Maine Prescription Drug Affordability Board
Monday May 19th, 2025 @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: 109 Capitol St, Augusta Maine, 04330

Board Members in Attendance: Kelsie Snow, Sharon Treat, Noah Nesin, Peter Hayes, Rhonda Selvin, Jennifer Reck
(Total = 6)

Board Members Absent: Julia Redding, Susan Wehry
Vacant Seat(s): 0

Others Present:
Advisory Council: Kristy Gould, Jennifer Kent, Kate Ende, Jonathan French, Shonna Poulin-Gutierrez
OAHC: Meg Garratt-Reed, Katherine Senechal, Ceilidh Shea
All Others: Joseph Oros, Lucas Perry, Shuri Senbanjo, Amy Yee, Jakob Giron, Adam Ferguson, Evelyn Pereira, Sooah Cheung, Zack Friend, Rachel Cottle Latham, Keisha Vaughn, Olivia Backhaus, Bill Eicholzer, Martha Auster

Agenda Item:	Discussion:	Action/Next Steps:
I. Call to Order	**Kelsie Snow** called the meeting to order.	
II. Introductions	Board members were introduced.	
III. Approval of the Minutes (March 24th, 2025)	There were no changes to the minutes discussed.	Noah Nesin made a motion to approve the minutes from March 24th, 2025. Sharon Treat seconded the motion.
IV. Administrative Update	**1. Presentation on Reponses to the PDAB's Public Payors Questionnaire** Meg Garratt-Reed prefaced the presentation, saying she planned to walk through the answers to the questionnaire, summarizing more straight forward responses, but then planned to allow participants to engage in discussion with the Board on some of the longer, more substantive questions. She noted that the respondents included Maine Education Association Benefits Trust, the Municipal Employees Health Trust, MaineCare, the State Employee Health Plan, which also includes the Maine Community College System.	

	Meg Garratt-Reed presented the first responses, which asked participants about overall membership numbers and whether there was anything specific about the health of the covered population the PDAB would benefit from knowing. The Education Association Benefits Trust had about 68,000 members. Meg Garratt-Reed asked for confirmation of that number. Jennifer Kent responded that 68,000 represents total number of covered lives., including dependents and their plus 65 Medicare Advantage retirees. So, a little over 10,000 of their total is comprised of Medicare Advantage retirees. Meg Garratt-Reed said that the Municipal Employees Health Trust had around 20,000 members and the State Employee Health Plan reported 27,000. They noted a relatively high average age and a higher rate of obesity. Meg Garratt-Reed said the questionnaire also asked participants about vendors involved in administering their prescription drug benefit and details on the timeline of those contracts. She said that the Education Association Trust and the Municipal Employees utilized Carlon as a PBM because they're both contracted with Anthem for their health benefits coverage. Though it sounds like the Education Association is full insured with Anthem, whereas the Municipal employees Trust is self insured, so different models. It also looks like they have similar contracting timelines, she said. For the Education Association, they indicated they are in contract from 2025 to 2028 and the Municipal employees are contracted from 2024 to 2026. In regard to MaineCare, they use Change Healthcare Pharmacy Solutions. Meg Garratt-Reed said she knows that MaineCare uses a bit of a different model where they are much more involved in shaping their pharmacy benefits management than a lot of other state Medicaid programs. The State Employee Health Plan, they contract with CapitalRx as a PBM and are on a similar 2024 to 2026 contract cycle. Jennifer Kent noted that although the Education Association has a three-year contract, that is mostly for fixed costs, such as admin and program fees, but they look at their pharmacy benefits, contracting, and pricing, every year to make sure they have the most aggressive contract in place. So, they do assess every year even though they are in a three-year agreement.	

	Meg Garratt-Reed asked, when referring to price enhancements, is that about strategy for rebates with the PBM or what are the nature of those conversations outside of the fee structure you have with the PBM? Jennifer Kent responded that that includes examination of the rebate agreement, and price structure as far as the discounts they receive, and the guarantees that are in the contract to make sure they are the most favorable. Meg Garratt-Reed stated that the questionnaire also asked about the involvement of the plan sponsor in formulary decisions. She said for the Education Association and Municipal Employees Health Trust, it sounds like Carleon makes those decisions, given the nature of their agreements and relationship to Anthem. MaineCare and the State Employee Health Plan seem to have a bit more of a degree of decision making in terms of things like formulary placement. Noah Nesin said it would be interesting to hear about the balance between the narrow formulary and control over customization. Meg Garratt-Reed agreed and proposed the potential to have the State Employee Health Plan share information on that at a future meeting, because she said their whole procurement process has been interesting to learn about. She said that CapitalRx is a transparent PBM, so there is a much more understandable pass-through fee structure. Noah Nesin asked, for those who use Carelon as a PBM, is there opportunity for customization based on population and use patterns? Jennifer Kent responded that one thing she wanted to point out that a restrictive formulary doesn't always equate to savings to the plan because of rebates. So, they have looked at more restrictive formularies and in some instances, they would be an additional cost to the trust, which may seem counterintuitive, but because of the more open formulary and the rebates that help offset the total cost for all members, they haven't looked to move to a more restrictive formulary. Kristy Gould added that as a self inured group, they do not have their own clinical staff that could make decisions about drugs that should be on the	

