CHAPTER 143

AN ACT concerning the State Health Benefits Program and the School Employees' Health Benefits Program, amending P.L.1961, c.49 and P.L.2007, c.103, and supplementing P.L.1961, c.49 (C.52:14-17.25 et seq.).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.52:14-17.30a Findings, declarations relative to health care costs.

1. The Legislature finds and declares that:

a. The cost of health care in this country has been increasing at a pace that will make our current system of health care delivery unsustainable on its present trajectory.

b. As health care costs continue to rise more quickly than the average annual income, those costs displace other priorities for individuals, such as saving for retirement or their children's education, and even discourage people from obtaining recommended health care. The litany of research in this area has demonstrated that all necessary action must be taken to reduce costs wherever possible.

c. One way to reduce costs is to increase the oversight that a self-insured employer, such as the State, exercises over health care programs, as occurs when hiring a third-party medical claims reviewer to examine claims processing.

d. Hiring a third-party medical claims reviewer to provide regular, frequent, and ongoing review and oversight of the claims process, which process includes, but is not limited to, the receipt, management, adjudication, and payment of claims, serves the best interests of the State, participating employers, and the thousands of employees and their dependents covered under the State Health Benefits Program and the School Employees' Health Benefits Program. A third-party medical claims reviewer would act in the best interests of the State, participating employers, and program participants, work toward identifying and eliminating systemic errors, recover overpayments, and ensure that only the required and appropriate amounts due and owing on claims are paid as a result of proper adjudication.

e. For the purpose of facilitating greater efficiency and transparency in the adjudication of health benefits claims to State employees, their eligible family members, and participating local government and education employees and their eligible family members, the State of New Jersey deems it fitting and crucial to procure a third-party medical claims reviewer expeditiously, with a goal for implementation in the plan year beginning in January of 2020.

C.52:14-17.30b Contract for services of a third-party medical claims reviewer.

2. a. Notwithstanding the provisions of any other law to the contrary, a contract for the services of a third-party medical claims reviewer for the State Health Benefits Program and the School Employees' Health Benefits Program shall be procured in an expedited process and in the manner provided by this section.

b. The Division of Purchase and Property in the Department of the Treasury shall procure, without the need for formal advertisement, but through the solicitation of proposals from professional services vendors, a third-party medical claims reviewer, which shall be responsible for the strict oversight of the adjudication and processing of direct payments for health care services rendered to participants in the State Health Benefits Program and School Employees' Health Benefits Program. The third-party medical claims reviewer shall perform all duties in accordance with all applicable State and federal laws and with the rules and regulations issued by the State Treasurer and the State Health Benefits Commission and the School Employees' Health Benefits Commission, and shall act in the best interests of the

State, participating employers, and covered persons under the programs. The third-party medical claims reviewer shall not be the carrier, or a subsidiary, related party, or affiliate thereof, with which the State has contracted pursuant to section 4 of P.L.1961, c.49 (C.52:14-17.28) or section 35 of P.L.2007, c.103 (C.52:14-17.46.5) for the provision of hospital, surgical, obstetrical, and other covered health care services and benefits or for the provider networks for those services. The third-party medical claims reviewer shall not exercise any authority over the provision of health care benefits for Medicare-eligible retirees. The contract awarded for the services of the third-party medical claims reviewer may include provisions permitting the compensation of the third-party medical claims reviewer based upon a percentage of the costs recovered by the State as a result of the information provided by the third-party medical claims reviewer in the performance of its duties.

c. Notwithstanding the provisions of any other law to the contrary, for the purpose of expediting the procurement of a third-party medical claims reviewer, the following provisions shall apply as modifications to law or regulation that may interfere with the expedited procurement:

(1) the timeframes for challenging the specifications shall be modified as determined by the division;

(2) in lieu of advertising in accordance with sections 2, 3, and 4 of P.L.1954, c.48 (C.52:34-7, C.52:34-8, and C.52:34-9), the division shall advertise the request for proposals for the above service and any addenda thereto on the division's website;

