

Maine Prescription Drug Affordability Board
Monday May 18th @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: 109 Capitol St, Augusta Maine, 04330

Board Members in Attendance: Kelsie Snow, Jennifer Reck, Lisa Nola, Sharon Treat, Noah Nesin, Rhonda Selvin, Karynlee Harrington
(Total = 7)

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

Others Present: Jim Jones, Melissa Hillmyer

Advisory Council: Jennifer Kent, Kristy Gould, Robert Payne, Dan Mickool, Shonna Poulin-Gutierrez, Jonathan French

OAHC: Meg Garratt-Reed, Ceilidh Shea

All Others: Austin Williams, Sergio M, Miranda Ryzenman, Margaret Reynolds, Nina Fisher, John Addelman, Rachel Perkins, Suhanee Patel, Vanessa Lathan, Evelyn Pereira, Anthony Madoroma, Kevin Bourque, Shuri Senbanjo, Dan Demeritt, Mark Hobraczk, Kristine Ossenfort, Stasha Parker, Meredith Dart, Olivia Backhaus

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 (April 27th, 2026)	Kelsie Snow said that MediaMeds should be changed to NeedyMeds.org. Jennifer Reck said that there was a typo on the bottom of page 13 and that the word is needed to be added.	Sharon Treat made a motion to approve the minutes with the changes discussed. Lisa Nolan seconded the motion.
IV. Administrative Update	Ceilidh Shea said that as a reminder, the Office of Affordable Health Care team is traveling for a conference for a separate scope of work, so this meeting will take a bit of a different form. Before passing things off to Board members for questions about data collection, she asked Karynlee Harrington whether there is anything she wanted to start with, such as updates on rulemaking. Karynlee Harrington said that she was excited to report to the PDAB that MHDO has a working draft of their new dashboard for	

their top 25 drugs. She said this is one of the major reports MHDO does with their prescription drug data. She said she would like to demo the draft for the PDAB to solicit any initial feedback the Board might have. After the meeting, she said she would send the link to the draft out to members if they would like to spend more time with it. They can email her any feedback or suggestions. She asked if now is a good time to jump into that.

Ceilidh Shea responded yes. She asked whether Karynlee Harrington wanted to demo use of the dashboard or whether she was looking for live feedback. She said if Karynlee Harrington wanted to walk through a demo then it would make most sense for Board members to share initial reactions, with the understanding that there will also be an opportunity to review the dashboards in greater detail offline, should members be interested. Ceilidh Shea said that after the demo and feedback, she would open up the meeting to any other questions or topics the Board wanted to raise in response to the materials she had shared on data collection efforts in Maine to date.

Karynlee Harrington said that she was joined by a few of her colleagues, including Jim Jones, the pharmacy expert MHDO contracts with, and Melissa Hillmyer, who is their data vendor. She said Melissa Hillmyer would share her screen to walk through the dashboard draft. Karynlee Harrington said that MHDO has a wealth of information relative to pharmacy data and they are in the process of collection some additional elements that will help fill in some of the gaps, although there is a lot of data that they already have. She said the greatest challenge is figuring out how to present the data so it is accessible and speaks to what people are asking. Karynlee Harrington said the challenge is finding the middle group in making sure the data being put out is actionable. People often do not know MHDO reports on the costliest and most utilized drugs in the state. She said she wants to figure out how to do better and appreciates the PDAB's engagement in the process.

Karynlee Harrington asked Melissa Hillmyer to screen share the dashboard. She said that if members had seen previous versions

of the dashboard, those look different than this planned update, given they have retooled this version. She said the changes they have made are more in line with some of the best practices when reporting this kind of data or this amount of data.

Karynlee Harrington provided an overview of the draft dashboard. She highlighted the state overview first and then the tab specifically dedicated to costliest drugs. She showed the group the other two remaining tabs, which display the most frequently prescribed rugs and drugs with the highest year-over-year price increases. Karynlee Harrington noted that on the state overview tab, users are able to see the category of drug, whether it be for the top 25 most frequently prescribed or the top 25 with highest year-over-year increases, including the summary level look for each. She said that users can also look at all the drugs that all into the top 25 or they can select a specific drug class, insurance type, drug types (brand versus generic).

Karynlee Harrington asked the Board whether they had any initial thoughts. She also mentioned that the methodology tab is not live right now because the dashboard is still a draft/demo but that the methodology would be available once published. It's a very detailed document that outlines the caveats and the methodology more generally.