	formulary. So, they do rely on Carelon to make those decisions, but they do ultimately review the formulary and preform disruption analysis, which led them to determine that moving to a more restricted pharmacy would have significant disruption on the population. She said that this year the Trust moved to that enhanced preventive list, which increased the number of drugs that are on their lowest tier to encourage people to get their preventive maintenance drugs. Sharon Treat asked what makes the State Employee Health Plan's PBM more transparent versus not? Meg Garratt-Reed responded that asking the State Employee Health Plan team to come in and present would make sense, given they have a lot more information. She said that her understanding if that their transparent PBM has much more of a clear fee structure, where there is a set amount paid for their services as opposed to it being based on a share of savings a PBM achieves, which might not be opaque about how much they're taking. So, in this model, it's a little bit clearer as to rebates and savings achieved. She said that one of the issues is what defines a rebate in this structure pass through to the purchaser and plan sponsor, and only a clear A and B for service payment is paid. Sharon Treat asked whether there is any way, when comparing all of these different models, for people to discern what the actual costs are for a service between Carelon, for example, and another PBM. Meg Garratt-Reed responded that she has heard from purchasers that it can be very challenging to discern meaningful differences between PBMs. Sharon Treat said that she raised the point because she wonders whether there could be policies in place that would aid in public payors being able to make those kinds of comparisons. Kristy Gould said that there is a bill in the legislature right now that would expand their ability to know what rebates were by therapeutic class and drug, to have a better understanding and make the rebates not quite so tied in. That would not impact fully insured plans, but as a self-insured plan, I believe so. She said it is the AUDIT act, or LD 1906, which she testified on before the Health Coverage, Insurance, and Financial Services committee.	

	Jennifer Kent added that when they go through a full RFP process, looking at different vendors, we all work with broker partners and do repricing exercises to try to get to that apples to apples comparison. When you're looking at a pass through PBM, you're paying more in admin fees rather than discounts and all of those pieces, so it certainly gets more complex. She said to the point that Kristy raised, they do not have their own staff, which is why they contract with their actuaries as well as brokers to help make those comparisons. Meg Garratt-Reed asked, when you go through a procurement process, you are typically doing a single procurement for a TPA that brings a PBM with it, right? Kristy Gould responded that at their most recent RFP, they did the PBM separate from the TPA and ended up coming up with the combined one. There certainly are some efficiencies and other advantages to having them together but they did bid them separately. Jennifer Kent said that they did not do a separate RFP from the carriers. They did medical and pharmacy at the same time as two separate pieces. They did not look for a standalone PBM, due to the efficiencies mentioned earlier. There's complexity in how they are structured and this doesn't necessarily mean they won't look to do things differently in the future. She said they have the right in their contract to carve that benefit out of their medical contract as well, meaning they are not contractually locked in to keeping medical tied to pharmacy, it's just that the decisions they have made to date mean they have relied on the same carrier to provide both benefits. Meg Garratt-Reed said that the survey asked about historical spending, particularly in regard to targets and/or historical medical CPI trends that have been put out. How does that compare to the actual experiences of these purchasers? She noted that the Education Association and Municipal Employees Trust have had similar experiences in the past five years with mid-teen percentage level growth on prescription drug spending. It looks like the State Employee Health Plan had numbers that were a bit lower in 2023 to 2024 at 6% but then that increases in the 2024 to 2025 period to about 12%, which is consistent with what the other purchasers reported. Peter Hayes said that he has noticed, through some of Adam Fine's work at Drug Channels, that pharma's bottom line is decreasing, meaning there are far more	

