

**Maine Prescription Drug Affordability Board
Monday November 24th, 2025 @ 10:30 am
Microsoft TEAMS Meeting**

In Person Location: 109 Capitol St, Augusta Maine, 04330

Board Members in Attendance: Kelsie Snow, Noah Nesen, Sharon Treat, Susan Wehry, Peter Hayes, Jennifer Reck
(Total = 6)

Board Members Absent: Julia Redding, Rhonda Selvin
Vacant Seat(s): 0

Others Present:

Advisory Council: Kate Ende, Jonathan French, Shonna Poulin-Gutierrez, Jennifer Kent, Kristy Gould

OAHC: Meg Garratt-Reed, Ceilidh Shea, Katherine Senechal

All Others: Patrick Appolonia, David Large, Anthony Madorma, Martha Auster, Evelyn Pereira, Karynlee Harrington, Jim Jones, James Parker, Rachel Cottle Latham, Suhanee Patel, Jenna Doerr, Lucas Perry, Vanessa Lathan, Olivia Backhaus, Shuri Senbanjo, Laurie Ritchie

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 (September 24th, 2025)	There were no changes to the minutes discussed	Sharon Treat made a motion to approve the minutes. Peter Hayes seconded.
IV. Administrative Update	<p>1. 2025 Prescription Drug Transparency Report Presentation – Maine Health Data Organization (MHDO)</p> <p>Karynlee Harrington said she would provide a quick walk through of the prescription drug data sets that MHDO collects, along with an overview of the mandated reports they are responsible for. She said that her colleague Jim Jones would then share some highlights from information contained in the 2025 report.</p>	

To begin, Karynlee Harrington reminded the Board that MHDO was created by the legislature in 1995. They are an independent executive agency, similar to the Office of Affordable Health Care, not part of a larger organization within state government. Karynlee Harrington said she serves at the pleasure of the Board of Directors, each member being appointed by the Governor, representing an array of perspectives, including providers, hospitals, payers, consumers, and government representatives. She said it is their job to create and maintain a comprehensive health information data set that's used broadly to the health of and cost of health care for Maine citizens, and to improve the transparency of the cost and quality of healthcare in partnership with Maine Quality Forum. Part of that transparency is in the cost of prescription drug information. She said that part of that transparency is in the cost of prescription drug information and over the years, especially under Governor Mill's leadership, the legislature has produced more mandates requiring the collection of prescription drug data and the reporting of that data.

Karynlee Harrington said that the data MHDO collects on prescription drugs fall under four different rules. Chapter 243 is the data MHDO collects from health insurance companies in the state as well as public payors, including medical claims and prescription drug claims. Under Chapter 570, MHDO collects prescription drug cost information from manufacturers wholesale distributors, and pharmacy benefit managers. She said MHDO now collects data from hospitals that participate in the federal 340B program under Chapter 340. Lastly, under Chapter 800, they also collect data on acquisition costs of insulin from manufacturers. She mentioned that at the end of her slide deck, there are links to more information on each of these rules.

Jim Jones provided a brief overview of the mandated annual reports produced by MHDO related to prescription drug pricing. He discussed reports on the 25 costliest drugs, 25 most frequently prescribed drugs in the state, and 25 drugs with the highest year-over-year cost increases. Of the data points that they provide in these dashboards, they provide the wholesale acquisition costs (which is basically the list price from the manufacturer), the average wholesale price (which is oftentimes the starting point for the negotiated rates that are paid), and then ultimately what is paid by payers and consumers in that state, which is data collected through the APCD. HE said they are scheduling a release of refreshed data that will capture the July 24 through June 25 period, which will come out in the first quarter of 2026.

Peter Hayes said that Capital Rx is starting to use a whole different index on how they pay pharmacies. He asked whether MHDO tracks information to that or if that is something they are able to do.

Jim Jones responded that they have other data points in the dataset, although they don't go to a specific payer level although that data is certainly available if there is interest in additional analytics. Some of the information they do provide are the net app costs so you can actually see what the national average acquisition of the drugs that are in the dashboard.

