

[Second Reprint]

ASSEMBLY, No. 5217

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED JANUARY 23, 2025

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SYNOPSIS

Requires third-party discounts and payments for individuals covered by health benefits plans to apply to copayments, coinsurance, deductibles, or other out-of-pocket costs for covered benefits.

CURRENT VERSION OF TEXT

As amended by the Senate on June 30, 2025.

(Sponsorship Updated As Of: 12/18/2025)

1 AN ACT concerning health insurance accumulators, ²and²
 2 supplementing P.L.1997, c.192 (C.26:2S-1 et seq.) and
 3 ²[amending and supplementing]² P.L.2015, c.179 ²(C.17B:27F-
 4 1)².

5
 6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
 7 *of New Jersey:*

8
 9 1. ²[(New section)]² This act shall be known and may be cited
 10 as the “Ensuring Fairness in Cost-Sharing Amounts Act of ²[2024]
 11 2025².”

12
 13 2. (New section) As used in section 3 of P.L. , c. (C.)
 14 (pending before the Legislature as this bill):

15 “Carrier” means an insurance company, health service
 16 corporation, hospital service corporation, medical service
 17 corporation, or health maintenance organization authorized to issue
 18 health benefits plans in this State, or any other entity subject to the
 19 insurance laws and rules of insurance in this State or subject to the
 20 jurisdiction of the Department of Banking and Insurance, that
 21 contracts, or offers to contract to provide, deliver, arrange for, pay
 22 for, or reimburse any of the costs of health care services under a
 23 health benefits plan in this State.

24 “Cost-sharing amount” means any copayment, coinsurance,
 25 deductible, or other similar charges required of an enrollee for a
 26 health care service covered by a health benefits plan, including a
 27 prescription drug, and paid by or on behalf of the enrollee.

28 “Enrollee” means any individual entitled to coverage of health
 29 care services from a carrier.

30 “Health benefits plan” means a policy, contract, certification, or
 31 agreement offered or issued by a carrier to provide, deliver, arrange
 32 for, pay for, or reimburse any of the costs of health care services.

33 ¹For the purposes of P.L. , c. (C.) (pending before the
 34 Legislature as this bill), “health benefits plans” shall not include the
 35 following plans, policies, or contracts: accident only; credit
 36 disability; long-term care; Medicare supplemental coverage;
 37 TRICARE supplement coverage; coverage for Medicare services
 38 pursuant to a contract with the United States government; the State
 39 Medicaid program established pursuant to P.L.1968, c.413
 40 (C.30:4D-1 et seq.); coverage arising out of a worker’s
 41 compensation or similar law; the State Health Benefits Program; the
 42 School Employees’ Health Benefits Program; or a self-insured
 43 health benefits plan governed by the provisions of the federal
 44 “Employee Retirement Income Security Act of 1974,” 29 U.S.C.

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 thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Senate SBA committee amendments adopted June 9, 2025.

²Senate floor amendments adopted June 30, 2025.

1 s.1001 et seq.; coverage under a policy of private passenger
2 automobile insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1
3 et seq.), or hospital confinement indemnity coverage.¹

4 “Health care service” means an item or service furnished to any
5 individual for the purpose of preventing, alleviating, curing, or
6 healing human illness, injury or disability.

7 “Third party administrator” has the same meaning as defined in
8 N.J.S.17B:27B-1.

9
10 3. ²**[(New section)]**² a. The annual limitation on cost-sharing
11 amounts provided for in section 1302 of the Patient Protection and
12 Affordable Care Act, Pub.L.111-148 (42 U.S.C. s.18022) shall
13 apply to all health care services covered under any health benefits
14 plan offered or issued by a carrier in this State. ²Nothing in this
15 subsection shall be construed to limit or supersede the authority of the
16 Department of Banking and Insurance to impose additional cost
17 sharing limits consistent with State law and regulations, including
18 minimum standards established pursuant to N.J.A.C.11:22-5.1 et seq.²

19 b. When calculating an enrollee’s contribution to any
20 applicable cost-sharing amount requirement, a carrier or third-party
21 administrator shall give credit for the amount, or any portion
22 thereof, of any cost-sharing amount paid by the enrollee or on
23 behalf of the enrollee by another party. If a health benefits plan
24 qualifies as a high-deductible health plan for which medical
25 expenses are paid using a health savings account established
26 pursuant to section 223 of the federal Internal Revenue Code of
27 1986 (26 U.S.C. s.223), this subsection shall apply to a high-
28 deductible health plan with respect to the deductible after the
29 enrollee has satisfied the minimum deductible required under
30 section 223, except for with respect to items or services that are
31 preventive care pursuant to section 223(c)(2)(C) of the federal
32 Internal Revenue Code (26 U.S.C. s.223), in which case the
33 requirements of this subsection shall apply regardless of whether
34 the minimum deductible under section 223 has been satisfied.

