

SENATE, No. 4779

STATE OF NEW JERSEY
222nd LEGISLATURE

INTRODUCED OCTOBER 5, 2026

Sponsored by:
Senator BRIAN P. STACK
District 33 (Hudson)

SYNOPSIS

Requires health claims utilization data to be shared with public entity plan sponsors.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning public entity health claims utilization data and
2 supplementing various parts of the statutory law.

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. This act shall be known and may be cited as the “Data
8 Ownership Now Enforced Act” or the “DONE Act.”

9
10 2. The Legislature finds and declares that:

11 a. Public entities in New Jersey, including municipalities,
12 school districts, counties, and their joint insurance funds and health
13 insurance funds, face double-digit percentage increases in health
14 benefits costs. The Legislature finds that an emergency exists in the
15 public health benefits market requiring immediate legislative action.

16 b. The fundamental cause of uncontested, above-market
17 renewals is data asymmetry: incumbent carriers, third-party
18 administrators, fund administrators, and the State Division of
19 Pensions and Benefits hold claims utilization data that is necessary
20 for competing entities to develop credible alternative proposals, and
21 they routinely fail to provide that data proactively, timely, or at no
22 cost. Public entities have a compelling interest in accessing this
23 data, generated by public expenditures on their behalf, and this act
24 establishes and enforces that right of access.

25 c. The State Health Benefits Program and School Employees'
26 Health Benefits Program, administered by the Division of Pensions
27 and Benefits within the Department of the Treasury, collectively
28 cover hundreds of thousands of New Jersey public employees and
29 represent the single largest segment of the public health benefits
30 market. The division currently provides claims data to participating
31 public entities occasionally, only upon specific request, and charges
32 a fee of up to \$2,000 for detailed claims data reports. This practice
33 insulates the State programs from competitive market forces and
34 imposes a cost barrier on the public entities the programs are
35 intended to serve. The Legislature finds this practice to be contrary
36 to the public interest.

37 d. The proactive, automatic, cost-free dissemination of claims
38 data to every public entity plan sponsor, without requiring a formal
39 request, is the only mechanism that can realistically allow the
40 January 1, 2027 renewal cycle to be competitive. Requiring a
41 request-based system imposes administrative friction that
42 advantages incumbents and disadvantages public entities,
43 particularly smaller ones without dedicated benefits staff.

44 e. In September 2025, the New Jersey Office of the State
45 Comptroller issued a report entitled “Local Government and School
46 Board Health Insurance Funds: A Report on Conflicts of Interest
47 and Procurement Violations,” documenting systemic conflicts of
48 interest, procurement violations, and governance failures within the

1 health insurance fund structure serving hundreds of New Jersey
2 local governments and school boards. The comptroller found that
3 the absence of independent oversight and transparent data had
4 created conditions in which public contracts were awarded without
5 genuine competitive process, and called upon the Legislature to
6 strengthen oversight of joint insurance funds. The Legislature finds
7 that mandatory proactive claims data disclosure is a necessary and
8 foundational component of the reforms the comptroller has
9 recommended.

10 f. New Jersey's public health benefits market operates through
11 multiple distinct structures, including commercial carriers, third
12 party administrators, municipal health insurance funds, school
13 district health insurance funds, the State Health Benefits Program,
14 and the School Employees Health Benefits Program, all of which
15 must be subject to uniform proactive disclosure obligations for this
16 act to be effective.

17 g. This act is intended to operate immediately upon enactment,
18 with a 30-day universal dissemination deadline applying to all data
19 custodians for existing claims data already in their possession, so
20 that public entities have the data they need as soon as possible.

21

22 3. As used in this act:

23 "Authorized representative" means a licensed insurance
24 producer, licensed third-party administrator, enrolled actuary, or
25 other agent holding a professional license in New Jersey or
26 executing a data use agreement with enforceable professional
27 liability exposure, designated in writing by a plan sponsor to
28 receive claims data on its behalf for the purpose of evaluating,
29 soliciting, or obtaining competing health benefits proposals.

30 "Benchmark comparison report" means a de-identified actuarial
31 report produced by a data custodian comparing a plan sponsor's
32 utilization patterns, cost per member per month, and claim
33 distribution against an anonymized cohort of similarly-sized and
34 similarly-situated groups in the same geographic rating area,
35 furnished in lieu of individual claim-line data when group size falls
36 below the threshold in section 6 of this act.

