Maine Prescription Drug Affordability Board
Monday September 22nd, 2025 @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: 109 Capitol St, Augusta Maine, 04330

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

Board Members Absent: Peter Hayes, Julia Redding
Vacant Seat(s): 0

Others Present:
Advisory Council: Kate Ende, Jennifer Kent, Christina Moylan, Johnathan French,
OAHC: Meg Garratt-Reed, Ceilidh Shea, Katherine Senechal
All Others: Lucas Perry, Brock Ingmire, Kevin Bourque, Joe Miller, Rachel Cottle Latham, Evelyn Pereira, Shuri Senbanjo, Ann Woloson, Jena Doerr, Zach Lynkiewicz, Roswell Cole, Tiffany Westrich-Robertson, Amy Yee, Daniel Vigil, Corey O'Brien, Will Dane

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 (May 19th, 2025)	There were no changes to the minutes discussed	Noah Nesin made a motion to approve the minutes. Sharon Treat seconded. Susan Wehry obtained due to her absence at the May 19th meeting.
IV. Administrative Update	**1. Presentation on Policy Options & LD 697** Meg Garratt-Reed said that the presentation created for the meeting aims to explore potential policies the Board may be interested in assessing, should LD 697 become law. She said that the status of LD 697 is a bit of an unusual situation. Typically, when there is a ten-day window after a bill is passed in the House and Senate, during which the Governor can either sign or veto a bill. If she doesn't take either of those actions, the bill becomes law without her signature. However, the PDAB's bill, along with	

	some others, was passed right at the end of session, when the legislature adjourned immediately, which means the ten day window does not apply. Therefore, the bill is held until the convening of the second session, in January 2026. It will become law unless the Governor vetoes it within three days after the reconvening of the legislature. To that end, the PDAB will have more information about the status of LD 697. Meg Garratt-Reed said that she wanted to start having conversations about broader process, even though the bill's outcome is not yet known. The scope of the bill is big, so it definitely makes sense to lay some groundwork ahead of time. Sharon Treat said that this is the right way to approach the situation, especially given that if the bill were to go into effect, there are some short-term deadlines that may have to be changed ultimately, but it would be good to get on a fast track to action. Even if the bill is vetoed, though, the Board would still be in a good position, having done the foundational work, to be in a position to make the case for a broadening the Board's mandate. Meg Garratt-Reed provided a broad overview of the legislation, including a list of the strategies to lower prescription drug costs that the Board would be tasked with assessing: Upper payment limits, referenced based pricing, transparency requirements and supply chain regulation for entities, reducing out-of-pocket costs, provider engagement and education, regulation of insurance and rate review reform, aligning the payment of drugs with actual acquisition costs, and recommending annual spending targets to public payors or segments of the commercial market. Meg Garratt-Reed said that the bill also includes language about feasibility considerations for each of these strategies, considering what it would actually look like to implement them, as opposed to only considering the theories behind them. She said that she put together some policy ideas that the Board will walk through, but they are by no means an exhaustive list of all policy opportunities available. She said that she welcomes any additional thoughts.	

	Meg Garratt-Reed said that, as was mentioned in a previous slide, a future step in the process will be considering the varying feasibility of policy options. The first of those that is important to keep in mind are legal considerations. She said that the Office has thought about three particular areas where states working on prescription drug pricing have faced successful legal challenges. The first legal consideration the Office notes was the Dormant Commerce Clause, which essentially limits state's ability to enact laws that impact commerce or business in across the country or outside of their scope. And while it was established through case law, which in this situation can make things more unpredictable, she said it is important to flag given it is probably the number one legal challenge that states have faced. For example, in 2017, Maryland had an anti-price gouging law that was struck down because it was found to be in violation of the Dormant Commerce Clause. Sharon Treat said that for those who are interested in pursing this topic more, the O'Neill Institute at Georgetown Law School has a nice summary of state actions on drug pricing. She said that there have been a couple of cases that have involved the State of Maine and some of the laws have actually been upheld. In 2003, which is the one she looked at on the Commerce Clause, may not be relevant with the current Supreme Court, but regardless, it is important to recognize there have been a number of cases that have gone all the way up to the Supreme Court, two of which ended up being upheld, and the other being the PBM law. Meg Garratt-Reed said that these examples are certainly not intended to convey that they block action, just that these are some of the laws that come to mind when you're designing policy. It's important to be prepared because you essentially certainly face legal challenges. Jennifer Reck asked for the O'Neill Institute report be shared with the group.	Ceilidh Shea will share the O'Neill Institute report with MPDAB members via email.