(3) the period of time that the State Comptroller has to review the request for proposals for the procurement of a third-party medical claims reviewer for compliance with applicable public contracting laws, rules, and regulations, pursuant to section 10 of P.L.2007, c.52 (C.52:15C-10), shall be 10 business days or less if practicable, as determined by the State Comptroller;

(4) the timeframes for submission under section 4 of P.L.2012, c.25 (C.52:32-58) and section 1 of P.L.1977, c.33 (C.52:25-24.2) shall be extended to prior to the issuance of a Notice of Intent to Award;

(5) the provisions of section 1 of P.L.2005, c.92 (C.52:34-13.2) shall not apply to technical and support services, under this section, provided by a vendor using a "24/7 follow-the-sun model" as long as the contractor is able to provide such services in the United States during the business day; and

(6) the term "bids" in subparagraph (f) of subsection a. of section 7 of P.L.1954, c.48 (C.52:34-12) shall not include pricing which will be revealed to all responsive bidders during the negotiation process.

d. The division may, to the extent necessary, waive or modify any requirement under any other law or regulation that may interfere with the expeditious procurement of this service.

e. Upon the expiration of the initial contract for a third-party medical claims reviewer procured pursuant to subsection b. of this section, the procurement of such service thereafter shall be required and in accordance with P.L.1954, c.48 (C.52:34-6 et seq.) and any other applicable law governing the awarding of public contracts by a State agency.

3. Section 6 of P.L.1961, c.49 (C.52:14-17.30) is amended to read as follows:

C.52:14-17.30 State payment of premium, periodic charges.

6. a. For each active covered State employee and for the eligible dependents the employee may have enrolled at the employee's option, the State, from funds appropriated therefor, shall

pay its share of the premium or periodic charges for the benefits provided under the contract purchased by the commission pursuant to subsection a. of section 4 of P.L.1961, c.49 (C.52:14-17.28).

An employee may, on an optional basis, enroll the employee's dependents for coverage under the contract subject to such regulations and conditions as the commission and the carrier may prescribe.

b. There is hereby created a health benefits fund. Said fund shall be used to pay the premiums or periodic charges for which the State is responsible under this act.

c. The fund shall contain a dedicated subaccount reserved for payment of claims and other health services fees for covered health services and prescription drug benefits provided to covered State employees and their enrolled eligible dependents. No person shall use or authorize the use of the assets in the subaccount, or the investment earnings thereon, for any purpose other than for the provision of benefits in accordance with the terms of the State Health Benefits Program and for defraying the reasonable costs of administering the subaccount.

A third-party medical claims reviewer, procured pursuant to section 2 of P.L.2019, c.143 (C.52:14-17.30b), shall, in the performance of services for the program, act in the best interests of the State, participating employers, and covered State employees and their enrolled eligible dependents. Nothing in this subsection shall be construed as subjecting the program, its plans, the State, or any participating employer to the provisions of the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.).

The third-party medical claims reviewer shall collect, store and maintain a secure archive of medical and prescription drug claims data and other health services payment information and provide such data and other reports in compliance with applicable State and federal laws, including the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191, to document the cost and nature of claims incurred, demographic information on the covered population, emerging utilization and demographic trends, and such other information as may be available to assist in the governance of the program and in timely response to any requests from the Governor, the State Treasurer, the Division of Pensions and Benefits, the State Health Benefits Commission, the State Health Benefits Plan Design Committee, the President of the Senate, and the Speaker of the General Assembly. Such claims data shall include, but not be limited to, for each claim, the claim number, provider information, amount charged, amount paid, and the Current Procedural Terminology (CPT) code. The State Health Benefits Commission, the State Health Benefits Plan Design Committee, the State Treasurer, or the Division of Pensions and Benefits may direct the third-party medical claims reviewer to provide appropriate medical and prescription drug claims and other health services payment data to a health care services provider or other authorized entity, in compliance with applicable State and federal laws, including the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191, for the specific purpose of improving the quality and value of health care services delivered to program participants.

