2026 New Jersey Health Care Affordability Snapshot

The Health Care Value Hub ("the Hub") is proud to launch the 2026 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties a tool to compare their state's health policies across other states. The categories examined in this resource explore a variety of policy options that impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of May 15, 2026. Sources for this information can be found in the downloadable ***Data and Source Document*** **available on the** Dashboard **page. Definitions and descriptions for each policy category can be found in the *Glossary*.**

The Hub offers support dedicated to understanding health care policy and connecting advocates and other interested parties together to help build a patient-centered, high-value health care system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Health Care Spending Benchmark	**Authority to Enforce Health Care Spending Benchmarks**	**Hospital or Primary Care Spending Oversight Entity**	**All-Payer Claims Database**	**Price Transparency Tool**	**Prescription Drug Price Transparency Reporting Requirements**
Ownership Transparency	**Cost Oversight Office or Commission**	**Health Care Financing Taskforce**	**Consolidation Transaction Notification Requirements**	**Authority to Modify or Reject Consolidation Transactions**	**Affordability Criteria Included in Transaction Review**
Restricts All-or-Nothing Contract Provisions	**Restricts Anti-Tiering or Anti-Steering Contract Provisions**	**Restricts Most-Favored Nation Contract Provisions**	**Restricts Price Secrecy and Gag Clause Contract Provisions**		

Key:

- State has passed legislation to implement these policies
- State has passed not legislation to implement these policies

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Health Care Spending Benchmark		State has established a health care spending benchmark for providers, insurance carriers, or both	New Jersey's health care cost growth benchmark is set at 3.2% for 2024, 3% for 2025, and 2.8% for 2026-2027. Total medical expenses are calculated at the state level, by insurance market, by individual insurer, and for large provider entities. The state tracks primary care and prescription drug spending as a percent of total spending but does not set a benchmark.
Authority to Enforce Health Care Spending Benchmark		State has not established an enforcement mechanism for their health care spending benchmark(s)	The benchmark does not have an enforcement mechanism at this time. Bill A5376 and Bill S4299 introduced in 2024-2025 session would have introduced in 2024 would have created commissions/offices and regulations with the power to impose civil penalties for hospitals that failed to respond to or comply with corrective action plans, but they did not pass.
Hospital or Primary Care Spending Oversight Entity		State monitors and reports hospital spending, primary care spending, or both	The New Jersey Department of Health's Division of Health Facilities monitors hospital finances. Additionally, on 1/17/2025, New Jersey's Office Health Care Affordability and Transparency which monitors hospital spending and primary care spending was formally established within the Department of Health.

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
All-Payer Claims Database Established	✖	State does not have a(n) all-payer or multi-payer claims database	
Price Transparency Tool(s)	✖	State does not have a public-facing price transparency tool	
Prescription Drug Price Transparency Reporting Requirement(s)	◉	Organizations are required to report prescription drug price information to a state entity	Drug manufacturers must annually report wholesale acquisition costs (WAC) and specific increases in WAC of drugs, introduction of new drugs exceeding the Medicare Part D specialty threshold, or a biosimilar that is not more than 15 less than the referenced biologic to the Division of Consumer Affairs.

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Ownership Transparency		State requires providers and facilities to report ownership data annually	New Jersey hospitals are required to annually post governance, financial, and operating information included in their Form 990 submitted to the IRS. If the hospital does not file a Form 990 with the IRS, then the hospital must annually report the same information to the state Department of Health. Additional ownership and operational information is required if the hospital is owned or managed by a for-profit entity.
Cost Oversight Office or Commission		State has a cost oversight office or commission	The New Jersey Office of Health Care Affordability and Transparency (OHCAT) works to make high-quality care more affordable and accessible. It partners with state agencies, health care leaders, and consumer advocates to address rising costs and supports people-centered policies. OHCAT oversees the Health Care Affordability, Responsibility, and Transparency Program, which sets cost growth benchmarks and analyzes cost drivers. New Jersey also established a Health Care Affordability Interagency Working Group under Executive Order 217.
Health Care Financing Taskforce		State does not have a health care financing task force	While New Jersey does not have a standalone commission or task force, the state has publicly released estimates quantifying the potential impact of federal policy changes on their state Medicaid program.

