

§1
C.26:2S-3.1
and Note to §4
§§2,3
C.26:2S-3.2
and 26:2S-3.3
§4
C.17B:27F-6.1
§5
Note

P.L. 2025, CHAPTER 199, *approved January 9, 2026*
Assembly, No. 5217 (*Second Reprint*)

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.

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

4 ¹For the purposes of P.L. , c. (C.) (pending before the
5 Legislature as this bill), “health benefits plans” shall not include the
6 following plans, policies, or contracts: accident only; credit
7 disability; long-term care; Medicare supplemental coverage;
8 TRICARE supplement coverage; coverage for Medicare services
9 pursuant to a contract with the United States government; the State
10 Medicaid program established pursuant to P.L.1968, c.413
11 (C.30:4D-1 et seq.); coverage arising out of a worker’s
12 compensation or similar law; the State Health Benefits Program; the
13 School Employees’ Health Benefits Program; or a self-insured
14 health benefits plan governed by the provisions of the federal
15 “Employee Retirement Income Security Act of 1974,” 29 U.S.C.
16 s.1001 et seq.; coverage under a policy of private passenger
17 automobile insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1
18 et seq.), or hospital confinement indemnity coverage.¹

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

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

24
25 3. ²[(New section)]² a. The annual limitation on cost-sharing
26 amounts provided for in section 1302 of the Patient Protection and
27 Affordable Care Act, Pub.L.111-148 (42 U.S.C. s.18022) shall
28 apply to all health care services covered under any health benefits
29 plan offered or issued by a carrier in this State. ²Nothing in this
30 subsection shall be construed to limit or supersede the authority of the
31 Department of Banking and Insurance to impose additional cost
32 sharing limits consistent with State law and regulations, including
33 minimum standards established pursuant to N.J.A.C.11:22-5.1 et seq.²

34 b. When calculating an enrollee’s contribution to any
35 applicable cost-sharing amount requirement, a carrier or third-party
36 administrator shall give credit for the amount, or any portion
37 thereof, of any cost-sharing amount paid by the enrollee or on
38 behalf of the enrollee by another party. If a health benefits plan
39 qualifies as a high-deductible health plan for which medical
40 expenses are paid using a health savings account established
41 pursuant to section 223 of the federal Internal Revenue Code of
42 1986 (26 U.S.C. s.223), this subsection shall apply to a high-
43 deductible health plan with respect to the deductible after the
44 enrollee has satisfied the minimum deductible required under
45 section 223, except for with respect to items or services that are
46 preventive care pursuant to section 223(c)(2)(C) of the federal
47 Internal Revenue Code (26 U.S.C. s.223), in which case the

1 requirements of this subsection shall apply regardless of whether
2 the minimum deductible under section 223 has been satisfied.

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

8 d. By ²~~December~~ March² 31 of each year, each carrier and
9 third party administrator authorized to conduct business in the State
10 shall certify to the Commissioner of Banking and Insurance, in a
11 form and manner as determined by the commissioner, that it has
12 fully and completely complied with the requirements of this section
13 throughout the prior calendar year. The certification shall be signed
14 by the chief executive officer, chief financial officer, or designee, of
15 the carrier or third party administrator.

16 e. ²~~In~~ implementing the requirements of this section, the State
17 shall only regulate a carrier to the extent permissible under
18 applicable law.

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

23

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

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

31 “Average wholesale price” means the average wholesale price of
32 a prescription drug determined by a national drug pricing publisher
33 selected by a carrier. The average wholesale price shall be
34 identified using the national drug code published by the National
35 Drug Code Directory within the United States Food and Drug
36 Administration.

37 “Brand-name drug” means a prescription drug marketed under a
38 proprietary name or registered trademark name, including a
39 biological product.

40 “Carrier” means an insurance company, health service
41 corporation, hospital service corporation, medical service
42 corporation, or health maintenance organization authorized to issue
43 health benefits plans in this State.

