount will be made available under the discount medical plan;

h. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical or ancillary services to members;

i. A copy of the form of any contract made or arrangement to be made between the applicant and any individual listed in Subparagraph e. of this paragraph;

j. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any function, including marketing, administration, enrollment, investment management and subcontracting for the provision of medical or ancillary services to members;

k. A description of the proposed methods of marketing, including, but not limited to, describing the use of marketers, use of the Internet, sales by telephone, and use of salespersons to market the discount medical plan benefits;

l. A description of the member complaint procedures to be established and maintained by the applicant;

m. The name and address of the applicant's Delaware statutory agent for service of process, notice or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the Commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all process in any legal action or proceeding against the discount medical plan organization on a cause of action arising in this state may be served; and

n. Any other information the Commissioner may reasonably require.

(c) Within ninety (90) days after the date of receipt of a completed application, the Commissioner shall:

(1) Issue a license if the Commissioner is satisfied that the applicant has met the following

a. The requirements of Subsection (b) have been met;

b. The ownership, control and management of the applicant are competent and trustworthy and possess managerial experience that would make the proposed operation of the discount medical plan organization beneficial to discount medical plan members; or

(2) Disapprove the application and state the grounds for disapproval.

(d) Prior to licensure by the Commissioner, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of Section 8308(b).

(e) (1) A license is effective for one (1) year, unless prior to its expiration the license is renewed in accordance with this subsection or suspended or revoked in accordance with Subsection (f).

(2) At least ninety (90) days before a license expires, the discount medical plan organization shall submit:

a. A renewal application form; and

b. The renewal fee.

(3) The Commissioner shall renew the license of each holder that meets the requirements of this Act and pays the appropriate renewal fee required by Chapter 7 of this Title.

(f) (1) The Commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a discount medical plan organization's license if the Commissioner finds that any of the following conditions exist:

a. The discount medical plan organization is not operating in compliance with this Act;

b. The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising

c. The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

d. The continued operation of the discount medical plan organization would be harmful to its members or contrary to their interests.

(2) If the Commissioner has cause to believe that grounds for the non-renewal, suspension or revocation of a license exists, the Commissioner shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to renew or suspension or revocation and may pursue a hearing on the matter in accordance with the provisions of Title 29, Chapter 101 of the Delaware Code.

(3) When the license of a discount medical plan organization is non-renewed, surrendered or revoked, the discount medical plan organization shall proceed, immediately following the effective date of the order of revocation or, in the case of a non-renewal, the date of expiration of the license, to wind up its affairs transacted under the license. The discount medical plan organization shall not engage in any further advertising, solicitation, collecting of fees or renewal of contracts.

(4) a. The Commissioner shall, in his or her order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its license to enroll members.

b. The Commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

c. The license of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The Commissioner shall not grant the request for reinstatement if the Commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(g) In lieu of suspending or revoking a discount medical plan organization's license under Subsection (f), whenever the discount medical plan organization has been found to have violated any provision of this Act, the Commissioner may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) Impose any penalties consistent with Section 8313.

(h) Each licensed discount medical plan organization shall notify the Commissioner immediately whenever the discount medical plan organization's license, or other form of authority, to operate as a discount medical plan organization in another state is suspended, revoked or non-renewed in that state.

(i) A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a license under this Act as a discount medical plan organization.

§ 8304. Surety Bond or Deposit Requirements

(a) Each licensed discount medical plan organization shall maintain in force a surety bond in its own name in an amount not less than $50,000 to be used in the discretion of the Commissioner to protect the financial interest of members. The amount and form of the surety bond shall be determined by and subject to the approval of the Commissioner. The bond shall be issued by an insurance company licensed to do business in this state.

(b) In lieu of the bond specified in Subsection (a), a licensed discount medical plan organization may deposit and maintain deposited with the Commissioner, or at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to the Commissioner. The assets in the deposit, including assets such as securities which

fluctuate in market value, shall be subject at all times to the review and approval of the Commission, who may require that different assets be placed on deposit.

(c) All income from a deposit made under Subsection (b) shall be an asset of the discount medical plan organization.

(d) Except for the Commissioner, the assets or securities held in this state as a deposit under Subsections (a) or (b) shall not be subject to levy by a judgment creditor or other claimant of the discount medical plan organization.

§ 8305. Examinations and Investigations

(a) The Commissioner may examine or investigate the business and affairs of any discount medical plan organization to protect the interests of the residents of Delaware.

