Janet T. Mills
Governor

STATE OF MAINE
Maine Prescription Drug Affordability Board
11 State House Station
Augusta, ME 04333

Kelsie Snow, PharmD
Chair

Maine Prescription Drug Affordability Board
Monday July 22nd, 2024 @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: Burton M. Cross Building, Augusta, Maine - Room 400, 4th Floor, ME

Board Members in Attendance (6): Peter Hayes, Rhonda Selvin, Jennifer Reck, Sharon Treat, Dr. Kelsie Snow, Dr. Susan Wehry.
Board Members Absent (2): Dr. Noah Nesin, Dr. Julia Redding.
Vacant Seat(s): 0

Others Present:
Advisory Council: Kristy Gould, Jennifer Kent, Christina Moylan, Shonna Poulin-Gutierrez, Kate Ende, Jonathan French
OAHC: Meg Garratt-Reed and Katie Senechal
All Others: Rachel Cottle Latham, Timothy McSherry, Joseph Oros, Nicole Pinkerton, Adam Ferguson, Suhanee Patel, Brenna Moreno, Patrick McGarry, Mary Kate Barnauskas, Mark Gallagher, Brian DuVal, Ethan Goodman, Paula Witt, unidentified participant representing Artia Solutions.

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. Meg Garratt-Reed introduced Katie Senechal, new Senior Analyst in the Office of Affordable Health Care.	
III. Approval of the Minutes (May 20th, 2024)	There were no changes to the minutes discussed	Jennifer Reck made a motion to approve the minutes, Sharon Treat seconded the motion. The minutes were unanimously approved.
IV. Monthly Business	**Review of Mission and Vision** **Meg Garratt-Reed** reviewed the language of the previously adopted mission and vision for the Board. **Jennifer Reck** generally felt the mission and vision were still helpful and accurate in reflecting the Board's current statutory role. Wanted to call attention to the mention of affordability in the final line of the vision. It may be helpful to clarify what is meant by "affordability" and ensure that the definition is broad and includes affordability for consumers and the system. **Sharon Treat** agreed with Jennifer's assessment of the mission and vision	It was decided that a workgroup would meet to develop draft legislation for discussion at the September meeting. Meg Garratt-Reed will send slides, reminder of workgroup membership, and draft questions around to the group for consideration between meetings. Members will review questions and share additional suggestions as "homework."

	as it relates to current statute. Would just note that the Board has since discussed a broader mission and a desire to **Susan Wehry** – The Board must have a mission and vision that reflects the statutory mandate, but not sure the Board is limited to that mandate. To some extent the Board has articulated that vision in the legislation it proposed. **Sharon Treat** – Enabling legislation has duties and responsibilities, but doesn't an articulate a purpose. **Meg Garratt-Reed** – Proposed to make agenda item for meeting in September to include a discussion of goals. Could integrate a conversation about affordability at this meeting. **Sharon Treat –** Suggested it would be best to have some drafts circulated so there can be a more full discussion at the next meeting. **Meg Garratt-Reed** – Proposed the previously discussed workgroup could meet between meetings and share proposed language with the Board for discussion at the next meeting. Noted that another PDAB has more directly focused on systemic costs, so there is variation in how affordability is interpreted and applied. **Review of Policy Areas** **Meg Garratt-Reed** – Reviewed the language on policy areas that had been included for the Board to assess in the language of the Board's proposed legislative change. **Sharon Treat** – Suggested including pilot projects and referencing the IRA and upper payment limits. Also noted some other PDABs are more closely affiliated with insurance departments, which have regulatory authority that PDABs do not have and additional access to information. **Kelsie Snow** – Highlighted that some drugs are getting a lot of attention for driving insurance costs, including GLP1s. Also regularly sees patients whose "reasonable" out-of-pocket costs for drugs are unreasonable, so agrees in the interest in the role of insurance regulation as it relates to	

	drugs. **Meg Garratt-Reed** – Noted that there can be tension in balancing reasonable out-of-pocket costs for individuals with high-cost drugs with the impact of the cost of those drugs on overall premiums. **Sharon Treat** – Agreed that a discussion about this would be helpful. **Susan Wehry** – Asked for clarification: is the suggestion that the Board report to the Bureau of Insurance and they should review the Board's recommendations on how to use their authority? **Sharon Treat** – That would be a very soft approach. Was mainly thinking that some other PDABs are more closely integrated with their Departments of Insurance, which may be good or bad, but those agencies do have regulatory authority. Would just like to open the conversation and evaluate whether it is a tool that could be used to make things happen. **Susan Wehry –** Noted that the last bullet, aligning payment for drugs with acquisition costs, is a different value statement than aligning payment with impact on vulnerable patients, or impact on consumers. Not an either/or, but there is more focus on acquisition cost than on other data. **Kelsie Snow –** Agrees that would be helpful. Noted that GLPs are fueling the re-evaluating of rates. Reviews the charge reports and sees that in many cases charges come in below costs, and that can also have a patient impact if it is financially unsustainable. **Rhonda Selvin** – Agrees with Susan. Very Important. **Jennifer Reck** – Supports Sharon's suggestion to explore the work of regulatory agencies with scope that relate to PDAB work. Regarding the final bullet on acquisition cost, thought that may refer more to large gaps between actual price and acquisition cost being a contributor to high systemic spending. **Peter Hayes** – Added in chat that he believes 340B is a huge opportunity. **Meg Garratt-Reed** – Reviewed slide summarizing current state of Upper	

