Maine Prescription Drug Affordability Board

Monday, April 27th @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: 109 Capitol St, Augusta Maine, 04330

Board Members in Attendance: Kelsie Snow, Sharon Treat, Jennifer Reck, Rhonda Selvin, Karynlee Harrington, Lisa Nolan
(Total = 5)

Board Members Absent: Noah Nesin, Susan Wehry
Vacant Seat(s): 1

Others Present:
Advisory Council: Kate Ende, Dan Mickool, Jennifer Kent, Robert Payne, Anthony Cantillo, Shonna Poulin-Gutierrez, Christina Moylan, Jonathan French, Kristy Gould
OAHC: Meg Garratt-Reed, Ceilidh Shea, Katherine Senechal
All Others: Anthony Madorma, Miranda Ryzenman, Sergio M., Laura Ritchie, Kevin Bourque, Rachel Cottle Latham, Joesph Oros, Rose Kesselman, Bren Moreno, Julia Underwood, Cody Austin, Mark Hobraczk, Dan Riley, Cody Hill, Melody Calkins, Lora Saunders, Hannah Hudson

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 23rd, 2026)	There were changes to the minutes discussed. Sharon Treat identified a typo, suggesting proposed be changed to opposed to on page 10. Lisa Nolan said that on page three, LD 1783 should be clarified as referring to all payments made on behalf of patients, through coupon programs and other similar things.	Jennifer Reck made a motion to approve the minutes with changes discussed. Sharon Treat seconded the motion.
IV. Administrative Update	Ceilidh Shea started by sharing the MPDAB's 2026 schedule, with the reminder that the goal of the meeting is to cover transparency for patients and providers, which is a separate topic from data collection. She said the agenda does include a conversation about the May 18th meeting and whether the transparency topic can be condensed into just one meeting.	

	Ceilidh Shea said that this topic has served as somewhat of a catch-all for quite a few priorities, but the ones that were mentioned in the January meeting and over email, included marketing to providers, real time pricing tools, gag clauses, patient navigator programs, direct to consumer advertising, and the Maine Independent Clinical Information Service. Ceilidh Shea thanked Board members for their input on and additions to the agenda. Ceilidh Shea said that to start, she would share what laws are on the books in Maine regarding each topic before diving into each individually. For marketing to providers, LD 719, a bill passed in 2011, repealed Maine's market and cost disclosure provision, which previously had required manufacturers to report all of their costs related to marketing, such as advertising, direct promotion, gifts, etc. The stated objective of the bill was to eliminate any potential overlap with federal reporting requirements, which were included in the ACA and accomplished something similar to the original provisions of market and disclosures provisions in Maine. Ceilidh Shea said the Maine Pharmacy Act, passed in 2017, does prohibit manufacturers and wholesalers from providing cash gifts to prescribers when reciprocity is expected or implied. Ceilidh Shea said that in regards to real time prescription benefit tools, LD 523, which passed in 2021, required that by 2023, carriers provide a real time benefit tool in at least one of their plans. The tool would have to integrate with preexisting delivery system. She said she would review in more detail exactly what these tools do, but the law also required that they display cost-sharing amounts, alternatives, coverage status, etc. The tool also has to comply with prior authorization requests. Ceilidh Shea said that Maine has two laws specifically related to gag clauses, which have been covered in previous meetings, but as a reminder at LD 1504, passed in 2019, which prohibits PBMs from including gag clauses in contracts, which would essentially prohibit a provider from sharing cost sharing information. The other law, LD 6, passed in 2017, requires that if information related to out-of-pocket cost is available to a provider, they cannot be penalized for sharing that information with an enrollee.	