Improve Transparency and Market Oversight

Consolidation Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Transaction Notification Required		Requires health systems or providers to notify the state of consolidation transactions.	New Jersey requires the state Attorney General and Commissioner of Health be notified of acquisitions of nonprofit hospitals. Transfers of ownership of general hospitals are also regulated under the Certificate of Need law in the state.
Authority to Modify or Reject Consolidation Transactions		Has authority to approve, set conditions, or disapprove consolidation transactions	The Attorney General (AG) and Commissioner of Health shall review acquisition applications and can support or oppose the proposed acquisition or can extend the time for review, after which the Superior Court must approve the proposed acquisition with advice from the AG. The Certificate of Need process requires approval for transactions.
Affordability Criteria Included in Transaction Review		Does not include consumer affordability or price growth in review criteria, approval conditions, or both	

Improve Transparency and Market Oversight

Anti-Competitive Contract Provisions

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Restricts All-or-Nothing Contract Provisions	✖	No law restricting All-or-Nothing contract provisions	
Restricts Anti-Tiering and Anti-Steering Contract Provisions	✖	No law restricting Anti-Tiering or Anti-Steering contract provisions	
Restricts Most Favored Nation Contract Provisions	●	Law restricts Most Favored Nation contract provisions	New Jersey bans Most Favored Nation clauses in carrier-provider contracts, prohibiting requirements for providers to match or lower rates based on other contracts.
Restricts Price Secrecy and Gag Clause Contract Provisions	✖	State law does not prohibit price secrecy or gag clause restrictions in contracts between health insurance carriers and health care providers	

Glossary

Health Care Spending Benchmarks

Health care spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or “benchmark.” Benchmarks may examine overall spending or spending for specific hospitals or insurers. Of note, as of 2026 there is pending litigation against health care cost growth benchmarks in some states which may affect the status of these policies.

Authority to Enforce Health Care Spending Benchmarks

Some states grant oversight entities the authority to enforce health care spending benchmarks. In these states, if the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital or Primary Care Spending Oversight Entity

Health spending oversight entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital spending, or both.

All-Payer Claims Database

All-payer claims databases (APCDs) compile diverse health care data that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight.

Price Transparency Tool

A website that displays price information on healthcare services, allowing consumers to “shop” for the best price and budget for expected services. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Prescription Drug Price Transparency Reporting Requirement

Prescription Drug Price Transparency Reporting Requirements enforce policies for drug manufacturers, insurers, and pharmacy benefit managers to report detailed information about how prescription drug prices are set and increased over time. They are set to promote accountability, reduce hidden costs, and give insight into rising drug costs.

Ownership Transparency

States, policymakers, and the public frequently have no clear picture of who actually owns and controls the providers delivering care to their residents. Requiring annual ownership reporting addresses this transparency gap. When states have accurate, up-to-date ownership data, they can identify consolidation trends before they become entrenched, enforce antitrust and corporate practice of medicine rules more effectively, and hold entities accountable when ownership changes lead to price increases or quality declines.

Glossary

Cost Oversight Office or Commission
To address health care affordability concerns across state populations, some states have established Cost Oversight Offices or Commissions focused on analyzing drivers of high health care costs, working with stakeholders, and creating recommendations for administrative or regulatory solutions. These groups provide broad cost oversight of entire health care systems within a state, from hospitals to insurance practices.

Health Care Financing Taskforce
In an effort to assess health care spending, some states have launched Health Care Financing Taskforces and other entities to evaluate Medicaid financing mechanisms, evaluate Medicaid spending growth, and reduce duplicative spending and inefficiencies in Medicaid program administration while maintaining access to and quality in health care.

Consolidation Transaction Notification Required
Health care consolidation refers to health care entities (i.e. doctor's offices or hospitals) joining together under a common owner through a merger or acquisition. Some states require health care systems and/or providers to notify the state of consolidation transactions.

Authority to Modify or Reject Consolidation Transactions
During health care consolidation transactions, some states have the authority to approve, modify, or deny the transactions based on their own reviews.

Affordability Criteria Included in Transaction Review
When health care entities consolidate, some states require that affordability criteria like consumer affordability or price growth be considered in approval conditions, review criteria, or both.

Restricts All-or-Nothing Contract Provisions
Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. For example, All-or-Nothing contract provisions are typically applied by health systems to require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.

Restricts Anti-Tiering or Anti-Steering Contract Provisions
These contract provisions require insurers to place certain providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Restricts Most Favored Nation Contract Provisions
In health care, Most-Favored Nation clauses are contract terms in which a health insurance company requires a provider or health system to guarantee that no other health plan will receive the same prices at a lower price. This restriction prevents providers or health systems from offering better pricing to competitors and can lead to higher overall prices when insurers and providers work together to maintain these rates.

Restricts Price Secrecy and Gag Clause Contract Provisions
Gag clauses are contractual provisions that prevent providers and insurers from disclosing prices, including negotiated rates, to patients, employers, or plan sponsors. These provisions can limit price transparency and make it harder for patients, self-funded employers, and policymakers to identify where health care markets are not functioning effectively. Congress passed the Consolidated Appropriations Act of 2020, which prohibits most gag clauses in health insurance contracts.