17B:27A-29.1

LEGISLATIVE HISTORY CHECKLIST

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(Small employer insurance reform)

NJSA:	17B:27A-29.1		
LAWS OF:	1995	**CHAPTER:**	298
BILL NO:	A2662		
SPONSOR(S):	Garrett and others		
DATE INTRODUCED:	March 23, 1995		
COMMITTEE:	**ASSEMBLY**	Insurance	
	SENATE:	Health	
AMENDED DURING PASSAGE:		Yes	Amendments during passage denoted by superscript numbers
DATE OF PASSAGE:	**ASSEMBLY:**	May 22, 1995	Re-enacted 12-11-95
	SENATE:	June 26, 1995	Re-enacted 12-18-95
DATE OF APPROVAL:	December 22, 1995		

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT:		Yes
COMMITTEE STATEMENT:	**ASSEMBLY:**	Yes
	SENATE:	Yes
FISCAL NOTE:		No
VETO MESSAGE:		Yes
MESSAGE ON SIGNING:		No

FOLLOWING WERE PRINTED:

REPORTS:	No
HEARINGS:	No

KBP:pp

[THIRD REPRINT]

ASSEMBLY, No. 2662

STATE OF NEW JERSEY

INTRODUCED MARCH 23, 1995

By Assemblymen GARRETT and DORIA

1 *AN ACT* concerning small employer insurance plans, amending
2 and supplementing P.L.1992, c.162 and repealing parts of
3 statutory law.
4
5 BE IT ENACTED *by the Senate and General Assembly of the*
6 *State of New Jersey:*
7 1. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to
8 read as follows:
9 1. As used in this act:
10 "Actuarial certification" means a written statement by a
11 member of the American Academy of Actuaries or other
12 individual acceptable to the commissioner that a small employer
13 carrier is in compliance with the provisions of section 9 of
14 P.L.1992, c.162 (C.17B:27A-25), based upon examination,
15 including a review of the appropriate records and actuarial
16 assumptions and methods used by the small employer carrier in
17 establishing premium rates for applicable health benefits plans.
18 "Anticipated loss ratio" means the ratio of the present value of
19 the expected benefits, not including dividends, to the present
20 value of the expected premiums, not reduced by dividends, over
21 the entire period for which rates are computed to provide
22 coverage. For purposes of this ratio, the present values must
23 incorporate realistic rates of interest which are determined
24 before federal taxes but after investment expenses.
25 "Board" means the board of directors of the program.
26 "Carrier" means any insurance company, health service
27 corporation, hospital service corporation, medical service
28 corporation or health maintenance organization authorized to
29 issue health benefits plans in this State. For purposes of this act,
30 carriers that are affiliated companies shall be treated as one
31 carrier, except that any insurance company, health service
32 corporation, hospital service corporation, or medical service
33 corporation that is an affiliate of a health maintenance
34 organization located in New Jersey or any health maintenance
35 organization located in New Jersey that is affiliated with an
36 insurance company, health service corporation, hospital service
37 corporation, or medical service corporation shall treat the health
38 maintenance organization as a separate carrier.
39 "Commissioner" means the Commissioner of Insurance.
40 "Community rating" means a rating methodology in which the
41 premium for all persons covered by a policy or contract form is
42 the same based upon the experience of the entire pool of risks

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AIN committee amendments adopted March 23, 1995.
[2] Senate SHH committee amendments adopted June 1, 1995.
[3] Assembly amendments adopted in accordance with Governor's recommendations December 11, 1995.

covered by that policy or contract form without regard to age, gender, health status, residence or occupation.

"Department" means the Department of Insurance.

"Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

"Eligible employee" means a full-time employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week, work on a temporary or substitute basis or are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

"Financially impaired" means a carrier which, after the effective date of this act, is not insolvent, but is deemed by the commissioner to be potentially unable to fulfill its contractual obligations or a carrier which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit insurance coverage, automobile medical payment insurance, [or] personal injury protection coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) and stop loss or excess risk insurance.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: a. was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment; b. has lost coverage under that other employer's health benefits plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and c. requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also

shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

"Member" means all carriers issuing health benefits plans in this State on or after the effective date of this act.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as determined by the commissioner, and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Plan of operation" means the plan of operation of the program including articles, bylaws and operating rules approved pursuant to section 14 of P.L.1992, c.162 (C.17B:27A-30).

"Preexisting condition provision" means a policy or contract provision that excludes coverage under that policy or contract for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to section 12 of P.L.1992, c.162 (C.17B:27A-28).

["Reinsuring carrier" means a small employer carrier electing to receive reimbursement from the program in accordance with section 19 of P.L.1992, c.162 (C.17B:27A-35).]

["Risk-assuming carrier" means a small employer carrier electing to assume risks pursuant to section 18 of P.L.1992, c.162 (C.17B:27A-34).]

"Qualifying previous coverage" means benefits or coverage provided under:

a. Medicare or Medicaid or any other federally funded health benefits program;

b. a group health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, or an employer-based,self-funded or other health benefit arrangement; or

c. an individual health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization.

Qualifying previous coverage shall not include the following

policies, contracts or arrangements, whether issued on an individual or group basis: specified disease only, accident only, credit, disability, long-term care, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of this act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this act which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan for small employers approved by the commissioner pursuant to section 17 of P.L.1992, c.162 (C.17B:27A-33).

