

MAINE STATE LEGISLATURE

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LAWS
OF THE
STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND THIRTY-SECOND LEGISLATURE

FIRST REGULAR SESSION
December 4, 2024 to March 21, 2025

FIRST SPECIAL SESSION
March 25, 2025 to June 25, 2025

THE GENERAL EFFECTIVE DATE FOR
FIRST REGULAR SESSION
NONEMERGENCY LAWS IS
JUNE 20, 2025

THE GENERAL EFFECTIVE DATE FOR
FIRST SPECIAL SESSION
NONEMERGENCY LAWS IS
SEPTEMBER 24, 2025

PUBLISHED BY THE REVISOR OF STATUTES
IN ACCORDANCE WITH THE MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4.

Augusta, Maine
2025

Sec. B-2. Report. By November 4, 2026, the taxpayer advocate and experience officer within the Department of Administrative and Financial Services, Bureau of Revenue Services shall submit to the joint standing committee of the Legislature having jurisdiction over taxation matters a report consisting of the taxpayer advocate and experience officer's findings and recommendations, including any suggested legislation. The joint standing committee of the Legislature having jurisdiction over taxation matters may report out legislation related to the report to the 133rd Legislature in 2027.

PART C

Sec. C-1. Funding for free volunteer tax assistance. On or before June 30, 2027, the State Controller shall transfer \$50,000 from the unappropriated surplus of the General Fund to the All Other line category in the University of Maine System, New Ventures Maine program, Other Special Revenue Funds account to support a coalition of approximately 50 organizations providing free volunteer tax assistance and other financial education services to low-income individuals and families statewide.

Sec. C-2. Report. No later than December 1, 2027, the Chancellor of the University of Maine System, in maintaining the so-called New Ventures Maine program pursuant to the Maine Revised Statutes, Title 20-A, section 10922, shall submit a report to the joint standing committee of the Legislature having jurisdiction over taxation matters that includes a description of how the coalition receiving the funds transferred pursuant to section 1 of this Part is using those funds, how many individuals and families the coalition has served and how many individuals the coalition assisted in filing their taxes with those funds.

Sec. C-3. Appropriations and allocations. The following appropriations and allocations are made.

UNIVERSITY OF MAINE SYSTEM, BOARD OF TRUSTEES OF THE

New Ventures Maine Z169

Initiative: Allocates one-time funds to support a coalition of approximately 50 organizations providing free volunteer tax assistance and other financial education services to low-income individuals and families statewide.

OTHER SPECIAL REVENUE FUNDS	2025-26	2026-27
All Other	\$0	\$50,000
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$50,000

See title page for effective date.

CHAPTER 487 S.P. 747 - L.D. 1906

An Act to Improve Accountability and Understanding of Data in Insurance Transactions

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §1914 is enacted to read:

§1914. Plan sponsor access to claims data; right to audit

1. High-cost claims data. Upon request of a plan sponsor that has certified its compliance with the use and disclosure requirements of 45 Code of Federal Regulations, Section 164.504(f), an administrator shall provide data on a high-cost claim so that a plan sponsor may perform an audit to ensure compliance with the plan sponsor's contract prior to payment of the high-cost claim. The data must include any itemized billing statements and medical records associated with the claim in the possession of the administrator or the administrator's agents. The plan sponsor or the plan sponsor's designee shall make a request for data on a high-cost claim within 2 business days of receipt of the claim and the administrator must provide the requested information within 30 business days of the request. For the purposes of this subsection, "high-cost claim" means any claim related to an individual provided health coverage by a plan sponsor that exceeds \$100,000.