	dollars being extracted from rebates and other discounts, yet if the employer's side is actually going up at these rates, that's a real disconnect. If pharma's margins are declining and plan sponsors costs are going up, that means that intermediaries like PBMs are not sharing the discounts they are getting. He said that a lot of PBMs have offshore accounts where they're sending a lot of these rebate dollars and they're not getting back to the plan sponsor or consumers. He said he is curious as to the contradictory decline in pharma's bottom line but sustained increased to plan costs has been teased out of the procurement process and discussions with PBMs. Meg Garratt-Reed responded that it isn't necessarily plausible to draw a direct line between these phenomenon because pharmaceutical manufacturer profits would be influenced by public purchasers as well. In the commercial sector, there could be other dynamics affecting the public payors that might influence profits and manufacturers. Peter Hayes said that is you look at United Healthcare, 60% of their revenue is being generated by OptumRx. It would certainly suggest globally, that the PBMs are keeping a lot more of these discounts than they are passing on. So, his curiosity lies in whether that has come up in discussions with PBMs. Kelsie Snow said she thinks that was echoed in the FTC reports on PBMs, too. Jennifer Kent said that she would have to look back to their reporting to see if these increases are net of rebates or not, although she thinks they are not. Kristy Gould confirmed that theirs are not net of rebates. Jennifer Kent said that these increases are truly mostly driven by the high cost of specialty drugs, which essentially are all in their tier 4. She said that her top list of prescription drugs are almost always specialty medications. Kristy Gould said that their numbers are not net of rebates because the rebates lag in the time frame that they receive them, so they do not correspond directly to the time when they were earned when the drug was prescribed. Then, the numbers do not line up in many situations. While the numbers don't line up well to give overall trend numbers, she said that the trend is reduced by more than half after rebates. She said that a portion of that is because their new contract	

	changed from when they used to have sixty percent of rebates pass through when the other forty was used, the PBM used that as their revenue line. She said they have negotiated one hundred percent pass through in this contract. They increased their admin fee instead, so that is one of the reasons they're seeing bigger numbers, but again, when they receive versus earn rebates does not correspond well. Meg Garratt-Reed said that, based on the following slide that asked payors about specific drivers of utilization, the general takeaway was that growth and utilization were pretty small when compared to price growth and on the product mix that is being prescribed. She said that the Municipal Employees Health Trust had noted GLP1s, psoriasis care, and autoimmune conditions. The State Employee Health Plan noted treatment for chronic conditions like cancer and diabetes in particular. They also identified GLP1s. Jennifer Kent noted that MEA Benefits Trust does not cover medication used primarily for weight loss, so, for example, GLP1s with an obesity diagnosis are not covered under their plan, however, they are still in the Trust's top ten drug list for treatment of diabetes. So, the GLP1 spend has increased dramatically in their plan, but not for the same reason as the State Employee Health Plan because, she said, she believes they do cover them for obesity. Humira, Embrel, and the other medications you see high volumes of advertising for, are all represented in their top 10 drug spend list. Kelsie Snow said that something that has changed since the Board's last meeting is that there are now direct to consumer options for purchasing the drugs. Instead of costing somewhere in the ballpark of $1,300, they're now closer to $500 for a 30-day supply. She said she can't imagine that decrease has been captured anywhere yet, though. Noah Nesin asked what the note in the MaineCare column means on the slide deck. Meg Garratt-Reed responded that the note indicated the introduction of new drugs, specifically high cost, effective drugs, into the market as a driver of historical spending. She said she is pretty sure MaineCare covers GLP1s for the treatment of diabetes.	

	Kristy Gould added that the Municipal Employees Health Trust does not cover GLP1s exclusively for weight loss. Meg Garratt-Reed said that everyone acknowledges the clinical benefit, but the burden is so significant in terms of cost. Kelsie Snow said that they have been waiting on some cost benefit data for long term outcomes and there should be some of that coming out in the future that she can share. Meg Garratt-Reed asked Jennifer Kent to discuss strategies used to contain prescription drug costs for MEA Benefits Trust. Jennifer Kent mentioned prior authorization and limitations on quality limits because they know that a lot of times on a first fill somebody might not be able to tolerate the medication and therefore, they stop that therapy and try something else, so in certain instances limiting that first fill to a smaller amount. To address waste issues, they've instituted step therapy edits to get people to try different therapeutic options before jumping right into higher cost alternatives. She said they also have a four-tier pharmacy co-pay structure with tier one being generics. They have a split tier one with low and high-cost generics. She also mentioned the Trust had to increase all of their co-pays this coming July due to their renewal. They tried very hard not to increase them because they don't want them to impact medication adherence but the biggest change that is coming in July is related to their Tier 4 specialty medication. They previously had an $85 co-pay for those prescriptions but are moving towards a 20% increase up to $150 maximum co-pay for Tier 4 drugs given that is where the largest costs are. Meg Garratt-Reed asked whether it was correct that Jennifer Kent had said a 25% increase up to $250. Jennifer Kent responded that their Tiers 1 through 3 are a straight co-pay, 30-day supply or for maintenance medications you can get a 90-day supply for two co-pay, so they forgive one co-pay for people to get those 90-day supplies. However, their Tier 4 is a 20% coinsurance up to $150 maximum per prescription. Those drugs are not eligible for greater than 30-day supplies. So,	