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses, wherein neither the employees or other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for the purposes of P.L.1992, c.162 (C.17B:27A-17 et seq.), the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

a. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $25,000 per covered person per plan year; and

b. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125% of expected claims per plan year.

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity non-expense incurred basis.

(cf: P.L.1994, c.11, s.1)

2. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to read as follows:

6. a. No health benefits plan subject to this act shall include any preexisting condition provision, provided that, a preexisting

condition provision may apply to a late enrollee or to any group of two to five persons if such provision excludes coverage for a period of no more than 180 days following the effective date of coverage of such enrollee, and relates only to conditions manifesting themselves during the six months immediately preceding the effective date of coverage of such enrollee in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or as to a pregnancy existing on the effective date of coverage; provided that, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition provision shall apply to any such enrollee.

b. In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefits plans shall credit the time that person was covered under any [previous health benefits plan] qualifying previous coverage if the previous coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan.

(cf: P.L.1992, c.162, s.6)

[1][3. Section 7 of P.L.1992, c.162 (C.17B:27A-23) is amended to read as follows:

7. Every policy or contract issued to small employers in this State pursuant to P.L.1992, c.162(C.17B:27A-17 et seq.) shall be renewable with respect to all eligible employees or dependents at the option of the policy or contract holder, or small employer except under the following circumstances:

a. Nonpayment of the required premiums by the policyholder, contract holder, or employer;

b. Fraud or misrepresentation of the policyholder, contract holder, or employer or, with respect to coverage of eligible employees or dependents, the enrollees or their representatives;

c. The number of employees covered under the health benefits plan is less than the number or percentage of employees required by participation requirements under the health benefits policy or contract;

d. Noncompliance with a carrier's employment contribution requirements;

e. Any carrier doing business pursuant to the provisions of this act ceases doing business in the small employer market, if the following conditions are satisfied:

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small group market, during which time the carrier shall continue to be governed by this act with respect to business written pursuant to this act. For the purposes of this subsection, "date of withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (2) of this subsection;

(2) No later than two months following the date of the

1 notification to the commissioner that the carrier intends to cease
2 doing business in the small employer market, the carrier shall
3 mail a notice to every small business employer insured by the
4 carrier that the policy or contract of insurance will be
5 terminated. This notice shall be sent by certified mail to the
6 small business employer not less than six months in advance of
7 the effective date of the cancellation date of the policy or
8 contract;
9 (3) Any carrier that ceases to do business pursuant to this act
10 shall be prohibited from writing new business in the small
11 employer market for a period of five years from the date of
12 notice to the commissioner;
13 f. In the case of policies or contracts issued in connection with
14 membership in an association or trust of employers, an employer
15 ceases to maintain its membership in the association or trust; or
16 g. [The number of employees covered under the health benefits
17 plan is less than two.] (Deleted by amendment, P.L. , c.)
18 (pending before the Legislature as this bill)
19 (cf: P.L.1993, c.162, s.4)][1]
20 [1][4.]3.[1] Section 8 of P.L.1992, c.162 (C.17B:27A-24) is
21 amended to read as follows:
22 8. Any small employer carrier may require a reasonable
23 specified minimum participation of eligible employees, which
24 shall not exceed 75%, or reasonable minimum employer
25 contributions in determining whether to accept a small group
26 pursuant to this act. The standards so established by the carrier
27 shall be first approved by the board and shall be applied uniformly
28 to all small groups, except that in no event shall a carrier require
29 an employer to contribute more than 10% to the annual cost of
30 the policy or contract, or an amount as otherwise provided by the
31 board, and any minimum participation standards established by
32 the carrier shall be reasonable. In establishing the percentage of
33 employee participation, a one-to-one credit shall be given for
34 each employee covered by a spouse's health benefits coverage [or
35 for each employee participating in an employee welfare benefits
36 plan established pursuant to a collective bargaining agreement].
37 In calculating an employer's participation, the carrier shall
38 include all insured employees, regardless of whether the
39 employees chose an indemnity plan or a health maintenance
40 organization, or a combination thereof.
41 (cf: P.L.1994, c.11, s.3)
42 [1][5.]4.[1] Section 9 of P.L.1992, c.162 (C.17B:27A-25) is
43 amended to read as follows:
44 9. a. (1) Beginning on the third 12-month anniversary date of
45 any policy or contract issued in 1994, no small employer health
46 benefits plan shall be issued in this State unless the plan is
47 community rated.
48 (2) Beginning January 1, 1994 and upon the first 12-month
49 anniversary date thereafter of the policy or contract, the
50 premium rate charged by a carrier to the highest rated small
51 group purchasing a small employer health benefits plan issued
52 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall not be
53 greater than 300% of the premium rate charged to the lowest
54 rated small group purchasing that same health benefits plan ;

provided, however, that the only factors upon which the rate differential may be based are age, gender and geography, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board.

(3) Beginning on the second 12-month anniversary after the date established in paragraph (2) of this subsection of the policy or contract, the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall not be greater than 200% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan ; provided, however, that the only factors upon which the rate differential may be based are age, gender and geography, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board.

(4) (Deleted by amendment, P.L.1994, c.11).

(5) Any policy or contract issued after January 1, 1994 to a small employer who was not previously covered by a health benefits plan issued by the issuing small employer carrier, shall be subject to the same premium rate restrictions as provided in paragraphs (1), (2) and (3) of this subsection, which rate restrictions shall be effective on the date the policy or contract is issued.

