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Senate of Maine
Senate District 31

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Testimony of Senator Donna Bailey introducing

LD 1906, An Act to Improve Accountability and Understanding of Data in Insurance Transactions

Before the Joint Standing Committee on Health Coverage, Insurance and Financial Services
Tuesday, May 13, 2025

Representative Mathieson and Esteemed Colleagues on the Joint Standing Committee on Health Coverage, Insurance and Financial Services, as you know, my name is Donna Bailey, and I proudly represent Senate District 31, which includes Buxton, Old Orchard Beach, and Saco. Today I am pleased to introduce my bill LD 1906, **"An Act to Improve Accountability and Understanding of Data in Insurance Transactions."**

LD 1906 seeks to empower Maine employers with the tools they need to manage healthcare costs effectively and fulfill their fiduciary responsibilities. Maine employers collectively spend billions of dollars annually to provide health care for employees and their families, yet current contractual practices severely limit their ability to confirm whether those dollars are being spent correctly.

Restrictive audit terms in contracts with third-party administrators (TPAs) and pharmacy benefit managers (PBMs) create significant challenges for employers. These restrictions make it nearly impossible to identify billing errors, overpayments, or instances of non-compliance with contractual terms. Employers are effectively asked to pay sizeable healthcare bills without the transparency necessary to ensure accuracy—a practice unheard of in any other industry.

Many contracts with TPAs and PBMs limit the number of claims that can be audited, restrict access to critical data, limit employers' choice of auditor, and prohibit meaningful analysis of claims. These limitations can lead to erroneous or over payments and also expose employers to legal risks for failing to fulfill their fiduciary responsibilities. Lawsuits against self-funded employers have highlighted the consequences of inadequate oversight, which underscores the need for robust audit capabilities.

LD 1906 addresses these challenges by prohibiting restrictive audit terms in contracts between TPAs, PBMs, and self-insured employers. It ensures employers can access their claims data, including detailed payment and provider information, and conduct audits without undue restrictions on scope, frequency, or methodology. And employers—not carriers—will bear the cost of audits and associated data access, ensuring no undue financial burden is placed on TPAs or PBMs.

These provisions align with successful legislation enacted in Indiana and create a clear pathway for employers to verify that plan payments are accurate and compliant with contractual terms. This bill is not about imposing onerous demands but about granting employers the basic rights they need to manage their healthcare spending prudently.

By enacting LD 1906, Maine can reduce erroneous payments, improve accountability, and empower employers to meet their fiduciary duties effectively.

I thank the Committee for its time, and I would be happy to answer any questions.

Donna Bailey
State Senator, Senate District 31
Buxton, Old Orchard Beach, and Saco

standing in a respiratory care program approved by the committee. The graduation of a student permit holder from a respiratory care program approved by the committee does not cause the student permit to expire under this subdivision.

(4) Sixty (60) days after the date that the permit holder graduates from a respiratory care program approved by the committee.

(5) The date that the permit holder is notified that the permit holder has failed the licensure examination.

(6) Two (2) years after the date of issuance.

SECTION 9. IC 25-36.1-2-2.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 2.8. As used in this chapter, "surgical assistance" means intraoperative surgical patient care that involves the following:**

(1) Making incisions.

(2) Closing surgical sites.

(3) Manipulating or removing tissue.

(4) Implanting surgical devices or drains.

(5) Placing catheters or clamps.

(6) Cauterizing blood vessels or tissue.

(7) Applying dressing to a surgical site.

(8) Harvesting veins.

(9) Injecting local anesthetic.

(10) Other minor surgical tasks similar to those described in subdivisions (1) through (9).

SECTION 10. IC 25-36.1-2-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 7. (a) An individual who provides evidence to a health care facility that the individual was employed before July 1, 2009:**

(1) to provide surgical assistance;

(2) under the supervision of a surgeon; and

(3) in a health care facility;

may provide surgical assistance in a health care facility.

(b) This chapter does not require a health care facility to permit an individual described in subsection (a) to provide surgical assistance at the health care facility.