37 "Carrier" means any insurance company, hospital service
38 corporation, medical service corporation, health service corporation,
39 or health maintenance organization authorized to issue health
40 benefits plans in New Jersey.

41 "Claims data package" means the structured data set required to
42 be disclosed under sections 4 and 5 of this act.

43 "CPT code" means a Current Procedural Terminology code
44 published by the American Medical Association, or any successor
45 coding system, used to identify medical, surgical, diagnostic, and
46 other health care services.

47 "Data custodian" means any carrier, third-party administrator,
48 health insurance fund administrator, joint insurance fund

1 administrator, stop-loss carrier, or the Division of Pensions and
2 Benefits, that holds, processes, or maintains claims data on behalf
3 of a plan sponsor or fund member. For purposes of the State Health
4 Benefits Program and School Employees' Health Benefits Program,
5 the Division of Pensions and Benefits shall be the data custodian.

6 "De-identified data" means health information from which all
7 direct and indirect identifiers have been removed consistent with 45
8 C.F.R. s.164.514(b).

9 "Diagnosis code" means an ICD-10-CM code, or successor
10 standard, used to classify diagnoses and conditions for claims
11 processing purposes.

12 "Division" means the Division of Pensions and Benefits within
13 the New Jersey Department of the Treasury.

14 "Fund administrator" means the executive director,
15 administrator, or third-party management firm engaged to
16 administer operations of a health insurance fund or joint insurance
17 fund on behalf of its fund commissioners.

18 "Health Benefits Data Compliance Designee" or "designee"
19 means the individual designated by a public entity pursuant to
20 Section 8 of this Act.

21 "Health insurance fund" means a joint insurance fund established
22 to provide group health and related employee benefits, formed
23 pursuant to P.L.1983, c.372 (C.40A:10-36 et seq.) for municipal
24 members, or P.L.1983, c.108 (C.18A:18B-1 et seq.) for school
25 district members, and regulated by DOBI under N.J.A.C.11:15-3 or
26 11:15-5 respectively, including any regional employee benefits fund
27 or municipal employee benefit fund operating under those statutes.

28 "Joint insurance fund" means a joint insurance fund established
29 under P.L.1983, c.372 (C.40A:10-36 et seq.) providing property,
30 liability, workers' compensation, or health benefits, or any
31 combination thereof, to local government units. Where a joint
32 insurance fund provides health benefits, it is subject to this act with
33 respect to those health benefits.

34 "Municipal Reinsurance Health Insurance Fund" means a
35 second-tier joint insurance fund whose members are other health
36 insurance funds, formed under P.L.1983, c.372 (C.40A:10-36 et
37 seq.) for the purpose of providing aggregate stop-loss reinsurance to
38 member health insurance funds.

39 "NDC code" means a National Drug Code assigned by the U.S.
40 Food and Drug Administration to identify pharmaceutical products.

41 "Plan sponsor" means a public entity that sponsors, participates
42 in, or maintains a group health benefits plan through any
43 mechanism, including a commercial carrier, third-party
44 administrator, health insurance fund, joint insurance fund, the State
45 Health Benefits Program, or the School Employees' Health Benefits
46 Program.

47 "Public entity" means any municipality, county, school district,
48 regional school district, vocational school district, special district,

1 authority, board, commission, or other unit of local government in
2 this State.

3 "Standard annual claims data package" means the claims data
4 package required under section 5 of this act, including all medical
5 claims data, pharmacy claims data, summary utilization statistics,
6 and plan design and financial summary elements. A standard
7 annual claims data package does not include custom actuarial
8 modeling, predictive analytics, population health projections, or
9 other analytical products beyond the data elements specified in
10 section 5 of this act. The Division of Pensions and Benefits may not
11 reclassify any element required under section 5 as a special
12 analytical report for purposes of imposing a fee.

13 "Stop-loss carrier" means an insurance company providing
14 specific or aggregate excess loss coverage to a self-funded plan,
15 health insurance fund, or joint insurance fund, which in doing so
16 receives and holds individual or aggregate claims data.

17 "Third-party administrator" means any entity licensed under
18 N.J.S.A. 17B:27B-1 et seq. or otherwise engaged to process health
19 benefits claims on behalf of a self-funded plan, health insurance
20 fund, or joint insurance fund.