The State Treasurer shall deposit into the subaccount the moneys necessary to accomplish the purposes of this subsection, including moneys paid by employers participating in the program, and contributed by employees and retirees of the State and employees and retirees of employers other than the State participating in the program. Deposits and contributions to the subaccount shall be applied to the distribution of payments for the costs of health care services and prescription drug benefits and to fund the reasonable costs of administering the subaccount. Assets in the subaccount shall be expended or withdrawn, and deposits and

withdrawals shall be reconciled, in accordance with regulations and procedures adopted pursuant to this subsection.

Moneys in the subaccount shall be invested in permitted investments or shall be held in interest-bearing accounts in such depositories as the State Treasurer may select, and may be invested and reinvested in permitted investments or invested and reinvested in the same manner as other accounts in the custody of the State Treasurer as provided by law. All interest or other income or earnings derived from the investment or reinvestment of moneys in the subaccount shall be credited thereto and shall be determined on an aggregate basis for all participating employers.

The State Treasurer shall adopt, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), such rules and regulations as may be necessary to implement the provisions of this act, P.L.2019, c.143 (C.52:14-17.30a et al.).

4. Section 4 of P.L.1961, c.49 (C.52:14-17.28) is amended to read as follows:

C.52:14-17.28 Purchase of contracts; conditions.

4. a. The commission shall negotiate with and arrange for the purchase, on such terms as it deems to be in the best interests of the State and its employees, from carriers licensed to operate in the State or in other jurisdictions, as appropriate, contracts providing hospital, surgical, obstetrical, and other covered health care services and benefits covering employees of the State and their dependents, and shall execute all documents pertaining thereto for and on behalf and in the name of the State.

b. Except for contracts entered into after June 30, 2007, the commission shall not enter into a contract under this act unless the benefits provided thereunder equal or exceed the minimum standards specified in section 5 of P.L.1961, c.49 (C.52:14-17.29) for the particular coverage which such contract provides, and unless coverage is available to all eligible employees and their dependents on the basis specified by section 7 of P.L.1961, c.49 (C.52:14-17.31), except that a State employee enrolled in the program on or after July 1, 2003 and all law enforcement officers employed by the State for whom there is a majority representative for collective negotiations purposes may not be eligible for coverage under the traditional plan as defined in section 2 of P.L.1961, c.49 (C.52:14-17.26) pursuant to a binding collective negotiations agreement or pursuant to the application by the commission, in its sole discretion, of the terms of any collective negotiations agreement binding on the State to State employees for whom there is no majority representative for collective negotiations purposes.

c. The commission shall not enter into a contract under P.L.1961, c.49 (C.52:14-17.25 et seq.) after June 30, 2007, unless the contract includes the successor plan, one or more health maintenance organization plans and a State managed care plan that shall be substantially equivalent to the NJ PLUS plan in effect on June 30, 2007, with adjustments to that plan pursuant to a binding collective negotiations agreement or pursuant to action by the commission, in its sole discretion, to apply such adjustments to State employees for whom there is no majority representative for collective negotiations purposes, and unless coverage is available to all eligible employees and their dependents on the basis specified by section 7 of P.L.1961, c.49 (C.52:14-17.31), except as provided in subsection d. of this section.

d. Eligibility for coverage under the successor plan may be limited pursuant to a binding collective negotiations agreement or pursuant to the application by the commission, in its sole discretion, of the terms of any collective negotiations agreement binding on the State to State employees for whom there is no majority representative for collective negotiations purposes. Coverage under the successor plan and under the State managed care plan required to be

included in a contract entered into pursuant to subsection c. of this section shall be made available in retirement to all State employees who accrued 25 years of nonconcurrent service credit in one or more State or locally-administered retirement systems before July 1, 2007. Coverage under the State managed care plan required to be included in a contract entered into pursuant to subsection c. of this section shall be made available in retirement to all State employees who accrue 25 years of nonconcurrent service credit in one or more State or locally-administered retirement systems on or after July 1, 2007.