2. Claims data; right to audit. An administrator that contracts with a plan sponsor to provide health coverage shall permit a plan sponsor to perform a post-payment audit of all claims paid to ensure compliance with the contract at least once in a calendar year as long as the request is not earlier than 6 months following a previously requested audit. Upon request of a plan sponsor as part of an audit, an administrator shall disclose within 30 business days to a plan sponsor that has certified its compliance with the use and disclosure requirements of 45 Code of Federal Regulations, Section 164.504(f) or, to the extent permitted by law and if requested by the plan sponsor, to the plan sponsor's designated business associate the following information specific to the plan sponsor:

A. Claims data received by the administrator via electronic claims transactions on any current standardized claim form approved by the Federal Government for professional services or institutional services. The form or transaction may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191;

B. Claims payments, electronic funds transfers or remittance advice notices provided by the administrator as electronic files compliant with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, including, but not limited to, electronic claims transactions for both the billed amount and the paid amount for professional services and both the billed amount and the paid amount for institutional services. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the federal Health Information Technology for Economic and Clinical Health Act of 2009, Title XIII, Subtitle D, Public Law 111-5, and any regulations promulgated under those laws;

C. Any fees charged to the plan sponsor related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees or enhanced review fees; and

D. Any out-of-network fees or out-of-network negotiated discounts, aligned incentive program fees, pay-for-performance payments and recoveries, cost-containment program fees, overpayment recovery program fees, subrogation fees and any other special program fees and discounts.

3. No conditions or fees on audit. An administrator may not impose on a plan sponsor:

A. Any fees relating to an audit request under this section that exceed the direct expenses properly and actually incurred by the administrator to provide the data; or

B. Any conditions that would restrict a plan sponsor's right to conduct an audit under this section, including, but not limited to, restrictions on:

(1) The time period covered by the audit, except that a request pursuant to this section must be made within 24 months of the end of each plan year to be audited;

(2) The number of claims analyzed;

(3) The type of analysis conducted;

(4) The data elements used in the analysis;

(5) The means by which an auditor is compensated by a plan sponsor; or

(6) The plan sponsor's choice of auditor as long as the plan sponsor certifies that the auditor has adequate conflict of interest protection provisions to prevent conflicts of interest from adversely affecting the outcome of the audit.

4. Nondisclosure and data use agreement. An administrator may require that the plan sponsor and the plan sponsor's designated business associate execute a nondisclosure and data use agreement that reasonably

restricts the auditor's use of data provided by the administrator to the sole purpose of conducting an audit on behalf of a plan sponsor. The coverage limits of any cybersecurity insurance or liability insurance policy required under the nondisclosure and data use agreement may not exceed the administrator's limit of liability under the services agreement between the plan sponsor and the administrator, if such limit applies. In addition, an administrator is not required to provide data to an auditor selected by a plan sponsor if the auditor has previously breached a nondisclosure and data use agreement with that administrator or refuses to execute a nondisclosure and data use agreement.

5. Compliance with federal law. Information provided by an administrator to a plan sponsor in accordance with this section must comply with any applicable requirements of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the federal Health Information Technology for Economic and Clinical Health Act of 2009, Title XIII, Subtitle D, Public Law 111-5, and any regulations promulgated under those laws.

6. Application. An administrator may not enter into, issue, amend or renew any contract or network services agreement with a plan sponsor on or after January 1, 2026 that contains any provision that violates this section.

7. Exclusive enforcement; violation. Notwithstanding section 12-A, a violation of this section is subject to exclusive enforcement under the Maine Unfair Trade Practices Act, including any of the remedies provided for in the Act. A violation is committed each time a prohibited act under this section occurs. Investigations of violations by administrators may include a 3rd party that may possess evidence supporting such investigation.

Sec. 2. 24-A MRSA §4347, sub-§18-A is enacted to read:

18-A. Plan sponsor. "Plan sponsor" has the same meaning as in section 1901, subsection 8, except that "plan sponsor" does not include an employer that offers or provides a health plan that is insured by an insurer authorized to do business in this State.