	Meg Garratt-Reed responded that the Office's staff would share the report. She then provided another legal example, the Fifth Amendment's Takings Clause, which bars the government from taking private property for public use absent just compensation. She said this has been used by drug manufacturers to argue that their proprietary, intellectual property is being taken when the government is demanding a lower price that removes their ability to bring in a higher profits or revenue. She cited a 2018 law in Oregon, which focused on disclosure of information. So, it can happen in a couple of different ways, either through laws that are demanding savings or lower prices, but also through laws that looking to increase transparency. Pharma was successful in this example. Jennifer Reck said that there is actually there is a recent update because Oregon appealed the ruling last month. A 9th Circuit court ruled in Oregon's favor, so the law was actually upheld as constitutional. She said this is an important example. While legal challenges are very likely to come, they are not always going to be successful. She said she does not think the presence or threat of legal challenges should discourage action. Meg Garratt-Reed clarified that the Office does not mean to say nothing can be done, just that policies must be designed with these kinds of legal challenges in mind. Meg Garratt-Reed then provided another example of legal challenges, having to do with ERISA or the Employee Retirement Income Security Act, which is a federal law that sets standards for employer sponsored benefit plans, including health plans. What it means in practice, is that states have very limited ability to regulate plans that are self-ensured or employer sponsored. That represents the majority of the commercial market in Maine and across the country. Jennifer Reck noted that in regards to the 2019 Oklahoma law cited in the presentation, a Supreme Court ruling in 2020 actually upheld am Arkansas law that had been challenged on ERISA grounds. She said this is an important example for states and even	

	though states can't do much to impact plan design, there is legal room to maneuver and take actions on impacts of costs. Meg Garratt-Reed responded, saying ERISA, like the Dormant Commerce Clause, can often feel a bit contradictory in this realm. It is very unclear how courts interpret some of the more marginal attempts, it is not black and white and the gray area can be unpredictable in terms of outcomes. Sharon Treat added that a Maine case, which had to do with ERISA and PBM regulation was upheld by an intermediate appeals court and the Supreme Court declined to review it, letting it stand. She said Maine does have some history with our own laws. Meg Garratt-Reed said it is important to consider implementation and operational challenges at a high level. This includes thinking through enforcement mechanisms or limitations and hurdles with the Dormant Commerce Clause on placing requirements directly on manufacturers, for example. She said that NASHP has done a lot of work thinking about ways to influence the prices set by manufacturers in potentially less direct ways. It's important to keep in mind that this issue is usually quite different than other state law where there's much clearer authority for the state to directly get at a problem. Moving policies forward will require creative thinking and tough conversations about how to structure policy in a way that will be effective and where there is a high likelihood of compliance from regulated entities. She said it is also important to consider implementation resources. There is some structure to build on, but as the Board considers different policies, it's important to think about state staffing, contractors, cost of implementation for particular policies. These are always considerations but they are particularly acute when a policy enacts new authority or changes the scope of preexisting programs. It can be a fairly significant scope of work for the state. Jennifer Reck asked about if LD 697 becomes law in January, whether it would be enacted after the end of legislative session.	

	Meg Garratt-Reed responded that it is her understanding that all bills passed in session, it would become effective following the end of the adjournment of the legislature. She said she thinks it is a 90 day window between adjournment and when the law goes into effect, so the Board would likely be looking at late summer or fall of 2026. She said that there is a position created to staff the Board as part of the legislation, however it has been her experience that after we are permitted to hire, there's a job analysis process that typically takes about six months to get the authority to put out a job listing. Sharon Treat asked about pausing to discuss, in greater detail, implementation processes and considerations. If we are discussing PB, regulation, for example, she said, the Bureau of Insurance already has a great deal of authority that might be helpful to think more about. The Board should consider where there are areas of preexisting authority and whether it makes sense to build on those existing structures of if there are other pieces that are needed. For example, she said the Board had had the Superintendent of Insurance mentioned their office felt they did not feel they needed additional authority in regard to PBM oversight, but it could be helpful to think about other issue areas as well. She said she has been reviewing PBM statute and still thinks there is room to clarify or strengthen enforcement and enforcement resources. These kinds of considerations are important in the planning process for the Board. Meg Garratt-Reed said that the Office felt like a good first step was to create a list of policy options so that we don't get further down the road and realize we may have missed a policy that members felt was important to assess. Ceilidh Shea added that in LD 697, the Board has specific strategies to assess, but there are numerous policies that can fall under each of the strategies, so it's important to first outline which specific policies should be explored, and then conversations about enforcement can follow. If the Board decides to focus on PBM	

