



August 31, 2020

Mr. Eric Cioppa, Superintendent  
c/o Susan P. Tardiff  
Maine Bureau of Insurance  
34 State House Station  
Augusta, Maine 04333-0034

Re: Proposed Rule Chapter 210, Standards for Pharmacy Benefit Managers

Dear Superintendent Cioppa:

Thank you for the opportunity to submit comments on proposed Rule Chapter 210, Standards for Pharmacy Benefit Managers. On behalf of Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue cross and Blue Shield, I would like to submit the following comments with respect to the proposed rule:

### **Section 3, Definitions**

*Section 3(1)*, definition of “Pharmaceutical rebate.” The definition of pharmaceutical rebate is overly broad, and does not reflect the realities of rebates paid by pharmaceutical manufacturers. First, the rebates are paid to pharmacy benefit managers (PBMs) by manufacturers, not by third parties. Second, while manufacturer rebates may reduce the cost of the claim to the health plan, they do not reduce the price paid by the health plan to the pharmacy. Finally, health plans do not have any insight into any rebates or compensation a pharmacy might receive from a PBM or any third party. As a result, we would suggest that the Bureau adopt the definition of pharmaceutical rebate proposed by the Pharmaceutical Care Management Association (PCMA). At a minimum, the phrase “or third party” should be stricken.

### **Section 4, Licensing**

We support the comments of the Pharmaceutical Care Management Association (PCMA) with respect to the licensing requirements.

### **Section 5, Oversight and Contracting Responsibilities**

*Section 5(1), Fiduciary Duty, paragraph A.* The statute provides that “the pharmacy benefits manager acts as the carrier's agent and owes a fiduciary duty *to the carrier* in the

pharmacy benefits manager's management of activities related to the carrier's prescription drug benefits.” (24-A M.R.S. § 4349(2), emphasis added.) However, section 5(1)(A)(1) 5(1)(A)(2) attempt to impose a fiduciary duty on the PBM with respect to the carrier and its enrollees. This is inappropriate for two reasons. First, it exceeds the statutory authority, as the statute explicitly establishes that the fiduciary duty is owed to the carrier, not the carrier and its enrollees. Second, the PBM has no authority over the health plan and no ability to ensure a direct benefit to the members of a health plan. As a result, the phrase “and its enrollees” should be deleted from the proposed Section 5(A)(1), and 5(A)(2) should be deleted in its entirety.

***Section 5(1) Fiduciary Duty, subsection (A), paragraph (4).*** Carriers and PBMs are sophisticated entities with the ability to negotiate on their own behalf. There may be instances where such an arrangement is agreed to, in exchange for other benefits or concessions. As a result, we would suggest section 5(1), subsection (A), paragraph 4 be modified to prohibit such compensation or benefits unless fully disclosed to the carrier.

***Section 5(1) Fiduciary Duty, subsection B.*** Both the carrier and the PBM are required to comply with the provisions of Chapter 56-C (24-A M.R.S. § 4347, *et seq.*). It is unnecessary to require the proposed Agreement Concerning Fiduciary Obligations and it is not clear what need is served, or what value it provides—in the event of a suspected violation, the Superintendent’s inquiry or investigation is not going to be impacted by the existence of such an Agreement, nor is the liability of the parties.

***Section 5(2), Compensation for the Benefit of Covered Persons.*** This requirement is already addressed in statute (24-A M.R.S. § 4350-A(1)), and it is therefore unnecessary to include in the rule. Furthermore, the language included in the proposed rule is not consistent with that of the statute; if it is to be included, it must be consistent with the statute to avoid any potential conflict between the statute and the rule.

***Section 5(3), Covered Person’s Right to Waive Coverage and Pay Cash.*** This requirement is already addressed in statute (24-A M.R.S. § 4349(3(A))) and it is therefore unnecessary to include in the rule. Furthermore, the language included in the proposed rule is not consistent with that of the statute; if it is to be included, it must be consistent with the statute to avoid any potential conflict between the statute and the rule. We recognize this is a statutory requirement and, as a result, the Bureau has little flexibility around this requirement. We would note, however, that this requirement may actually be detrimental to the member. The industry standard already requires transmission of the cash price and ensures that the member pays the cash price in the event it is lower than the member cost-share. However, this provision allows the prescription to be filled without a claim being processed. The member always has the option to pay cash and not have a claim submitted; however, actually requiring it can negatively impact the member in two ways: first, the amounts paid by the member will not accumulate toward the deductible and out-of-pocket maximum; and second, it creates a potential health and safety issue and interferes with the coordination of care through programs such as Anthem’s Enhanced Personal Health Care.

**Section 5(4). Pharmacy Provider's Right to Provide Information.** This requirement is already addressed in statute (24-A M.R.S. § 4349(3)(B)), and it is therefore unnecessary to include in the rule. Furthermore, the language included in the proposed rule is not consistent with that of the statute; if it is to be included, it must be consistent with the statute to avoid any potential conflict between the statute and the rule.

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Thank you once again for the opportunity to share our comments with respect to the proposed rule. Please do not hesitate to contact me if you have any questions or would like additional information.

Sincerely,

A handwritten signature in blue ink, reading "Kristine M. Ossenfort".

Kristine M. Ossenfort, Esq.  
Senior Government Relations Director