SECTION 11. IC 27-1-24.5-0.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.7. As used in this chapter, "contract holder" means:**

(1) an individual or entity that offers health insurance

coverage to its employees or members through a self-funded health benefit plan, including a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.);

(2) a health plan; or

(3) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient;

that contracts with a pharmacy benefit manager to provide services.

SECTION 12. IC 27-1-24.5-25, AS AMENDED BY P.L.32-2021, SECTION 81, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 25. (a) A ~~party that has contracted with a pharmacy benefit manager to provide services~~ **contract holder** may, ~~at least~~ one (1) time in a calendar year **and not earlier than six (6) months following a previously requested audit,** request an audit of compliance with the contract. **If requested by the contract holder,** the audit ~~may~~ **shall** include full disclosure of **the following data specific to the contract holder:**

(1) Rebate amounts secured on prescription drugs, whether product specific or general rebates, that were provided by a pharmaceutical manufacturer. **The information provided under this subdivision must identify the prescription drugs by therapeutic category.** ~~and~~

(2) Pharmaceutical and device claims received by the pharmacy benefit manager on any of the following:

(A) The CMS-1500 form or its successor form.

(B) The HCFA-1500 form or its successor form.

(C) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

(D) The HIPAA X12 837I institutional form or its successor form.

(E) The CMS-1450 form or its successor form.

(F) The UB-04 form or its successor form.

The forms or transaction may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2).

(3) Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the pharmacy benefit manager as ASC X12N 835 files or a successor format. The files may be modified as necessary to

comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2). In the event that paper claims are provided, the pharmacy benefit manager shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any other revenue and fees derived by the pharmacy benefit manager from the contract, **including all direct and indirect remuneration from pharmaceutical manufacturers regardless of whether the remuneration is classified as a rebate, fee, or another term.**

(b) A ~~contract~~ **pharmacy benefit manager** may not ~~contain provisions that~~ impose **the following:**

(1) ~~unreasonable~~ Fees **for:**

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the pharmacy benefit manager.

(2) Conditions that would ~~severely~~ restrict a ~~party's~~ **contract holder's** right to conduct an audit under this ~~subsection;~~ **section, including restrictions on the:**

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor:

(i) does not have a conflict of interest;

(ii) meets a threshold for liability insurance specified in the contract between the parties;

(iii) does not work on a contingent fee basis; and

(iv) does not have a history of breaching nondisclosure agreements.

~~(b)~~ **(c)** A pharmacy benefit manager shall disclose, upon request from a ~~party that has contracted with a pharmacy benefit manager;~~ **contract holder,** to the ~~party~~ **contract holder** the actual amounts **directly or indirectly** paid by the pharmacy benefit manager to **the pharmacist or** ~~any~~ pharmacy **for the drug and for pharmacist services related to the drug.**

~~(c)~~ **(d)** A pharmacy benefit manager shall provide notice to a ~~party~~ **contract holder** contracting with the pharmacy benefit manager of any consideration, **including direct or indirect remuneration,** that the pharmacy benefit manager receives from a ~~pharmacy~~ **pharmaceutical** manufacturer **or group purchasing organization** for ~~any name brand~~

~~dispensing of a prescription when a generic or biologically similar product is available for the prescription.~~ **formulary placement or any other reason.**

~~(d)~~ **(e)** The commissioner may establish a procedure to release information from an audit performed by the department to a ~~party~~ **contract holder** that has requested an audit under this section in a manner that does not violate confidential or proprietary information laws.

~~(c)~~ **(f)** ~~Any provision of~~ A contract **that is** entered into, issued, **amended,** or renewed after June 30, ~~2020;~~ **2024, may not contain a provision** that violates this section. ~~is unenforceable.~~

(g) A pharmacy benefit manager shall:

(1) obtain any information requested in an audit under this section from a group purchasing organization or other partner entity of the pharmacy benefit manager; and

(2) confirm receipt of a request for an audit under this section to the contract holder not later than ten (10) business days after the information is requested.