e. Actions taken by the commission before the effective date of P.L.2007, c.103 in anticipation of entering into any contract pursuant to subsection c. of this section are hereby deemed to have been within the authority of the commission pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.).

f. Any carrier with which the commission contracts for the provision of hospital, surgical, obstetrical, and other covered health care services and benefits pursuant to this section shall provide to the third-party medical claims reviewer, procured pursuant to section 2 of P.L.2019, c.143 (C.52:14-17.30b), information in that carrier's provider network contracts, such as claims information and contractual discounts provided thereunder, that are applicable to a health benefits plan offered under the State Health Benefits Program.

Documents, materials and other information in the possession or control of the State, or the third-party medical claims reviewer, that are obtained or created by, or disclosed to, the State or any other person pursuant to this subsection shall be recognized by this State as being proprietary and containing trade secrets. All such documents, materials or other information shall be confidential by law and privileged, and shall not be subject to P.L.1963, c.71 (C.47:1A-1 et seq.); except that the State is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commission's or third-party medical claims reviewer's official duties. The State and the third-party medical claims reviewer shall not disclose, sell, or transfer the documents, materials or other information without the prior written consent of the carrier. This subsection shall not be construed as pertaining to medical claims data.

g. A contract entered into with a carrier pursuant to this section shall include therein the State's existing right to withhold payment for administrative services or to pursue any other remedy deemed appropriate by the State Treasurer if the carrier is found by the State upon information provided by the third-party medical claims reviewer to have committed errors resulting in a loss to the State in a quantity or value, or both, beyond a certain threshold, as shall be provided in the contract or by rules promulgated by the State Treasurer. The contract shall permit the State to recover any loss resulting from errors identified by the third-party medical claims reviewer.

h. Information provided to or obtained by the third-party medical claims reviewer shall be delivered, received, maintained, and reviewed in a manner and shall contain only material consistent with the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191. To the extent necessary in accordance therewith, a carrier shall ensure that information provided to the medical claims reviewer is attendant to only persons who are participants in the State Health Benefits Program.

5. Section 35 of P.L.2007, c. 103 (C.52:14-17.46.5) is amended to read as follows:

C.52:14-17.46.5 Purchase of contracts providing benefits.

35. a. The commission shall negotiate with and arrange for the purchase, on such terms as it deems in the best interests of the State, participating employers and those persons covered

hereunder from carriers licensed to operate in the State or in other jurisdictions, as appropriate, contracts providing benefits required by the School Employees' Health Benefits Program Act, as specified in section 36 of P.L.2007, c.103 (C.52:14-17.46.6), or such benefits as the commission may determine to provide, so long as such modification of benefits is in the best interests of the State, participating employers and those persons covered hereunder, and is consistent with the provisions of section 40 of that act (C.52:14-17.46.10). The commission shall have authority to execute all documents pertaining thereto for and on behalf of the State. The commission shall not enter into a contract under the School Employees' Health Benefits Program Act, unless the benefits provided thereunder are equal to or exceed the standards specified in section 36 of that act, or as such standards are modified pursuant to section 40 of that act.

b. The rates charged for any contract purchased under the authority of the School Employees' Health Benefits Program Act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined based upon accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

c. The commission shall be authorized to accept an assignment of contract rights from or enter into an agreement, contract, memorandum of understanding or other terms with the State Health Benefits Commission to ensure that coverage for eligible employees, retirees and dependents under the School Employees' Health Benefits Program whose benefits had been provided through the State Health Benefits Program is continued without interruption. The transition provided for in this subsection shall occur within one year of the effective date of the School Employees' Health Benefits Program Act, sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11).

d. Benefits under the contract or contracts purchased as authorized by the School Employees' Health Benefits Program Act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

e. The initial term of any contract purchased by the commission under the authority of the School Employees' Health Benefits Program Act shall be for such period to which the commission and the carrier may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

f. Any carrier with which the commission contracts for the provision of hospital, surgical, obstetrical, and other covered health care services and benefits pursuant to this section shall provide to the third-party medical claims reviewer, procured pursuant to section 2 of P.L.2019, c.143 (C.52:14-17.30b), information in that carrier’s provider network contracts, such as claims information and contractual discounts provided thereunder, that are applicable to a health benefits plan offered under the School Employees’ Health Benefits Program.