	because these drugs are so high cost, in most instances the co-pay will become $150, but if their 20% is lower than $150, the patient would pay that amount. Meg Garratt-Reed asked Kristy Gould whether there were any strategies she wanted to highlight for the group. Kristy Gould said that many of their strategies are similar to those outlined by Jennifer Kent, but she highlighted the fact that the Trust has an in-house call center. So, when one of their employees has a question, they reach one of four employees located in Augusta, as opposed to speaking directly with Anthem or Carelon. That allows them to collect additional information and provide additional education in a different way. She mentioned they also have a program where they track all of the coupons and manufacturer incentives available for the most common specialty drugs and direct their members to that information. She said they just switched to an enhanced preventative tier with additional preventative medications this year. The Trust also increased co-pays in January 2025. Lastly, they also increased the specialty co-pay, which went from $80 to $150. Meg Garratt-Reed asked if there was anything Shonna Poulin-Gutierrez wanted to speak to on behalf of the State Employee Health Plan, particularly related to their PBM and the restrictive structure they've implemented for formulary design. Shonna Poulin-Gutierrez said that so far the State Employee Health Plan has had a really successful relationship with their new PBM, CapitalRx and are seeing higher rebates with CapitalRx than they did with their previous vendor. She also said that they are looking at limiting GLP1s to a 30-day supply as opposed to 90-day for those using the drugs outside of a diabetes diagnosis. She said they are also looking at GLP1s being filled at retail rather than mail order pharmacies as another way to ensure they are able to reduce waste and be fiscally responsible with spend. Meg Garratt-Reed said that the next question had asked about feedback on prior recommendations made by the Board. The following question asked about whether there is any new kind of authority that would be helpful. Kristy Gould responded that on Slide 9 she tried to look at the actual strategies the PDAB has recommended in its annual reports. She mentioned they do take	

	the PDAB reports and look through them as a Board. She said they conducted a review with their actuary to assess wasteful drugs and found that they had very little to almost no use of any of the drugs on that list. They also worked with Anthem to make sure that they weren't going to be covering those. She said they support anything that is going to increase transparency, particularly of rebates. They are becoming a very large source of revenue, and they have very limited reporting that allows them to make decisions. Jennifer Kent agreed that transparency is very important. She said recommendations on strategies are the most helpful, given the PDAB is looking at multiple different markets – the individual, small, and large group. Even with groups that wouldn't be subject to mandates, there is opportunity to make tailored and unique recommendations. When it comes to mandating coverage of certain drugs though, that can become difficult because something that works well in one market may not be successful in another, including leading to unintended ripple effects for other markets. She ended by saying that increased transparency is where she believes the PDAB can have the most impact. Meg Garratt-Reed said that reflecting back on comments among the Board about minimal impact, it is hopeful to keep in mind that some purchasers have implemented recommended strategies into their PBM procurement process. She said that we are beginning to see a shift in, at least to the extent possible, more visibility into rebate pass through or at least thoughtful considerations about the balance of those things. So, it does feel like there are opportunities for change outside of mandated shifts. Jennifer Kent agreed, adding that the PDAB's feedback is extremely helpful and MEA Benefits Trust is happy to be engaging in these conversations. Sharon Treat asked Kristy Gould about rebate transparency and given they have negotiated 100% pass through, how can they be sure they are actually receiving that full amount and how to address that situation. Kristy Gould responded that they are concerned that they don't have an excellent way to verify that information. They don't think that their TPA is doing anything fishy, but when looking at this year's budget, there are $20 million in rebates. They are very concerned about making sure they get everything they are supposed to. That is why the organization testified in support of LD 1906 in	

	front of the HCIFS committee this legislative session. The actual rebates negotiated are proprietary and they have asked over and over again, but they are just not able to get to the level of the drug or even therapeutic class that they are receiving back in the rebates. She said this is one of their biggest challenges and one of the things they'd like to be increased transparency in. Peter Hayes added that in his earlier comments, there is something to the fact that a lot of these offshore group purchasing offices that PBMs have set up are part of the problem. Things that used to be classified as rebates are being reclassified as admin fees and other things, so I think there are accounting things happening behind the scenes too. There's a reason why the PBMs have record profits and a lot of it is because when they say they say they pass on 100% of rebates, what they're saying is that they pass on 100% of what they define as rebates. There's another big chunk that's not getting passed on and it would be interesting to try to get some insight into that which he thinks is what the Board is hearing around the transparency piece. Meg Garratt-Reed said there are two more questions to review from the questionnaire. The Board had asked the purchasers whether there is anything in particular related to affordability barriers that they wanted to share. Jennifer Kent responded that the cost of specialty medications is primarily driving their trend increases. They have more utilizers and more prescriptions being filled, but it's really the cost that is driving the trend. She said pharmacy trend used to be such a small part of their total pie as far as looking at inpatient, outpatient, professional, and pharmacy trends. Now pharmacy, particularly if you add in medical pharmacy, inpatient and outpatient settings are now the largest piece of the pie. And a lot of that is cost. Kristy Gould said that her organization is tracking the same thing, which is pharmacy inside of medical spend, which brings them to about 33% of pharmacy. And rebates are not paid on pharmacy in medical spend. So that is another real challenge. Kelsie Snow asked whether they had information about when negotiated copays are more expensive than the pharmacy cash price.	