	transparency, then examining the role and enforcement authority of the Bureau makes sense. Sharon Treat said that actually they go together and that passing laws without enforcement does not ensure compliance. Ceilidh Shea started the policy areas section of the presentation, noting that if members thought there were any specific policies missing in each strategy section the Board could be tasked with assessing, to please add them. She also stated that LD 697 charges the Board with assessing strategies to reduce costs, not actually implementing the strategies or policies. Ceilidh Shea started with Upper Payment Limits (UPLs), explaining that they establish a maximum price that state regulated health plans or large purchasers can pay for prescription drugs. She said that programs in other states have established a board with the uthority to identify drug that pose affordability challenges and determine an appropriate UPL, but it could also be possible to establish a program that implemented a state-level UPL referenced to prices established in the Medicare Drug Negotiation Program. She said that legislation to enact UPLs in Maine has been proposed in previous sessions but has not been successful. Some policy options in this category would include charging the Board with the authority to conduct affordability reviews to establish UPLs for select drugs which would apply to all state-regulated health plans or to establish a reference rate program that would apply to public purchasers. Another option would be requiring that state-regulated insurers pay no more than the negotiated Medicare price for drugs subject to Part D negotiation. Ceilidh Shea said that there are four states with PDABs that have the authority to set UPLs. It is still very much an ongoing process, but Colorado is the leader on this work, having conducted their first rule making hearing for the drug Enbrel, which took place in April 2025. A UPL for Enbrel would be the first in the country. Colorado's PDAB faced legal challenges from Amgen, a pharmaceutical company, which argues that the Colorado law	

	establishing the PDAB violates the Due Process Clause and Dormant Commerce Clause. They also claimed that the UPL is preempted by federal patent law. A district court dismissed the case, and Amgen has filed an appeal. She said it is her understanding that the Colorado PDAB is continuing on with the rule making process for an Enbrel UPL. Jennifer Reck said that on a previous slide it was stated that states haven not tied a UPL to the Medicare negotiated drug prices, but Colorado is considering, for Enbrel, the Medicare negotiated price. She said they are still one rule making step away from that, but that is definitely the direction they're headed in. Ceilidh Shea said that Washington is another state with UPL making authority, although they cannot implement anything unil 2027, so they are currently conducting affordability reviews. Similarly, Minnesota and Maryland have been authorized to set UPLs since 2022 but have yet to impose any limits. Minnesota is in the midst of moving towards establishing a framework for affordability reviews. She said that affordability reviews can take into consideration multiple factors like wholesale acquisition cost, out of pocket costs and spending, patient assistance programs, alternative treatment methods. NASHP has produced a lot of resources that guide states through identifying drugs for affordability review and actually conducting the reviews themselves. Meg Garratt-Reed said that in Colorado, it seems like the decision to have Enbrel be one of their drugs considered unaffordable happened in parallel with the Medicare process. She asked Jennifer Reck whether that decision was perhaps based on an opportunity to capitalize on the newly negotiated Medicare rates or if the program itself was formally tied to Medicare price negotiations. She asked if something happened where the Colorado PDAB where they are now more formally focusing on the drugs that are subject to the Medicare negotiations? Jennifer Reck said that there is nothing in statute that ties their UPLs to the Medicare negotiated rates. It could even be that when	