	Ceilidh Shea said that these laws can be discussed in more detail if needed, but that is the current landscape in Maine. Moving on to marketing to providers, which was the main top Board members expressed interest in, Ceilidh Shea said there is a lot of research about how marketing can influence prescribing patterns. This often looks like prescribing towards higher cost drugs over equally effective low-cost alternatives, which can greatly contribute to healthcare spending. She said one of the main issues is how marketing influenced clinical decision making. Ceilidh Shea said that on both the state and federal levels, there have been steps taken to limit the influence of marketing, which has primarily come in the form of transparency. The Physician Payments Sunshine Act mentioned earlier and included in the ACA requires public reporting of payments to doctors. Many states have gone a bit further by requiring disclosure of spending, restricting certain gifts, restrictions on cash gifts in any amount, banning the sale of prescribing data, or even prohibiting some marketing practices at face value. Ceilidh Shea said that Colorado passed a bill in 2019 that requires manufacturers to include the wholesale acquisition cost of a drug when marketing to providers. The law also requires that they share the names of at least three generic alternatives in the same therapeutic class. Connecticut passed a bill in 2023 that requires pharma reps to include a list price of a drug and if available, information about the variation in efficacy between different racial and ethnic groups. Lastly, and this is a much older law, Vermont passed a bill in 2005 that requires the disclosure of the average wholesale price when marketing to prescribers. She said these are three examples of what state level legislation specifically targeting price transparency can look like. Ceilidh Shea said there are a lot of examples of these kinds of laws, but in regard to laws targeting the more general practice of advertising to providers, there are some dating as far back in 1993, in Minnesota, which restricts gifts, fees, or payments to providers over $50. It also requires the disclosure of payments of $100 or more, excluding educational materials, but would include things like travel, meals, and gifts. She said that included in the previously mentioned 2005 Vermont	

	law are also provisions that prohibits manufacturers from offering most gifts, whether that be meals, entertainment, travel, etc. It also requires manufacturers report any payments to the Vermont Attorney General. California has a 2004 law that requires pharmaceutical companies, on their own, to create compliance programs that specifically limit gifts and incentives offered to providers. So, pharmaceutical companies create a yearly dollar limit on what they will spend on those activities, and that is subject to public disclosure. Ceilidh Shea said these are a few examples of laws targeting more general marketing practices. Lastly, though, Maryland has initiated a different approach with the introduction of SB 987 this year. The bill, which seems to still be in an introductory phase, is an amendment to existing tax law that would require corporations add back certain direct to consumer advertising expenses to their Maryland taxable income. That revenue would then be used to fund a health insurance subsidy program that they are independently running at the state level. Ceilidh Shea said that before pausing for discussion, direct to consumer advertising can be a difficult issue to address because it is primarily regulated through the FDA on the federal level. There is some indirect regulation through state level consumer protection laws that target false or misleading advertising, though. She said it seems like there may be some appetite at the federal level, though not necessarily within the current administration, to tackle the issue of direct to consumer advertising. For example, Senator Bernie Sanders (VT) has introduced the End Prescription Drug Ads Now Act, that would ban prescription drug advertising in all forms. Of note is that Maine Senator Angus King is a co-sponsor. She said it is her understanding that the bill is still in the introductory phase but significant industry pushback is expected in addition to quite a few constitutional challenges related to Direst Amendment protections of commercial speech. Similarly, last year Maine Senator Angus King introduced the Responsibility in Drug Advertising Act, which would prohibit direct to consumers advertising for new drugs, specifically during the first three years following DFA approval. She said this bill is also still in the introductory phase, so there is not much information on specifically what the debate will look like.	