21

22 4. a. Within 30 days of the effective date of this act, every data
23 custodian shall proactively transmit, without any request,
24 application, or fee, a complete claims data package to every plan
25 sponsor for which it holds claims data, covering the most recently
26 completed plan or fund year and, if available, the two preceding
27 years. This obligation shall apply to data already in the data
28 custodian's possession. A data custodian may not claim that
29 additional time is needed to compile, prepare, or format data that it
30 already maintains in its ordinary course of business.

31 b. Notwithstanding any other provision of law, including any
32 fee schedule or administrative rule of the Division of Pensions and
33 Benefits, the division shall, within 30 days of the effective date of
34 this act:

35 (1) transmit a claims data package as specified in section 5 of
36 this act, covering the most recently completed plan year and, if
37 available, the two preceding years, to a public entity currently
38 participating in the State Health Benefits Program or the School
39 Employees' Health Benefits Program at no charge to the public
40 entity;

41 (2) establish a dedicated data disclosure function within the
42 division that is staffed to respond to public entity data requests
43 within 15 business days;

44 (3) post on the division's public website a plain-language notice
45 to all participating public entities describing their rights under this
46 act, including their right to receive data at no cost and to designate
47 an authorized representative to receive data on their behalf; and

1 (4) provide the claims data in the standardized machine-readable
2 format specified by the Commissioner of Banking and Insurance
3 under subsection d. of section 5 of this act or, if that format
4 specification has not yet been promulgated, in a comma separated
5 value (CSV), Excel, or structured spreadsheet format with field
6 definitions sufficient for actuarial use.

7 c. The Division of Pensions and Benefits shall not charge any
8 fee to a participating public entity for the standard annual claims
9 data package required under this act. The division may charge a
10 reasonable cost-recovery fee, not to exceed \$500, for special
11 analytical reports or custom data extracts requested beyond the
12 standard annual claims data package as defined in section 3 of this
13 act. Any existing fee schedule, rule, or practice charging any
14 amount for standard claims data disclosure to a participating public
15 entity shall be superseded and void.

16 d. Following the initial 30-day proactive dissemination, every
17 data custodian shall furnish a complete claims data package to
18 every plan sponsor within 30 days of the close of each plan or fund
19 year, without request and without charge.

20 e. A plan sponsor or its authorized representative may at any
21 time request a claims data package from any data custodian. The
22 data custodian shall furnish the requested data within 15 business
23 days of receipt of a written request. No fee shall be charged for
24 standard claims data packages.

25 f. When a plan sponsor or its authorized representative
26 provides written notice that a competitive procurement is actively
27 underway, the data custodian shall furnish any requested
28 supplemental data within 10 business days.

29 g. A plan sponsor may direct any data custodian to transmit its
30 claims data package directly to a designated authorized
31 representative. The data custodian shall transmit the package
32 within five business days and shall continue to transmit to the
33 authorized representative on all future disseminations until revoked
34 in writing.

35 h. When a public entity participates in a health insurance fund
36 or joint insurance fund as a member, the fund administrator is the
37 data custodian and shall proactively transmit to each member entity
38 a claims data package specific to that member's covered lives on the
39 same 30-day schedule. A member entity's right to its own
40 population's data is independent of any aggregate fund-level
41 reporting.

42 i. A municipal reinsurance health insurance fund shall furnish
43 to each member health insurance fund, within 30 days of this act's
44 effective date and annually thereafter, aggregate claims data for that
45 member health insurance fund's covered population held in
46 connection with the municipal reinsurance health insurance fund's
47 stop-loss reinsurance function.

1 j. A stop-loss carrier shall furnish to the plan sponsor or fund
2 administrator, within 30 days of this act's effective date and within
3 15 business days of any subsequent request, all individual large-
4 claim data and aggregated claims data it holds in connection with
5 stop-loss claims administration.

6 k. No data custodian shall refuse, delay, charge a fee for, or
7 otherwise restrict the disclosure of claims data required under this
8 act. Any contract provision, fund by-law, administrative rule, or fee
9 schedule having the effect of delaying or charging for required
10 disclosure is void and unenforceable against public policy. This
11 prohibition applies with equal force to the Division of Pensions and
12 Benefits.