(6) The board shall establish, pursuant to section 17 of P.L.1993, c.162 (C.17B:27A-51):

(a) up to six geographic territories, none of which is smaller than a county; and

(b) age classifications which, at a minimum, shall be in five-year increments.

b. (Deleted by amendment, P.L.1993, c.162).

c. [2][Notwithstanding any other provision of law to the contrary, no carrier offering any health benefits plan pursuant to the provisions of this act shall act to circumvent the intent of this act by acting as a third party administrator for groups of small employers, any one of whom was insured as of September 1, 1992; provided, however, that this provision shall not act to limit a bona fide group of small employers who voluntarily act together to provide health benefits to their employees.][2] (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill)

d. Notwithstanding any other provision of law to the contrary, this act shall apply to a carrier which [issues] provides a health benefits plan to one or more small employers through a policy issued to an association or trust of employers[, if the group includes one or more member employers or other member groups which have at least two but no more than 49 employees or members exclusive of spouses and dependents; except that, this act shall not apply to a carrier which issued a policy exclusively to the members of an association, on or before the effective date of P.L.1992, c.162 (C.17B:27A-17 et seq.), if the policy was written in the name of the association, the carrier writes no other group health insurance policy in this State and the aggregate number of insured association members exceeds 49].

A carrier [which is not exempt from the provisions of this act

pursuant to this subsection and which issues a policy] which provides a health benefits plan to one or more small employers through a policy issued to an association or trust of employers after the effective date of P.L.1992, c.162 (C.17B:27A-17 et seq.), shall be required to offer small employer health benefits plans to non-association or trust employers in the same manner as any other small employer carrier is required pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

e. Nothing contained herein shall prohibit the use of premium rate structures to establish different premium rates for individuals and family units.

f. No insurance contract or policy subject to this act may be entered into unless and until the carrier has made an informational filing with the commissioner of a schedule of premiums, not to exceed 12 months in duration, to be paid pursuant to such contract or policy, of the carrier's rating plan and classification system in connection with such contract or policy, and of the actuarial assumptions and methods used by the carrier in establishing premium rates for such contract or policy.

g. (1) Beginning January 1, 1995, a carrier desiring to increase or decrease premiums for any policy form or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19) subject to this act may implement such increase or decrease upon making an informational filing with the commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for a policy form shall not be less than 75% of the premium therefor. Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for each of the five standard policy forms offered by the carrier pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19), at least 75% of the aggregate premiums collected for the policy form during that calendar year. Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for each such policy form for the previous calendar year. In each case where the loss ratio for a policy fails to substantially comply with the 75% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 75% of the aggregate premiums collected for the policy form in the previous calendar year. The dividend or credit shall be issued to each policy which was in effect as of March 30th of the applicable year and remains in effect as of the date the dividend or credit is issued. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the

1 dividends and credits, as well as an explanation of the carrier's
2 plan to issue dividends or credits. The instructions and format
3 for calculating and reporting loss ratios and issuing dividends or
4 credits shall be specified by the commissioner by regulation.
5 Such regulations shall include provisions for the distribution of a
6 dividend or credit in the event of cancellation or termination by a
7 policyholder.
8 h. (Deleted by amendment, P.L.1993, c.162).
9 i. The provisions of this act shall apply to health benefits plans
10 which are delivered, issued for delivery, renewed or continued on
11 or after January 1, 1994.
12 j. Except as provided in subsection j. of section 3 of P.L.1992,
13 c.162 (C.17B:27A-19), a policy or contract covering two or more
14 employees of a small employer issued by a carrier prior to
15 January 1, 1994 shall remain in effect until the first 12-month
16 anniversary date after February 28, 1994 of that policy or
17 contract, but at least 60 days before the first 12-month
18 anniversary date thereof the carrier shall be required to offer the
19 small employer a policy or contract pursuant to section 3 of
20 P.L.1992, c.162 (C.17B:27A-19).
21 (cf: P.L.1994, c.11, s.4)
22 [1][6] 5[1]. Section 11 of P.L.1992, c.162 (C.17B:27A-27) is
23 amended to read as follows:
24 11. a. Every policy or contract issued to a small employer in
25 this State, including, but not limited to, policies or contracts
26 which are subject to this act and which are delivered, issued,
27 renewed, or continued on or after January 1, 1994, shall offer
28 continued coverage under the plan to any employee whose
29 employment was terminated for a reason other than for cause and
30 to any employee covered by such plan whose hours of employment
31 were reduced to less than [30] 25 subsequent to the effective date
32 of coverage for that employee. The employee shall make a
33 written election for continued coverage within 30 days of a
34 qualifying event. For the purposes of this section, "qualifying
35 event" shall mean the date of termination of employment, or the
36 date on which a reduction in an employee's hours of employment
37 becomes effective. For the purposes of this section, the date on
38 which a health benefits plan is continued shall be the anniversary
39 date of the issuance of the plan.
40 b. Coverage continued pursuant to subsection a. of this section
41 shall consist of coverage which is identical to the coverage
42 provided under the policy or contract to similarly situated
43 beneficiaries whose coverage has not been terminated or hours of
44 employment reduced. If coverage is modified under the policy or
45 contract for any group of similarly situated beneficiaries, this
46 coverage shall also be modified in the same manner for persons
47 who are qualified beneficiaries entitled pursuant to subsection a.
48 of this section to continued coverage. Continuation of coverage
49 may not be conditioned upon, or discriminate on the basis of, lack
50 of evidence of insurability.
51 c. The health benefits plan may require payment of a premium
52 by the employee for any period of continuation coverage as
53 provided for in this section, except that the premium shall not
54 exceed 102% of the applicable premium paid for similarly

situated beneficiaries under the health benefits plan for a specified period, and may, at the election of the payor, be made in monthly installments. No premium payment shall be due before the 30th day after the day on which the covered employee made the initial election for continued coverage.