(h) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 13. IC 27-2-25.5-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.5. As used in this chapter, "plan sponsor" means an individual or entity that offers health insurance coverage to its employees or members through a self-funded health benefit plan, including:**

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

SECTION 14. IC 27-2-25.5-0.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.7. As used in section 3 of this chapter, "third party administrator" means an individual or entity that performs administrative services for a self-funded health benefit plan, including:**

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

SECTION 15. IC 27-2-25.5-3 IS ADDED TO THE INDIANA

CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 3. (a) This section applies to a contract entered into, issued, amended, or renewed after June 30, 2024.**

(b) A contract:

(1) between a:

(A) third party administrator; and

(B) plan sponsor;

(2) between a:

(A) prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees; and

(B) plan sponsor; or

(3) between:

(A) a pharmacy benefit manager (as defined in IC 27-1-24.5-12); and

(B) either a:

(i) plan sponsor; or

(ii) third party administrator for the administration of a self-funded health benefit plan on behalf of the plan sponsor;

must provide that the plan sponsor owns the claims data relating to the contract. However, a plan sponsor's ownership of the claims data under this section may not be construed to require the pharmacy benefit manager or third party administrator to disclose a trade secret (as defined in IC 24-2-3-2).

(c) Any claims data provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 16. IC 27-2-25.5-4 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 4. (a) A plan sponsor that contracts with a third party administrator, the office of the secretary of family and social services that contracts with a managed care organization (as defined in IC 12-7-2-126.9) to provide services to a Medicaid recipient, or the state personnel department that contracts with a prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees may, one (1) time in a calendar year and not earlier than six (6) months following a previously requested audit, request an audit of compliance with the contract. If requested by the plan sponsor, office of the secretary of family and social services, or state personnel department, the audit shall include full disclosure**

of the following concerning data specific to the plan sponsor, office of the secretary, or state personnel department:

(1) Claims data described in section 1 of this chapter.

(2) Claims received by the third party administrator, managed care organization, or prepaid health care delivery plan on any of the following:

(A) The CMS-1500 form or its successor form.

(B) The HCFA-1500 form or its successor form.

(C) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

(D) The HIPAA X12 837I institutional form or its successor form.

(E) The CMS-1450 form or its successor form.

(F) The UB-04 form or its successor form.

The forms or transaction may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2).

(3) Claims payments, electronic funds transfer, or remittance advice notices provided by the third party administrator, managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2). In the event that paper claims are provided, the third party administrator, managed care organization, or prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any fees charged to the plan sponsor, office of the secretary of family and social services, or state personnel department related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees.

(b) A third party administrator, managed care organization, or prepaid health care delivery plan may not impose:

(1) fees for:

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the third party administrator, managed care organization, or prepaid health care delivery plan; or

(2) conditions that would restrict a party's right to conduct an audit under this section, including restrictions on the:

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor:

(i) does not have a conflict of interest;

(ii) meets a threshold for liability insurance specified in the contract between the parties;

(iii) does not work on a contingent fee basis; and

(iv) does not have a history of breaching nondisclosure agreements.

(c) A third party administrator, managed care organization, or prepaid health care delivery plan shall confirm receipt of a request for an audit under this section to the plan sponsor, office of the secretary of family and social services, or state personnel department not later than ten (10) business days after the information is requested.

(d) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(e) A contract that is entered into, issued, amended, or renewed after June 30, 2024, may not contain a provision that violates this section.

(f) A violation of this section is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

(g) The department may also adopt rules under IC 4-22-2 to set forth fines for a violation under this section.

SECTION 17. [EFFECTIVE JULY 1, 2024] **(a) 844 IAC 13-5-4(a) is void. The publisher of the Indiana Administrative Code and the Indiana Register shall remove this subsection from the Indiana Administrative Code.**

(b) This SECTION expires July 1, 2025.

SECTION 18. **An emergency is declared for this act.**

requirements under this chapter not more than two (2) business days after receiving the request.