Sec. 3. 24-A MRSA §4349-A is enacted to read:

§4349-A. Plan sponsor access to claims data; right to audit

1. Prescription drug data. Within 30 business days of a request from a plan sponsor that has certified its compliance with the use and disclosure requirements of 45 Code of Federal Regulations, Section 164.504(f), a pharmacy benefits manager shall provide data to the plan sponsor regarding the actual amounts directly or indirectly paid by the pharmacy benefits manager to a pharmacy or pharmacist on behalf of the plan sponsor

for a prescription drug and any dispensing fee for a prescription drug.

2. Claims data; right to audit. Notwithstanding section 4350-C, a pharmacy benefits manager that contracts with a plan sponsor to provide prescription drug coverage shall permit a plan sponsor to perform a post-payment audit of claims paid to ensure compliance with the contract at least once in a calendar year as long as the request is not earlier than 6 months following a previously requested audit. Upon request of a plan sponsor as part of an audit, a pharmacy benefits manager shall disclose within 30 business days to a plan sponsor who has certified its compliance with the use and disclosure requirements of 45 Code of Federal Regulations, Section 164.504(f), or, to the extent permitted by law and if requested by the plan sponsor, to the plan sponsor's designated business associate the following information specific to the plan sponsor:

A. Rebate amounts, identified by the drug and therapeutic category, secured on prescription drugs provided by a pharmaceutical manufacturer that are generated by claims processed through the plan maintained by the plan sponsor and administered by the pharmacy benefits manager;

B. Prescription drug and device claims received by the pharmacy benefits manager via electronic claims transactions on any current standardized claim form approved by the Federal Government for these services. The form or transaction may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the federal Health Information Technology for Economic and Clinical Health Act of 2009, Title XIII, Subtitle D, Public Law 111-5, and any regulations promulgated under those laws;

C. Prescription drug and device claims payments, electronic funds transfers or remittance advice notices provided by the pharmacy benefits manager as electronic files. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the federal Health Information Technology for Economic and Clinical Health Act of 2009, Title XIII, Subtitle D, Public Law 111-5, and any regulations promulgated under those laws; and

D. Any other revenue and fees derived by the pharmacy benefits manager from the contract, including all direct or indirect remuneration from pharmaceutical manufacturers regardless of whether the remuneration is classified as a rebate, fee or other classification.

3. No conditions or fees on audit. A pharmacy benefits manager may not impose on a plan sponsor:

A. Any fees relating to an audit request under this section that exceed the direct expenses properly and actually incurred by the pharmacy benefits manager to provide the data; or

B. Any conditions that would restrict a plan sponsor's right to conduct an audit under this section, including, but not limited to, restrictions on:

(1) The time period covered by the audit, except that any request pursuant to this section must be made within 24 months of the end of each plan year to be audited;

(2) The number of claims analyzed;

(3) The type of analysis conducted;

(4) The data elements used in the analysis;

(5) The means by which an auditor is compensated by a plan sponsor; or

(6) The plan sponsor's choice of auditor as long as the plan sponsor certifies that the auditor has adequate conflict of interest protection provisions to prevent conflicts of interest from adversely affecting the outcome of the audit.

4. Nondisclosure and data use agreement. A pharmacy benefits manager may require that the plan sponsor and the plan sponsor's designated business associate execute a nondisclosure and data use agreement that reasonably restricts the auditor's use of data provided by the pharmacy benefits manager to the sole purpose of conducting an audit on behalf of a plan sponsor. The coverage limits of any cybersecurity insurance or liability insurance policy required under the nondisclosure and data use agreement may not exceed the pharmacy benefits manager's limit of liability under the services agreement between the plan sponsor and the pharmacy benefits manager, if such limit applies. In addition, a pharmacy benefits manager is not required to provide data to an auditor selected by a plan sponsor if the auditor has previously breached a nondisclosure and data use agreement with that pharmacy benefits manager or refuses to execute a nondisclosure and data use agreement.