	Jennifer Reck said that the Maryland bill, SB 987, did have a hearing in March, but they did not take a vote in the committee and Maryland's legislature has since adjourned, so it did not move this session. She said she wanted to share the bill because it seemed like a creative approach and because they technically aren't regulating direct to consumer advertising, they're just addressing the state tax exemption for it, which a state has the legal right to do. Sharon Treat asked whether Maine has a similar tax exemption. She also said, to clarify, that the Maine Pharmacy Act does ban cash gifts in any amount, but if the gift was not in cash, there would be no restrictions. Ceilidh Shea said that based on the language, that is her understanding. Kelsie Snow said that there are also federal restrictions. So, reps engaged in these practices have a lot of rules they need to follow. She said she has a number of people that come to see her and at most they can drop off a coffee and you have to sign for it. The law that was repealed in Maine seemed to have been intended to address that. She said she would be curious as to whether there are things that aren't prohibited under the ACA that other state laws would cover, like in Vermont or Minnesota. Ceilidh Shea said that what was included in the ACA requires public disclosure, but does not include specific limits. A lot of states have these federal level regulations, of course, and pair them with varying degrees of restrictions or bans. She said it is her understanding that if a gift is not a cash gift, it's not included in the Maine law. Sharon Treat said that seems like a rather large loophole. Kelsie Snow said that they are not supposed to purchase any alcohol for prescribes, so when they put on these drug dinners, there are presentations about the data that goes into developing medications, but if anyone at the dinner gets alcohol, that person is supposed to pay. She said she does not know where that rule or practice comes from.	

	Sharon Treat said this is a topic she would like to explore again because it relates to prescribing decisions. Kelsie Snow said she has conflicting feelings about the End Prescription Drug Ads Now and Responsibility in Drug Advertising Act mostly because there's so much being developed all of the time. She said she has seen dozens of instances where a patient saw information somewhere about a medication for their disease and it's the first time their prescriber has heard about it. Kelsie Snow said she worries that in a state like Maine, where we are already lagging years behind urban and metropolitan areas. She said that at the same time though, she doesn't like ads. Ceilidh Shea said she found a 2023 study that found that less than a third of drug ads focus on high value drugs, which they defined as drugs that are proven to work at a reasonable price. She said she did not look into the methodology, but in other words, most dollars are going towards promoting drugs that aren't necessarily the most affordable or effective, which it sounds like is also seen at the pharmacy counter. It's something worth keeping in mind. She said she will keep an eye on the federal level legislation, although again, she is not aware of any appetite from the current administration to work on this issue. Ceilidh Shea said the Office wanted to add in real time prescription benefit tools to the conversation, which are software tools that can be included in health records and varying pharmacy dispensing systems. The tools are designed to provide patient specific, up to date costs on certain prescriptions, coverage details, lower cost alternatives, all of the things that prescribers want to know when they are making these decisions. She said it is her understanding that this kind of information would normally be seen by a pharmacist when they're submitting a claim. The value add of these tools is that they are displaying that information in real time and ideally would be integrated into the prescribing workflow. There is not a lot of information out there about their integration into different dispensing systems and workflows, though. Their accessibility and ease of use aren't well understood yet, so it seems clear we need more data, particularly as it relates to their impact on prescribing patterns and whether they save patients money.	

	Lisa Nolan said that a lot of these programs are being offered from the purchaser perspective. When they have larger purchasers with pharmacy plans, they will add that on to their benefit program as a way to work with providers to make sure that their members are getting access to the lowest cost alternatives, to the extent they are comparable. That is one of the pathways to get those tools, it's sort of a vendor offered service. Ceilidh Shea said that is an important point. What was particularly interesting in learning more about these tools was the difference approaches to implementation. It might be on the purchaser side, but it can sometimes be a prescriber taking initiative to look into whether there are tools available to be implemented on a singular pharmacy level. Of course, whether the tools are available is another thing, but there are multiple ways these tools show up in different settings. Ceilidh Shea said that on the federal level, CMS had required that by 2023, CMS had required that all Part D plan sponsors implement at least one of these tools. Also at the federal level, the Health Data Technology and Interoperability Electronic Prescribing Real Time Prescription Benefit and Electronic Prior Authorization Final Rule, released in 2025, sets new requirements for how certified IT systems handle both insurance approvals and prescription approvals. It finalizes new criteria that requires very specific standards for real time benefit tools. This comes at things from more of an IT approach. However, these rules apply to providers who use IT systems within CMS programs, but we do see commercial payors frequently follow CMS rules. While there is some lag time in uptake, she said she thinks we can expect to see these tools become more common. Ceilidh Shea said that state specific legislation related to these tools was harder to find. Aside from the law in Maine, one example comes from Colorado, which is not a piece of legislation but rather a program within their Medicaid program. Colorado became the first state to provide a comprehensive and cohesive prescriber tool that supports providers who are working in both Colorado's Medicaid program and commercial health plans. Like other benefit tools, it's a multifunctional platform accessible to prescribers through most health record systems. In addition to	

