Maine Prescription Drug Affordability Board
Monday January 27th @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: 109 Capitol St, Augusta Maine, 04330

Board Members in Attendance: Kelsie Snow, Jennifer Reck, Sharon Treat, Dr. Noah Nesin, Peter Hayes, Dr. Susan Wehry, Rhonda Selvin, Julia Redding
(Total = 8)

Board Members Absent:
Vacant Seat(s): 0

Others Present: Karynlee Harrington, Jim Jones
Advisory Council: Jan Wright, Jonathan French, Christina Moylan, Jenny Boyden, Kristy Gould, Kate Ende, Shonna Poulin-Gutierrez, Jennifer Kent
OAHC: Meg Garratt-Reed, Katie Senechal, Ceilidh Shea
All Others: Lisa Kimbrough, Keisha Vaughn, Kelly Memphis, Lucas Perry, Lauren Bates-Rowe, Nimesh Patel, Bren Moreno, Zach Friend, Martha Auster, Daniel Vigil, Shuri Senbanjo, Mark Hobraczk, Katie Didier, Olivia Backhaus

Agenda Item:	Discussion:	Action/Next Steps:
I. Call to Order	**Kelsie Snow** called the meeting to order	
II. Introductions	Board and Advisory Council members were introduced, along with guests joining from the Bureau of Insurance.	
III. Approval of the Minutes (November 25, 2024)	There were no changes to the minutes discussed.	Kelsie Snow made a motion to approve, Jennifer Reck seconded the motion. The minutes were unanimously approved.
IV. Administrative Update	**1. Discussion of Annual Report** Meg Garratt-Reed sought feedback on the 2024 Annual Report. Jennifer Reck shared that she found the report reflective of the board's activities and discussions.	

	Kelsie Snow mentioned there was one area in the report she made a slight adjustment to. Meg Garratt-Reed asked the group whether they wanted to take a vote to finalize the report or whether they feel comfortable accepting as is with the OAHC team finalizing. Sharon Treat asked whether submission of the report will also include an introduction of the Board to the Health Coverage, Insurance, and Financial Services committee. She asked Kelsie whether they Board had heard from the committee. Kelsie Snow responded that she had not heard anything. Sharon Treat noted that the committee had expressed interest in an introduction to the Board but that it's likely an event would be pushed out into February. Meg Garratt-Reed mentioned that the committee asked the Office of Affordable Health Care to present on the findings of specific reports back to the legislature. That is likely to be scheduled in the second week of February. Part of the reasoning was so that the Office could present on reports rather than a more traditional orientation. Sharon Treat noted the Board might anticipate being asked by mid February. Meg Garratt-Reed shared that, with the group's approval, she could work with Kelsie to send in the Annual Report. That way if something is scheduled the committee has the report on hand. **2. Presentation on MHDO Report by Karynlee Harrington** Karynlee Harrington thanked the Board for the opportunity to share information and data that the MHDO is mandated to collect through various legislation. She shared that her components of the	Susan Wehry made a motion to approve, Sharon Treat seconded the motion. The annual report was unanimously approved. • **Ceilidh Shea will submit the Annual Report to the HCIFS committee by January 31st, 2025.**

	presentation will highlight what MHDO is required to report on by law, including some level setting before handing things off to Jim Jones, the CFO and founding partner at Ten2Eleven Business Solutions. She expressed openness to collaboration with the Board. She mentioned that MHDO is required to collect all kinds of data related to prescription drugs (such as cost and spendings) and if the board has specific areas of interest that they would like her team to look into, she welcomes further conversations about that. Her team is interested in making this data accessible and actionable and usable. Karynlee Harrington began her presentation with an overview of prescription drug data that MHDO is responsible for collecting, including the mandates for reporting. She shared that the purpose of the MHDO is to create and maintain a useful, objective, reliable, and comprehensive health information data warehouse that is used broadly to improve the health of Maine citizens and to promote transparency of the cost and quality for health care including prescription drug cost information in the state. She mentioned that the role of MHDO in the comprehensive drug reform package that passed years ago was to promote transparency and use their data to provide information about spending in the state. She also provided a brief overview of the primary use of MHDO data and shared information regarding access to MHDO data, which aims to make data as publicly available and accessible to the broadest extent consistent with the laws protecting individual privacy and proprietary information. Jim Jones shared an overview of the MHDO data sets that are pertinent to prescription drugs, including: - Chapter 243: All Payer Claims Database (APCD) - Chapter 570: Prescription Drug Cost Information - Chapter 340 (NEW): 340B Drug Program Data from Hospitals - Chapter 800 (IN PROCES): Acquisition Costs of Insulin	