	Kristy Gould responded that yes, they do, and in the tier 1 generics, often their pharmacy copays are higher than the negotiated price and the member pays the lower price. She said they have downward protection. Jennifer Kent said that they have the same experience. If the cost of the drug is lower than the copay, the member just pays the cost of the drug under the plan. Kelsie Snow asked whether that is part of their contracts. As a dispensing pharmacist, she said she knows that is not true for a number of folks. She asked how they are able to do that. Jennifer Kent responded that they've always had that lesser of logic built in, but she thinks that is the standard for anthem's national formulary. Noah Nesin asked whether it does require that the employee understand that option at the point of purchase. Jennifer Kent responded that for example, for a drug with a $10 copay for a generic medication, where the actual cost of the drug is $2.50, the patients would be presented that option at the point of sale through the adjudication process. Kelsie Snow responded that she would be curious to get more information about that, just because she has a number of patients that are asking, at the point of sale, how she is able to get them a drug for $13 when they pay $200 to $300 through their insurance plan. She said she wonders whether that may be a potential future direction for the Board too, because it is illegal to charge more through the pharmacy if the payor is federal, but that is not necessarily true if it's a commercial payor. She said she has not met many folks who are aware enough to ask that difference at the pharmacy counter. A lot of time, if they are not asked, the pharmacy doesn't do it whether they are aware of it or not. Kristy Gould said that their plan has also always been set up that way. Kelsie Snow said that she has seen a number of plans where the cash price varies depending on how it's billed.	

	Jennifer Kent said that she doesn't personally have any information so far as what's considered cash price. However, if the negotiated price with the PBM and the pharmacy is less than the copay, which is often the case with generic drugs, the member pays the lesser of. The lessor of logic is built into all of their tiers. She said that gets a definition too, for example cash price versus negotiated price. That's where there could be some differences and how that's being described. Kelsie Snow said she wonders if maybe she is off base. She said she wonders if they could come up with a list of some drugs with their negotiated rate. Jennifer Kent said it is going to depend on the pharmacy and also the point in time because that can vary pharmacy by pharmacy as well. Kelsie Snow agreed and said that is another thing, to build off of what Peter Hayes said earlier, there is another whole component to it as well, for example what rates pharmacies can purchase things at. She said she thought there was a state law on this. She said she also wonders whether at the municipal employee call center, for example, could do some sort of education on this. Peter Hayes said he is curious about the reaction to some type of index for pricing, including both Trump's most favored nation approach and the CMS negotiated drug approach. He asked whether that makes its way into any if the discussions with the PBMs. Using some outside type of metric to establish price plans, that is. Kristy Gould responded that they have discussed it with their board because they are interested and have questions. But there haven't been any conversations at the level of making decisions based on any of those policies. She said she didn't necessarily want to speak for their board. She said they did have some conversation, though, with a consultant, about the prices being negotiated for Medicare and of course they don't have to sell those negotiated drugs to commercial payors so they may end up taking them off our formula to avoid losing money on them. She said she doesn't know whether those policies would actually trickle down to help commercial payors.	

	Peter Hayes asked whether that approach is acceptable, though. He said it's really hard to negotiate with PBMs because of lack of transparency. He asked whether outside pricing mechanisms are helpful or concerning? Kristy Gould responded she is mostly concerned it would cause cost shifting. Jennifer Kent said that as more information comes out about it, they are learning more about what the impacts would be to their plan and whether access would become an issue if there are caps on what they are allowed to pay for a particular drug. One concern is whether those drugs would still be available to them at those prices or whether they then end up in a situation where certain drugs aren't available through the plan because the cap that's being attached to it. That is the biggest concern she sees initially, but if there are ways around that, anything to bring down the cost of that they charge would be helpful. Rhonda Selvin added that she wanted to reinforce the primary care perspective. There is a real need for education because patients are completely confused by this issue and what they have to pay for things. They can barley navigate the idea that there is a GoodRx card, for example. Noah Nesin said that what is really needed are real time resources for consumers at the point of service, to access information about what their best deal might be. He said when he was at PCHC, they used some of their 340B revenue to provide that service pass through. So any patient at PCHC could use that service to see if the manufacturer program or coupons or cash price were their best deal. No amount of broad education will work as well has that real time support service. He said he thinks we will have to do something to make it a mandate above the pharmacy. A lot of pharmacies don't allow their pharmacists to see it. Kelsie Snow said that when a provider or patient asks for a drug to be billed through cash only, not using any insurance, a lot of the time the difference is of a few hundred dollars. It's not insignificant. To add to the complexity there, though, one thing that gives her heartburn is navigating considerations for their other medical costs throughout the year, because if they aren't paying for a drug through insurance and contributing to their deductible, that adds another layer. The patient might be paying more today, but actually over the course of year, it could save them money.	