	Payment Limits in other states. **Jennifer Reck** – MN has the ability to reference Medicare negotiated prices but does not have to. MD has put forward six drugs that they are proposing cost reviews on, and public comment on those drugs closes today. Notably two of the drugs selected are GLP-1s. **VT** has enacted legislation to explore using the Green Mountain Care Board to regulate affordability of prescription drugs, and that includes reviewing what other states are doing with PDABs and upper payment limits. More of a study – due January 2025, with a plan for implementing a program due in 2026. **Kelsie Snow** - asked if there have been movement on consistent preferred drugs lists in other States? **Jennifer** thought Washington had made some progress on this but will take the question back and check. **Sharon Treat** – Noted ME was in some kind of public PBM with overlapping preferred drug lists with other states, at least 10 years ago. On that point, there are things that people have tried and it is always good to know about it. At some point it may be interesting to have a Northern NE meeting on some of these issues. Even if it is a brainstorming session. **Peter Hayes** – Noted the Board has been meeting for several years now with what seems like very little tangible progress. What do other states, who are better at moving the dial, do to get tangible results? **Sharon Treat** – other states have the legislative authority to set upper payment limits which help them do this work. **Peter Hayes** – Other states have been successful in getting legislature on board to given PDABs this authority. How can we work with other states to learn from their efforts. **Meg Garratt-Reed** – In most cases the PDABs in other states did not request additional authority, it was included in legislation creating them. If the Board would like to request meetings to invite other states to our meetings to learn from them we can. **Sharon Treat** – We did put a bill forward that has made progress. Is	

	committed to getting over the finish line. It certainly is possible and we had support. **Peter Hayes** – Thanks for sharing all of that. Would love to have tangible steps forward. Maybe finding some of the authors of the bills that have passed in other states. Can do some research and figure out what the authors did. **Meg Garratt-Reed** – Moving on to transparency. Did not do a summary of other states for simplicity, given that many states have laws in this area. Thinking about a few realms of transparency: 1) General transparency on drug spending looking at high spend drugs and high price drugs. Maine general reporting and transparency requirements that facilitate MHDO's drug spending dashboards. A challenge, however, is inability to report data on rebates to get a clear picture of actual net spending. 2) Transparency on PBM practices and 3) 340B program transparency. Peter noted frustration about lack of action in Maine, but would note that Maine passed a law requiring PBMs to be licensed and regulating some of their practices. Maine had been a leader nationally here. There was also a bill 340B transparency considered in the last session, which was significantly narrowed to require hospitals to report using an AHIP-developed structure. **Jennifer Reck** – I agree with that and brings us back to Sharon's point about reaching out to Bureau of Insurance. **Meg Garratt-Reed** – Reviewed slide on volume purchasing policies. Noted Maine's Medicaid program already participates in multi-state purchasing compact. **Sharon Treat** – On bulk purchasing, there was an effort to establish bulk purchasing, but state employee program was not comfortable with the approach. **Kelsie Snow** – Do you remember why they were uncomfortable? **Sharon Treat** – State employee program is a negotiated contract and there was concern it could create issues in contract negotiation.	

	Kelsie Snow – Wonder if a more pared-down version, perhaps focused on highest cost drugs, could be workable. **Meg Garratt-Reed** – Important distinction is whether the idea is bulk purchasing of specific drugs or perhaps joint procurement of a PBM. Could be arguments for each one. **Jennifer Reck** – NV just joined ArrayRx, a multi-state PBM purchasing collaborative with WA and OR. Clearly these are west coast states but they are open to all states. For the PBM roll in negotiating the rebates. **Meg Garratt-Reed** – Reviewed importation slide. Some states have new Section 804 State Importation Programs to import drugs from Canada. ME has a law on this as well as FL, CO and other states. FL is limited to Medicaid program. ME and CO statute envisions reaching commercial payors as well. **Meg Garratt-Reed** – Reviewed consumer cost and OOP component slide. Many states have predated the federal law to cap OOP costs for insulin. Maine law also requires that spending on drugs via coupon programs be counted toward deductible and OOP maximum. **Jennifer Reck** – Added that some states are expanding from insulin cap model and capping out of pocket costs for epi pens and asthma inhalers. **Rhonda Selvin** – I see patients who are still unable to afford their drugs which are not brand new or highly expensive. We have a lot of people in Maine struggling with this. Also, once we align purchasing lists, they need to align with prescribing practices or we have not achieved anything. **Kelsie Snow** – I would like to echo what Rhonda said, I see patients everyday in outpatient practices that cannot afford inhalers or insulin. Now see individuals coming into the hospital with emergencies because they could not afford insulin. I would like to reinforce that we are not where we need to be. **Sharon Treat** – Going back to our mission. Other states often do have this two step process of starting by looking at drugs and doing an affordability	