Jim Jones then presented more information on the group of top 25 reports, specifically on costs and utilization in Maine at retail and mail order pharmacies. He said that their last publication captured July 23 to June 24, where they saw just under three billion in total spend in the retail and mail order space. He mentioned this does not include any kind of inpatient spend, which is all in the claims and harder to tease out, although the vast majority of prescription drugs are going through this retail data set. He also noted that the top 25 costliest drugs in Maine represent 31% of the total spend but only 4% of prescriptions filled. This is probably not super surprising, but it is a trend they continue to see.

Jim Jones provided an overview of MHDO's dashboards, as well, of which there are three different flavors. He said on their website, you can easily change views from the highest year over year cost to the top 25 most frequently prescribed drugs. He said users can also filter by the type of payer and while they do not get to the payer level, they do segregate the data by commercial claims, Medicare claims, and MaineCare claims. He said users can also cut the data to look at just generics or just brand name drugs. You can also look at specific drugs of interest, where you'll get more granular specifics, such as national average drug acquisition cost on a per unit basis.

Jennifer Reck asked Jim Jones whether he noticed any surprising changes in the data? For example, in other states that track similar data, there have been trends that show Humira, which used to be #1, being knocked down due to the introduction of biosimilars.

Jim Jones said that they would see how that looks when the new version of the dashboards are published at the beginning of 2026, although looking now Humira is one of the number two NDCs for the period that was July 2023 through June 2024.

He said there is a bit of a lag at this point, particularly given those biosimilars hit the market right around the tail end of 2024. That is starting to have an impact, which is why we see it coming down in the rankings, but because of its frequency of use it may still show up in the top 25, if not right at the top.

Jim Jones said the next type of annual report MHDO releases as part of the prescription drug transparency program includes granular data related to information by NDC from manufactures, wholesalers, and PBMs. While they are allowed to display information at the NDC level, they cannot describe any kind of contractual arrangement, so they don't get into the specific rebate by PBMs for specific drug levels. Most of the information they provide in the annual report is an aggregate level to and inform policy. He said that if there are members of the PDAB interested in drilling down into more specifics, MHDO is also to provide that level of analysis.

Jim Jones said that a key finding they have had over the past five years has been the around the way that the average wholesale price is usually much higher for generic drugs than what they see as a percentage of the Wholesale Acquisition Cost (WAC) in the brand name space. That's a concern when it comes to the cost of drugs in the state because the contracted rate is usually tied to Average Wholesale Price (AWP), a vast majority of the time. As a result, while there may be a great spread in the cost individual pharmaceutically equivalent drugs for various WAC prices. Oftentimes, the AWP is very similar, if not the same, across those equivalents, which means that payers and consumers wind up paying pretty much the same amount across all manufacturers, even though the pharmacies are able to pick and choose from the manufacturers that have the lowest cost. So, when they acquire a drug, there's an opportunity for prescription drug cost reductions in the state of payment for prescription drugs more closely aligned with the actual acquisition costs. He said that is something they are beginning to see nationally, with a couple new programs. Amazon has launched their own kind of generic drug space, but Mark Cuban has also launched Cost Plus Drugs, their models using the strategy of marking price up from the WAC at a transparent 15%. It's resulting in drastic savings, especially for some drugs that are available in a retail setting but fall into the specialty tier, like some of the pill form cancer drugs.

Jim Jones said that in this year's report, in the commercial and Medicare space for year 2023, over two thirds of the drugs in the commercial space and three fourths of the drugs in the Medicare space were marked up by more than that 15%, that the Mark Cuban cost plus drugs model is using. He said MHDO used that as a

benchmark, knowing that it is possible as a decent markup. He said that if the baseline is a 15% markup, the vast majority of claims were marked up more than that. In the Medicare space, 29% of claims were marked up more than 115% for brand name drugs. In the commercial market, it was only about 5% of drugs. While the vast majority of this markup takes place in the generic space within the Medicare payer type, they see that markup in the brand name space as well.

Jim Jones said that amongst the data set he has presented and talked about, drugs that are marked up more than 115%, Mainers have spent a total of 638 million for these drugs. Of that, 258 million went to the supply chain. Another way to look at it is that 353 million went to manufacturers themselves. Just to pay for the drugs, 258 million above what was paid to the manufacturers went to intermediaries such as wholesalers, PBMs, and pharmacies. That is a pretty big amount. It represents roughly 10% of the entire ingredient cost for all drugs across all payers in the state.