	Sharon Treat responded that she knows this is kind of a brainstorming session that Peter Hayes wanted to dive into soon, particularly about strategies that the Board could be promoting and legislation they could support amongst other things. She said she thinks the Board should be keeping a list of all of these ideas for future in depth discussions. She added that she could imagine an app, for example, that patients could use to find the best price at the pharmacy counter. Kelsie Snow said the challenge is that every bit of it is proprietary. From her point of view, the availability, reliability, and timeliness of the data would be a bigger challenge than the mechanics of a project like that. Meg Garratt-Reed said there was a question in the survey about new fiduciary duty requirements and asked for thoughts on that. Noah Nesin said that looking at the summary of the FTC report, it would be great for the Board to be a part of that. Meg Garratt-Reed said they could consider adding that to the agenda for a future meeting and it would be interesting to see what comes out of that audit act for self insured employers that would basically remove some of the barriers to contract language that restricts the availability of data or some of the ability employers have to audit their own claims. Noah Nesin said that a shared understanding amongst the Board of the coupon industry could be helpful. Meg Garratt-Reed said that although it took some time to have this conversation about the public payors questionnaire, it feels good to bring together some of this important feedback. She thanked Kristy Gould and Jennifer Kent for their participation and insights. She said she is going to pass things off to Ceilidh Shea, who has done some research on a couple of executive orders (EOs) coming out of the White House. **2. Federal and State Action on Prescription Drug Affordability** Ceilidh Shea said that she planned to provide a brief overview of two recent EOs. The first one focuses on a wider variety of issue areas listed on the slides. And	

	like Peter Hayes mentioned, the second order is focused on most favored nation pricing. When looking at the first EO, the first substantive section is Section 3 focuses on improvements to the Inflation Reduction Act, filling in gaps that some argue were left by the Biden administration. The first is to seek guidance on price negotiation for 2026, 2027, and 2028. It also includes improving transparency of the program, prioritizing the selection of drugs with high costs to the program and minimizing any impacts on pharmaceutical innovation. She said it is somewhat unclear whether transparency referenced here is transparency for participating manufacturer or whether that's transparency for the public, consumers, or external stakeholders. Another unclear component is how you measure impacts on pharmaceutical innovation. A common theme is that we don't have a lot of answers to these questions. Ceilidh Shea said that the section subsection is to provide recommendations to the President on how best to stabilize and reduce Medicare Part D premiums. She said she would expect that much of this comes from changes the Biden administration made, including in the Inflation Reduction Act, such as capping out of pocket spending on prescriptions drugs to $2,000 annually per enrollee. The Biden administration has already done work to stabilize part D premiums, including reductions across the board and caps on year over year increases. It will be interesting to see how this subsection might parallel any work done in the previous administration. Ceilidh Shea said the last subsection in section 3 is related to working with Congress to fix the small molecule pill penalty, which many of you may be familiar with, but refers to provisions in the IRA that some view as disincentivizing research and development on small molecule drugs, which are essentially drugs typically taken in pill form, by making them eligible for price negotiations sooner than large molecule or biologics. There is already legislation making its way through Congress, the Epic Act, that would make negotiations eligible 11 years post FDA approval for both small molecule and biologics. It will be interesting to see how the administration might work with Congress to get that preexisting legislation through. Ceilidh Shea said that section 4 focuses on developing and implementing a payment model to improve Medicare's ability to obtain better value for high-cost prescription drugs. It is currently unclear what those models might look like. She said that it is also important to note that for a lot of the actions outlined in these	