	Jim Jones also provided an overview of the data elements available in the APCD. MHDO gets very specific information about drugs, including what patients are paying and their copay amounts. They are able to identify the specific pharmacy where a drug is dispensed and can run analysis by provider. If there was any interest in looking at specific drugs and any kind of volume dispensing by provider, MHDO could look at that. Jim Jones shared information on Chapter 570, data about manufacturers. Chapter 570 started with a focus on drug price increases and new introductions of drugs from manufacturers. Originally, manufactures were required to report a brand name drug if it's wholesale acquisition cost (or list price) increased by more than 20%. For generics, manufacturers are required to report on drugs with prices per pill of $10 or more and the price of the drug increased by more than 20%. He also mentioned that any new drugs introduced in the state must be reported on if their list price is greater than the amount that would classify the drug as a specialty drug under Medicare Part D (which is currently $950). Jim Jones stated that MHDO both simplified and expanded this law so that other supply chain entities can provide more information. Now, with these changes, MHDO reports on drugs that have met the aforementioned thresholds but also requests data for specific drugs that are of public interest. MHDO has focused on drugs that have significant markups and/or fall on the list of Maine's 25 Costliest Drugs or have highest year-over-year increases. Jim Jones also shared some of the pricing component data that MHDO collects under Chapter 570. He highlighted patient volume, volume of sales, manufacturer revenue, value of rebates paid back to wholesalers, and PBM revenue. Karynlee Harrington then moved on to the new 340B Drug Pricing Program Data from participating Maine hospitals. The hospitals will be reporting their top three costliest 340B drugs and top three most frequently prescribed 340B drugs. She mentioned that the rule started out with more data collection requirements for	

	hospitals but after discussions with hospitals about administrative burden, the requirements were simplified and shortened. The first report will be released at the end of 2025. Karynlee Harrington transitioned to a discussion of Chapter 800, which is in progress. The MHDO board provisionally adopted the rule but it must also be passed in the legislature as a major substantive rule. The rule requires each insulin product reported to include information on NDC, category of insulin, WAC amount per NDC, and WAC amount per pricing unit. She stated that there will be a public hearing and then the rule will need final adoption from the MHDO board. Ideally, she hopes to begin gathering data in 2026. Karynlee Harrington presented MHDOs prescription drug reporting mandates, which include the 25 costliest drugs, the 25 most frequently prescribed drugs, and the 25 drugs with the highest year over year increases. Karynlee expressed that MHDO has realized they could add more elements providing greater context. She mentioned that a new version of the dashboards including this information will be released in February 2025, with additional data that has been missing. Karynlee Harrington also shared information on a more recent law, Chapter 470, which requires MHDO to submit an annual report on prescription drugs pricing. The reports must include information on trends in cost, analysis of manufacturer prices and price increases, major components of prescription drug pricing along the supply chain, impacts on insurance premiums and cost-sharing, and other information MHDO determines is relevant to providing greater consumer awareness of the factors contributing to cost. To date, MHDO has produced four of these reports. She shared that each year, MHDO considers and struggles with how to make this information more accessible, particularly for the use of policy making. Karynlee also stated that this year MHDO will be combining this report with the Tableau dashboard report on the top 25 and some of this information on trends into one page on their website. The goal of combining these reports is to provide	

	greater context. She welcomes the feedback of the board on this project, as well. Karynlee Harrington presented on Public Law 2021, Chapter 305, which allows MHDO to share information in the aggregate, particularly regarding information collected in Chapter 570, even if it allows for the identification of an individual drug, as long as it is not released in a manner that allows the determination of individual prescription drug pricing contract terms covering a manufacturer, wholesale drug distributer or PBM. This is similar to a lot of MHDO's data, who does not want to expose charges and payments, for example. Having said that, with the new federal mandates for hospitals to post data on their charges and payments online, things are changing. Federal transparency requirements are requiring things to go farther, exposing all transactions along the way. Karynlee Harrington shared information on Public Law 2021, Chapter 606, which requires MHDO to identify the 100 most costly prescriptions in Maine and the 100 most frequently prescribed drugs in the state. MHDO is then required to compare this information to information available in Canadian provinces. It is much more complicated than that, but there is also a website that takes you to that information and a calculation of potential savings if our pricing aligned with Canadian pricing. She stressed the complexity and difficulty comparing the prices, given the entire system is different. Jim Jones stated that Maine is on the forefront of trying to figure out what is going on in the market. California passed the first prescription drug pricing transparency law, requiring manufacturer to provide information and then Maine quickly followed, looking for additional information from wholesalers and PBMs. As MHDO has received this data, Maine's programs have allowed for a deeper dive. Jim shared that what they have found is, despite legislators and the public's understanding that manufactures drive prices and their conceptions that brand-name drugs are more expensive than generics, while some of that is true, sometimes often times it's	