Jim Jones shared some other highlights from the annual report. First, he reinforced that the AWP is generally more related to the cost of the brand drug when the first generic hits the market. As a result, the average amount paid by payers, knowing that AWP is generally the marker off which payments are driven, after rebates, at an NDC level, about 76% of the average WAC amount for branded ECs. But conversely, for generics, which are obviously cheaper, they are still seeing payments around 400%, or four times the amount it cost to acquire the drug.

Jim Jones also mentioned the variation of rebates from one drug to another and from one PBM to another. On aggregate, though, MHDO is seeing about 17% of average WAC amount in the brand space is a rebate. They actually saw a higher trend for generics around 3.5%, whereas in previous reports it has been less than one percent. So, there could be some outliers in this year's data, but overall, around 4% of the total WAC spend reported from PBMs came back in some form of rebate and of that, about 90% was passed through to payers and consumers.

Jim Jones said that one thing they always like to highlight is that while there is a lot of focus on the amount of increase in drug spend for manufacturers, 86% of drugs actually have no change in WAC at all during the period. They have seen that year over year. More information on that is available in the report itself. Jim Jones said that for about 3,000 drugs had price increases in 2023. There are about 34,000 active drugs on the market at any given time, so a fairly low percentage of that total amount had increases. He said that about 5% of those drugs had decreases in 2023

and that the average amount of decrease was around 47%. So, as we would expect, the prices come down in a commoditized generic space. Again, he said they do not see AWP fall at the same rate. Oftentimes once an AWP is set by a generic manufacturer, it stays static for the life of the drug, while the WAC decreases. Of those 1,400 and some drugs that had price decreases, 94.5% were generics, so again, a lot of the decreases are due to commoditization in the generic space.

Jennifer Reck asked, of the 2,950 drugs with price increases, at a high level are those increases at or near inflation or are they looking more like double digit price increases. She asked Jim Jones to characterize the increases as bit more.

Jim Jones said that they would circle back to the question after finishing up the next few slides.

Jim Jones said that the next variety of report coming out of MHDO has to do with 340B drug spend. There is a new data set they have been collecting and while the report will come out in the next few months, there are some high-level findings to share. 27 Maine hospitals participate in the 340B program and have reported information for their fiscal year 2024. In aggregate, those 27 hospitals spend about 410 million to acquire prescription drugs at the discounted prices under the 340B program, so that represented about 60% of their total spend. Of that amount, they were able to generate just under 326 million in savings on acquisition costs. From those savings, hospitals reported over 100 different programs that were supported by those saving, at least in some part. In the report coming out, those programs will be detailed by hospital. He said that there have been some changes in law, which Karynlee Harrington will discuss.

Karynlee Harrington said that she wanted to make the Board aware that there was a change this past legislative session in Public Law 2025, Chapter 388, sections P1 to P4, which includes new requirements specific to what hospitals must report to MHDO regarding 340B data. It is much more detailed than what they passed the first time around. As a result of the new requirements, MHDO has to go back to rulemaking and amend the rule that governs collection of this data, which the Board is prepared to do on December 4th. They will hold a public hearing with opportunity for public comment. If all goes as planned, they will then begin the process of adopting a routine technical rule change. The MHDO Board can accept the changes as presented or with amendments based on public comment. She said they hope to

have the rule adopted by March of 2026. Hospitals will report by the end of March and then MHDO will produce their report before the end of the year.

Peter Hayes asked Jim Jones about slide 11 of his presentation, during which Jim Jones discussed attempting to measure how much of the spend was going to intermediaries. Peter Hayes recalled a 300 million figure. Peter Hayes asked if Jim Jones had any specific suggestions for policies that might claw back at some of that 300 million that is being directed to intermediaries.

