[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)

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

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

1. [2]**[**(New section)**]**[2] This act shall be known and may be cited as the "Ensuring Fairness in Cost-Sharing Amounts Act of [2]**[**2024**]** 2025[2]."

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

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

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

"Enrollee" means any individual entitled to coverage of health care services from a carrier.

"Health benefits plan" means a policy, contract, certification, or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. [1]For the purposes of P.L. , c. (C.) (pending before the Legislature as this bill), "health benefits plans" shall not include the following plans, policies, or contracts: accident only; credit disability; long-term care; Medicare supplemental coverage; TRICARE supplement coverage; coverage for Medicare services pursuant to a contract with the United States government; the State Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.); coverage arising out of a worker's compensation or similar law; the State Health Benefits Program; the School Employees' Health Benefits Program; or a self-insured health benefits plan governed by the provisions of the federal "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:
[1]Senate SBA committee amendments adopted June 9, 2025.
[2]Senate floor amendments adopted June 30, 2025.

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

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

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

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

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

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

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

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

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

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

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

"Average wholesale price" means the average wholesale price of a prescription drug determined by a national drug pricing publisher selected by a carrier. The average wholesale price shall be identified using the national drug code published by the National Drug Code Directory within the United States Food and Drug Administration.

"Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State.

"Contracted pharmacy" means a pharmacy that participates in the network of a pharmacy benefits manager through a contract with:

a. the pharmacy benefits manager directly;

b. a pharmacy services administration organization; or

c. a pharmacy group purchasing organization.

"Cost-sharing amount" means **[**the amount paid by a covered person as required under the covered person's health benefits plan for a prescription drug at the point of sale**]** <u>any copayment, coinsurance, deductible, or other similar charges required of a covered person for a health care service covered by a health benefits plan, including a prescription drug benefits plan, and paid by or on behalf of the covered person</u>.

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

"Department" means the Department of Banking and Insurance.

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

"Health benefits plan" means a benefits plan which pays hospital or medical expense benefits for covered services, or prescription

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

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

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

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

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

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

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

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

"Pharmacy benefits management services" means **[**the provision of any of the following services on behalf of a purchaser: the procurement of prescription drugs at a negotiated rate for dispensation within this State; the processing of prescription drug claims; or the administration of payments related to prescription drug claims**]**:

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

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

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

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

"Pharmacy services administrative organization" means an entity operating within the State that contracts with independent pharmacies to conduct business on their behalf with third-party payers.

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

"Prescription drug benefits" means the benefits provided for prescription drugs and pharmacy services for covered services under a health benefits plan contract.

["Purchaser" means any sponsor of a health benefits plan who enters into an agreement with a pharmacy benefits management company for the provision of pharmacy benefits management services to covered persons.**]**

(cf: P.L.2023, c.107, s.1)**]**[2]

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

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

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

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

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

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

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

[2]f. As used in this section:

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

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

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

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

"Pharmacy benefits management services" means:

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

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

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

d. other services as the Commissioner of Banking and Insurance may deem necessary.[2]

[2]⟦6.⟧ 5.[2] This bill shall take effect [2]⟦on January 1, 2025⟧ on the 90th day next following the date of enactment and shall apply to plans, policies, and contracts that are delivered, issued, executed or renewed on or after that date[2].