13

14 5. a. Subject to the size thresholds in section 6 of this act, the
15 claims data package shall include:

16 (1) medical claims data. For each medical claim processed
17 during the covered period:

18 (a) CPT code identifying the procedure or service rendered;

19 (b) ICD-10-CM diagnosis code, up to the number of diagnosis
20 fields submitted;

21 (c) date of service, reported as month and year only;

22 (d) place of service code (inpatient, out-patient facility,
23 professional office, urgent care, emergency department, telehealth,
24 or other);

25 (e) provider specialty code as classified by the data custodian's
26 network management system;

27 (f) billed charges;

28 (g) allowed amount (contractual or reasonable and customary
29 allowance);

30 (h) plan-paid amount;

31 (i) member cost-sharing amount, as deductible, copay, and
32 coinsurance combined;

33 (j) claim status and denial reason code where applicable;

34 (k) network status of rendering provider (in-network or out-of-
35 network);

36 (l) de-identified member identifier, which shall be a consistent
37 anonymized code permitting longitudinal claim linkage without
38 revealing identity;

39 (m) member relationship code (subscriber or dependent); and

40 (n) member age band, classified using five-year age bands and
41 biological sex;

42 (2) pharmacy claims data. For each pharmacy claim processed
43 during the covered period:

44 (a) NDC code identifying the pharmaceutical product dispensed;

45 (b) generic or brand indicator;

46 (c) drug class under the formulary tier structure;

47 (d) quantity dispensed and days' supply;

48 (e) ingredient cost, dispensing fee, and plan-paid amount;

1 (f) member cost-sharing amount;
2 (g) point-of-sale rebate applied, if any, as a dollar amount;
3 (h) de-identified member identifier consistent with subparagraph
4 (l) of paragraph (1). of this subsection; and
5 (i) member age band and biological sex; and
6 (3) mental health and substance use disorder claims included
7 within medical claims data using applicable CPT and ICD-10-CM
8 codes and de-identified to a stricter standard consistent with 42
9 C.F.R. Part 2 where applicable. Any data cell that would have a
10 reasonable probability of permitting re-identification shall be
11 suppressed.

12 b. The claims data package pursuant to subsection a. of this
13 section shall include:

14 (1) total covered member months and enrollment by tier at
15 beginning and end of the period;
16 (2) total plan-paid claims by claim type (inpatient, out-patient,
17 professional, emergency, pharmacy);
18 (3) high-cost claimant concentration report: number of claimants
19 with aggregate plan-paid claims exceeding \$50,000, \$100,000, and
20 \$250,000, without identifying those claimants;
21 (4) top 25 CPT codes by total plan-paid amount;
22 (5) top 25 ICD-10-CM diagnosis codes by frequency;
23 (6) top 25 pharmaceutical products by total plan-paid amount,
24 identified by NDC code and generic name; and
25 (7) network utilization rate.

26 c. The claims data package pursuant to subsection a. of this
27 section shall also include:

28 (1) summary of plan designs in effect, including deductible, out-
29 of-pocket maximum, copay, and coinsurance structure;
30 (2) total premium, assessment, or contribution paid (employer
31 and employee combined);
32 (3) medical loss ratio or loss ratio, as applicable;
33 (4) claims incurred but not reported reserve estimate as of the
34 close of the period;
35 (5) for health insurance funds and joint insurance funds: total
36 fund surplus or deficit; stop-loss attachment points (specific and
37 aggregate); and name and license number of any stop-loss carrier;
38 and
39 (6) for the State Health Benefits Program and the School
40 Employees' Health Benefits Program, the division shall provide
41 per-entity cost-per-member-per-month data, employer contribution
42 rate, and aggregate loss ratio for the participating entity's covered
43 population, in addition to all other required data elements;

44 d. The Commissioner of Banking and Insurance shall
45 promulgate emergency data format regulations within 30 days of
46 the effective date of this act pursuant to subsection (f) of section 4
47 of P.L.1968, c.410 (C.52:14B-4), establishing a structured machine-
48 readable format in Java Script Object Notation or CSV, a

1 standardized field schema and data dictionary, and secure
2 transmission standards. Pending promulgation, data custodians shall
3 furnish data in CSV or Excel format with field labels sufficient for
4 actuarial use. The Division of Pensions and Benefits shall
5 coordinate with the commissioner to implement compatible format
6 standards within the same timeframe.