	they selected Enbrel, there wasn't even a Maximum Fair Price yet. But as they've been moving through the process and a key price indicator has become available, they are looking at it. Minnesota's PDAB actually has language in their statute, though, that says that if they are looking at establishing a UPL for a drug that already has a Medicare negotiated rate, that would be the default UPL. Jennifer Reck also highlighted that the Maryland processes is a bit unique in that if they determine that a drug is not affordable, they don't immediately set a UPL but instead start a policy review. In looking at a specific drug, they don't exclude the possibility of a UPL, but they also don't limit their action to a UPL. They really try to tailor their policy response based on the specific drug identified. Ceilidh Shea then presented on the transparency requirements section of strategy that is outlined in LD 697, noting that if Board members had other specific policy ideas to please add them. She said that generally speaking some states have passed laws seeking more transparency into various programs or actors in the supply chain with the goal of better understanding how money is spent and general industry practices. Recent transparency initiatives have particularly focused on the role of PBMs and the federal 340B program, both of which the Board has explored in past meetings. Maine has robust reporting and transparency requirements that inform Maine Health Data Organization's drug spending dashboards, which were presented last year. Recent legislation passed in Maine has included increased 340B transparency requirements for hospitals, which she said she would discuss in greater detail during the legislative update towards the end of the presentation. She said that one idea here, and this is something Kelsie Snow has brought up from the pharmacist perspective, would be greater transparency into how retail prices are set at pharmacies themselves. Ceilidh Shea said that she is not aware of any state laws that details requirements for greater transparency into retail price setting at pharmacies, although this could tie into prescriber education and consumer education, as well. One example of a policy could look like increased awareness of cost and access for pharmacists or the implementation of real time pricing tools at pharmacies across the state.	

	Sharon Treat said that this may fit better somewhere else, but there was legislation last year that was put in by the health plans to get them greater audit authority, which was not passed, correct? Ceilidh Shea said that was LD 1906 and it was passed at the end of last session. Sharon Treat said she would take a look at the enforcement mechanisms included in that bill because it is very difficult for plan sponsors to determine whether or not a PBM is complying with their fiduciary duties. Ceilidh Shea said that it was her understanding that the bill ended up in a place that felt robust for stakeholders and that some of the PDAB's Advisory Council members were involved in the legislative process. She added that one provision of the legislation allows sponsors to audit PBMs or TPAs at least once a year to ensure they are in compliance with their contracts. Ceilidh Shea then presented on PBM regulation and noted that many states, including Maine, have sought to enable greater oversight and regulation of PBMs as a means of addressing business practices that can lack transparency and lead to increasing costs for consumers and health plans. She said that some recent legislation includes LD 1162, which passed in 2019 and was sponsored by Senator Vitelli requires manufacturers to report to MHDO when they increase the wholesale acquisition cost of drugs by certain thresholds. The law also authorizes MHDO to require pricing component information for specific prescription drugs from various actors along the supply chain. As of 2020, PBMs are required to obtain a license to operate in the state from the Bureau of Insurance. More recently, LD 1580, which passed in 2025, bans spread pricing. LD 180, also passed this past session, prohibits PBMs and carriers from reimbursing pharmacies at rates less than they would reimburse pharmacies affiliated with tat carrier or PBM.	

	Ceilidh Shea said there are a few options for policy in this domain, including banning the ownership of PBMs by health plans or establishing a program for more intensive legal review of PBM business practices by the state. She said she is not aware of another state law that bans ownership of PBMs by health plans, however in 2025, Arkansas became the first state to ban PBM ownership of retail pharmacies, in a similar attempt to disrupt vertical integration that can affect downstream costs for patients and health plans. At least thirty states require registration or licensure of PBMs, such as in Maine with the Bureau of Insurance, but some states have notable programs or stringent business practice reviews. One example is New York, which has established the Pharmacy Benefits Bureau to oversee the PBM industry and manage licensing and reporting requirements. Massachusetts has a new law that will take effect in 2026 that established a PBM licensure program and grants the Office of the Insurance Commissioner enforcement authority. California, New York, and Louisianna have laws imposing a duty of care on PBMs that vary in strength and enforcement but generally require PBMs to act in good faith and fair dealing towards health plans. Sharon Treat said that she was looking at a Government Accountability Office report and one thing that became clear while reading it was that Maine has very good policies but basically does not have any staff to enforce any of it, including the new spread pricing and audit bills passed in the most recent session. Even though the Superintendent of Insurance said he does not need any more enforcement authority, when she looks at what other states are doing and the staff they're devoting to it, in this case the Bureau is funded through fees on PBMs, which is limited. She said one thing to talk about is staffing levels and how to make a good law on paper effective in the real world. Meg Garratt-Reed said she did just hear from Oklahoma that they have a team of fourteen people in their Attorney General's office that are just working on PBM business practices, although this is	