	not. There are variations in pricing and rebate practices that go between manufacturers and wholesale distributors, the way PBMs pass through rebates, and pharmacy kickbacks that go back to PBMs all affect the ultimate price consumers pay for drugs and health plans. Jim Jones presented on key factors to keep in mind going forward, especially from a policy perspective. First, manufacturers specify the wholesale acquisition cost (WAC) for wholesalers to buy from manufacturers, it is not ever used in the supply chain after this transaction. Therefore, it is a good place to start but is not the whole picture. Jim Jones said that then, wholesalers typically pay manufacturers the WAC prices to acquire drugs and later sell the drugs to pharmacies at market prices (usually less than the WAC). As wholesalers sell drugs, they will have rebates called chargebacks that go back to the manufacturer, allowing them to recover some of the money they initially paid to the manufacturer. The chargebacks are in place to incentivize wholesalers to move the product, and they bring down the cost of the drug. He shared that because the wholesalers know they will have the chargebacks and some amount of rebates, in the generic space especially, they provide the cost of the drug to pharmacies at less than the WAC. We start seeing some price erosion there as the product hits the shelf for certain types of drugs. Jim Jones said there is also another price component called the AWP, which stands for average wholesale price. It is never a price that is used by wholesalers, so it is a misnomer, but is used by PBMs to set contracted rates. In the brand-name space, manufacturers typically do not manipulate the AWP in any way, they provide their WAC price to drug data wholesalers who then set a default markup from WAC of 20%. In the generic space, however, most manufacturers set a suggested AWP. It is usually based on the AWP of the brand-name equivalent, making it quite a bit higher than what we see in the generic WAC space. Jim Jones emphasized how complex and hard to follow the figures are, particularly for the public. Lastly, he highlighted how PBMs negotiate contracted rates between pharmacies and payers. These contracted rates are typically a discount from the AWP plus a fixed	

	price dispensing fee. Therefore, when the AWP values are set higher than WAC, payers may pay significantly more. This process varies greatly depending on whether a drug is brand name or generic. Jim Jones stated that a lot of price transparency work is focused on manufacturers and how WAC is manipulated. This is relevant in the brand-name drug area, but when we look at the whole picture, there are about 35,000 drugs for which we have claims data and only about 3,000 in 2022 had price increases. That's a little less than ten percent. Of those with increases, 46% were for brand products, 31% were for multi-source brand drugs, and 21% were for generic products. He shared that MHDO also looked at drugs with price decreases. There were about 1,500 drugs in 2022 with price decreases. Usually, single source brand name drugs do not decrease in price, and the same is true of multi-source drugs. However, amongst generic drugs, the WAC usually decreases as more competitors enter the market. Next, Jim Jones shared that in the brand-name space, the WAC does continue to go up at a rate that generally exceeds the annual consumer price index. Patents really do protect these innovators. While it can make sense, there are some players who really take advantage of their patent. He said that while generic drugs sometimes show a decrease in WAC, generic manufactures set their AWP at the static AWP price. If they don't report an AWP, the default is the static 20% markup referenced earlier. This is important because thinking back to the PBMs contracted rate, the paid amount is a discount off of the AWP, therefore we're looking at a discount on a price point that never changes. So, in looking at some of the price decreases mentioned earlier, the average rate of decrease was 49% but the price that decreases for the plans is only about 10% for those same drugs. He said that we can also see that for that same amount of decrease over time for all drugs is there, but this is not reflective of WAC decreases, but rather there are calendar-based milestones in the projected rates that increase that amount of discount of AWP for products. As a result, in the brand space the average amount paid by payers, including	