7
8 6. a. The following size-based disclosure tiers shall apply:

9 (1) Tier 1: 100 or more covered lives. Full claims data package
10 as specified in Section 5, including claim-level de-identified data.

11 (2) Tier 2: 50 to 99 covered lives. Full claims data package with
12 enhanced cell-suppression: any cell representing fewer than 11
13 individuals shall be suppressed. The data custodian shall include a
14 written attestation that cell-suppression was applied.

15 (3) Tier 3: fewer than 50 covered lives. Individual claim-line
16 data shall not be required. In lieu thereof, the data custodian shall
17 furnish:

18 (a) full summary utilization statistics and financial summary
19 under subsections b. and c. of section 5 of this act;

20 (b) a benchmark comparison report comparing the group's cost
21 per member per month, utilization rates by major service category,
22 and top condition categories against an anonymized cohort of
23 similarly-sized groups in the same geographic rating area,
24 consisting of no fewer than 500 covered lives;

25 (c) aggregate pharmacy utilization data including total claims
26 count, total plan-paid pharmacy costs, and generic dispensing rate;

27 (d) a narrative summary prepared by the data custodian's actuary
28 or medical director describing major cost drivers and utilization
29 trends observable at the aggregate level without identifying
30 individuals; and

31 (e) an attestation from a credentialed actuary (FCAS, MAAA, or
32 FSA) that the benchmark report was produced consistent with
33 Commissioner standards and that no individual claimant can be
34 identified from the disclosed data.

35 b. If a data custodian cannot produce a compliant benchmark
36 comparison report from its own book of business because it does
37 not maintain a cohort of 500 or more similarly-sized covered lives
38 in the same geographic rating area, it shall: notify the plan sponsor
39 and the Commissioner in writing within 10 days of the
40 dissemination deadline; contract with a qualified third-party data
41 aggregator to produce a compliant benchmark report; and furnish
42 the completed benchmark report within 60 days of the
43 dissemination deadline. This 60-day extension applies only to the
44 benchmark comparison report and does not extend the deadline for
45 any other element of the claims data package.

46 c. A plan sponsor covering fewer than 50 lives in any single
47 year but whose three-year aggregate covered life count equals or
48 exceeds 150 life-years may request claim-level de-identified data

1 pooled across those three years under Tier 2 cell-suppression
2 methodology. The data custodian shall furnish pooled data within
3 15 business days.

4 d. For public entities participating in the State Health Benefits
5 Program or the School Employees' Health Benefits Program with
6 fewer than 50 covered lives, the division shall furnish the full Tier 3
7 package pursuant to paragraph (3) of subsection a. of this section,
8 including a benchmark comparison against similarly-sized State
9 Health Benefits Program or School Employees' Health Benefits
10 Program participating entities, at no cost. The division shall not use
11 small group size as a basis for withholding or reducing data
12 disclosure.

13 e. Nothing in this section shall limit any right of access a plan
14 sponsor independently possesses as a group health plan
15 administrator under 45 C.F.R. s.164.504(f).

16

17 7. a. Claims data furnished pursuant to this act shall be used
18 solely for:

- 19 (1) evaluating incumbent coverage terms and pricing;
20 (2) soliciting and evaluating competing proposals from
21 alternative carriers, third-party administrators, or stop-loss
22 reinsurers;
23 (3) disease management and population health management;
24 (4) plan design analysis;
25 (5) actuarial analysis and consulting; and
26 (6) required government reporting.

27 b. Claims data shall not be sold, licensed, or used for
28 commercial data aggregation or marketing purposes unrelated to the
29 plan sponsor's coverage.

30 c. An authorized representative receiving claims data shall
31 execute a written data use agreement with the plan sponsor prior to
32 receiving data.

33

34 8. a. Each public entity that participates in any group health
35 benefits plan, whether through a commercial carrier, third-party
36 administrator, health insurance fund, joint insurance fund, the State
37 Health Benefits Program or the School Employees' Health Benefits
38 Program, shall designate one existing employee as its health
39 benefits data compliance designee within 30 days of the effective
40 date of this act.