	displaying out of pocket cost and coverage information, it also shows preferred medications from a preferred drug list. One goal of the program is to reward prescribers for using and implementing the tool and perhaps generating savings. She said she could not find information on outcomes so far. She said the uptake of the tool seems dependent on prescriber initiative, uptake being something prescribers and administrators work through on the back end to integrate into their systems, so it's not necessarily a blanket requirement. Ceilidh Shea said it is more of an available tool that can be implemented if it is compatible with the health systems record used in a certain setting. Jennifer Reck asked Rhonda Selvin if she had any feedback to share on using these tools in her practice. Rhonda Selvin said she has limited experience with these tools. She asked what the reward for providers was in the Colorado model. She said unless they are rewarded with time, there is no reward that works. If the tools are navigable by support staff and system leadership allows them to use the tools, then they are a good intervention. Prescribers are absolutely looking for these tools but they have to be developed in a way that actually meets the prescriber's restrictions. Meg Garratt-Reed said that while she does not know specifically about the Colorado program, at the federal level, the use of software that's compliant with high tech requirements and therefore includes some of these tools is a factor in quality incentive payment bonuses. So, it's kind of a plus up in terms of payment, particularly from Medicare. While it is not mandates, it is highly incentivized. She said that's one example and is not sure if they use inventive payment in Colorado or some other kind of benefit. Sharon Treat said that if at some point the Board is querying providers and pharmacists, it would be helpful to include questions related to how these tools are being used and whether they are useful or not. Separately, she asked about this kind of information being available to pharmacists at the time of payment. Ceilidh Shea said that the information displayed by these tools would	

	previously only have been available when submitting a claim, which occurs after the interaction with a patient at the pharmacy counter. Sharon Treat said that is an important interaction with the patient who may want to know whether there is a less expensive alternative out there. So timing wise, it seems like it might be after it is actually useful. Kelsie Snow said that when prescribers write a prescription, they are color coded at her clinic. If they're red that means that theoretically they are not covered. If they are green, it means they theoretically are covered. The patient comes to the pharmacy, the team gets the prescription, types it, processes it, and then adjudicates it against that patient's insurance plan and/or discount cards. If it is expensive, she can find discount cards or other programs. By that point, hopefully she can identify that there is a cheaper alternative, contact the patient, and get that fixed before they show up. But many times, they come right out of an appointment hoping to pick up a prescription. Either it's inexpensive and not super complicated, or it's expensive and the patient has to leave without it due to cost. Kelsie Snow said she would love to send out a questionnaire. She said she has recently had several prescribers reach out to her sharing how overwhelmed they are by getting some of these new evidence based drugs covered for patients and how much of a burden that is. Rhonda Selvin added that not only is it a huge use of resources to work on coverage, but the risk of error is really high. She offered to help Kelsie Snow work on a survey for providers. Kelsie Snow said there are a lot of pharmacies being equated to pharmacy sweatshops. Pharmacists don't have time in a twelve-hour shift to even use the bathroom, let alone spend time talking to consumers about their options. That poses a huge patient safety risk. Rhonda Selvin said we are on the wrong track if we are trying to encourage providers or pharmacists to make these changes by compensating them with anything but time.	