35 c. A carrier or third party administrator shall not directly or
36 indirectly set, alter, implement, or condition the terms of health
37 benefits plan coverage, including the benefit design, based in part or
38 entirely on information about the availability or amount of financial
39 or product assistance available for a prescription drug.

40 d. By ²**[December]** March² 31 of each year, each carrier and
41 third party administrator authorized to conduct business in the State
42 shall certify to the Commissioner of Banking and Insurance, in a
43 form and manner as determined by the commissioner, that it has
44 fully and completely complied with the requirements of this section
45 throughout the prior calendar year. The certification shall be signed
46 by the chief executive officer, chief financial officer, or designee, of
47 the carrier or third party administrator.

1 e. ²[In implementing the requirements of this section, the State
2 shall only regulate a carrier to the extent permissible under
3 applicable law.

4 f.]² The Commissioner of Banking and Insurance, pursuant to
5 the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1
6 et seq.), shall adopt rules and regulations to effectuate the purposes
7 of this section.

8
9 ²[4. Section 1 of P.L.2015, c.179 (C.17B:27F-1) is amended to
10 read as follows:

11 1. “Anticipated loss ratio” means the ratio of the present value
12 of the future benefits payments, including claim offsets after the
13 point of sale, to the present value of the future premiums of a policy
14 form over the entire period for which rates are computed to provide
15 health insurance coverage.

16 “Average wholesale price” means the average wholesale price of
17 a prescription drug determined by a national drug pricing publisher
18 selected by a carrier. The average wholesale price shall be
19 identified using the national drug code published by the National
20 Drug Code Directory within the United States Food and Drug
21 Administration.

22 “Brand-name drug” means a prescription drug marketed under a
23 proprietary name or registered trademark name, including a
24 biological product.

25 “Carrier” means an insurance company, health service
26 corporation, hospital service corporation, medical service
27 corporation, or health maintenance organization authorized to issue
28 health benefits plans in this State.

29 “Contracted pharmacy” means a pharmacy that participates in
30 the network of a pharmacy benefits manager through a contract
31 with:

- 32 a. the pharmacy benefits manager directly;
33 b. a pharmacy services administration organization; or
34 c. a pharmacy group purchasing organization.

35 “Cost-sharing amount” means [the amount paid by a covered
36 person as required under the covered person's health benefits plan
37 for a prescription drug at the point of sale] any copayment,
38 coinsurance, deductible, or other similar charges required of a
39 covered person for a health care service covered by a health benefits
40 plan, including a prescription drug benefits plan, and paid by or on
41 behalf of the covered person.

42 “Covered person” means a person on whose behalf a carrier or
43 other entity, who is the sponsor of the health benefits plan, is
44 obligated to pay benefits pursuant to a health benefits plan.

45 “Department” means the Department of Banking and Insurance.

46 “Drug” means a drug or device as defined in R.S.24:1-1.

47 “Health benefits plan” means a benefits plan which pays hospital
48 or medical expense benefits for covered services, or prescription

1 drug benefits for covered services, and is delivered or issued for
2 delivery in this State by or through a carrier or any other sponsor.
3 For the purposes of P.L.2015, c.179 (C.17B:27F-1), health benefits
4 plan shall not include the following plans, policies or contracts:
5 accident only, credit disability, long-term care, Medicare
6 supplement coverage; TRICARE supplement coverage, coverage
7 for Medicare services pursuant to a contract with the United States
8 government, the State Medicaid program established pursuant to
9 P.L.1968, c.413 (C.30:4D-1 et seq.), coverage arising out of a
10 worker's compensation or similar law, the State Health Benefits
11 Program, the School Employees' Health Benefits Program, or a self-
12 insured health benefits plan governed by the provisions of the
13 federal "Employee Retirement Income Security Act of 1974," 29
14 U.S.C. s.1001 et seq., coverage under a policy of private passenger
15 automobile insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1
16 et seq.), or hospital confinement indemnity coverage.

17 "Health care service" means an item or service furnished to any
18 individual for the purpose of preventing, alleviating, curing, or
19 healing human illness, injury, or disability.

20 "Maximum allowable cost" means the maximum amount a health
21 insurer will pay for a generic drug or brand-name drug that has at
22 least one generic alternative available.