41 b. The designee shall be an existing officer or employee. No
42 new position shall be created and no additional compensation is
43 required solely by virtue of this designation. Appropriate designees
44 include:

- 45 (1) The municipal clerk, business administrator, or chief
46 financial officer for municipalities;
47 (2) The school business administrator or superintendent for
48 school districts;

1 (3) The human resources director or director of employee
2 benefits where such position exists; or

3 (4) The fund administrator for a health insurance fund or joint
4 insurance fund, with respect to that fund's compliance obligations
5 independently of individual member entities.

6 c. The designee shall: serve as named point of contact for all
7 data custodians; respond to covered member privacy inquiries;
8 coordinate with authorized representatives for competitive
9 procurement; ensure data use agreements are executed and
10 maintained; and file the annual attestation required under subsection
11 e. of this section.

12 d. Each public entity shall file the name, title, and contact
13 information of its designee with the Department of Banking and
14 Insurance within 30 days of the effective date of this act, and within
15 15 days of any subsequent change. The department shall maintain a
16 publicly accessible online registry of designees.

17 e. The designee shall execute and file with the department an
18 annual attestation confirming: review of the applicable provisions
19 of this act; receipt of the annual claims data package or filing of a
20 complaint if not received; use of claims data only for permitted
21 purposes; and absence of any known unauthorized disclosure or
22 reporting of any such event as required by law. The attestation
23 form shall be available at no cost on the department's website.

24 f. The designee is a named accountability contact, not a
25 credentialed compliance professional. No fee, license, or course of
26 study is required.

27 g. Designation under this section shall not require the public
28 entity to hire additional personnel, obtain any licensure, or pay any
29 fee to the State.

30

31 9. a. With respect to the 30-day proactive dissemination
32 obligation under subsections a. and b. of section 4 of this act,
33 penalties shall accrue without prior notice or compliance order as
34 follows: \$1,000 per data custodian per day for each day of non-
35 compliance beginning on the 31st day after enactment, up to a
36 maximum of \$100,000 per data custodian per month.

37 b. For violations of the ongoing annual obligation and all other
38 requirements following the initial 30-day period, the commissioner
39 may issue compliance orders and impose penalties not to exceed
40 \$5,000 per day per plan sponsor following a 15-day cure period, or
41 \$25,000 per day for willful non-compliance, and may require
42 reimbursement of documented costs.

43 c. Non-compliance by the division shall be reported by the
44 commissioner to the Governor, the President of the Senate, and the
45 Speaker of the General Assembly within 45 days of the 30-day
46 deadline, together with a remediation plan. In addition, any public
47 entity aggrieved by the division's failure to comply may seek a writ
48 of mandamus in the Superior Court of New Jersey compelling the

1 division to perform its ministerial duty of data disclosure under this
2 act. A court shall give those applications priority and may issue
3 orders on an expedited basis.

4 d. A plan sponsor may bring a civil action in Superior Court for
5 declaratory or injunctive relief, compensatory damages, and
6 attorneys' fees. The court may issue a temporary restraining order
7 compelling disclosure on an expedited basis without bond upon a
8 showing of imminent renewal deadline.

9 e. A plan sponsor may apply for an order of immediate
10 disclosure on an order to show cause returnable within five business
11 days, which shall receive priority calendar treatment.

12 f. Complaints shall be acknowledged within three business
13 days and receive a preliminary determination or investigation
14 within 20 calendar days.

15 g. No data custodian, including the Division of Pensions and
16 Benefits, shall take any adverse action against a plan sponsor for
17 exercising rights under this act or filing a complaint.

18 h. The commissioner's existing examination authority over
19 health insurance funds and joint insurance funds under N.J.A.C.
20 11:15 et seq. is expressly extended to enforce this act against fund
21 administrators and third-party administrators as data custodians.

22 i. To the extent any health insurance fund or joint insurance
23 fund's status as a governmental plan within the meaning of 29
24 U.S.C. s.1002(32) is contested in any proceeding, this act shall
25 apply with full force to the data custodians serving that fund,
26 including any carrier, third-party administrator, or stop-loss carrier,
27 as entities subject to Title 17B of the New Jersey Statutes,
28 independently of the fund's own classification. The Legislature's
29 intent is that no gap in coverage shall result from any ERISA
30 classification dispute.