d. Coverage continued pursuant to this section shall continue until the earlier of the following:

(1) The date upon which the employer under whose health benefits plan coverage is continued ceases to provide any health benefits plan to any employee or other qualified beneficiary;

(2) The date on which the continued coverage ceases under the health benefits plan by reason of a failure to make timely payment of any premium required under the plan by the former employee having the continued coverage. The payment of any premium shall be considered to be timely if made within 30 days after the due date or within such longer period as may be provided for by the policy or contract; or

(3) The date after the date of election on which the qualified beneficiary first becomes:

(a) Covered under any other health benefits plan, as an employee or otherwise, which does not contain a provision which limits or excludes coverage with respect to any preexisting condition of a covered employee or any spouse or dependent who is included under the coverage provided the covered employee, for such period of the limitation or exclusion; or

(b) Eligible for benefits under Title XVIII of the Social Security Act, Pub.L.89-97 (42 U.S.C. §1395 et seq.).

e. Notice shall be provided to employees [1][at] in the certificate of coverage prepared for employees by the carrier on or about[1] the commencement of coverage and [1]by the small employer[1] at the time of the qualifying event as to their continuation rights under the plan. A qualified beneficiary may elect continuation coverage offered pursuant to this section no later than 30 days after the qualifying event. For the purposes of this section, "qualified beneficiary" means any person covered under a small employer group policy.

f. The provisions of this section shall not apply to any person who is a qualified beneficiary for the purposes of continuation of coverage as provided in accordance with section 3011(a) of Title III of Pub.L.100-647 (26 U.S.C. §4980B et al.).

g. In no event shall any continuation of coverage provided for under this section exceed 12 months from the qualifying event.

(cf: P.L.1993, c.162, s.23)

[1][7.] 6.[1] Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended to read as follows:

13. a. Within 60 days of the effective date of this act, the commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within 90 days of the effective date. The members shall elect the initial board, subject to the approval of the commissioner. The board shall consist of 10 elected public members and two ex officio members who include the Commissioner of Health and the commissioner or their designees. Initially, three of the public members of the board

1 shall be elected for a three year term, three shall be elected for
2 a two year term, and three shall be elected for a one year term.
3 Thereafter, all elected board members shall serve for a term of
4 three years. The following categories shall be represented among
5 the elected public members:
6 (1) [Two] Three carriers whose principal health insurance
7 business is in the small employer market;
8 (2) One carrier whose principal health insurance business is in
9 the large employer market;
10 (3) A health, hospital or medical service corporation;
11 (4) [A] Two health maintenance [organization] organizations;
12 and
13 (5) [A risk-assuming carrier;](Deleted by amendment, P.L. ,
14 c.) (pending before the Legislature as this bill)
15 (6) [A reinsuring carrier utilizing the excess coverage provided
16 for in this act; and] (Deleted by amendment, P.L. , c.)
17 (pending before the Legislature as this bill)
18 (7) Three persons representing small employers, at least one of
19 whom represents minority small employers.
20 No carrier shall have more than one representative on the
21 board.
22 The board shall hold an election for the two members added
23 pursuant to P.L. , c. (pending before the Legislature as this
24 bill) within 90 days of the date of enactment of that act.
25 Initially, one of the two new members shall serve for a term of
26 one year and one of the two new members shall serve for a term
27 of two years. Thereafter, the new members shall serve for a
28 term of three years. The terms of the risk-assuming carrier and
29 reinsuring carrier shall terminate upon the election of the two
30 new members added pursuant to P.L. , c. (pending before the
31 Legislature as this bill), notwithstanding the provisions of this
32 section to the contrary.
33 In addition to the 10 elected public members, the board shall
34 include six public members appointed by the Governor with the
35 advice and consent of the Senate who shall include:
36 Two insurance producers licensed to sell health insurance
37 pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.);
38 One representative of organized labor;
39 One physician licensed to practice medicine and surgery in this
40 State; and
41 Two persons who represent the general public and are not
42 employees of a health benefits plan provider.
43 The public members shall be appointed for a term of three
44 years, except that of the members first appointed, two shall be
45 appointed for a term of one year, two for a term of two years and
46 two for a term of three years.
47 A vacancy in the membership of the board shall be filled for an
48 unexpired term in the manner provided for the original election
49 or appointment, as appropriate.
50 b. If the initial board is not elected at the organizational
51 meeting, the commissioner shall appoint the public members
52 within 15 days of the organizational meeting, in accordance with
53 the provisions of paragraphs (1) through (7) of subsection a. of
54 this section.