	Sharon Treat said the Board is doing a large process by going through a lot of different topics, so there may be other things that come up that the Board wants to ask. She said the Board should not send out multiple questionnaires, so maybe it makes sense to wait until the end of the process. Kelsie Snow said her favorite insurance to work with is MaineCare, our state Medicaid program, because very quickly, she can pull up their preferred drug list. For example, if a patient has diabetes, she can easily find out what to prescribe. The people at the MaineCare pharmacy help desk are super helpful, she can get someone on the phone in less than two minutes, where with some other insurance plans you end up on the phone for half an hour, at a minimum. Kelsie Snow said that if there could be an effort to get other insurance carriers to make their preferred drug lists available that would be super helpful. Sharon Treat said that is a great suggestion that maybe should be flagged for the Bureau of Insurance. These are things that could potentially be done through regulation. They have to be done by statute, but there are already laws that require carriers to offer these tools. Kelsie Snow said if they wanted to take it a step further, when a patient is in for a visit and they have a diagnosis for that visit, then a real time tool that shows a provider the condition and the meds that are covered for that condition, would be helpful. Ceilidh Shea said the Colorado tool does include a preferred drug list which seems to be include in addition to the more regularly expected information on out of pocket costs and coverage. Dan Mickool thanked Kelsie Snow for the MaineCare shoutout. He said the preferred drug list is different than just a formulary publisher, which maybe various commercial providers do. The preferred drug list has clinical criteria and that is super helpful. It has a stepwise approach, so the logic is built into the preferred drug list. So, if the Board were to consider recommending something similar for commercial payors to adopt, they should go the full step and provide the same sort of preferred drug list that MaineCare has been modeling for decades now.	

	Kelsie Snow agreed and said she wonders if there is any utility in getting more states to have a similar preferred drug list to reduce costs instead of each state having a separate list. Dan Mickool said Maine has unique requirements. For example, Massachusetts has not only a preferred drug list, they also have managed care layered within their Medicaid program, so it becomes a little bit more challenging to get a uniform PDL. Lisa Nolan said there is a big difference between increasing transparency around what those formularies may look like and trying to get one that is uniform even across just one state. All the carriers have different arrangements with PBMs, so while there are some drugs that you'd see consistently within preferred formulary tiers, but you're never going to get them identical. She said she likes the idea of sharing those ideas, though. It sounds like it could be very helpful for prescribers. List Nolan said the only other thing to mention, and it is the case with any kind of statutory fix, is that with ERISA exemptions, some policies do not necessarily apply to the vast majority of commercially insured individuals who are covered through self-insured products here in Maine. There are some clever and creative ways that some states are trying to get around those rules. Regardless, it's important to keep in mind that anything that directs plans to do something probably wouldn't apply to self-insured plans. Kelsie Snow said she understands that it's probably not feasible. But, having worked in multiple places where it is clear that administrative burden can no longer be passed on to providers. It enormously increases the workload and adds to delays to care, especially when you have carriers changing the meds that they cover mid-year. Karynlee Harrington thanked the Board for the letter of support regarding one of the proposed changes int eh collection of pharmacy data at MHDO. She said, as a reminder, MHDO is proposing to add a formulary designation in claims data. She said they received a comment from Anthem saying it is not possible for them to provide that information. They did not say it exactly like this, but they can't provide it	