31
32 10. The Division of Pensions and Benefits shall, without request
33 and without charge, transmit to each public entity participating in
34 the State Health Benefits Program a standard annual claims data
35 package as defined in P.L. , c. (C.) (pending before the
36 Legislature as this bill) within 30 days of the close of each plan year
37 and within 30 days of the effective date of that act for the most
38 recently completed plan year. The division shall not charge any fee
39 for the standard annual claims data package. No administrative
40 rule, fee schedule, or internal policy of the division may be
41 construed to limit, delay, or impose a cost on the disclosure of
42 claims data required by this section. The Director of the Division
43 of Pensions and Benefits shall designate a data disclosure
44 coordinator within the division responsible for timely compliance
45 with this section.

46
47 11. The Division of Pensions and Benefits shall, without request
48 and without charge, transmit to each school district participating in

1 the School Employees' Health Benefits Program a standard annual
2 claims data package as defined in P.L. , c. (C.) (pending
3 before the Legislature as this bill) within 30 days of the close of
4 each plan year and within 30 days of the effective date of that act
5 for the most recently completed plan year. The division shall not
6 charge any fee for the standard annual claims data package. The
7 data disclosure coordinator designated pursuant to section 10 of
8 P.L. , c. (C.) (pending before the Legislature as this bill)
9 shall also be responsible for compliance with this section.

10
11 12. Any existing regulation, fee schedule, administrative
12 directive, or practice of the Division of Pensions and Benefits that
13 charges any amount for standard claims data disclosure to a
14 participating public entity is hereby superseded and of no further
15 force or effect upon enactment of this act.

16
17 13. a. The commissioner shall exercise emergency rulemaking
18 authority pursuant to subsection (f) of section 4 of P.L.1968, c.410
19 (C.52:14B-4) to promulgate temporary regulations implementing
20 this act within 30 days of enactment, to remain in effect for 365
21 days and be replaced by permanent regulations within 12 months.

22 b. Emergency regulations shall address: standardized data
23 format specifications; secure transmission protocols; de-
24 identification certification requirements; benchmark comparison
25 report standards including minimum cohort size, matching
26 methodology, and the benchmark fallback procedure under
27 subsection d. of section 6 of this act; designee registration and
28 attestation forms; complaint procedures; and cell-suppression
29 methodology.

30 c. The Legislature finds that double-digit health benefits cost
31 increases and the imminent January 1, 2027 renewal cycle
32 constitute an emergency of sufficient urgency to justify emergency
33 rulemaking authority.

34
35 14. a. This act shall be construed consistent with HIPAA.
36 Where any disclosure requires additional safeguards, the data
37 custodian shall notify the plan sponsor within five business days
38 and work cooperatively to establish a compliant arrangement,
39 without using the HIPAA process as a basis for delay beyond the
40 30-day dissemination deadline.

41 b. To the extent any provision is preempted by ERISA with
42 respect to self-funded private-sector plans, that provision shall have
43 no force as applied to those plans. All provisions apply in full to
44 public entity plans, which are governmental plans exempt from
45 ERISA under 29 U.S.C. s.1003(b)(1).

46 c. Public entity health benefits plans, including those operated
47 through health insurance funds, joint insurance funds, the State
48 Health Benefits Program, and the School Employees' Health

1 Benefits Program, are governmental plans as defined under 29
2 U.S.C. s.1002(32) and are exempt from ERISA preemption. This
3 act applies with full force to those plans. Where the governmental
4 plan status of any health insurance fund or joint insurance fund is
5 disputed, subsection i. of section 9 applies.

6 d. Nothing in this act diminishes existing rights under
7 P.L.1992, c.160 (C. 17B:27A-1 et al.), P.L.2018, c.32 (C.26:2SS-1
8 et seq.), or P.L.2023, c.296 (C.17B:30-55.1 et seq.).

9 e. This act shall be liberally construed to promote market
10 competition, reduce costs for public purchasers, and ensure plan
11 sponsors possess the information necessary to make informed and
12 timely coverage decisions.

13
14 15. This act shall take effect immediately upon enactment.
15
16

17 STATEMENT

18
19 This bill enacts the “Data Ownership Now Enforced Act,” or
20 “DONE Act.” The bill requires health insurance carriers, third-
21 party administrators, health insurance fund and joint insurance fund
22 administrators, stop-loss carriers, and the Division of Pensions and
23 Benefits to proactively transmit structured, HIPAA-compliant
24 claims utilization data to every public entity plan sponsor within 30
25 days of enactment of the bill, without request and without charge.