Documents, materials and other information in the possession or control of the State, or the third-party medical claims reviewer, that are obtained or created by, or disclosed to, the State or any other person pursuant to this subsection shall be recognized by this State as being proprietary and containing trade secrets. All such documents, materials or other information shall be confidential by law and privileged, and shall not be subject to P.L.1963, c.71 (C.47:1A-1 et seq.); except that the State is authorized to use the documents, materials or other information in the

furtherance of any regulatory or legal action brought as a part of the commission's or third-party medical claims reviewer's official duties. The State and the third-party medical claims reviewer shall not disclose, sell, or transfer the documents, materials or other information without the prior written consent of the carrier. This subsection shall not be construed as pertaining to medical claims data.

g. A contract entered into with a carrier pursuant to this section shall include therein the State's existing right to withhold payment for administrative services or to pursue any other remedy deemed appropriate by the State Treasurer if the carrier is found by the State upon information provided by the third-party medical claims reviewer to have committed errors resulting in a loss to the State in a quantity or value, or both, beyond a certain threshold, as shall be provided in the contract or by rules promulgated by the State Treasurer. The contract shall permit the State to recover any loss resulting from errors identified by the third-party medical claims reviewer.

h. Information provided to or obtained by the third-party medical claims reviewer shall be delivered, received, maintained, and reviewed in a manner and shall contain only material consistent with the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191. To the extent necessary in accordance therewith, a carrier shall ensure that information provided to the medical claims reviewer is attendant to only persons who are participants in the School Employees' Health Benefits Program.

6. Section 39 of P.L.2007, c.103 (C.52:14-17.46.9) is amended to read as follows:

C.52:14-17.46.9 Obligations of employer for charges for benefits; funds; subaccount.

39. a. For each active covered employee and for the eligible dependents the employee may have enrolled at the employee's option, from funds appropriated therefor, the employer shall pay to the commission the premium or periodic charges for the benefits provided under the contract in amounts equal to the premium or periodic charges for the benefits provided under such a contract covering the employee and the employee's enrolled dependents.

b. The obligations of any employer to pay the premium or periodic charges for health benefits coverage provided under the School Employees' Health Benefits Program Act, sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11), may be determined by means of a binding collective negotiations agreement, including any agreement in force at the time the employer commences participation in the School Employees' Health Benefits Program. With respect to employees for whom there is no majority representative for collective negotiations purposes, the employer may, in its sole discretion, modify the respective payment obligations set forth in law for the employer and such employees in a manner consistent with the terms of any collective negotiations agreement binding on the employer.

Commencing on the effective date of P.L.2010, c.2 and upon the expiration of any applicable binding collective negotiations agreement in force on that effective date, employees shall pay 1.5 percent of base salary, through the withholding of the contribution, for health benefits coverage provided under P.L.2007, c.103 (C.52:14-17.46.1 et seq.), notwithstanding any other amount that may be required additionally pursuant to this subsection by means of a binding collective negotiations agreement or the modification of payment obligations.

c. There is hereby established a School Employee Health Benefits Program fund consisting of all contributions to premiums and periodic charges remitted to the State treasury by participating employers for employee coverage. All such contributions shall be

deposited in the fund and the fund shall be used to pay the portion of the premium and periodic charges attributable to employee and dependent coverage.

d. The fund shall contain a dedicated subaccount reserved for payment of claims and other health services fees for covered health services and prescription drug benefits provided to covered employees and their enrolled eligible dependents. No person shall use or authorize the use of the assets in the subaccount, or the investment earnings thereon, for any purpose other than for the provision of benefits in accordance with the terms of the School Employees' Health Benefits Program and for defraying the reasonable costs of administering the subaccount.