(b) An examination or investigation conducted as provided in Subsection (a) shall be performed in accordance with the provisions of Chapter 3 of this Title, and the Commissioner shall have the authority with respect to examination of discount medical plan organizations as he or she has with respect to insurers under Chapter 3 of this Title.

(c) The discount medical plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount medical plan organization or applicant to pay the expenses is grounds for denial of a license to operate as a discount medical plan organization or revocation of a license to operate as a discount medical plan organization.

§ 8306. Fees; Refund Requirements; Bundling of Services

(a) A discount medical plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount medical plan.

(b) If a member cancels his or her membership in the discount medical plan organization within the first thirty (30) days after the date of receipt of the written document for the discount medical plan described in Section 8310(d), the member shall receive a reimbursement of all periodic charges upon return of the discount medical plan card to the discount medical plan organization.

1. Cancellation occurs when notice of cancellation is given to the discount medical plan organization.

2. Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed and postage prepaid to the mailing address of the discount medical plan organization or emailed to the email address of the discount medical plan organization.

(c) A discount medical plan organization shall return any periodic fee charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

(d) If the discount medical plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

(e) When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the fees for each discount medical plan shall be provided in writing to the member, unless the entire amount of the periodic charge for the discount medical plan and any other product will be refunded if the member cancels his or her membership in the discount medical plan organization within the first thirty (30) days after the date of receipt of the written document for the discount medical plan as provided in subsection (b) of this section.

(f) Any discount medical plan organization that is a health carrier licensed pursuant to Chapter 5 of this Title that provides a discount medical plan product that is incidental to an insured product sold to policyholders is not subject to this section.

§ 8307. Form Filing Requirements.

A discount medical plan organization shall file the initial written materials sent to new members, as described under Section 8310(d), with the Delaware Insurance Commissioner prior to use. If a discount medical plan organization uses a form template for marketers, filing of the template form shall be acceptable.

§ 8308. Provider Agreements; Provider Listing Requirements

(a) A discount medical plan organization shall have a written provider agreement with all providers offering medical or ancillary services to its members. The written provider agreement may be entered into directly with the provider or indirectly with a provider network to which the provider belongs. A provider agreement between a discount medical plan organization and a provider shall provide the following:

1. A list of the medical or ancillary services and products to be provided at a discount;

2. The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

3. That the provider will not charge members more than the discounted rates.

(b) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers that:

1. Contain the provisions described in Subparagraph (2);

2. Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and

3. Require the provider network to maintain an up-to-date list of its contracted providers and to provide the list on a monthly basis to the discount medical plan organization.

(c) A provider agreement between a discount medical plan organization and an entity that contracts with a provider network shall require that the entity, in its contract with the provider network, require the provider network to have written agreements with its providers that comply with Subparagraph (3).

(d) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.

(e) Each discount medical plan organization shall maintain on an Internet website page an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The Internet website address shall be prominently displayed on all of its advertisements, marketing materials, brochures and discount medical plan cards.

This subsection applies to those providers with which the discount medical plan organization has contracted with directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

§ 8309. Marketing Requirements

(a) A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.

(b) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling or distributing the discount medical plan. The agreement between the discount medical plan organization and the marketer shall prohibit the marketer from using advertising, marketing materials, brochures and discount medical plan cards without the discount medical plan organization's approval in writing. The discount medical plan organization shall be bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization. A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures and discount cards used by marketers to market, promote, sell or distribute the discount medical plan prior to their use. A discount medical plan organization shall promptly submit to the Commissioner all advertising, marketing materials and brochures regarding a discount medical plan.

§ 8310. Marketing Restrictions and Disclosure Requirements

(a) All advertisements, marketing materials, brochures, discount medical plan cards and any other communications of a discount medical plan organization provided to purchasers, prospective purchasers and members shall be truthful and not misleading in fact or in implication. An advertisement, any marketing material, brochure, discount medical plan card or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.

(b) A discount medical plan organization shall not:

(1) Except as otherwise required by this Act or as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, use in its advertisements, marketing material, brochures and discount medical plan cards the term "insurance";

(2) Except as otherwise required by state law, describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance benefits are incidental to the discount medical plan benefits;

(3) Use in its advertisements, marketing material, brochures and discount medical plan cards the terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;

(4) Use language in its advertisements, marketing material, brochures and discount medical plan cards with respect to being "licensed" by the state insurance department in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by the state;

(5) Make misleading, deceptive or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;

(6) Have restrictions on access to any listed discount medical plan providers, except for waiting periods and notification periods; or

(7) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan.