26 Public entities (municipalities, school districts, counties, health
27 insurance funds and joint insurance funds) are among the largest
28 purchasers of health benefits in New Jersey and among the least
29 equipped to evaluate the pricing they receive. The claims
30 utilization data necessary for a competing carrier or administrator to
31 develop a credible alternative proposal is held exclusively by the
32 incumbent data custodian. Without that data, competitive
33 procurement is not possible. The result is that renewal increases go
34 unchallenged, not because they are justified, but because the public
35 entity lacks the information to evaluate them. This bill corrects that
36 condition by establishing an affirmative, immediate, and cost-free
37 data disclosure obligation applicable to every data custodian in the
38 public health benefits market.

39 The absence of data transparency also creates the governance
40 conditions documented by the New Jersey Office of the State
41 Comptroller in its September 2025 report, “Local Government and
42 School Board Health Insurance Funds: A Report on Conflicts of
43 Interest and Procurement Violations.” The comptroller found that
44 the absence of independent oversight and transparent data had
45 created conditions in which public contracts were awarded without
46 genuine competitive process, and called upon the Legislature to
47 strengthen oversight of joint insurance funds. This bill implements
48 that recommendation at the foundational level, as no meaningful

1 oversight is possible without the underlying data that allows for
2 evaluation.

3 The current system denies elected officials and administrative
4 teams responsible for public funds the information necessary for
5 them to fulfill their fiduciary responsibilities to taxpayers. Smaller
6 public entities (small school districts, boroughs, and townships
7 without dedicated benefits staff) bear the heaviest burden of data
8 asymmetry, as they lack the leverage to extract data informally.
9 This bill creates a uniform disclosure floor so that every public
10 entity, regardless of size, receives the same proactive data package
11 automatically, enabling officials at every level to make informed
12 decisions about one of their largest budget expenditures.

13 The State Health Benefits Program and School Employees'
14 Health Benefits Program are the largest segment of the public
15 health benefits market in New Jersey. The Division of Pensions and
16 Benefits currently charges participating public entities up to \$2,000
17 for claims data reports and provides data only upon specific request.
18 This bill requires the division to transmit standard annual claims
19 data packages to every participating entity within 30 days of
20 enactment and annually thereafter, at no charge. Any fee schedule
21 charging for standard data disclosure is superseded on the date of
22 enactment. The State is subject to the same disclosure standard this
23 bill imposes on private data custodians.

24 New Jersey's public health benefits market operates through
25 multiple distinct legal structures. Health insurance funds and joint
26 insurance funds are not insurance companies, but statutory entities,
27 meaning standard carrier disclosure obligations do not
28 automatically apply to their administrators. This bill defines fund
29 administrators and third-party administrators as data custodians
30 with the same disclosure obligations as commercial carriers. The
31 Municipal Reinsurance Health Insurance Fund and stop-loss
32 carriers, which hold individual large-claim data not otherwise
33 accessible to plan sponsors, are separately addressed.

34 For public entities with fewer than 50 covered lives, individual
35 claim-line disclosure raises HIPAA re-identification concerns. In
36 lieu of claim-line data, this bill requires data custodians to furnish a
37 benchmark comparison report: an actuarially certified comparison
38 of the group's utilization and cost against an anonymized cohort of
39 similarly-sized groups in the same geographic rating area. A multi-
40 year pooling option allows small groups with three years of
41 coverage history to request Tier 2 claim-level data. A benchmark
42 fallback provision addresses data custodians that lack a sufficient
43 same-geography cohort.

44 The bill requires each public entity to designate an existing
45 employee as its health benefits data compliance designee. This
46 provision requires no new hire, no certification, and no fee. The
47 designee is a named accountability contact who serves as the point

1 of contact for data custodians, coordinates authorized representative
2 access, and files an annual attestation.

3 The bill provides for penalties for failure to meet the initial 30-
4 day dissemination obligation accrue without a cure period at \$1,000
5 per data custodian per day, capped at \$100,000 per month. Ongoing
6 violations carry penalties up to \$5,000 per day, or \$25,000 per day
7 for willful non-compliance. Plan sponsors may seek expedited
8 judicial relief on a five-business-day order to show cause with
9 priority calendar treatment. Non-compliance by the Division of
10 Pensions and Benefits is reported directly to the Governor and
11 Legislature, and public entities may seek a writ of mandamus
12 compelling division compliance.