	in the structure that MHDO is asking for because, without getting into all the details, MHDO was asking for it each time a prescription drug claim is processed. Karynlee Harrington said that based on this conversation, maybe what they should ask for from Anthem is their formularies and MHDO can work behind the scenes, organizing that in some way that is useful. However, there would need to be considerations and awareness of how that information changes. If they were to get the information from claims data, formulary changes would be reflected. But, if MHDO is going to ask for formularies they will need to consider how it is updated. She said the point is that they are receiving some pushback from the largest payor in the state, so MHDO needs to figure out an alternative approach that still allows MHDO to get that information but does not create major administrative burden on Anthem's end. Ceilidh Shea said that if there is any more information on their objection, she could circulate that to Board members, perhaps to consider how to engage in the rule making process moving forward. Kelsie Snow asked what options there are to pushback on Anthem's pushback. Anthem is a company that had $6 billion of net income in 2024 and they're telling us they can't get is the date for patients in the state. She asked if there is an opportunity to let them know that is unacceptable. She said it is hard to believe that it's a technical issue. Karynlee Harrington said she did talk to her Board chair about this and MHDO is of the opinion that they do have this data, it's just not structured in a way that allows them to easily include it on the claim level. No other payor said anything or raised objections, not even the Maine Association of Health Plans. The only objection came from Anthem, though that should not be minimized because they are the largest payor in the state. MHDO has tried to find a middle ground so they don't have to fight over these things, which has been successful in the past. She said they will get something, it's just a matter of working through a way for Anthem to send it to MHDO that is the least burdensome. Karynlee Harrington said that while this meeting has been going on, she received an email from a group that publishes statistics on pharmacy	

	data and utilization nationwide. The study they shared said that 69% of American adults take a prescription drug every day. One in three adults take four or more prescriptions and 9 in 10 Americans that are over the age of 65 take at least one prescription. She said or spending on prescription drugs across the country was up by 10% in 2024. They are estimating that will grow 9 to 11% in 2025. The problem is not going away. She said she thinks it's important to keep the pressure on transparency. Anthem can either work with MHDO or unfortunately this group could consider making these changes law, though MHDO should be able to figure something out. Kelsie Snow said that Anthem is the largest payor for state employees. She said they also had the issue with the Northern Light system not accepting Anthem. It seems like they have the information and data but simply do not want to share it, which is putting Maine people at a horrific disadvantage. She said she wonders what options there are to tell Anthem they have to provide the data. Karynlee Harrington said that while her Board could say that, but that is not the approach they have taken over the past 15 years. She said they have tried to work more collaboratively. She said her goal is to have a conversation with Anthem and figure out how they can make this work. Maybe it's not in the rule MHDO proposed and instead comes through an alternative rule, which is what they call their non-claims based rule. She said she will keep the PDAB updated. Jennifer Reck said that for federal context, plans are going to have to be dealing with the recent Consolidated Appropriations Act changes for PBMs. So PBMs serving plans are going to have to share new information about formulary placements and how rebate compensation links to all of that. She said she wanted to share that as a small piece of context to support Kelsie Snow's idea of pushing back against the Anthem pushback because this is something that is not happening just at a state level in terms of interest in wanting to better understand formularies. Karynlee Harrington said that she is not as familiar with that federal level requirement, so maybe she could touch base with Jennifer Reck offline.	

	Jennifer Reck said she would be happy to follow up. Ceilidh Shea said there are still a few remaining categories to cover before time at the end for open discussion. One of those categories is gag clauses. She said they were covered in both of the PBM meetings, but as a reminder, gag clauses that are included in PBM contracts previously prevented pharmacists from providing patients with information about cheaper alternatives and out of pocket costs. For a long time, these have been seen as liming transparency and liming a pharmacist's ability to share any information they have on lower costs alternatives. She said that there are two laws in Maine prohibiting 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. Ceilidh Shea said that federally, the 2018 Patient Right to Know Drug Prices Act prohibits PBMs and their carriers from using gag clauses in their contracts. The 2021 Consolidated Appropriations Act prohibits group health plans from entering into agreements with TPAs that restrict information about cost sharing, quality of care, and claims data more generally. That specific legislation is more geared towards contractual restrictions related to data at the plan level as opposed to that interaction at the pharmacy counter. Broadly speaking, state laws have expanded on or clarified these federal level protections. All states have laws that ban PBM gag clauses, whether at both the state and federal level or just the federal level. Ceilidh Shea said there was also interest in patient navigator programs when the Board discussed priorities back in January. Generally, navigator programs are a state specific strategy that attempt to reduce cost and connect patients to specific resources, whether that be lower cost drugs, manufacturer assistance programs, or state funded benefits, which	