23 "Network pharmacy" means a licensed retail pharmacy or other
24 pharmacy provider that contracts with a pharmacy benefits manager
25 either directly or by and through a contract with a pharmacy
26 services administrative organization.

27 "Pharmacy" means any place in the State, either physical or
28 electronic, where drugs are dispensed or pharmaceutical care is
29 provided by a licensed pharmacist, but shall not include a medical
30 office under the control of a licensed physician.

31 "Pharmacy benefits manager" means a corporation, business, or
32 other entity, or unit within a corporation, business, or other entity,
33 that, pursuant to a contract or under an employment relationship
34 with a carrier, health benefits plan, a self-insurance plan or other
35 third-party payer, either directly or through an intermediary,
36 **[administers prescription drug benefits on behalf of a purchaser]**
37 provides one or more pharmacy benefits management services on
38 behalf of a carrier, health benefits plan, self-insurance plan, and or
39 other third-party payer, and any agent, contractor, intermediary,
40 affiliate, subsidiary, or related entity of a person who facilitates,
41 provides, directs, or oversees the provision of the pharmacy benefits
42 management services.

43 "Pharmacy benefits manager compensation" means the
44 difference between: (1) the amount of payments made by a carrier
45 of a health benefits plan to its pharmacy benefits manager; and (2)
46 the value of payments made by the pharmacy benefits manager to
47 dispensing pharmacists for the provision of prescription drugs or

1 pharmacy services with regard to pharmacy benefits covered by the
2 health benefits plan.

3 “Pharmacy benefits management services” means **the provision**
4 of any of the following services on behalf of a purchaser: the
5 procurement of prescription drugs at a negotiated rate for
6 dispensation within this State; the processing of prescription drug
7 claims; or the administration of payments related to prescription
8 drug claims**];**

9 a. negotiating the price of prescription drugs, including
10 negotiating and contracting for direct or indirect rebates, discounts,
11 or other price concessions;

12 b. managing the aspects of a prescription drug benefit, including
13 but not limited to, the processing and payment of claims for
14 prescription drugs; arranging alternative access to or funding for
15 prescription drugs; the performance of drug utilization review; the
16 processing of drug prior authorization requests; the adjudication of
17 appeals or grievances related to the prescription drug benefit;
18 contracting with network pharmacies; controlling the cost of
19 covered prescription drugs; managing or providing data relating to
20 the prescription drug benefit; or the provision of services related
21 thereto;

22 c. performance of any administrative; managerial; clinical;
23 pricing; financial; reimbursement; data administration or reporting;
24 or billing service; and

25 d. other services as the Commissioner of Banking and Insurance
26 may deem necessary.

27 “Pharmacy services administrative organization” means an entity
28 operating within the State that contracts with independent
29 pharmacies to conduct business on their behalf with third-party
30 payers.

31 “Prescription” means a prescription as defined in section 5 of
32 P.L.1977, c.240 (C.24:6E-4).

33 “Prescription drug benefits” means the benefits provided for
34 prescription drugs and pharmacy services for covered services
35 under a health benefits plan contract.

36 **“Purchaser” means any sponsor of a health benefits plan who**
37 **enters into an agreement with a pharmacy benefits management**
38 **company for the provision of pharmacy benefits management**
39 **services to covered persons.**]****

40 (cf: P.L.2023, c.107, s.1)**]²**

41

42 ²**[5. (New section)] 4.**² a. The annual limitation on cost-sharing
43 amounts provided for in section 1302 of the Patient Protection and
44 Affordable Care Act, Pub.L.111-148 (42 U.S.C. s.18022) shall
45 apply to all health care services covered under any health benefits
46 plan offered or issued by a carrier in this State, including a health
47 benefits plan administered by a pharmacy benefits manager.

1 ²Nothing in this subsection shall be construed to limit or supersede the
2 authority of the Department of Banking and Insurance to impose
3 additional cost sharing limits consistent with State law and regulations,
4 including minimum standards established pursuant to N.J.A.C.11:22-
5 5.1 et seq.²

6 b. When calculating a covered person's contribution to any
7 applicable cost-sharing amount requirement, a pharmacy benefits
8 manager shall give credit for the amount, or any portion thereof, of
9 any cost-sharing amount paid by the covered person or on behalf of
10 the covered person by another party. If a health benefits plan
11 qualifies as a high-deductible health plan for which medical
12 expenses are paid using a health savings account established
13 pursuant to section 223 of the federal Internal Revenue Code of
14 1986 (26 U.S.C. s.223), this subsection shall apply to a high-
15 deductible health plan with respect to the deductible after the
16 covered person has satisfied the minimum deductible required under
17 section 223, except for with respect to items or services that are
18 preventive care pursuant to section 223(c)(2)(C) of the federal
19 Internal Revenue Code (26 U.S.C. s.223), in which case the
20 requirements of this subsection shall apply regardless of whether
21 the minimum deductible under section 223 has been satisfied.