1 c. [The board shall determine the Statewide average payment
2 per insured for each benefit plan provided for under this act.
3 Each carrier who satisfies the efficiency and risk management
4 standards promulgated by the board pursuant to subsection f. of
5 section 15 of this act and whose average cost of insuring
6 individuals covered by small employer health benefits plans
7 exceeds the Statewide average cost of insuring such individuals
8 by 20%, shall be reimbursed by the program for 80% of its costs
9 in excess thereof.] (Deleted by amendment, P.L. ,c.) (pending
10 before the Legislature as this bill)
11 d. All meetings of the board shall be subject to the
12 requirements of the "Open Public Meetings Act," P.L.1975, c.231
13 (C.10:4-6 et seq.).
14 e. At least two copies of the minutes of every meeting of the
15 board shall be delivered forthwith to the commissioner.
16 (cf: P.L.1994, c.97)
17 [1][8.] 7.[1] Section 15 of P.L.1992, c.162 (C.17B:27A-31) is
18 amended to read as follows:
19 15. The plan of operation shall constitute a public record and
20 shall include, but not be limited to, the following:
21 a. A method of handling and accounting for assets and moneys
22 of the program and an annual fiscal reporting to the
23 commissioner;
24 b. A means of providing for the filling of vacancies on the
25 board, subject to the approval of the commissioner; and
26 c. (Deleted by amendment, P.L.1993, c.162).
27 d. [The method to be used to determine the extent to which a
28 carrier's payment per insured for each of the health benefits
29 plans issued by a carrier pursuant to subsection a. of section 3 of
30 P.L.1992, c.162 (C.17B:27A-19), exceeds the Statewide average
31 payment per insured for each of the health benefits plans issued
32 by a carrier pursuant to subsection a. of section 3 of P.L.1992,
33 c.162 (C.17B:27A-19);] (Deleted by amendment, P.L. , c.)
34 (pending before the Legislature as this bill)
35 e. [The method for determining the extent to which a carrier
36 whose average cost of insuring individuals covered by small
37 employer health benefits plans issued by a carrier pursuant to
38 subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19)
39 exceeds the threshold described in subsection c. of section 13 of
40 P.L.1992, c.162 (C.17B:27A-29) may receive reimbursement from
41 the program;] (Deleted by amendment, P.L. , c.) (pending
42 before the Legislature as this bill)
43 f. [A statement of the efficiency and risk management
44 standards a carrier must meet before a carrier may receive
45 reimbursement from the program; and] (Deleted by amendment,
46 P.L. , c.) (pending before the Legislature as this bill)
47 g. Any additional matters which are appropriate to effectuate
48 the provisions of this act.
49 (cf: P.L.1994, c.11, s.5)
50 [1][9.] 8.[1] Section 16 of P.L.1992, c.162 (C.17B:27A-32) is
51 amended to read as follows:
52 16. The board shall have the authority to:
53 a. Enter into contracts as are necessary or proper to carry out
54 the provisions and purposes of this act;

1 b. Sue or be sued, including taking any legal actions as may be
2 necessary for recovery of any assessments due to the program or
3 to avoid paying any improper claims;
4 c. Establish rules, conditions, and procedures pertaining to the
5 [reimbursement and] assessment of members by the program;
6 d. Assess members in accordance with the provisions of this
7 act, including such interim assessments as may be reasonable and
8 necessary for organizational and reasonable operating expenses.
9 Such interim assessments shall be credited as offsets against any
10 regular assessments due following the close of the fiscal year;
11 e. Appoint from among its members appropriate legal,
12 actuarial, and other committees as necessary to provide technical
13 assistance in the operation of the program, policy and other
14 contract design, and any other function within the authority of
15 the program; and
16 f. Contract for an independent actuary or any other
17 professional services the board deems necessary to carry out its
18 duties under P.L.1992, c.162 (C.17B:27A-17 et seq.).
19 (cf: P.L.1993, c.162, s.19)
20 [1][10.] 9.[1] Section 25 of P.L.1992, c.162 (C.17B:27A-41) is
21 amended to read as follows:
22 25. Any carrier which violates this act shall be subject to a
23 penalty assessment, as determined by the commissioner[, whether
24 or not the carrier is a risk-assuming carrier or a reinsuring
25 carrier].
26 (cf: P.L.1992, c.162, s.25)
27 [1][11.] 10.[1] The Title of P.L.1992, c. 162 is amended to read as
28 follows:
29 *AN ACT* requiring certain health insurers, service corporations
30 and health maintenance organizations to offer standardized
31 health benefits programs to small groups [and establishing a
32 reinsurance program].
33 (cf: P.L.1992, c.162)
34 [1][12.] 11.[1] (New section) A member of the board and an
35 employee of the board shall not be liable in an action for damages
36 to any person for any action taken or recommendation made by
37 him within the scope of his functions as a member or employee, if
38 the action or recommendation was taken or made without
39 malice. The [3][Attorney General shall defend the person in any
40 civil suit and the State shall provide indemnification for any
41 damages awarded] members of the board shall be indemnified
42 and their defense of any action provided for in the same manner
43 and to the same extent as employees of the State under the "New
44 Jersey Tort Claims Act," P.L.1972, c.45 (C.59:1-1 et seq.) on
45 account of acts or omissions in the scope of their employment[3].
46 [1][13.] 12.[1] (New section) The board may, if necessary, adopt
47 rules and regulations pursuant to the "Administrative Procedure
48 Act," P.L. [2][196a] 1968[2], c.410 (C.52:14B-1 et seq.) to establish a
49 [2][risk adjustment mechanism] voluntary risk pooling
50 arrangement[2] for program members.
51 If the board determines that such [2][a mechanism] an
52 arrangement[2] is necessary, it shall submit the proposed rules and
53 regulations to the Legislature for review on a day that the
54 Legislature is in session and to the commissioner for his
55 approval. If the Legislature does not take action in 30 days to
56 amend or otherwise change the rules and regulations, the rules

1 and regulations shall be effective upon approval by the
2 commissioner or upon such later date as the board determines.
3 [1][14.] 13.[1] Sections 18 through 24, inclusive, and section 26 of
4 P.L.1992, c.162 (C.17B:27A-34 to 40 and 42) and section 18 of
5 P.L.1993, c.162 (C.17B:27A-52) are repealed.
6 [1][15.] 14.[1] This act shall take effect immediately [3][and shall
7 be retroactive to January 1, 1995][3].
8
9
10 ———
11
12 Makes various changes to small employer insurance reform law.