	review. That may be something this group can do concurrent with thinking about legislation. Perhaps have a hearing about what people are experiencing. **Kelsie Snow** – When I do patient reviews, I look in the chart for something noting the patient is unable to fill a prescription due to affordability. Could we get data from hospitals on how frequent this is? In my experience this is at least 75% of patients. Patient assistant program threshold criteria is spending more than 1-5% of household income on prescriptions. Wonder if it would be possible to get that information? **Sharon Treat** – Which drugs or treatments are popping up that are unaffordable in these ways? Is there something we can do in this area to start to make the case to the legislature or the Bureau of Insurance? **Susan Wehry** – From a purely clinical standpoint, there are a lot of those studies that have been done with respect to older adults. For example, data on adverse reactions when patients can afford their drugs, and data on drugs that should not be used in an older population that are used all the time. I imagine that there may also be literature on categories of drugs that result in emergency visits. Can't imagine there is not data on the flipside of drugs that are not taken, which result in hospitalization. Can we select some drugs (insulin, inhalers, and a third) and get that data? This would help to tell the story. **Kelsie Snow** – There is a case study of an SGLT inhibitor that is available at a cash price from specialty pharmacy for $60/month, compared to the more widely available at $600 that's an enormous difference especially considering the benefits of that drug class. **Susan Wehry** - There are so many things that go into this, including that what is prescribed is not always taken, cost is only one factor. All this said, the data is confusing but it is there. Looking at AI generated big data and looking at big themes could help us understand consumer behaviors and how much cost is a driver of higher health care spending. This is something that I'd like to see the Board do – take the clinical impressions we've shared, translate that into the literature, and get useful data we have in the state.	

	Christina Moylan – There may be some intersection between the frustration about what the Board has not accomplished due to limitations in statute and what the Board can accomplish given the statute. I think the Board could take better advantage of opportunities to develop the spending targets, communicating them, mining the public payors for what they have accomplished and what are the limitations – understanding that the public payor population could serve as a micro population that could be studied. That could be used as a launching point for what the board wants to do in the future. **Meg Garratt-Reed** – Noted challenges of accessing reliable data on patient experience especially in the large employer market. Reviewed update to 10 year rolling of average of CPI-M. Noted that US DOL publications pointed to lower retained revenue for insurers as a driver of lower CPI-M in 2024. **Sharon Treat** – Do we know why insurers have lower retained earnings? Because of regulations restricting their ability to retain rebates? **Meg** answered not sure, but noted that this measure is of all health spending, not specifically prescription drugs. One possibility is that it reflects rebounded utilization in 2022 resulting in higher than usual claims. **Meg Garratt-Reed** – Reviewed summary of prior public payor presentations and draft questions for public payors. **Kelsie Snow** – Suggested reviewing these questions as homework **Jennifer Reck** – Asked the idea would be that this is a survey sent to the payors? **Meg** answered yes. **Sharon Treat** – If they have any information on consumer impact that might be something to add in. **Meg Garratt-Reed** – when I send the slides out I can invite people to respond with additional suggestions. **Meg Garratt-Reed** – Briefly reviewed general timeline for legislative	

	session. I'm sure folks know that in the Nov. 5th election the whole legislature will be re-elected, given that it can be hard to know who will be in what committees. Shortly after, by mid-November, there will be caucus leadership elections, those leaders make decisions about committee assignments. The cloture date, when members of the legislature must submit legislation is usually by late December. Changes can be made after that and sometimes only a title is submitted for the cloture date. First day of session is the first Wednesday of the year, which in 2025 is New Years' Day, so may be that the first real day is January 8th. Governor's biennial budget proposal is generally in early January. **Sharon Treat** – Is there any potential to make requests to those putting the budget together to get funding coming from the Governor as part of the budget as opposed to getting funding later from individual pieces of legislation? By not engaging at the earliest possible stage we are missing out to get a foot in the door to get additional funding. **Meg Garratt-Reed** – Don't have great advice on this. A decision would be whether the Board should approach the Governor or to have a legislator or legislative leadership try to work/negotiate on that component. We do have budget requests mostly focused on operational needs, but we are very small and not the best to give advice about influencing the budget. **Sharon Treat** - If we want to have something in the future, trying to influence decision makers at the earliest possible point would be best. **Kelsie Snow** – Will look into this and see if we can get a move on that.	
VII. Open Discussion	There was no additional discussion as the meeting was over time.	
VIII. Adjourn	**Kelsie Snow** adjourned meeting.	

Next meeting: September 23rd, 2024