Maine Prescription Drug Affordability Board

April 27th, 2026

2026 Schedule

Meeting Date	Topic
February 23rd	PBMs: Meeting 1 – Education
March 23rd	PBMs: Meeting 2 – Follow up questions and discussion
April 27th	Transparency for patients and providers: Meeting 1 – Education
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Board Priorities – Transparency for Consumers and Providers

- Pharmecutical marketing to providers
- Real time pricing tools
- Gag clauses
- Patient navigator programs
- DTC advertising
- Maine Independent Clinical Information Service

Board Priorities – Transparency for Consumers and Providers in **Maine**

Category	State Legislation
Marketing to providers	LD 719 (2011) repealed Maine's marketing cost disclosure provision (Title 22: § 2698-A). Section 2698-A required all manufacturers and labelers of prescription drugs dispensed in Maine to report costs related to certain marketing activities conducted in the State including, expenses associated with advertising, marketing, and direct promotion; and food, entertainment, gifts, trips and travel provided to a Maine-licensed health care professional. The stated objective of LD 719 was to eliminate potential conflicts with federal reporting requirements and reduces regulatory obligations. The Maine Pharmacy Act (2017) does prohibit manufacturers and wholesalers from offering providers/prescribers with a cash gift in any amount or a gift for which reciprocity is expected or implied.
Real Time Prescription Benefit Tools	LD 523 (2021) requires that by January 1, 2023, health insurance carriers must provide providers with a real-time electronic benefit tool (unless they receive a waiver). This tool must integrate with prescribing or medical record systems and deliver accurate, patient-specific information at the time of prescribing, including cost-sharing amounts, formulary alternatives, drug coverage status, and any utilization review requirements. It must also support and comply with electronic transmission requirements for prior authorization requests for prescription drugs.

Board Priorities – Transparency for Consumers and Providers in **Maine**

Category	State Legislation
Gag Clauses	• LD 1504 (2019) prohibits PBMs from including clauses in its contracts that prohibit pharmacists from disclosing cost sharing information to patients, including the availability of lower cost alternatives • LD 6 (2017) requires that if information related to an enrollee's out-of-pocket cost or the clinical efficacy of a prescription drug or alternative medication is available to a pharmacy provider, a carrier or PBM may not penalize a pharmacy provider for providing that information to an enrollee

Transparency & Marketing to Providers

Pharmaceutical companies invest heavily in marketing to shape how doctors perceive and prescribe medications, including branding, sponsored education, and clinical messaging. This marketing can influence prescribing toward newer, higher-cost drugs over equally effective, lower-cost options, contributing to rising healthcare spending. The issue raises concerns about bias in clinical decision-making and the need for greater transparency and evidence-based prescribing.

In response, states and the federal government have taken steps to limit influence, primarily through transparency and regulation. The federal Physician Payments Sunshine Act (passed as part of the ACA) requires public reporting of payments to doctors, while many states have gone further by requiring disclosure of marketing spending, restricting certain gifts, banning the sale of prescribing data, or even prohibiting some marketing practices altogether

Examples from Other States – Transparency When Marketing to Providers

State Legislation	Content
Colorado, HB19 – 1131 (2019)	• Requires a drug manufacturer engaged in prescription drug marketing to provide to a prescriber with the wholesale acquisition cost of a drug • Requires the manufacturer disseminate the names of at least 3 generic prescription drugs from the same therapeutic class
Connecticut, HB 6669, 2023	• Requires pharmecutical representatives to include the list price of the prescription drug and, if available, "information on the variation efficacy of the drug marketed to different racial and ethnic groups" when marketing to providers
Vermont, 18 V.S.A. § 4633 (2005)	• Requires a marketer to disclose to the physician/prescriber the average wholesale price (AWP) of the drugs being marketed, the AWP of the lowest dose of other brand-name drugs in the same class, and the AWP of generic versions of the drug