1 d. Assess members in accordance with the provisions of this
2 act, including such interim assessments as may be reasonable and
3 necessary for organizational and reasonable operating expenses.
4 Such interim assessments shall be credited as offsets against any
5 regular assessments due following the close of the fiscal year;
6 e. Appoint from among its members appropriate legal,
7 actuarial, and other committees as necessary to provide technical
8 assistance in the operation of the program, policy and other
9 contract design, and any other function within the authority of
10 the program; and
11 f. Contract for an independent actuary or any other
12 professional services the board deems necessary to carry out its
13 duties under P.L.1992, c.162 (C.17B:27A-17 et seq.).
14 (cf: P.L.1993,c.162,s.19)
15 10. Section 25 of P.L.1992, c.162 (C.17B:27A-41) is amended
16 to read as follows:
17 25. Any carrier which violates this act shall be subject to a
18 penalty assessment, as determined by the commissioner[, whether
19 or not the carrier is a risk-assuming carrier or a reinsuring
20 carrier].
21 (cf: P.L.1992,c.162,s.25)
22 11. The Title of P.L.1992, c. 162 is amended to read as follows:
23 *AN ACT* requiring certain health insurers, service corporations
24 and health maintenance organizations to offer standardized
25 health benefits programs to small groups [and establishing a
26 reinsurance program].
27 (cf: P.L.1992,c.162)
28 12. (New section) A member of the board and an employee of
29 the board shall not be liable in an action for damages to any
30 person for any action taken or recommendation made by him
31 within the scope of his functions as a member or employee, if the
32 action or recommendation was taken or made without malice.
33 The Attorney General shall defend the person in any civil suit and
34 the State shall provide indemnification for any damages awarded.
35 13. (New section) The board may, if necessary, adopt rules and
36 regulations pursuant to the "Administrative Procedure Act,"
37 P.L.196a, c.410(C.52:14B-1 et seq.) to establish a risk adjustment
38 mechanism for program members.
39 If the board determines that such a mechanism is necessary, it
40 shall submit the proposed rules and regulations to the Legislature
41 for review on a day that the Legislature is in session and to the
42 commissioner for his approval. If the Legislature does not take
43 action in 30 days to amend or otherwise change the rules and
44 regulations, the rules and regulations shall be effective upon
45 approval by the commissioner or upon such later date as the
46 board determines.
47 14. Sections 18 through 24, inclusive, and section 26 of
48 P.L.1992, c.162 (C. 17B:27A-34 to 40 and 42) and section 18 of
49 P.L.1993, c.162 (C.17B:27A-52) are repealed.
50 15. This act shall take effect immediately and shall be
51 retroactive to January 1, 1995.
52
53 SPONSOR'S STATEMENT
54
55 This bill clarifies and changes various provisions in the small
56 employer health reform law, P.L.1992, c.162.

1 The bill defines the term "stop loss or excess risk insurance"
2 and provides that such insurance is not considered a health
3 benefits plan. Stop loss or excess risk insurance is defined as an
4 insurance policy designed to reimburse a self-funded arrangement
5 of one or more small employers for catastrophic, excess or
6 unexpected expenses wherein neither the employees or other
7 individuals are third party beneficiaries under the insurance
8 policy. In order to be considered stop less or excess risk
9 insurance, the policy shall establish a per person attachment
10 point or retention or aggregate attachment point or retention, or
11 both, which meet the following requirements:
12 - the per person attachment point or retention shall not be less
13 than $25,000 per covered person per plan year; and
14 - the aggregate attachment point or retention shall not be less
15 than 125% of expected claims per plan year.
16 The bill also defines "qualifying previous coverage" to specify
17 those types of insurance coverage (that a person had prior to
18 seeking small employer coverage) for which credit shall be given
19 in determining if a person meets any applicable preexisting
20 condition requirements. The bill also deletes language in section
21 8 of P.L.1992, c.162 (C.17B:27A-24) about establishing the
22 percentage of employee participation to conform the law to
23 changes that were made in P.L.1994, c.11 in the definition of
24 "eligible employee."
25 The bill amends section 7 of P.L.1992, c.162 (C.17B:27A-23) to
26 delete the condition for renewal of a small employer health
27 benefits plan which provides that a plan is not renewable when
28 the number of emplyees covered under the plan is less than two.
29 The amendment will enable small employers who have at least
30 two full-time employees, only one of whom is covered under the
31 health benefits plan because the other employees are covered
32 under other plans, to be able to continue to participate in a small
33 employer health benefits plan. Permitting the small employer to
34 participate in the plan will enable that employer to offer small
35 employer health benefits coverage to any new employee who does
36 not otherwise have coverage.
37 The bill also deletes the exemption from the provisions of the
38 small employer law (subsection d. of section 9 of P.L.1992, c.162,
39 (C.17B:27A-25)) that was provided for policies issued to a
40 specific type of association. This exemption is no longer
41 necessary, as this specific type of association policy is no longer
42 available in the State.
43 The bill also reduces the minimum number of required
44 employment hours from 30 to 25 in section 11 of P.L.1992, c.162
45 (C.17B:27A-27) that would apply as a qualifying event for
46 purposes of maintaining continuation of coverage. This change
47 conforms section 11 of the law to the law's definition of eligible
48 employee which provides that the person work at least 25 hours
49 per week.
50 The bill repeals the provisions of the law which establish a
51 reinsurance program (sections 18 to 24 and 26 of P.L.1992, c.162
52 (C.17B:27A-34 to 40 and 42) and, instead, authorizes the New
53 Jersey Small Employer Health Benefits Program board to
54 establish a risk adjustment mechanism by regulation, if it

