LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND THIRTY-FIRST LEGISLATURE

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TITLE 3, SECTION 163-A, SUBSECTION 4.

Augusta, Maine
2024

CHAPTER 573
H.P. 522 - L.D. 833

An Act to Establish Separate Inauguration and Transition Committees for a Governor-elect and to Limit Donations to Each

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

Sec. 1. 1 MRSA §1051, as amended by PL 2019, c. 564, §1, is further amended by amending the section headnote to read:

§1051. Gubernatorial ~~transition committee~~ inauguration and transition committees

Sec. 2. 1 MRSA §1051, sub-§2, as amended by PL 2019, c. 564, §1, is further amended to read:

2. ~~Transition and inaugural activities~~ Inauguration committee; funding. A person may solicit and accept donations for the purpose of financing costs related to the ~~transition to office and~~ inauguration of a Governor-elect. A person who accepts donations for ~~these purposes must~~ this purpose shall establish a committee and appoint a treasurer who is responsible for keeping records of donations and for filing a financial disclosure statement required by this section. All donations received must be deposited in a separate and segregated account and may not be commingled with any contributions received by any candidate or political committee ~~or~~, any personal or business funds of any person or donations received by a committee established under subsection 2-A. All donations received by the committee established under this subsection must be used for expenses related to the ~~transition to office or~~ inauguration; any surplus funds must be disposed of pursuant to subsection 7. A person may make donations to the committee established under this subsection aggregating no more than the amount that an individual may contribute to a gubernatorial candidate under Title 21-A, section 1015, subsection 1.

Sec. 3. 1 MRSA §1051, sub-§2-A is enacted to read:

2-A. Transition committee; funding. A person may solicit and accept donations for the purpose of financing costs related to the transition to office of a Governor-elect. A person who accepts donations for this purpose shall establish a committee and appoint a treasurer who is responsible for keeping records of donations and for filing a financial disclosure statement required by this section. All donations received must be deposited in a separate and segregated account and may not be commingled with any contributions received by any candidate or political committee, any personal or business funds of any person or donations received by a committee established under subsection 2. All donations received by the committee established under this subsection must be used for expenses related to the transition to office; any surplus funds must be disposed of pursuant to subsection 7. A person may make donations to the committee established under this subsection aggregating no more than the amount that an individual may contribute to a gubernatorial candidate under Title 21-A, section 1015, subsection 1, except that the appropriation from the Governor-elect's Expense Account under Title 2, section 3 may be transferred, in whole or in part, to the committee established under this subsection.

Sec. 4. 1 MRSA §1051, sub-§4, as amended by PL 2019, c. 564, §1, is further amended to read:

4. Limitation on fund-raising activity. A committee established pursuant to this section may accept donations until March 31st of the year following the gubernatorial election. The commission may authorize the acceptance of donations after March 31st of the year following the gubernatorial election if ~~the~~ a committee requests such authorization in order to pay a debt or loan related to the transition to office for a committee established under subsection 2-A or inauguration for a committee established under subsection 2.

See title page for effective date.

CHAPTER 574
H.P. 903 - L.D. 1407

An Act to Amend the Maine Insurance Code Regarding Payments by Health Insurance Carriers to Providers

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

Sec. 1. 24-A MRSA §4303, sub-§9, as amended by PL 2021, c. 311, §1, is further amended to read:

9. Notice of amendments to provider agreements. A carrier offering or renewing a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date and may file such notice of a proposed amendment to a provider agreement only 4 times per calendar year on January 1st, April 1st, July 1st and October 1st, except that, at any time, a carrier may file a notice of a proposed amendment in response to a requirement of the State or Federal Government or due to a change in current procedural terminology codes used by the American Medical Association. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to

procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. If the change is to a reimbursement policy and the estimated aggregate change to participating provider reimbursement as a result of the change is more than $500,000 per year, the notice must include the carrier's good faith estimate of the total annual financial impact of the amendment on the aggregate amount of reimbursement payments made by the carrier to all providers within the State with whom the carrier has a provider agreement. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment. If the notice required by this subsection is provided by electronic communication, the subject line of the electronic communication must indicate that notice of an amendment to a provider agreement or manual, policy or procedure document is included in the communication and the notice of the amendment must be provided as an attachment to the communication, as a separate document. As part of the notice required under this subsection, a carrier shall provide a copy of the revised provider agreement, manual, policy or procedure document without changes being noted and a copy of the revised provider agreement, manual, policy or procedure document with changes being noted by underlining added language and by striking through deleted language.

Sec. 2. 24-A MRSA §4303, sub-§10, as amended by PL 2007, c. 106, §1, is further amended to read:

10. Limits on retrospective denials. ~~A~~ Except as provided in paragraphs C and D, a carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless~~:~~ the carrier has provided the reason for the retrospective denial in writing to the provider and the time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.

~~A. The carrier has provided the reason for the retrospective denial in writing to the provider; and~~

~~B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:~~

~~(1) The claim was submitted fraudulently;~~

~~(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;~~

~~(3) The health care services identified in the claim were not delivered by the provider;~~

~~(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;~~

~~(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or~~

~~(6) The claim payment is the subject of legal action.~~

C. The retrospective denial of a previously paid claim may be permitted from 12 months from the date of payment until no later than 36 months from the date of payment for the following reasons only:

(1) The claim payment was incorrectly made because the provider or the insured was already paid in full for the health care services identified in the claim;

(2) The health care services identified in the claim were not delivered by the provider;

(3) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(4) The claim payment is the subject of legal action.

D. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment for the following reasons only:

(1) The claim was submitted fraudulently; or

(2) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act.

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the reimbursement rates for future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.

See title page for effective date.