Examples from Other States – General Marketing to Providers

State Legislation	Content
Minnesota, MN Statute 151.461 (1993)	Manufacturers, wholesalers, and their agents cannot provide gifts, fees, or payments to practitioners over $50 in a calendar year. The law also requires disclosures of payments of $100 or more, excluding pharmaceutical samples, publications, and educational materials.
Vermont, 18 V.S.A. § 4633 (2005)	In addition to providing pricing information to providers, Vermont law also prohibits pharmaceutical manufacturers from offering most gifts, meals, entertainment, travel, or cash to health care providers. It also requires manufacturers report any permissible payments or economic benefits to the Vermont Attorney General's Office.
California, Health & Safety Code § 119400–119402, 2004	Requires pharmaceutical companies to adopt a comprehensive compliance program and a specific limit on gifts and incentives provided to healthcare professionals. Companies must establish a yearly dollar limit on promotional materials, items, or activities (such as meals) given to individual healthcare professionals. These, along with other marketing interactions, are subject to public disclosure.

Examples from Other States – General Marketing to Providers (cont.)

State Legislation	Content
Maryland, SB 987*, 2026 *Not yet passed	Amends existing tax law to require corporations to add back certain direct-to-consumer prescription drug advertising expenses to their Maryland taxable income. The income tax revenue will be used to fund health insurance subsidy programs.

Direct-to-consumer (DTC) advertising is primarily regulated at the federal level by the FDA, with limited, indirect regulation through state-level consumer protection laws targeting false or misleading advertising.

- In 2025, Senator Bernie Sanders (VT) introduced the End Prescription Drug Ads Now Act, which would would ban prescription drug advertising in all forms. Maine Senator Angus King is a co-sponsor. The bill is still in the introductory phase but significant industry pushback is expected, along with the high-probability of constitutional challenges based on First Amendment protections for commercial speech.
- Also in 2025, Maine Senator Angus King introduced the Responsbility in Drug Advertising Act of 2025, legislation that would prohibit direct-to-consumer advertising of new drugs during the first three years following their approval by the FDA. The bill is still in the introductory phase.

Real Time Prescription Benefit Tools

- Real Time Prescription Benefit Tools (RTPB) are software tools integrated into Electronic Health Records and pharmacy dispensing systems. They provide patient-specific, up-to-date medication costs, coverage details, and lower-cost alternatives at the point of care.
    - This information would normally only be seen by pharmacists when submitting a claim, so RTPB tools add new value by displaying it to the clinician during the prescribing workflow.
- The accessibility, ease of use, and effectiveness of these tools are not well understood. More data is needed on how RTPB tools are used and implemented, as well as their potential impact on prescribing patterns, patient out-of-pocket costs, and integration into clinician workflows.

Federal Level Regulations

- As of January 1, 2023, CMS requires all Medicare Part D plan sponsors to implement at least one electronic RTPB tool.
- Also at the federal level, the *Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (HTI-4)* final rule, released in 2025, sets new requirements for how certified health IT systems handle prescriptions and insurance approvals. It finalizes a new certification criterion requiring the use of the National Council of Prescription Drug Plans (NCPDP) Real-Time Prescription Benefit standard.
    - These rules apply to healthcare providers who use certified health IT within CMS's programs but, because commercial payors frequently follow CMS rules, these RTPB tools are likely to become increasingly common in the coming years

Real Time Prescription Benefit Tools in Other States

In 2021, Colorado became the first in the nation to provide a cohesive Prescriber Tool that supports patients and health care providers in both Health First Colorado (Colorado's Medicaid program) and commercial health plans.

- The tool is a multifunctional platform accessible to prescribers through most electronic health record (EHR) systems. It provides patient-specific benefit and cost information to prescribers at the point of care, including insight into preferred medications from the preferred drug list (PDL)
- One goal of the program is to reward prescribers for using the tool and generating savings, though information on those outcomes is not available

Gag Clauses

Gag clauses in PBM contracts prevented pharmacists from telling patients when a prescription would be cheaper if paid out-of-pocket rather than through insurance. Policymakers viewed these provisions as limiting transparency and increasing patient costs.