Jim Jones said that he would be happy to provide ideas and draft considerations if that is of interest. He said if the state were to implement a policy to align price with acquisition cost for consumers and some amount of maximum markup, that would be able to tap into some of those savings. He said they already see this in the MaineCare space, which is already regulated and based on NADAC, so there's not a whole lot of mark-up in that space as a result. For MaineCare payers, they see costs pretty similar to what you would see from the manufacturers themselves. It's not as easy as just saying ok, we are going to put a cap on things, though. There are processes that can impact small and independent pharmacies, such as direct and indirect remuneration from PBM's claw backs. A lot of small independent pharmacies that aren't vertically integrated with PBMs wind up having to pay back a lot through various rebates and rules, so there would have to be some kinds of protections there. That said, there has to be some level of checks and balances, recognizing that manufacturers should have some about of return on their investment and PBMs should be paid for helping to design benefit plans and administering claims. Those are all reasonable things but finding a way to make it so that we are not having big markups, especially in the vertically integrated spaces, is important.

Peter Hayes asked Jim Jones whether MHDO data showed what the spread is between what hospitals acquired drugs for under 340B and what they actually price them as in the retail space. Peter Hayes said he suspects that delta is much bigger than the savings they report.

Jim Jones said that all they are showing is what hospitals have reported in terms of savings for acquisition, under the statute of what is defined as 340B savings. If they are selling 340B drugs at the same retail price they would for any claim, that is obviously quite a markup. So, there is revenue that is generated but the actual savings is what is collected under this program.

Peter Hayes said that at one point the Board had looked at something that claimed that for a drug bought at ten cents, the average retail price was \$7,000. There is a huge, huge spread. Peter Hayes asked, in the enhancements that are coming, whether they will track the real difference between what hospitals buy and sell 340B drugs for. He also asked about the current regulations requirement that hospitals report on spending on programming. He asked whether they actually have to report what the cost of programming is so that we can actually determine whether we're getting a good value and that their programming spend is equal to savings.

Karynlee Harrington responded that the law does not require them to specify how much is spent on each program, however it is set up so that hospitals are able to report that information if they have it and wanted to.

Peter Hayes asked whether these would be appropriate to raise as part of the rulemaking process at the December Board meeting.

Karynlee Harrington responded that they do not have the authority to change the law, but the PDAB could certainly make comments about what, from your perspective, you feel is missing. But again, the Board does not have the authority to change what the law requires.

Peter Hayes asked whether the PDAB can influence the MHDO Board. He also asked whether the PDAB would have any impact on helping to influence the MHDO Board to make things like the rule changes he raised, happen.

Karynlee Harrington said that the PDAB's voice is an important one and that the MHDO Board has not heard from the group before. She said that while she has not talked to Meg Garratt-Reed about this, if LD 697 passed, MHDO will gain a seat on the PDAB's advisory council, which would help make that connection. She said it would be really important and that perhaps Meg Garratt-Reed or someone from the Office's team could come and speak to the MHDO Board about the role of the PDAB and its work. She said the PDAB is an important stakeholder in the realm of prescription drug policy, but just to clarify, MHDO is not a policy-making entity. Karynlee Harrington shared that from her perspective, MHDO's responsibility is to make sure that the data they have or are collecting helps support the entities that are policy making or are responsible for making recommendations around policy.

Meg Garratt-Reed reminded the group that the 340B language was included in the budget, so the standalone bill did not pass and was folded in the budget package which makes it more difficult to confirm, but she is pretty sure that budget language was identical to the original bill contents. The OAHC team was very engaged in the work on that bill and on changes to the transparency requirements, so it does include aggregate payment amounts received for prescription drugs obtained under the 340B program, and dispensed to patients to get at that issue of cost or expense versus income, or that revenue that the hospitals are receiving. She suggested that after the meeting, the OAHC can examine the language included in the budget and recirculate that to members, it would be worth confirming whether the request is more about reaffirming the value of certain data collection or something methodological that the group would like to recommend to Karynlee Harrington's Board. She said the OAHC can help facilitate the PDAB's participation in the rulemaking process, should they be interested.