SECTION 60. IC 27-2-25-15, AS ADDED BY P.L.93-2020, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 15. A health carrier that provides ~~an Internet web site~~ **a website** for the use of its covered individuals shall ensure that the ~~Internet web site~~ **website** includes a printed notice that:

(1) is designed, lettered, and featured on the ~~Internet web site~~ **website** so as to be conspicuous to and readable by any individual with normal vision who visits the ~~Internet web site;~~ **website;** and

(2) states the following, or words to the same effect: "A covered individual may at any time ask the health carrier for an estimate of the amount the health carrier will pay for or reimburse to a covered individual for nonemergency health care services that have been ordered for the covered individual or the applicable benefit limitations of the ordered nonemergency health care services a covered individual is entitled to receive from the health carrier. The law requires that an estimate be provided within ~~5~~ ~~business~~ **2 business** days.".

SECTION 61. IC 27-2-25.5-3, AS ADDED BY P.L.152-2024, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 3. (a) This section applies to a contract entered into, issued, amended, or renewed after June 30, 2024.

(b) A contract:

(1) between a:

(A) third party administrator; and

(B) plan sponsor;

(2) between a:

(A) prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees; and

(B) plan sponsor; or

(3) between:

(A) a pharmacy benefit manager (as defined in IC 27-1-24.5-12); and

(B) either a:

(i) plan sponsor; or

(ii) third party administrator for the administration of a self-funded health benefit plan on behalf of the plan sponsor;

must provide that the plan sponsor owns the claims data relating to the contract. ~~However, a plan sponsor's ownership of the claims data under this section may not be construed to require the pharmacy benefit~~

~~manager or third party administrator to disclose a trade secret (as defined in IC 24-2-3-2).~~

(c) Any claims data provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 62. IC 27-2-25.5-4, AS ADDED BY P.L.152-2024, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) A plan sponsor that contracts with a third party administrator, the office of the secretary of family and social services that contracts with a managed care organization (as defined in IC 12-7-2-126.9) to provide services to a Medicaid recipient, or the state personnel department that contracts with a prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees may, one (1) time in a calendar year and not earlier than six (6) months following a previously requested audit, request an audit of compliance with the contract. If requested by the plan sponsor, office of the secretary of family and social services, or state personnel department, the audit shall include full disclosure of the following concerning data specific to the plan sponsor, office of the secretary, or state personnel department:

(1) Claims data described in section 1 of this chapter.

(2) Claims received by the third party administrator, managed care organization, or prepaid health care delivery plan on any of the following:

(A) The CMS-1500 form or its successor form.

(B) The HCFA-1500 form or its successor form.

(C) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

(D) The HIPAA X12 837I institutional form or its successor form.

(E) The CMS-1450 form or its successor form.

(F) The UB-04 form or its successor form.

The forms or transaction may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). ~~or to redact a trade secret (as defined in IC 24-2-3-2).~~

(3) Claims payments, electronic funds transfer, or remittance advice notices provided by the third party administrator, managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). ~~or to~~

~~redact a trade secret (as defined in IC 24-2-3-2).~~ In the event that paper claims are provided, the third party administrator, managed care organization, or prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any fees charged to the plan sponsor, office of the secretary of family and social services, or state personnel department related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees.

(b) A third party administrator, managed care organization, or prepaid health care delivery plan may not impose:

(1) fees for:

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the third party administrator, managed care organization, or prepaid health care delivery plan; or

(2) conditions that would restrict a party's right to conduct an audit under this section, including restrictions on the:

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor:

(i) does not have a conflict of interest;

(ii) meets a threshold for liability insurance specified in the contract between the parties;

(iii) does not work on a contingent fee basis; and

(iv) does not have a history of breaching nondisclosure agreements.

(c) A third party administrator, managed care organization, or prepaid health care delivery plan shall confirm receipt of a request for an audit under this section to the plan sponsor, office of the secretary of family and social services, or state personnel department not later than ten (10) business days after the information is requested.

(d) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(e) A contract that is entered into, issued, amended, or renewed after June 30, 2024, may not contain a provision that violates this section.

(f) A violation of this section is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.