	EOs, timelines vary significantly. Some are 30 days whereas others could be a year. We haven't necessarily seen any substantial outcomes, yet, from either of the EOs presented today. Ceilidh Shea said that section 5 focuses of appropriately accounting for acquisition costs of drugs in Medicare. The actions associated with this subsection include conducting a survey to determine hospital acquisition costs for covered outpatient drugs and then base don those results, any actions they deem necessary to align Medicare payments with actual cost of acquisition. This builds on previous Trump administration efforts to reduce Medicare payments to 340B hospitals, which was blocked by the Supreme Court in 2022, in part because a survey such as the one outlined in the EO had not yet been conducted. Ceilidh Shea said that subsection 6 includes recommendations to the President to ensure that manufacturers pay accurate Medicaid drug rebates, how to promote innovation in Medicaid drug payment methodologies, how to link payments for drugs to value obtained, and how best to support states in managing drug spending. There aren't any details provided on specific Medicaid policies that the Trump administration wants to work on, so in that area specifically things are a bit more vague. Ceilidh Shea said that section 7 focuses on taking action to ensure future grants to health center are based on whether they make insulin and EpiPens available at or below discounted 340B prices to patients who have high cost sharing. This is similar to a rule finalized in 2022 by the Trump administration, which was later withdrawn from the Biden administration for its unknown and excessive administrative burden placed on FQHCs. It's important to note here that this applies only to health center and not other covered entities in the program. Ceilidh Shea said that section 8 is also more broad. It directs the administration to provide recommendations to the President on how to best promote a more competitive, efficient, transparent, pharmaceutical value chain. There isn't specific language here on PBMs but based on interest in PBMs in the previous Trump terms, PBMs may be the focus here. Ceilidh Shea said that section 9 targets accelerating competition for high cost prescription drugs, issuing a report that provides recommendations to accelerate approval of generics and biosimilars, and then also to improve the process for prescription drugs to be reclassified as OTC meds. She said there has been specific conversations about	

	reclassification of birth control as an OTC medication, in Maine particularly. It is important to keep in mind though, that a streamlined approval process doesn't necessarily translate to increased access or inclusion in a formulary. For the last section in this EO, section 10, the focus is on Section 804 and importation programs. The goal here is to streamline and improve the program to make it easier for states to obtain approval. This also builds on previous Trump administration efforts on drug importation, including the creation of the entire Section 804 process. To date, Florida is the only state that has obtained FDA approval for importation. Colorado has submitted a revised application for approval. However, actually engaging in importation, outside of actual application approval, is a complex process that is yet to be realized. Ceilidh Shea said that section 11 focuses on reducing cost of care for seniors. This includes the proposal of regulations to ensure Medicare payments are not encouraging a shift in administration volume, including ensuring that payments are not shifting care away from less costly physician offices to hospital level inpatient or outpatient departments. The Trump administration had previously proposed site neutral payments for Medicare Parts B and D and Congress is also considering site neutral payment policies beyond just prescription drugs. Section 12 is aimed at increasing transparency into PBMs and their role in the supply chain. She said that the Board had previously touched on this when discussing LD 1906, the Audit Act, but the goal here would be to propose regulations to improve fiduciary transparency into direct and indirect compensation received by PBMs. Finally, the last section in this EO highlights targeting anti-competitive behavior by drug manufacturers. This includes listening sessions and a report with recommendations to reduce anti-competitive behavior. Ceilidh Shea said that this overview has very briefly covered all of the substantive sections the Board may be interested in related to this EO. Ceilidh Shea moved on to discuss a more recent EO, issued on May 12th, which is titled, Delivering Most Favored Nation Prescription Drug Pricing to American Patients. While this EO doesn't cover as many issue areas, there are two substantive sections to focus on with the greatest relevance to the Board. Section 4 related to facilitating direct to consumer purchasing at most favored nation prices whereas section 5 works to establish most favored nation pricing itself. The language here is worth pointing out. The EO describes communicating most favored nation pricing targets to manufacturers to bring prices in line with comparatively developed nations. If significant progress toward that pricing is	