Meg Garratt-Reed also responded to a question raised by Peter Hayes surrounding area of work for the Board, saying that the eighth item on the list of policy ideas that the PDAB is looking to explore if LD 697 passes and the charge is updated, would be aligning payments for drugs to acquisition costs. She said she believes some of that work was included, in part, in response to some of the prior work done by MHDO and included in their reports as a category that the PDAB was interested in exploring within the scope of potential policy ideas. She said she wanted to clarify that that is already in the legislative language at this point.

Jennifer Reck shared that a lot of this information validates the PDAB's work in Maine. She said that the Minnesota Drug Price Transparency Program has also honed in on these generic markups and they have produced a list of drugs of public interest. That was the first list of drugs they identified as being somewhat problematic. She said she is curious as to whether this is worthy of further attention from their Board. Jennifer Reck also highlighted Minnesota's second annual 340B drug price transparency program report, which will come out later in the month. She said she thinks this is a helpful model and will also include additional data this year on physician administered drugs. She said she would share that report out with the group once it is public.

Kelsie Snow asked whether there is a section in the report presented by MHDO that separates out how much of cost or spend is attributed to the vertically integrated PBM associated pharmacies and how much isn't?

Jim Jones responded that they do not currently go into that level of detail in the report but they certainly have data available that could help tease that out. He said they do not capture information in the rule around various affiliations between payers and PBMs and pharmacies. A lot of that information is publicly available, though, so they could use that public information to identify those relationships and build out some analytics there. He added that while the Minnesota report around drugs of public interest is not yet released, he has seen some early iterations, and they do look into some of those exact same questions.

Kelsie Snow asked whether hospital 340B savings can be in some way correlated to hospital DRG codes under reimbursement for hospital stays and how much hospitals lose there.

Jim Jones responded that that is not currently in the scope of their program. He deferred to Karynlee Harrington on whether that could be examined through some of the medical claims MHDO receives.

Karynlee Harrington said that depending on the specifics of the request, MHDO has a lot of data to look at something like that. She added also that one of the new requirements allows MHDO to collect both retail and administered data, as opposed to just retail under the previous rule. So, there will be a whole new set of data that has not previously been a part of Maine's 340B program.

Sharon Treat said that there is a lot of really interesting data out there related to vertical integration, that could potentially help the Board make informed policy recommendations. She said that it would be important for the Board to consider priorities in terms of data collection and the analysis of it.

Karynlee Harrington said that while MHDO has a lot of data, there is a pretty significant level of complexity when analyzing the data and integrating disparate data sets together, which they have the ability to do. She added that MHDO does have some resources and one of the things she would like to do is redirect some of it not all of their work with the transparency report and focus it instead on supporting questions that this group and others have.

Meg Garratt-Reed agreed with Karynlee Harrington and said that this would be a good item to integrate into the next agenda item related to work planning. She said there is a reciprocal relationship between data analysis and policy development

where the two need to be in concert. She said it is important to be specific and targeted about where there are gaps that can reasonably be filled. Maybe that looks like putting together a list of questions that the PDAB brings to MHDO to guide a conversation about what is feasible and possible to answer with data and what is not. She thanked Karynlee Harrington and Jim Jones for their presentation and time. Meg Garratt-Reed said that for the next section of the meeting, the OAH had taken Sharon Treat's email and suggestions to inform the agenda.

Kelsie Snow asked the Board their thoughts on meeting more frequently or in a subcommittee format in 2026 to create more time and capacity to tackle the new charge of the Board, if LD 697 passes.

Sharon Treat said that if this does end up becoming the charge of the Board, they will need to meet more frequently and that all Board positions are filled. She proposed longer meeting times as well, perhaps starting at 10 am as opposed to 10:30 am. She said that the Board often doesn't have enough time to engage in discussion after presentations. Also, in the past the Board has worked in subcommittees. It's easier to get smaller groups of people together, too.

Kelsie Snow agreed that it would be helpful to extend meeting times, although she recognized it can often be difficult to find the time.

Susan Wehry said she endorses the idea of monthly meetings. She said that she also endorses letting the bill language assist the Board in defining the work of those meetings. She said subcommittees are helpful if they have a specific charge. Whether or not the bill is signed, this all would be a helpful exercise, and the work would still be valuable. Susan Wehry said that two-hour meetings may be too lengthy and would prefer to stick to the current hour and a half. Susan Wehry also mentioned that the December 4th MHDO public hearing on 340B rulemaking could be a good opportunity for the Board to engage in processes related to the data the group needs. She said she would like to see the cost of the programs funded by 340B savings, not just a list of the programs themselves. She said she would like to move forward in a subcommittee or with this group on asking these targeted, specific questions.