- Federally, The Patient Right to Know Drug Prices Act (S.2554), signed into law in 2018, prohibits PBMs and insurers from using gag clauses in contracts that restrict pharmacists from informing patients about lower-cost options.
- The Consolidated Appropriations Act, 2021 (CAA) prohibits group health plans from entering agreements with providers or TPAs that restrict sharing cost, quality-of-care, or de-identified claims data. Plans must annually attest to compliance. While PBM gag clause laws are designed to ensure pharmacists can inform patients about lower-cost drug options at the point of sale, the CAA targets contractual restrictions that limit plan-level access to and sharing of data.
- State laws have complemented and often expanded on Federal level protections before and after federal action in 2018. These laws often go further by explicitly requiring pharmacists' right to disclose cheaper options and/or regulating PBM conduct (such as pricing practices, reimbursement, transparency). Today, all states either have explicit laws banning PBM gag clauses or are covered by federal law.

Patient Navigator Programs

State prescription navigator programs are a flexible, state-specific strategy to reduce medication barriers by guiding patients through complex financial assistance systems, connecting them to resources such as low-cost drug options, manufacturer assistance programs, or state-funded benefits. Some states run formal navigator networks, while others embed navigation into broader efforts like State Pharmaceutical Assistance Programs (SPAPs). They are typically targeted toward low-income individuals, older adults, people with chronic conditions, or uninsured/underinsured populations who struggle with prescription costs or access.

Maine does not operate a patient navigator program. The state does operate other programs for assistance, inclduing the DEL program (Low Cost Drugs for the Elderly or Disabled), Maine Rx Plus, and the Maine Rx Card. These programs are oriented less towards better understanding cost and more towards maximizing assistance with out of pocket costs through dicounts.

Examples from Other States – Patient Navigator Programs

State Legislation	Content
Kentucky HB 406, 2008	Established and funded a community-based service delivery model with a team of two full-time state employees and a part-time contractor to support a broad network of partner organizations and local advocates. The program helps qualifying individuals identify sources of free and low-cost medications offered by pharmaceutical companies. The state team manages the hotline, licenses the software to partners and provides training and oversight for the community network.
Washington SB 5558, 2005	Created a non-profit foundation that provides support for residents with inadequate coverage and distributes grants to fund local patient assistance initiatives across the state. The foundation's program counterpart is a direct-to-consumer hotline where care coordinators guide patients through existing assistance options to find the most affordable ways to access their medications.
Maryland PDAB Proposal	Proposes Maryland implement a patient navigator program modeled after the Kentucky Prescription Assistance Program, including the following PDAB involvement: • Phase 1: Strategic Assessment (4 Months): PDAB and state partners conduct an assessment of current state capacity and opportunities to develop navigator program. • Phase 2: Operational Design (5 Months): Staff develops operational protocols and resource library for providing navigator services. Staff can begin tests and soft rollout on ad hoc bases. • Phase 3: Legislative Phase (4 Months): Introduction of funding and full-time equivalent (FTE) allocation legislation to authorize and create the navigator program. • Phase 4: Program Launch (Milestone): Full program launch; develop partner network, and begin patient navigation services.

Maine Independent Clinical Information Service

MICIS is an educational outreach program designed to offer independent, evidence-based prescribing information directly to prescribers. MICIS began in 2009 and is a program of the Maine Medical Association, though it is funded through a contract with the Maine Department of Health and Human Services, Office of MaineCare Services.

Examples of upcoming events in the Spring/Summer of 2026 include:

- Evidence Based Treatment of Insomnia
- CDC Opiod Prescribing Guideline
- Controlled Substance Prescribing in Maine: Requirements and Recommendations
- OUD and Buprenorphine

Discussion

- Content for next meeting
- Scheduling for next meeting

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