	not realized, there are plans outlines for potential rulemaking and potential waivers for consistent importation of prescription drugs on a case by case basis depending on their price in other countries. It also includes, if prices communicated aren't realized, enforcement action against any anti-competitive practices in the pharmaceutical industry. This is similar to an EO issues in Trumps first term that focused on most favored nation pricing for Medicare parts B and D. She said she believes that was either rescinded or there was an injunction that later led to it being rescinded by the Biden administration. Pharma also ended up challenging that EO. This one, though, unlike the first, doesn't have a defined scope. There are some questions left up in the air, such as how you define a comparably developed nation or how to assess anti competitive practices. It's is also unclear what enforcement actions might look like. While it is unclear where these EOs might lead, the OAHC team thought it was important to share updates on them given they constitute significant federal action on prescription drug pricing. Ceilidh Shea then moved onto a brief legislative update in the Maine legislature. She said that while the content is not an exhaustive list of all prescription drug related work this session, it does contain some of the bigger policy areas explored. She said that the PDAB's legislation, LD 697, received a majority ought to pass vote out of the HCIFS committee. She said there are still votes to be taken in the House and Senate on LD 697, though. There also have not been House or Senate votes on LD 1053, which would require rebates be passed on to patients at the point of sale. The bill doesn't appear to be going anywhere after receiving a unanimous ought not to pass vote out of HCIFS due to concerns about feasibility. Ceilidh Shea said that LD 1580 essentially bans spread pricing and got an ought to pass as amended vote out of the HCIFS committee. The amendment is not publicly posted yet but it will be an interesting one to track. She said that LD 627 and LD 480 were both GLP1 coverage mandate bills, one in the commercial market and another in MaineCare, both of which got unanimous ought not to pass votes out of HCIFS and HHS respectively. So while they are both awaiting House and Senate votes, they don't appear to be going anywhere. Lastly, LD 180 and LD 1018 both focus on 340B. LD 1019 was presented to the Board by Hannah Hudson from the Maine Primary Care Association. Both bills got ought to pass as amended votes out of HCIFS. LD 1018 had transparency language largely borrowed from Minnesota law, that was discussed with Dr. Nikpay at the last meeting. It includes but is not limited to aggregate acquisition	

	costs for all 340B drugs, total number of 340B drugs dispensed, total payments made to contract pharmacies for 340B related services, amongst others. Meg Garratt-Reed added that on LD 1018, the transparency reporting requirements were limited to 340B hospitals, not all covered entities. She said it also includes several metrics that are not included in the MHDO law, most significantly, the actual difference between what the cost of acquisition is and the payment they are receiving from the purchaser. Sharon Treat asked about the status of LD 1906, which was discussed earlier in the meeting. Ceilidh Shea responded that the committee had tabled the bill but had a work session scheduled for May 20th. **3. Insulin and Opiod Registration Fees** Kelsie Snow said that she attends the Board of Pharmacy meetings as often as she is able and has been teaching pharmacy law for quite a while now, which is why she found it peculiar that a very large company asked to be exempted from a registration fee. For background, she said, insulin and opioid manufacturers have registration fees they are supposed to be paying registration fees to the state. One company asked to be exempted and while that received some scrutiny from some Board members, it ended up getting tabled. She said she believes the insulin registration fee is $25,000 a year and the opioid registration fee is $75,000 a year. The former Board administrator, who has since retired, made mention that the fee has only been paid by one company one time despite being on the books for a number of years. It seems like that leaves a lot of money that should have been paid into the state that has never been collected. Sharon Treat said she wonders if there might be potential to write a letter to the state auditor, or someone else. She asked if the money is used to run the pharmacy board. Kelsie Snow responded not yet. Sharon Treat asked whether the money is designated for certain things and secondly, if it is not designated, the Board will have to figure put potential	

	funding streams for LD 697 if it passes through the House and Senate, and this is one potential source that could be worth checking out. Meg Garratt-Reed responded that she thought there were two kinds of programs, one for insulin manufacturers that was intended to support an affordability program for people accessing those medications. Kelsie Snow responded that the program is not necessary. The state has spent a lot of time and energy to create this affordability access program and a safety net for those who use insulin, but it's not any better than programs that already exist. Meg Garratt-Reed asked whether it would be worth inviting people from the Board of Pharmacy to come and speak about this or whether she should reach out first. She also asked when the program is referred to as not yet implemented, is that because they have not attempted to collect the fees or because they have faced insurmountable barriers to doing so. Sharon Treat said that obviously these are profit making companies and they should be paying these fees. Kelsie Snow said that when this came up at the Board meeting, the fees had never been asked about before, which is why she wanted to come to the PDAB to see what the group thinks would be most appropriate. Sharon Treat responded that at the very least, a letter would make things more official. If there is capacity to do so, it would be a good place to start. She said she would like to know what amount of money has been foregone and over what period of time. Meg Garratt-Reed said she is happy to help facilitate directly and work on next steps with Kelsie Snow. She added that one other agenda item for the meeting was planning for the subsequent meeting, which would likely be informed by final information on LD 679. Sharon Treat said that the original planned date for the next meeting does not work for her. She asked if it was possible to move the meeting. Having an in	

	depth discussion about what the Board wants to be doing and how we might want to engage with the legislature is important. Kelsie Snow said that a poll can be sent out to gauge availability for other dates.	**Ceilidh Shea will send out a poll for other available meeting dates in July.**
VII. Open Discussion		
VIII. Adjourn	Noah Nesin made a motion to adjourn. Sharon Treat seconded the motion. The meeting was adjourned.	

Next meeting: July 28th, 2025