1 determines that such a mechanism is necessary. The bill requires
2 that the board submit any proposed regulations to establish the
3 mechanism to the Legislature for review and to the
4 Commissioner of Insurance for approval. The reinsurance
5 program originally established in the law is repealed because it is
6 too cumbersome to implement and may not be necessary to
7 achieve the purposes of the small employer insurance reform law.
8 The bill also changes the composition of the New Jersey Small
9 Employer Health Benefits Program board to reflect the repeal of
10 the reinsurance program. The bill deletes the risk-assuming and
11 reinsuring carrier members and, instead, adds as members an
12 additional small employer carrier and an additional health
13 maintenance organization.
14 Finally, the bill repeals section 18 of P.L.1993, c.162
15 (C.17B:27A-52), concerning submission of the board's original
16 five health benefits plans to the Legislature for review, as the
17 plans were submitted as required and this provision is no longer
18 necessary.
19
20
21 ---
22
23 Makes various changes to small employer insurance reform law.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2662

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 23, 1995

The Assembly Insurance Committee reports favorably and with committee amendments, Assembly Bill No. 2662.

As amended by the committee, this bill clarifies and changes various provisions in the small employer health reform law, P.L.1992, c.162.

The bill defines the term "stop loss or excess risk insurance" and provides that such insurance is not considered a health benefits plan. Stop loss or excess risk insurance is defined as an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses wherein neither the employees or other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

- the per person attachment point or retention shall not be less than $25,000 per covered person per plan year; and

- the aggregate attachment point or retention shall not be less than 125% of expected claims per plan year.

The bill also defines "qualifying previous coverage" to specify those types of insurance coverage (that a person had prior to seeking small employer coverage) for which credit shall be given in determining if a person meets any applicable preexisting condition requirements. The bill also deletes language in section 8 of P.L.1992, c.162 (C.17B:27A-24) about establishing the percentage of employee participation to conform the law to changes that were made in P.L.1994, c.11 in the definition of "eligible employee."

The bill also deletes the exemption from the provisions of the small employer law (subsection d. of section 9 of P.L.1992, c.162, (C.17B:27A-25)) that was provided for policies issued to a specific type of association. This exemption is no longer necessary, as this specific type of association policy is no longer available in the State.

The bill also reduces the minimum number of required employment hours from 30 to 25 in section 11 of P.L.1992, c.162 (C.17B:27A-27) that would apply as a qualifying event for purposes of maintaining continuation of coverage. This change conforms section 11 of the law to the law's definition of eligible employee which provides that the person work at least 25 hours per week.

The bill repeals the provisions of the law which establish a reinsurance program (sections 18 to 24 and 26 of P.L.1992, c.162 (C.17B:27A-34 to 40 and 42) and, instead, authorizes the New Jersey Small Employer Health Benefits Program board to establish

a risk adjustment mechanism by regulation, if it determines that such a mechanism is necessary. The bill requires that the board submit any proposed regulations to establish the mechanism to the Legislature for review and to the Commissioner of Insurance for approval. The reinsurance program originally established in the law is repealed because it is too cumbersome to implement and may not be necessary to achieve the purposes of the small employer insurance reform law.

The bill also changes the composition of the New Jersey Small Employer Health Benefits Program board to reflect the repeal of the reinsurance program. The bill deletes the risk-assuming and reinsuring carrier members and, instead, adds as members an additional small employer carrier and an additional health maintenance organization.

Finally, the bill repeals section 18 of P.L.1993, c.162 (C.17B:27A-52), concerning submission of the board's original five health benefits plans to the Legislature for review, as the plans were submitted as required and this provision is no longer necessary.

The amendments provide for proper notification of employers with respect to their continuation rights under a health benefits plan. The amendments also make technical changes which are necessary to conform the bill to current law.

SENATE HEALTH COMMITTEE

STATEMENT TO

[FIRST REPRINT]

ASSEMBLY, No. 2662

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 1, 1995

The Senate Health Committee favorably reports Assembly Bill No. 2662 [1R] with committee amendments.

As amended by committee, this bill clarifies and changes various provisions in the small employer health reform law, P.L.1992, c.162.

The bill defines the term "stop loss or excess risk insurance" and provides that such insurance is not considered a health benefits plan. Stop loss or excess risk insurance is defined as an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses wherein neither the employees or other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

- the per person attachment point or retention shall not be less than $25,000 per covered person per plan year; and

- the aggregate attachment point or retention shall not be less than 125% of expected claims per plan year.