	an outlier and many states also struggle with scope of work and complexity. Kelsie Snow asked whether there is potential to share the workload between states for in-depth legal reviews? Does each state need to come up with their own team? Meg Garratt-Reed responded that she did not have an answer to that at this time but noted that states sometimes collaborate on areas of mutual interest, but how formally that is done versus informal conversations between peers, she does not know. Sharon Treat said that back when Maine had a lot of prescription drug action, specifically spearheaded by the AG at the time, Steve Rowe, they had an interstate group of AGs that were specifically focused on prescription drug related issues. Now, what we see going on with vaccine policies, Maine is joining in the Northeastern States Consortium to actually set joint policy. The same thing is happening on the West Coast. These are interesting models to keep in mind. Jennifer Kent said she was glad Meg Garratt-Reed brough up the larger Oklahoma PBM unit they have established in their AG's office. She said that that unit actually pays for itself. She said there is also a lot of successful litigation and settlements coming out of that. Also, on the policy option related to banning ownership of PBMs by health plans, something else to consider is requiring transparency of ownership and getting greater insight into ownership structures and potential impacts they might be having on pricing in the state. Susan Wehry said she wanted to echo support for the notion of figuring out a way to actually enforce what sounds like existing, good laws. She said she likes the ideas from Sharon Treat and Kelsie Snow regarding sharing resources with other states and creating some sort of consortium. There is probably a body of work that can be conducted interstate, which could limit the amount of work that needs to be done in state. Thinking ahead to	

	the Boards responsibilities, however we can support staffing or coming up with strategies for getting the work done is important because more regulation is not of interest if we cannot enforce it. Ceilidh Shea said the next category the Board will be tasked with assessing is reducing out of pocket costs, including through rate review and insurance regulation. In general, legislation targeting out of pocket costs can focus on spending caps for very specific populations and/or drugs such as insulin or specialty drugs. Some states look further upstream to insulate patient from high out of pocket costs through programs that penalize unsupported price increases or price gouging by manufacturers or by establishing state purchasing pool buy ins. These are just a few examples. In Maine, we cap co-pays for insulin at $35 for a 30-day supply in the commercia market and we also include protections to ensure that consumers using cash assistance programs have that amount counted towards deductibles and out of pocket maximums. Some other ideas might be to institute an additional cap on out-of-pocket costs for specific drugs or categories by engaging with the Bureau on regulatory options. Another more regulatory focused approach would be requiring additional justification of reported pharmacy trends in pharmacy spending and rate fillings or limiting carriers out of pocket limits for prescription drugs. Maine currently sets an annual limit of $3,500 per year per specialty drug. Some other states to highlight are Delaware, Louisianna, and Maryland, which all limit consumer out of pocket spending on specialty drugs to $150 per 30-day supply. More than twenty states, Maine included limit how much a patient pays out of pocket for insulin. Sharon Treat said she was struck by how much insurance costs are expected to increase in 2026, especially with the loss of federal level subsidies. She said that Superintendent Carey's recent op-ed pointed to prescription drugs as making up a large portion of those costs, at least in terms of initial increases. She said it might be worth exploring what authority the Superintendent has in terms of prescription drug spending within rate review.	