(c) Each discount medical plan organization shall make the following general disclosures:

1. In writing in not less than twelve-point type;

2. On the first content page of any advertisements, marketing materials or brochures made available to the public relating to a discount medical plan; and

3. An addition to any enrollment forms given to a prospective or new member, the prospective or new members shall receive a statement which states:

a. That the plan is not insurance;

b. That the range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;

c. That the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

d. That the plan member is obligated to pay for all medical or ancillary services, but will receive a discount from those providers that have contracted with the discount medical plan organization; and

e. The toll-free telephone number and Internet website address for the licensed discount medical plan organization for prospective members and members to obtain additional information about and assistance on the discount medical plan and up-to-date lists of providers participating in the discount medical plan.

If the initial contact with a prospective member is by telephone, the disclosures required under Paragraph (1) shall be made orally and included in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

(d) In addition to the general disclosures required under Subsection (c), each discount medical plan organization shall provide to:

1. Each applicant, at the time of application, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan; and

2. Each new member a written document that contains the terms and conditions of the discount medical plan.

(e) The written document required under Paragraph (1)(b) shall be clear and include information on:

1. The name of the member;

2. The benefits to be provided under the discount medical plan;

3. Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

4. The mode of payment of any processing fees and periodic charges, such as monthly, quarterly, etc., and procedures for changing the mode of payment;

5. Any limitations, exclusions or exceptions regarding the receipt of discount medical plan benefits;

6. Any waiting periods for certain medical or ancillary services under the discount medical plan;

7. Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;

8. Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;

9. Renewal, termination and cancellation terms and conditions;

10. Procedures for adding new members to a family discount medical plan, if applicable;

11. Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact his or her local state insurance department; and

12. The name and mailing address of the licensed discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices and file complaints.

§ 8311. Notice of Change in Name or Address

Each discount medical plan organization shall provide the Commissioner at least thirty (30) days notice of any change in the discount medical plan organization's name, address, principal business address or mailing address or Internet website address.

§ 8312. Annual Reports

(a) If the information required in Subsection (b) is not provided at the time of renewal of a license under Section 8303(e), a discount medical plan organization shall file an annual report with the Commissioner in the form prescribed by the Commissioner, within three (3) months after the end of each calendar year.

(b) The report shall include:

(1) If different from the initial application for a license or at the time of renewal of a license or the last annual report, as appropriate, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with these persons and the discount medical plan organization, including any possible conflicts of interest;

(2) The number of discount medical plan members in the state;

(3) The discount medical plan's most recent audited financial statement and most current unaudited financial statement; and

(4) Any other information relating to the performance of the discount medical plan organization that may be required by the Commissioner.

(c) Any discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall:

(1) Forfeit:

a. Up to $500 each day for the first ten (10) days during which the violation continues; and

b. Up to $1,000 each day after the first ten (10) days during which the violation continues; and

(2) Upon notice by the Commissioner, lose its authority to enroll new members or to do business in this state while the violation continues.

§ 8313. Penalties

Section 329 and Chapter 24 of this Title, relating to administrative penalties and fraud, shall apply to discount medical plan organizations.

§ 8314. Injunctions

(a) In addition to the penalties and other enforcement provisions of this Act, the Commissioner may seek both temporary and permanent injunctive relief when:

a. A discount medical plan is being operated by a person or entity that is not licensed pursuant to this Act; or

b. Any person, entity or discount medical plan organization has engaged in any activity prohibited by this Act or any regulation adopted pursuant to this Act.

(b) The venue for any proceeding brought pursuant to this section shall be in the Delaware Court of Chancery.

(c) The Commissioner's authority to seek injunctive relief is not conditioned on having conducted any proceeding pursuant to Title 29, Chapter 101 of the Delaware Code."

Section 2. Create a new subsection 35 to Title 18, Section 701 of the Delaware Code which shall read as follows:

"(35) (a) For initial licensing of a Discount Medical Plan organization: $500

(b) For renewal of Discount Medical Plan organization license: $100."

Section 3. This Act shall be effective upon its enactment into law. A person doing business in this state as a discount medical plan organization on or before the effective date of this Act shall have 180 days following the Act's effective date to come into compliance with the requirements of this Act.

Approved August 30, 2010