The bill also defines "qualifying previous coverage" to specify those types of insurance coverage (that a person had prior to seeking small employer coverage) for which credit shall be given in determining if a person meets any applicable preexisting condition requirements. The bill also deletes language in section 8 of P.L.1992, c.162 (C.17B:27A-24) about establishing the percentage of employee participation to conform the law to changes that were made in P.L.1994, c.11 in the definition of "eligible employee."

The bill deletes the exemption from the provisions of the small employer law (subsection d. of section 9 of P.L.1992, c.162, (C.17B:27A-25)) that was provided for policies issued to a specific type of association. This exemption is no longer necessary, as this specific type of association policy is no longer available in the State.

The bill also reduces the minimum number of required employment hours from 30 to 25 in section 11 of P.L.1992, c.162 (C.17B:27A-27) that would apply as a qualifying event for purposes of maintaining continuation of coverage. This change conforms section 11 of the law to the law's definition of eligible employee which provides that the person work at least 25 hours per week.

The bill repeals the provisions of the law which establish a reinsurance program (sections 18 to 24 and 26 of P.L.1992, c.162 (C.17B:27A-34 to 40 and 42) and, instead, authorizes the New Jersey Small Employer Health Benefits Program board to establish a voluntary risk pooling arrangement by regulation, if it determines

that such an arrangement is necessary. The bill requires that the board submit any proposed regulations to establish the arrangement to the Legislature for review and to the Commissioner of Insurance for approval. The reinsurance program originally established in the law is repealed because it is too cumbersome to implement and may not be necessary to achieve the purposes of the small employer insurance reform law.

The bill also changes the composition of the New Jersey Small Employer Health Benefits Program board to reflect the repeal of the reinsurance program. The bill deletes the risk-assuming and reinsuring carrier members and, instead, adds as members an additional small employer carrier and an additional health maintenance organization.

Finally, the bill repeals section 18 of P.L.1993, c.162 (C.17B:27A-52), concerning submission of the board's original five health benefits plans to the Legislature for review, as the plans were submitted as required and this provision is no longer necessary.

The committee amended the bill to delete subsection c. of section 9 of P.L.1992, c.162 (C.17B:27A-25) because that subsection is no longer necessary with the bill's new language regarding stop loss or excess risk insurance. In addition, the bill was amended to allow the board to adopt rules and regulations to establish a voluntary risk pooling arrangement rather than a risk adjustment mechanism. As amended, this bill is identical to Senate Bill No. 2013 (Sinagra) which the committee also reported favorably, with amendments, on this date.

STATE OF NEW JERSEY
EXECUTIVE DEPARTMENT

September 18, 1995

ASSEMBLY BILL NO. 2662
(Second Reprint)

To the General Assembly:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Assembly Bill No. 2662 (Second Reprint) with my recommendations for reconsideration.

A. Summary of Bill

This bill amends the Small Employer Health Coverage Act ("SEH Act") for the purposes of correcting technical problems that have arisen since the bill was enacted and of halting abusive conduct by insurance companies who want to circumvent the Act. The bill makes changes in the areas of: (1) stop loss or excess risk insurance; (2) the pre-existing-condition waiting period; (3) carriers acting as third-party administrators; (4) elimination of an exemption for certain trade associations; (5) the reinsurance mechanism; and (6) tort immunity and indemnification for members of the New Jersey Small Employer Health Benefits Program Board (the "SEH Board"), which administers the program. The bill takes effect immediately on signing and is retroactive to January 1, 1995.

B. Recommended Action

I commend the Legislature for its diligence in keeping the SEH Act up-to-date and in amending it to prevent abuses that are taking place in the health-insurance market. However, the Attorney General advises me that the provision of the bill that immunizes members of the SEH Board from tort immunity and requires the Attorney General to defend them in civil actions is contrary to the provisions of the New Jersey Tort Claims Act and in fact provides for broader immunity than any other State employee enjoys.

Furthermore, the Attorney General also advises that the bill's retroactive effective date is problematic. Retroactive application of the laws is viewed as being unfair to regulated entities and to the regulated public because it does not offer

notice of what is being prohibited. This bill prohibits conduct and eliminates exceptions to the SEH Act. To do that retroactively would not only create confusion, but would also be of questionable legality.

Consequently, I am recommending that the bill be amended to offer tort immunity to members of the SEH Board that parallels that which other State employees are entitled to. I recommend further that the retroactivity provision of the bill be deleted so that the bill will become effective on the date it is signed.

Therefore, I herewith return Assembly Bill No. 2662 (Second Reprint) and recommend that it be amended as follows:

<u>Page 13, Section 11, Line 39</u>:	Delete "The Attorney General shall defend the person in any civil" insert "The members of the board shall be indemnified and their defense of any action provided for in the same manner and to the same extent as employees of the State under the "New Jersey Tort Claims Act," P.L.1972, c.45 (C. 59:1-1 et seq.) on account of acts or omissions in the scope of their employment."
<u>Page 13, Section 11, Lines 40-41</u>:	Delete in their entirety.
<u>Page 14, Section 14, Line 4</u>:	Delete "and shall be"
<u>Page 14, Section 14, Line 4</u>: [illegible]	Delete in its entirety.

Respectfully,

/s/ Christine Todd Whitman

GOVERNOR

[seal]

Attest:

/s/ Margaret M. Foti

Chief Counsel to the Governor