22 c. A pharmacy benefits manager shall not directly or indirectly
23 set, alter, implement, or condition the terms of health benefits plan
24 coverage, including the benefit design, based in part or entirely on
25 information about the availability or amount of financial or product
26 assistance available for a prescription drug.

27 d. By ²~~December~~ March² 31 of each year, each pharmacy
28 benefits manager authorized to conduct business in the State shall
29 certify to the Commissioner of Banking and Insurance, in a form
30 and manner as determined by the commissioner, that it has fully and
31 completely complied with the requirements of this section
32 throughout the prior calendar year. The certification shall be signed
33 by the chief executive officer, chief financial officer, or designee, of
34 the pharmacy benefits manager.

35 e. ²~~In~~ implementing the requirements of this section, the State
36 shall only regulate a pharmacy benefits manager to the extent
37 permissible under applicable law.

38 f.² The Commissioner of Banking and Insurance, pursuant to
39 the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
40 et seq.), shall adopt rules and regulations to effectuate the purposes
41 of this section.

42 ²f. As used in this section:

43 "Cost-sharing amount" means any copayment, coinsurance,
44 deductible, or other similar charges required of a covered person for a
45 health care service covered by a health benefits plan, including a
46 prescription drug benefits plan, and paid by or on behalf of the covered
47 person.

1 “Health benefits plan” means a benefits plan which pays hospital
2 or medical expense benefits for covered services, or prescription drug
3 benefits for covered services, and is delivered or issued for delivery in
4 this State by or through a carrier or any other sponsor. For the
5 purposes of P.L.2015, c.179 (C.17B:27F-1 et seq.), “health benefits
6 plan” shall not include the following plans, policies or contracts:
7 accident only; credit disability; long-term care; Medicare supplement
8 coverage; TRICARE supplement coverage; coverage for Medicare
9 services pursuant to a contract with the United States government; the
10 State Medicaid program established pursuant to P.L.1968, c.413
11 (C.30:4D-1 et seq.); coverage arising out of a worker's compensation
12 or similar law; the State Health Benefits Program; the School
13 Employees' Health Benefits Program; or a self-insured health benefits
14 plan governed by the provisions of the federal “Employee Retirement
15 Income Security Act of 1974,” 29 U.S.C. s.1001 et seq.; coverage
16 under a policy of private passenger automobile insurance issued
17 pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.); or hospital
18 confinement indemnity coverage.

19 “Health care service” means an item or service furnished to any
20 individual for the purpose of preventing, alleviating, curing, or healing
21 human illness, injury, or disability.

22 “Pharmacy benefits manager” means a corporation, business, or
23 other entity, or unit within a corporation, business, or other entity, that,
24 pursuant to a contract or under an employment relationship with a
25 carrier, health benefits plan, a self-insurance plan or other third-party
26 payer, either directly or through an intermediary provides one or more
27 pharmacy benefits management services on behalf of a carrier, health
28 benefits plan, self-insurance plan, and or other third-party payer, and
29 any agent, contractor, intermediary, affiliate, subsidiary, or related
30 entity of a person who facilitates, provides, directs, or oversees the
31 provision of the pharmacy benefits management services.

32 “Pharmacy benefits management services” means:

33 a. negotiating the price of prescription drugs, including
34 negotiating and contracting for direct or indirect rebates, discounts, or
35 other price concessions;

36 b. managing the aspects of a prescription drug benefit, including,
37 but not limited to, the processing and payment of claims for
38 prescription drugs; arranging alternative access to or funding for
39 prescription drugs; the performance of drug utilization review; the
40 processing of drug prior authorization requests; the adjudication of
41 appeals or grievances related to the prescription drug benefit;
42 contracting with network pharmacies; controlling the cost of covered
43 prescription drugs; managing or providing data relating to the
44 prescription drug benefit; or the provision of services related thereto;

45 c. performance of any administrative; managerial; clinical;
46 pricing; financial; reimbursement; data administration or reporting; or
47 billing service; and

1 d. other services as the Commissioner of Banking and Insurance
2 may deem necessary.²
3
4 ²【6.】 5.² This bill shall take effect ²【on January 1, 2025】 on the
5 90th day next following the date of enactment and shall apply to plans,
6 policies, and contracts that are delivered, issued, executed or renewed
7 on or after that date².