Noah Nesin said that the MHDO Board does not have the authority to change parameters of data collection and reporting. So, there may be times when a decision about a data point that is not collected, for example, requires legislation to do that

but it seems that the MHDO Board is more related to interpretation and implementation of existing requirements. He said it was important to call that out, but he is happy to engage in further discussion.

Noah Nesin also mentioned that meeting monthly is a good idea, whether it be for 90 minutes or two hours, as long as the Board makes good use of their time. He proposed that every other month be a pure work meeting, without presentation, where full discussion can occur. Then, presentations can occur in off months as one way to manage time.

Jennifer Reck said that 90-minute meetings seem sufficient. She said she feels that subcommittee meetings have been productive in the past, so that could be a good use of the off months. She said she also likes Noah Nesin's idea as well. We are a relatively small board, so it is important to think about what subcommittees would look like and what their charge would be.

Sharon Treat said that it could make sense to book the meetings monthly and as the work begins the Board can determine on a case-by-case basis whether off months are subcommittee meetings or Board meetings. She said the consensus seems to be that the Board stick with the same Monday time slot, for 90-minute meetings. She advocated that the Board begin with its first meeting in January.

Sharon Treat said that if LD 697 passes, the Board should be involved in the hiring process and that it should not be just left to others to make those decisions. Also, she said the Board needs to think about legislative priorities. Things come up that the Board would have credibility on if they weighed in. She said they could make a difference in things like the collection of data from MHDO, for example. Being able to be a bit more nimble in terms of not only being proactive on stuff, but being responsible to what comes up, would be good. She said a legislative subcommittee might be a good option for managing that work.

Meg Garratt-Reed said that for subcommittee meetings, prior notice for public access is required, so those would have to be pretty regularly scheduled so that the Office doesn't have to continuously email people with changes and agendas and scheduling updates. Certainty that could be workable but wanted to flag that with the legislature too, there would have to be a small group keeping track of the public hearings and work sessions scheduled. There would need to be a relatively standard cadence so other people could access them.

Meg Garratt-Reed also highlighted that the proposed staff position outlined in LD 697 would technically be a position within the Office of Affordable Health Care, but still subject to all of the state Bureau of Human Resources hiring requirements and regulations. She said she has not experienced a hiring process with Board involvement but there should be several touchpoints where the Board can be involved. The drafting of the job description for that does need to be within the parameters of the position created. There are requirements regarding level of experience, but there could be input from the Board and members can participate in the interview process and the decision-making process. She said the OAHC team does need to be involved. There is a very structured process within the state that needs to be followed.

Suan Wehry asked, regarding public notice, what the requirements are for advance notice of meetings?

Meg Garratt-Reed responded that the requirement is one week of advance notice. That is for full Board meetings but last year when checking in with the Attorney General's office they said subcommittee meetings do need to be noticed. Following the one-week requirement in statute is likely the best way to go.

Susan Wehry responded that that requirement is not too bad. She posed the idea of conducting a subcommittee meeting in December, perhaps before the MHDO public hearing on 340B rulemaking. She asked the group what they would like to ask the MHDO Board or suggest to them in their comments.

Noah Nesin responded that his understanding of the MHDO rulemaking hearing on December 4th would be an opportunity for the PDAB to express interest in increased transparency on 340B and potential interest in understanding the differential between the savings that hospitals report on 340B and the actual revenue that's generated because of those savings.

Meg Garratt-Reed noted that Karynlee Harrington had mentioned in the chat that there is a fifteen-day comment period, beyond the December 4th live hearing.

Sharon Treat said it seemed like Susan Wehry and Peter Hayes were interested in helping draft comments on the proposed rules.

Peter Hayes said that he thinks this is a big opportunity for the Board.

Sharon Treat said an ad-hoc subcommittee to work on comments would make sense, then.