44 “Contracted pharmacy” means a pharmacy that participates in
45 the network of a pharmacy benefits manager through a contract
46 with:

- 47 a. the pharmacy benefits manager directly;
48 b. a pharmacy services administration organization; or

1 c. a pharmacy group purchasing organization.

2 “Cost-sharing amount” means [the amount paid by a covered
3 person as required under the covered person's health benefits plan
4 for a prescription drug at the point of sale] any copayment,
5 coinsurance, deductible, or other similar charges required of a
6 covered person for a health care service covered by a health benefits
7 plan, including a prescription drug benefits plan, and paid by or on
8 behalf of the covered person.

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

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

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

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

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

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

38 “Network pharmacy” means a licensed retail pharmacy or other
39 pharmacy provider that contracts with a pharmacy benefits manager
40 either directly or by and through a contract with a pharmacy
41 services administrative organization.

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

46 “Pharmacy benefits manager” means a corporation, business, or
47 other entity, or unit within a corporation, business, or other entity,
48 that, pursuant to a contract or under an employment relationship

1 with a carrier, health benefits plan, a self-insurance plan or other
2 third-party payer, either directly or through an intermediary,
3 **【administers prescription drug benefits on behalf of a purchaser】**
4 provides one or more pharmacy benefits management services on
5 behalf of a carrier, health benefits plan, self-insurance plan, and or
6 other third-party payer, and any agent, contractor, intermediary,
7 affiliate, subsidiary, or related entity of a person who facilitates,
8 provides, directs, or oversees the provision of the pharmacy benefits
9 management services.

10 “Pharmacy benefits manager compensation” means the
11 difference between: (1) the amount of payments made by a carrier
12 of a health benefits plan to its pharmacy benefits manager; and (2)
13 the value of payments made by the pharmacy benefits manager to
14 dispensing pharmacists for the provision of prescription drugs or
15 pharmacy services with regard to pharmacy benefits covered by the
16 health benefits plan.

17 “Pharmacy benefits management services” means **【the provision**
18 **of any of the following services on behalf of a purchaser: the**
19 **procurement of prescription drugs at a negotiated rate for**
20 **dispensation within this State; the processing of prescription drug**
21 **claims; or the administration of payments related to prescription**
22 **drug claims】:**

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

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

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

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

41 “Pharmacy services administrative organization” means an entity
42 operating within the State that contracts with independent
43 pharmacies to conduct business on their behalf with third-party
44 payers.

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

1 “Prescription drug benefits” means the benefits provided for
2 prescription drugs and pharmacy services for covered services
3 under a health benefits plan contract.

4 【“Purchaser” means any sponsor of a health benefits plan who
5 enters into an agreement with a pharmacy benefits management
6 company for the provision of pharmacy benefits management
7 services to covered persons.】

8 (cf: P.L.2023, c.107, s.1)】²

9
10 ²【5. (New section)】 4.² 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, including a health
15 benefits plan administered by a pharmacy benefits manager.

16 ²Nothing in this subsection shall be construed to limit or supersede the
17 authority of the Department of Banking and Insurance to impose
18 additional cost sharing limits consistent with State law and regulations,
19 including minimum standards established pursuant to N.J.A.C.11:22-
20 5.1 et seq.²

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

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

42 d. By ²【December】 March² 31 of each year, each pharmacy
43 benefits manager authorized to conduct business in the State shall
44 certify to the Commissioner of Banking and Insurance, in a form
45 and manner as determined by the commissioner, that it has fully and
46 completely complied with the requirements of this section
47 throughout the prior calendar year. The certification shall be signed

1 by the chief executive officer, chief financial officer, or designee, of
2 the pharmacy benefits manager.

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

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

10 ²f. As used in this section:

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

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

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

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

47 “Pharmacy benefits management services” means:

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

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

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

16 d. other services as the Commissioner of Banking and Insurance
17 may deem necessary.²

18
19 ²**[6.] 5.**² This bill shall take effect ²**[on January 1, 2025]** on the
20 90th day next following the date of enactment and shall apply to plans,
21 policies, and contracts that are delivered, issued, executed or renewed
22 on or after that date².

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