	Jennifer Kent cautioned the group against imposing member or patient limits on how much they are responsible, because all this is doing is cost shifting back to the plan and sometimes those are levers that have to be pulled to reduce the overall premium costs of the plan as well, creating higher costs shares for members. Specifically, when discussing specialty medications, such as a 30-day supply of a medication with a cost of over $6,000 a month, that is being charged to the plan. If you limit the so-pays that a member is responsible for, it'd not solving the problem, it just shifts costs around. Pharmacy is the biggest piece of the pie when looking at inpatient, outpatient, and professional. On pharmacy, if you combine medical pharmacy and true retail pharmacy together, those outweigh any other segment. She said she would caution the group against cost shifting. Meg Garratt-Reed thanked Jennifer Kent for her comments and said that in the past, the Board has expressed interest in focusing on policies that really get at the underlying costs of prescription drugs, but in the spirit of laying out all the options we wanted to include some of these proposals as well for discussion. Given the charge from the legislature, there can be benefit in having these discussions and including some of the take aways in recommendations to the legislature. Jennifer Reck said that it's also interesting to consider some of these proposals not as solitary strategies but as something that might be able to bring consumers temporary relief while we might take be taking some bigger swings that would get at the overall healthcare system. If and when we report and convey perspective on these strategies, we can express nuance around this kind of approach. Ceilidh Shea said that the next category to explore is collaborating with providers to enhance consumer education. She said she knows there are quite a few providers on the Board, so welcome any specific perspective they may have to share. It's also important to note that providers have different perspectives on including cost information in prescribing decisions, however,	

	having greater insight into the cost of drugs can help facilitate adherence to certain medications. More awareness of cost during the prescribing process may also help to shift incentives for PBMs and health plans. To date, the Board has not explicitly explored consumer education as a solution to high prices. Some ideas to explore here include exploring options to provide drug cost data to prescribers to inform decision making and patient counseling. Another idea is to develop materials or resources that encourage providers to consider the intersection of cost and access. One example comes from Vermont, where the state mandates pharmaceutical manufactures disclose to Vermont physicians the other prescribers the average wholesale price of drugs they market within the state. Colorado requires pharmaceutical manufactures, when engaging in marketing, to provide the wholesale acquisition costs to Colorado prescribers. When it comes to developing materials or resources to engage providers on cost consideration and access, this doesn't strike me as something that would necessarily be state law, but there are organizations like the American Medical Association that has developed continuing education courses and materials for providers that can raise awareness of drug pricing, financial assistance programs, and how to have those conversations with patients. She asked if any providers had additional thoughts. Kelsie Snow said that as a dispensing pharmacist, generally all of the providers she works with are aware that things are very expensive. When everything is expensive, how do we pick a drug that the patient can actually get and what are some ways we can make it accessible to the patient? She said she does not know what the solution would be unless prescriptions were adjusted to the point of prescribing instead of at the pharmacy, which would be an incredibly huge shift. Some of the drugs she deals with everyday are thousands of dollars a month and that's not even the specialty stuff. So, increasing education about the accessory stuff, like patient assistance programs, can be helpful. Rhonda Selvin agreed with Kelsie Snow and expressed interest in working on this topic.	

	Susan Wehry said she also agrees, but doing any more education that makes being a physician more like being a businessperson is off the table for her. She did, though, like the idea of education about what supports are out there, like assistance programs. She said it is not about physicians not being aware of how expensive things are, but about a system out of control. Jennifer Reck added that it is important to leverage existing resources in the state, such as the Maine Independent Clinical Information Service. Ceilidh Shea said the next category the board would be tasked with assessing, should LD 697 pass, would be aligning payments to pharmacies with actual acquisition costs. As we all know, the supply and payment chain is extremely convoluted, so there can be little relationship between what a pharmacy pays to obtain drug from a wholesaler and the amount paid to the pharmacy by a PBM on behalf of a health plan. This can result in negative margins for some drugs and wide margins on others. In Maine, LD 180, which passed with an amendment that essentially replaced the original content of the bill, originally explored the idea of instituting a state benchmark for pharmacy reimbursement that would have required pharmacies be reimbursed at the national drug acquisition costs (NADAC) or the wholesale acquisition cost if NADAC is unavailable. The bill in this form faced pushback from the Pharmaceutical Care Management Association and the Maine Association of Health Plans. One policy idea to explore in this category would be requiting the commercial reimbursement of drugs using a specified structure like NADAC, as LD 180 pursued in its original form. Colorado, Kentucky, Arkansas, Delaware, Iowa, and West Virginia all require PBM's reimburse pharmacies at an amount no less than NADAC in their commercial market. Meg Garratt-Reed added that she went back and forth on this example, questioning whether it is an affordability policy or a pharmacy access policy. So maybe this is another one of those policies that makes sense if it is tied to something else given the	