	again, vary widely depending on the state. Some states run specific navigator networks and other states tend to embed their navigation processes into state pharmaceutical assistance programs, which will be covered in the out of pocket cost meeting later this year. She said navigator programs are often targeted towards specific subsets of the population, whether that be lower income people, older adults, or those managing chronic conditions. She said that Maine does not operate a patient navigator program for prescription drug assistance. There are some programs that will be covered more in depth at the out of pocket cost meeting, but included are the Low Cost Drugs for the Elderly and Disabled program, Maine Rx Plus, and the Maine Rx Card. These are specific programs that are not necessarily oriented towards transparency of cost or understanding the best way to maximize alternatives, but rather focus on discounts. Ceilidh Shea said that Kentucky passed a bill in 2008 that stood up a service delivery model with two full time state employees and a contractor to support a network of partner organizations and advocates. The program aims to help individuals identify sources of free and low-cost medication offered by pharmaceutical companies. They operate a hotline and provide training to community organizations. She said another example comes from a 2005 program in Washington, that established a nonprofit that provides support for Washington residents with inadequate coverage. Similar to Kentucky, the organization distributes grants to fund patient assistance initiatives across the state. She said she was unsure as to whether those initiatives are uniform or if they varying depending on setting, such as an FQHC, for example. Washington operates a hotline like Kentucky, as well. Ceilidh Shea said that Jennifer Reck had shared that the Maryland PDAB has created a proposal to implement a patient navigator program modeled after the Kentucky program. The Maryland PDAB has proposed an initial strategic assessment to better understand the state's capacity to stand up a program of this nature. They subsequently propose operationalizing and designing the program, conducting some testing, then actually launching the program, which will include partner networks.	

	Jennifer Reck said that Maryland is exploring this approach in tandem with a UPL. At their last meeting, they set their first UPL for Jardiance. So, while their Board has UPL authority if they find a drug to be unaffordable, they also do policy reviews to identify other approaches, either instead of or in addition to UPLs. She said she wanted to share that context because an approach like this is stronger if it's paired with something like a UPL that can take on the price more directly. Jennifer Reck said that her understanding of some of the Maryland PDAB's conversations were about how UPLs can create savings for payors that aren't immediately felt by consumers. So, the idea with the assistance program is to balance that out in terms of making sure consumers have the tools they need to access information and take advantage of supports that exist. Kate Ende said that in Maine, Consumers for Affordable Health Care's helpline does assist individuals with identifying prescription assistance programs and enroll in state programs like Maine Rx. She said she wanted to make sure folks were aware of that and that they would welcome any additional coordination with the PDAB, should it be helpful. Meg Garratt-Reed asked whether that prescription assistance is an explicit requirement or included in the scope of funding from the state or whether it is something they do as part of their broader mission around affordability. Kate Ende said it might be in the Consumer Assistance Program statute but that she was not positive and would check. Kelsie Snow said that she is somewhat concerned about the potential for UPLs to restrict access. To do that when discussing a drug like an SGLT2 inhibitor, proven to treat diabetes, heart failure, and chronic kidney disease, she would be hesitant to implement a UPL here until there is concrete evidence that that would not restrict access since that is such an evidence based medication. Kelsie Snow said that one of the tools she has used for years is NeedyMeds, which is a nonprofit that directly connects you to a whole library of patient assistance programs and coupon cards. She said she wonders how many patients know about that hotline and what can be done to raise awareness. Most prescribers	