	member cost sharing, after rebates was around 84%, but in the generic space we're seeing that drugs are marked up, on average, 335%. Lastly, he shared that rebates do play a role in the brand space especially. PBMs are requesting rebates in order to put those brand name drugs on preferred tiers. In the generic space we don't see those kinds of rebates. Jim Jones pointed out a number of websites where more information can be found on the topics covered in the MHDO presentation. Peter Hayes asked whether it is accurate to use the NDC as a baseline acquisition cost for 340B drugs when in reality, these 340B entities are buying drugs for pennies on the dollar? Aren't we underestimating what the real delta is between what these entities are buying the drugs for versus dispensing them for after they're pushed through a billing model? Jim Jones responded that yes, covered 340B entities purchase drugs for pennies on the dollar and then put them through the supply chain just like normal. The delta between what entities purchase a drug for through 340B and what they would have purchased it for outside of 340B becomes what is considered savings but is actually additional revenue. Peter Hayes asked whether entities are buying at the Total 340B Acquisition Cost (NDC) or an amount that is actually much lower? Jim Jones shared that NDC stands for National Drug Code and what he is highlighting in this slide is the MHDO collects this information at the NDC level. He clarified that the NDC is different National Average Drug Acquisition Cost (NADAC), which MHDO does not collect but does have access to given it is public information. Instead, through collecting the NDC, MHDO is asking how much an entity spent in total per year for each 340B drug specifically. NDC reflects manufacturer and molecule strength and size level, which is very specific data.	

	Peter Hayes asked whether MHDO has a way of tracing how much of rebates from manufacturers are passed on to the patient or plan sponsor? He mentioned that Adam Fein at Drug Channels has been charting the gross to net bubble for manufacturers for several years and the manufacturer net profit after rebates has actually been decreasing. Yet, plans sponsors and patients are paying more, which would suggest that not all the rebates are being passed through. Can you tease that out in your data reporting? Jim Jones responded that yes, they can. MHDO receives data about rebates receivable and rebates payable from PBMs. We get that data at multiple levels, including drug level. MHDO reports that information, which can be found in their legislative reports. He mentioned there is potential for cloudiness in the data. There is potential for PBMs to be reporting at a national level as opposed to state level. The difference between national and state level reporting is important because in Maine it is required that those rebates be passed through to the plans. It is unclear whether that is adhered to by all PBMs. Peter Hayes asked if Jim Jones had any advice regarding actions the board can take to try to control whether that money actually gets passed back to the plan sponsor? On the healthcare side, there is a movement towards only paying 200% of Medicare prices for hospital services. Do you have any suggestions on a creating a maximum ceiling for all drug pricing? Jim Jones responded no, not specifically, but did point out updates to APCD data collection rules, which will be implemented in 2025. Claims data will reflect rebates at point of sale, reflecting how consumers are impacted by the amount passed back through. MHDO also has a non-claims based record, part of Chapter 247, that will also be getting the total amount of rebates whether or not they occur at the point of sale. Jim Jones stated he did not have a policy recommendation to provide at this point in time because he does not feel we have good enough data. The new data that will	

	come out of rule changes mentioned earlier will provide much more information and clarity. Jennifer Reck asked what percentage of Maine's drug spend is on generics? How should the board understand this generic data in context? Jim Jones responded that he can follow up with precise detail but mentioned that brand spend is much higher. When looking at the 25 costliest drugs report, single source brand name drugs are the major contributors to cost. The generic markups and brand patents have to be taken together. If you just wanted to focus on brand drugs, that is difficult because you're preempted by patent law. In the generic space, because of what is happening with the markups, even though drugs come off of patent they do not erode in price for consumers. In trying to compare single source brand drugs to Canadian pricing, there are issues because the Canadian patent is much shorter. It's a different system with more regulation. Basically, the government is buying drugs at cost and selling them at cost. It's very similar to how Medicaid works here, where we mandate that drugs are bought and sold at near NADAC. The same thing happens in the generic drug space in Canada, but the drugs actually aren't being marked up at all. The commoditization causes the drugs to become so cheap so quickly that the brand manufacturer actually leaves the market. With all of that in mind, if policy were introduced that could do the same in the brand-name space, you would see the same fall out. Jim Jones agreed with Jennifer Reck, that the brand name drugs, while on patent, account for significant spend, but just the markup for generic drugs is also important. Karynlee Harrington added that the 25 costliest drugs dashboard includes a state total metric based on MHDO claims data, which represents about 91-92% of the total population. You can view the dashboard by brand as well. She mentioned that there is a lot of potential with generic pricing for policy changes.	