	connection between consumers and affordability isn't as clear with this example. Kelsie Snow responded that she agreed and that a policy like this one gets at trying to modulate the prices of some drugs to make up for losses on others, but if we could stop the losses, that might be able to clean things up across the board a little bit. While this is a great initiative, it would require a lot of work and support. Meg Garratt-Reed said that in looking at the commentary on LD 180, her sense is that there would probably be people saying that absent other changes this could actually increase costs for consumers. It requires a deep dive, like all of the policies presented today do. She also reiterated that if LD 697 goes into effect, the Board will be tasked with examining the pros and cons of many of the policies outlined today on a deeper level. Ceilidh Shea presented the last category, which explores recommending or reassessing spending targets for public payors, which the Board has done in previous years. A few other ideas might be collaborating with public payors on other cost containment strategies, in-depth analysis of barriers to meeting spending targets, or a revaluation of the spending targets themselves. She said that for examples from other states, she focused on collaborating with public payors and provided examples of state agencies combining purchasing power with the long-term goal of applying these strategies to the commercial sector. One example is the interstate purchasing pool buy-in program, the Northwest Prescription Drug Consortium. Kelsie Snow said that this is the idea she sees the most potential in and would be interested in working on a subcommittee to help with this idea in particular. Ceilidh Shea provided a brief legislative update to the group. She said the LD 1018, which the Maine Primary Care Association presented to the Board earlier in the year, was signed into law by the governor as part of the biennial budget package. Transparency	

	language was added that requires 340B hospitals report specific information to MHDO. LD 180 also passed, which prohibits a carrier or PBM from reimbursing a pharmacy at an amount less than they would reimburse an affiliated pharmacy. LD 1580 was signed into law and explicitly bans spread pricing. Lastly, LD 1906 or the audit act, was passed and allows plan sponsors to audit PBMs to ensure contract compliance and requires they provide certain claims information upon request. Meg Garratt-Reed said the Office wanted to put this presentation together to start the conversation, which will eventually lead to creating a structure to learn more about these policies and effectively assess them. Finding ways to prioritize work will come after the bill is passed. She said she welcomes thoughts for next steps. Jennifer Reck said that this was a very good list to start from, but with the changing federal landscape, there could be many more opportunities that arise in each of these categories, so it will be really helpful for the Board to be tracking and discussing those developments. For example, last meeting the Board got updates on Executive Orders, and closer to the end of this month is the deadline for manufacturers to take some sort of action on most favored nation. This is something we should monitor. There's also renewed focus on importation at the federal level. Sharon Treat said that the Board needs to think about how we structure ourselves and how frequently we meet. Another thing to consider is whether we have subcommittees that work on specific issues. Based on what Meg Garratt-Reed said, it is going to be a long way to hiring a staff member, but the Board may want to get involved in that process as well, perhaps through a hiring subcommittee. We could also have a legislative subcommittee that deals with who the Board interacts with legislation. She mentioned she would also like to know when term limits are reached for Board members so that the appointment and re-appointment process can run as smoothly as possible and not eat up too much time with empty seats.	

	Meg Garratt-Reed asked what Board members would like to discuss at the next meeting. Susan Wehry said she agreed with Sharon Treat and expressed interest in meeting more often. She asked Board members to come to the next meeting having thought about what subcommittees specifically make sense. Sharon Treat said that on the policy end, it would be helpful to have a moderated discussion, because this is a lot to discuss in a short time. It will take a bit or organization within the meeting to make it a productive conversation. Meg Garratt-Reed said there is a question of how much detail you want to get into on this full list of policies and then narrow them down and then deep dive. She asked that members consider what makes sense from their perspective. Kate Ende invite Board members to attend Consumers for Affordable Health Care's Health Care for Maine Conference and specifically invited any member of the PDAB to present on their work during a panel exploring rising health care costs. Meg Garratt-Reed said that the Office would follow up with the registration link and more information for Board members after the meeting. Jennifer Reck said that the Office of Affordable Health Care is having its annual public hearing soon and she would welcome hearing about how much prescription drugs may come up in testimony.	
VII. Open Discussion		
VIII. Adjourn	Susan Wehry made a motion to adjourn. Sharon Treat seconded the motion. The meeting was adjourned.	

Next meeting: November 24th, 2025