	she works with have no idea how to get meds to patients affordably. But even when connecting them to NeedyMeds, there is a large burden in helping the patient actually complete the assistance program. You often need a wet signature from the prescriber or to complete it through a portal. She said she wonders if there is anything the Board can do to raise awareness of existing programs without adding a lot of work load onto state employees. Sharon Treat said that PDABs with UPL authority who are going through that process include concerns about access in their affordability reviews. She said the assistance programs are such a patchwork, so she likes the idea of thinking more about how to create resources that simplify looking through everything that's offered. Lisa Nolan agreed. She said she likes the idea of combining more communication around existing tools and an easy way to access them. Potential additional state resources could be helpful to ease some of the burden for pharmacists, to the extent that is possible. If there were a resource to direct people to that helps with some of the paperwork and process, that could be a good step. Given the number if people who will go uninsured this year, there seems to be a real need to get people access to lower cost drugs, which may end up being something that state decides is worth putting staff resources into. That might look like additional funding for an existing resource, for example. Ceilidh Shea said that the last topic to cover is the Maine Independent Clinical Information Service, recommended by Jennifer Reck and Noah Nesin for inclusion in the conversation today. MICIS is funded through the Office of MaineCare Services but is an educational program housed in the Maine Medical Association. They offer independent evidence-based prescribing information or education directly to providers. She said what she could find were some topics they had planned for the Spring and Summer of 2026, which varied widely but included insomnia treatment and a heavy focus on SUD/OUD prescribing. She said it seems like the uptake or participation is optional, whether it is mandated for some providers she is unsure.	

	Jennifer Reck said that when MICIS first began the topics were broader but when the opioid epidemic hit Maine, MICIS was turned to as a ready standing resource to help educate providers about opioid prescribing. That is why you are seeing more of an emphasis on those topics. It's a way that the program has provided a lot of value, but is not limited to. Dan Mickool said he manages the MICIS contract for the Office of MaineCare Services. He said they try to plan topics a year in advance. The reason the opioid topics are included is also because they are largely consistent with the governor's priorities. In 2027 if there are expanded topics the Board would like to see, he would be happy to relay those because they try to conduct some needs assessment. Kelsie Snow said she is wondering about potential opportunities to work with the Maine Medical Association or the Maine Pharmacy Association to get different stakeholders together. She said previously the Maine Pharmacy Association has been able to send out emails to every licensee in the state to raise awareness of these things, like SUD, which is helpful, particularly in rural areas. As we are seeing people lose coverage this year, we cannot reasonably expect them to go from getting a $2,000 a month injection to having to pay for it themselves. Rhonda Selvin said she wanted to reinforce the idea of MICIS. It is already well established and well respected in the provider community. It's set up in a way that providers can attend over lunch. These things have to be realistically offered in order to be used appropriately. Like Jennifer Reck said, the topics were much broader but have more recently been focused on the governor's priorities. She said that another way to reach providers is at their annual meeting. There are always opportunities for additional topics during the pharmacy meeting. Dan Mickool said there is funding this year to have a pharmacists do some academic detailing. He said he cannot make any recommendations because it would be a conflict of interest but if Board members know any pharmacists who would like to take on that role, to let him know. Ceilidh Shea said that with only a few minutes left in the meeting, the Office wanted to raise a scheduling conflict for the next meeting on May	

	18th. The OAHC team will be traveling for a conference and will have limited ability to run the meeting as usual. She said there was communication about condensing the transparency for patients and providers topic into just one meeting, today, as opposed to two. If Board members are open to that, May 18th could be used to cover data collection. If members are not comfortable with OAHC having a limited role in that meeting, there is opportunity to reschedule. The OAHC team thought it might make sense to keep the May 18th date and have an open discussion on data collection with Karynlee Harrington present to field questions and engage on the topic. Board members agreed to keep the May 18th date and cover data collection at that time, as opposed to a second meeting on transparency for patients and providers.	
VII. Open Discussion		
VIII. Adjourn	Sharon Treat made a motion to adjourn. Kelsie Snow seconded. The meeting was adjourned.	

Next meeting: May 18th, 2026