A third-party medical claims reviewer, procured pursuant to section 2 of P.L.2019, c.143 (C.52:14-17.30b), shall, in the performance of services for the program, act in the best interests of the State, participating employers, and covered employees and their enrolled eligible dependents. Nothing in this subsection shall be construed as subjecting the program, its plans, the State, or any participating employer to the provisions of the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.).

The third-party medical claims reviewer shall collect, store and maintain a secure archive of medical and prescription drug claims data and other health services payment information and provide such data and other reports in compliance with applicable State and federal laws, including the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191, to document the cost and nature of claims incurred, demographic information on the covered population, emerging utilization and demographic trends, and such other information as may be available to assist in the governance of the program and in timely response to any requests from the Governor, the State Treasurer, the Division of Pensions and Benefits, the School Employees' Health Benefits Commission, the School Employees' Health Benefits Plan Design Committee, the President of the Senate, and the Speaker of the General Assembly. Such claims data shall include, but not be limited to, for each claim, the claim number, provider information, amount charged, amount paid, and the Current Procedural Terminology (CPT) code. The School Employees' Health Benefits Commission, the School Employees' Health Benefits Plan Design Committee, the State Treasurer, or the Division of Pensions and Benefits may direct the third-party medical claims reviewer to provide appropriate medical and prescription drug claims and other health services payment data to a health care services provider or other authorized entity, in compliance with applicable State and federal laws, including the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191, for the specific purpose of improving the quality and value of health care services delivered to program participants.

The State Treasurer shall deposit into the subaccount the moneys necessary to accomplish the purposes of this subsection, including moneys paid by employers participating in the program, and contributed by covered employees and retirees. Deposits and contributions to the subaccount shall be applied to the distribution of payments for the costs of health care services and prescription drug benefits and to fund the reasonable costs of administering the subaccount. Assets in the subaccount shall be expended or withdrawn, and deposits and withdrawals shall be reconciled, in accordance with regulations and procedures adopted pursuant to this subsection.

Moneys in the subaccount shall be invested in permitted investments or shall be held in interest-bearing accounts in such depositories as the State Treasurer may select, and may be invested and reinvested in permitted investments or invested and reinvested in the same manner as other accounts in the custody of the State Treasurer as provided by law. All interest or other income or earnings derived from the investment or reinvestment of moneys

in the subaccount shall be credited thereto and shall be determined on an aggregate basis for all participating employers.

The State Treasurer shall adopt, pursuant to the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), such rules and regulations as may be necessary to implement the provisions of this act, P.L.2019, c.143 (C.52:14-17.30a et al.).

e. Notwithstanding any law to the contrary and except as provided by amendment by P.L.2010, c.2, and by P.L.2011, c.78, the payment in full of premium or periodic charges for eligible retirees and their dependents pursuant to section 3 of P.L.1987, c.384 (C.52:14-17.32f), section 2 of P.L.1992, c.126 (C.52:14-17.32f1), or section 1 of P.L.1995, c.357 (C.52:14-17.32f2) shall be continued without alteration or interruption and there shall be no premium sharing or periodic charges for certain school employees in retirement once they have met the criteria for vesting for pension benefits, which criteria for purposes of this subsection only shall mean the criteria for vesting in the Teachers' Pension and Annuity Fund. For purposes of this subsection, "premium sharing or periodic charges" shall mean payments by eligible retirees based upon a proportion of the premiums for health care benefits.

7. This act shall take effect immediately, except that sections 4 and 5 shall take effect after the expiration of all contracts in effect on the date of enactment of this act purchased pursuant to subsection a. of section 4 of P.L.1961, c.49 (C.52:14-17.28) and of section 35 of P.L.2007, c.103 (C.52:14-17.46.5), respectively, but the Department of the Treasury and the commissions may take such anticipatory administrative action prior thereto as may be necessary to effectuate the purposes of this act.

Approved June 30, 2019.