5. Compliance with federal law. Information provided by a pharmacy benefits manager to a plan sponsor in accordance with this section must comply with any applicable requirements of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the federal Health Information Technology for Economic and Clinical Health Act of 2009, Title XIII, Subtitle D, Public Law 111-5, and any regulations promulgated under those laws.

6. Application. An administrator or pharmacy benefits manager may not enter into, issue, amend or renew any contract or network services agreement with a plan sponsor on or after January 1, 2026 that contains any provision that violates this section.

7. Exclusive enforcement; violation. Notwithstanding section 12-A, a violation of this section is subject to exclusive enforcement under the Maine Unfair Trade Practices Act, including any of the remedies provided for in the Act. A violation is committed each time a prohibited act under this section occurs. Investigations of violations by pharmacy benefits managers may include a 3rd party that may possess evidence supporting such investigation.

See title page for effective date.

CHAPTER 488
S.P. 755 - L.D. 1937

**An Act to Require Hospitals
and Hospital-affiliated
Providers to Provide Financial
Assistance Programs for
Medical Care**

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1715, as amended by PL 2017, c. 475, Pt. A, §29, is further amended to read:

§1715. Access requirements applicable to certain health care providers

1. Access requirements. Any person, including, but not limited to, an affiliated interest as defined in former section 396-L, that is subject to the requirements of this subsection, shall provide the services listed in paragraph C to individuals who are eligible for charity care in accordance with a charity care policy adopted by the affiliate or provider that is consistent with rules requirements applicable to hospitals under section ~~1716~~ 1716-A and any rules adopted pursuant to section ~~1716-A~~. A person is subject to this subsection if that person:

- A. Is either a direct provider of major ambulatory service, as defined in former section 382, subsection 8-A, or is or has been required to obtain a certificate of need under section 329 or former section 304 or 304-A;
- B. Provides outpatient services as defined in former section 382, subsection 9-A; and
- C. Provides one or more of the following services:
 - (1) Imaging services, including, but not limited to, magnetic resonance imaging, computerized tomography, mammography and radiology. For purposes of this section, imaging services do not include:
 - (a) Screening procedures that are not related to the diagnosis or treatment of a specific condition; or

(b) Services when:

- (i) The services are owned by a community health center, a physician or group of physicians;
 - (ii) The services are offered solely to the patients of that center, physician or group of physicians; and
 - (iii) Referrals for the purpose of performing those services are not accepted from other physicians;
- (2) Laboratory services performed by a hospital or by a medical laboratory licensed ~~in accordance with the Maine Medical Laboratory Commission, by the department~~ or licensed by an equivalent out-of-state licensing authority, excluding those licensed laboratories owned by community health centers, by a physician or by a group of physicians where at which the laboratory services are offered solely to the patients of that center, physician or group of physicians;
- (3) Cardiac diagnostic services, including, but not limited to, cardiac catheterization and angiography but excluding electrocardiograms and electrocardiograph stress testing;
- (4) Lithotripsy services;
- (5) Services provided by free-standing ambulatory surgery facilities certified to participate in the Medicare program; or
- (6) Any other service performed in an outpatient setting requiring the purchase of medical equipment costing in the aggregate \$500,000 or more and for which the charge per unit of service is \$250 or more.

2. Enforcement. The requirements of subsection 1 are enforced through the following mechanisms.

A. Any person who knowingly violates any provision of this section or any valid order or rule made or adopted pursuant to section ~~1716~~ 1716-A, or who willfully fails, neglects or refuses to perform any of the duties imposed under this section, commits a civil violation for which a forfeiture of not less than \$200 and not more than \$500 per patient may be adjudged with respect to each patient denied access unless specific penalties are elsewhere provided. Any forfeiture imposed under this section may not exceed \$5,000 in the case of the first judgment under this section against the provider, \$7,500 in the case of a 2nd judgment against the provider or \$10,000 in the case of the 3rd or subsequent judgment against the provider. The Attorney General is authorized to prosecute the civil violations.