	Kelsie Snow asked about whether it is possible to tell if a drug markup happens at a vertically integrated pharmacy more than it might at others? Jim Jones responded that they can do that analysis. Although for the specific example provided earlier, the cost looked to be similar across all pharmacies. That is because it is based on the contracted rates for a pharmacy network, which typically don't vary by much. However, in the specialty drug space there are far fewer pharmacies and most are vertically integrated, which is the concern of recent FTC investigations. Sharon Treat asked, based on a Minnesota law, whether the 340B data MHDO is collecting will reflect pharmaceuticals administered within hospitals? Jim Jones responded that the Minnesota law is quite a bit different, allowing for data collection of 50 NDCs at a more granular level than Maine law does for hospitals specifically. They also collect data on all covered entities not just hospitals, although the NDC level data is specific to hospitals. Maine's law is only for hospitals and is mainly at the entity level, we're only getting data for three NDCs. There was a lot of push back during the rule making process around specific metrics that allow for identification of things like volume. Sharon Treat mentioned there was some ambiguity in the Minnesota law that led to some hospitals not reporting on some drugs. Would we be able to get this kind of data from MHDO? Jim Jones responded that he will look at the rule. The change to the law that passed last session in Minnesota refined their definition of a drug to include those dispensed or administered in a hospital. Sharon Treat asked whether Maine is collecting that data or not?	

	Karynlee Harrington responded that she will double check, but in looking at the rule, it says all drugs acquired by the hospital, which she interprets as all drugs acquired regardless for whether it is inpatient or outpatient. This is a new rule and she will follow up. Sharon Treat responded that it seems like something that would be significant, given in Minnesota they cited it accounting for 80% of spend. Meg Garratt-Reed asked if MHDO has access to rebate data at a drug or unit level? Jim Jones responded that yes, MHDO does collect rebate data at the drug and NDC level. Right now, the data we have is under Chapter 570, so it is reflective of a subset of drugs. As the new rules for Chapter 243 and 247 take effect this year, we will start getting that information for all drugs (beyond the Chapter 570 subset). Meg Garratt-Reed asked if MHDO is able to publish that information at a drug level? Jim Jones responded that yes, they are able to publish at a drug level as long as they are aggregating across all participants in the supply chain (all PBMs). Jonathan French asked if companies have been pushing generic markups so drugs are more expensive than brand-name counterparts? Has there been any tracking of this type of markup? Jim Jones responded that even with markups, generics are never more expensive than a brand name drug. The push to generics is still important work, we just want to reduce that amount of markup so that plans and payers are realizing the prices manufacturers are putting the drugs on the market for. Kelsie Snow asked a clarifying question regarding 340B reporting requirements regarding outpatient versus inpatient drugs.	

	Karynlee Harrington responded that she will follow-up in writing given this is a new rule. Karynlee Harrington shared that their annual report that has a lot more detail, any of which they'd be happy to come back to discuss with the group. Sharon Treat asked if OAHC could share important legislative dates and events with the group? Such as the MHDO presentation to the HCIFS committee. Meg Garratt-Reed responded that yes, the OAHC team can do that and can also share recordings afterward. **3. Update on bill** Sharon Treat shared that the bill's sponsor, Senator Reny, is enthusiastic about the bill and finding co-sponsors. Sharon Treat intends to follow up with her about that process. She shared that it would be helpful to have some sort of one-pager on what the bill would do, including information about the budget and authority of other PDABs across the country. It would be helpful for finding co-sponsors and engaging the committee. Senator Reny now serves on the appropriations committee, which is helpful. Meg Garratt-Reed mentioned that bill titles were released on Friday. While the Office is happy to assist with the development of a one pager, there is a lot going on at the moment. Sharon Treat responded that she is also happy to help. **4. Update on public payors questionnaire** Meg Garratt-Reed shared that the questions the board developed for public payors was formatted into an online survey. She asked	• **Karynlee Harrington will follow up with more information on new 340B reporting requirements.** • **Sharon Treat will follow up with Senator Reny for updates.**