Meg Garratt-Reed responded that it would be acceptable to take consensus via email, to stand up a meeting between now and Wednesday for a meeting the week after, so there is sufficient notice.

Peter Hayes said he would be happy to serve on the subcommittee.

Meg Garratt-Reed said that the Office would include follow up and scheduling on next steps for the subcommittee meeting in an email.

Kelsie Snow said that with fifteen minutes left in the meeting, turning to final agenda items would be helpful. She said that she thought the FTC report should be discussed, but there is also the annual report to resolve as well.

Meg Garratt-Reed said she thought it would be important to discuss what Board members would like to focus on for the upcoming meeting in January before concluding. She said that one topic could be related to prioritization and work structure. The Board could start by focusing on consumer out of pocket costs or could start with briefings on specific policy interventions, for example. She said understanding the direction Board members would like to head in would be helpful when setting up the content for the January meeting.

Sharon Treat said she would prefer not to start at too high of a level. She said the bill is going to require the Board to come up with a plan. She asked what the elements of that plan would be. There are a lot of things listed in the bill that are worth doing some homework on before meetings so that Board members can come prepared to determine which policies are low hanging fruit and which would require more work to implement. For example, PBM regulation might be easier to approach given there are already laws in place. Perhaps that conversation is more related to beefing up enforcement, for example.

Jennifer Reck suggested Board members do some homework before the next meeting and bring their top three priorities based on the policy options presented at the last meeting. If there isn't a ton of consensus on those priorities maybe the

The Office will follow up with PDAB members to schedule a subcommittee meeting related to MHDO's 340B rulemaking process.

Board members will bring their three top priorities to the January 26th meeting for discussion.

Board could engage in a broader discussion about the mission and vision of the PDAB and how else to prioritize work.

Sharon Treat expressed interest in that idea.

Meg Garratt-Reed said the Board could use a straw poll structure to assess agreement amongst priorities.

Jennifer Reck expressed interested in continuing to keep updated on what other states are doing, like in Vermont, for example. She said they passed a law in 2024 that looks at cost containment strategies for prescription drugs, which the Board has looked at in the context of LD 697. She said there should be a report coming out soon on that work which she will share with Board members.

Board members agreed it was not feasible to meet in December as a full group but expressed interest in convening a subcommittee to work through MHDO rulemaking on 340B.

Kelsie Snow said that the last item of business to discuss is the annual report and solicited feedback from members.

Jonathan French said that Advisory Council membership was incorrectly listed as 2024. He also noted that his organization should be changed to Maine Service Employees Association. Lastly, he said there should be twelve Advisory Council members but only nine are listed.

Meg Garratt-Reed said the Office would make those corrections and noted that there are a few vacancies on the Advisory Council, which are expected to be filled in 2026.

Jennifer Reck said her title should be changed to Senior Policy Fellow at the National Academy for State Health Policy. She also suggested that the link to LD 697 be included in the report so those reading it can easily access the language, particularly given it's importance in the Board's work this year.

Sharon Treat asked whether there are any Board members who have terms that will expire or have expired.

	<p>Meg Garratt-Reed said that there is an annual reporting process for boards, which would be the way to flag expired terms. She said she would give a heads up to the presiding officers about expired terms. She said she believes Susan Wehry has been reappointed through 2028.</p> <p>Sharon Treat asked whether Meg Garratt-Reed could share that kind of information with the Board itself.</p> <p>Meg Garratt-Reed responded that members should have that information in appointment letters.</p> <p>Sharon Treat said she has her appointment letter, but not everyone else's. She said it also does not include information about expiration.</p> <p>Meg Garratt-Reed said she could compile that information and also asked that if there are any Board members who did not wish to continue serving on the PDAB, if they could reach out to her directly, that would be helpful.</p> <p>Susan Wehry said that her title in the annual report should be changed to University of New England School of Public and Planetary Health, not primary care.</p> <p>Kelsie Snow asked if there were any last comments. None were shared.</p>	
<p>VII. Open Discussion</p>		
<p>VIII. Adjourn</p>	<p>Sharon Treat made a motion to adjourn. There were no objections.</p>	

Next meeting: January 26th, 2025