	whether the group wanted to send the survey out now or hold off until later on/after legislative session. Kelsie Snow responded that she thinks sending the survey out now would be beneficial, with responses shared at the next meeting. **5. Plans for the next MPDAB meeting** Meg Garratt-Reed said that one idea for the next meeting was to look at GLP1 pricing and that category of weight loss drugs that tend to be high cost, including conversations about potential mandatory coverage. She mentioned it would be a timely issue to discuss, particularly given the legislature will likely be engaged in conversations about it as well. Kelsie Snow said it is an enormous topic. She said they are also still gathering new indications. One of the primary GLPs just gained a new indication that is going to expand how many people can qualify. She mentioned there was a study in the New England Journal that said the vast majority of people can qualify for use of a GLP. Given their cost, trying to figure out how to handle this is something a lot of groups are being tasked with. Meg Garratt-Reed asked if Jennfier Reck would be willing to reach out to PORTAL to see if they'd be willing to share some of their work on cost control available to states on this issue? Jennifer Reck responded that she would be happy to connect with PORTAL, but is also thinking about how some state employee health plans are trying to grapple with this topic. She asked about rescheduling Sahey Nikpay before the board moves to a new topic. Meg Garratt-Reed mentioned that it might be better to split up GLP1s and 340B presentations into two separate meetings to ensure presenters have enough time and the board is able to ask questions. She asked which order the board preferred for presentations.	• **Ceilidh Shea will send out the public payors questionnaire and summarize responses for the next meeting.** • **Jennifer Reck will reach out to PORTAL about presenting at a PDAB meeting.**

	Sharon Treat noted that these are very complicated policy areas and hour and a half long meets every two months do not allow for a lot of time. Jennifer Kent said she would like to prioritize GLP1s. They are very concerned about any potential mandates and the impact that would have on their plans. She said that from an advisory perspective, that is a topic that really needs to be looked at. Kelsie Snow said she is fine with that and that the 340B areas are regulated by ERISA so some others are thinking about it. She said some of the groups she has been working with have been spending many, many hours everyday to figure out access and cost. Meg Garratt-Reed said it might be best to start with the GLP topic, especially given interest from public payers. It would also give the board more time to exchange information with MHDO on their plans for reporting on 340B, including some of the interactions they're having with hospitals. She said it could work to merge a presentation from Minnesota with another update from MHDO. It's also less of a current legislative issue. Meg Garratt-Reed mentioned that if the board wanted to meet more frequently, we can certainly do that but leave t to the discretion of the board. Susan Wehry said she is inclined to think the board should meet more frequently to do justice to these topics. She said the thing about 340B is that there is a certain amount of public attention to it right now, which is good to build on. Susan Wehry said that makes her think 340B should be discussed next, although she recognizes GLP1s are equally pressing. She shared that this leads her to think the board should have an extra meeting in February. Noah Nesin responded that when the board decided to transition to bi-monthly meetings, going to monthly meetings if needed was an option. He said that if the board has a consensus that there is a lot to address and the timeline is challenging, that adding an extra meeting is acceptable to him.	

	Meg Garratt-Reed said we would plan on the final Monday in February. Sharon Treat responded that particularly in the legislative session, she noticed PBMs and 340B addressed in the same bill. She asked if the board could have assistance identifying prescription drug related bills. She mentioned that unless the bills are scheduled for a hearing, it can be difficult to keep track of them all. Kelsie Snow asked whether that is possible for the OAHC team, although she knows some people who are already doing so. Meg Garratt-Reed responded that she thinks so. The way the OAHC works on this is by identifying titles of interest and the relevant PDAB bills would likely be on our list anyway. She mentioned it wouldn't hurt to have other input from the group Kelsie Snow mentioned, if they're already doing this work. Kelsie Snow responded that her contact if from the Maine pharmacy group. Sharon Treat shared that it would be helpful because for the second session there is a whole list in advance but for this session that is not the case so it's easy to miss stuff. She said it would be helpful for the group to stay up to date on legislative action, particularly if they want to testify on something. Kelsie Snow said she was leading some students to testify on certain bills but then there just happened to be some other relevant bills, as well. Meg Garratt-Reed said the OAHC team can begin by looking at bill titles and that there will now be an added meeting in February. Dependent on speakers, we can decide the order to topics addressed.	• **Ceilidh Shea will create a list of bill titles relevant to the PDAB and share with the board.**

	Julia Redding added that during legislative session, meeting monthly makes sense. She suggested time during each meeting to review any relevant legislative action, even if it is certain talking points or people the board should be reaching out to.	
VII. Open Discussion		
VIII. Adjourn	Susan Wehry requested a motion to adjourn. Sharon Treat seconded the motion. The meeting was adjourned.	

Next meeting: February 24th, 2025