Lisa Nolan asked whether specialty drugs are classified as brand drugs or whether that is a separate category not included in the dashboard.

Jim Jones said that specialty drugs are included both for brand and generic and they're all in the same population, so they are included here. He said one caveat is that many specialty drugs are administered in the hospital setting, and those would fall in the medical claim set, which are not included here.

Kelsie Snow said she really liked the dashboard and that there is a lot of information on it that can be gleaned in a glance, which is really helpful. She said in follow up to Lisa Nolan's question, what

is MHDO considering to be a specialty drug. She said the PDAB has previously discussed there being no universal definition, so she asked what is being considered for the purposes of this dashboard.

Jim Jones said there is no differentiation in the dashboard, there is nowhere where specialty is defined. Their inclusion depends on the definition. For example, if they went by the statutory definition in for Chapter 570, it would be any of the drugs that are prices with a WAC of \$950 or more. He said there are obviously other ways of defining it, including by oncology or drugs that need specialty handling, for example. All of those claims are represented in the dashboard, they just aren't categorized as specialty, they are included in either brand or generic.

Jennifer Reck said the hospital administered drugs are probably a really large category of spending. She said it is her understanding that the dashboards use APCD data and that hospital administered drugs are not captured there. She asked about, in the future, whether there are thoughts on how that might be pulled into this data. She asked whether it's possible to get to a place where this is more all-encompassing, to capture the hospital administered drugs.

Jim Jones responded that it is a real challenge that many states are dealing with as well. He said the challenge is that the prescription drug ingredient costs are often embedded within the total medical claim and there is no way to break them out. For example, you might have a physician's charge and a facility charge rolled into one line of a claim. While there might be multiple lines on the claim, the cost is only embedded in one, so breaking it out is very difficult.

Karynlee Harrington said that on Compare Minae, MHDO has a dashboard for reporting infusion therapy in the hospital as well as in other settings. Depending on what you are talking about related to specialty drugs, injectables are one area where there are lots of costs and the variation in costs is pretty significant depending on the setting in which you have those services done. She said there

may be some opportunity to do some integration or include the infusion therapy drugs in a dashboard that is tied to this dashboard. Karynlee Harrington added that she thinks there is also going to be some opportunity with the 340B drugs that the hospitals will be reporting on, that are much more expensive this year than in the first year they began reporting on this data. This time around, the law changes where MHDO is collecting the top 50 drugs, and it's both drugs that are dispensed and drugs that are administered. She said she would envision it as an additional few categories, next to costliest and frequently prescribed, for example. She said they might be able to do that depending on what the information looks like and what questions the Board is interested in having answered.

Sharon Treat asked whether, if when the dashboard is live, users would be able to go into the methodology and see what is not included in the dashboards. She asked if someone, such as a reporter or member of the public looking to write some testimony, would be able to find information about the discussion the Board is having now, for example, which would indicate that some data is not currently represented in the dashboard.

Karynlee Harrington said there are some exclusions mentioned in the methodology, though it's not as comprehensive as what was just discussed, but that that is a good piece of feedback she will take back to her team.

Sharon Treat said maybe this would not belong in the methodology, but it could be nice to have some sort of notification about what is not included. If it is possible to be both informative and use easy to understand language, that would be great. Sharon Treat added that Karynlee Harrington had mentioned people not being aware that this data exists. She asked whether MHDO does any kind of outreach to media and other sources to let them know about updates, for example.

Karynlee Harrington said that she does not notify those kinds of parties or do any kind of press release for dashboard updates or

new releases. She said MHDO notifies various parties, though, like their committee of oversight at the legislature in HCIFS. She said they also notify HHS when certain reports are updated. They also notify all interested parties when reports are updated, though they do not do any kind of press release. Maybe a press release from the PDAB could be of interest, particularly if this group were to express interest in this data or were using it for specific purpose, for example. She said she would be happy to talk more about getting the work out, but often it can feel like while the information is interesting, there is a lack in direction or next steps. It's the now what part that needs to be more solidified. She said it is not necessarily MHDO's (or the agencies they work with) wheelhouse to work on policy. While they have some ideas based on the data, they are not the policy arm. Karynlee Harrington said that goes along with the sentiment that there is a lot of data here, but what are people supposed to do with it?

Ceilidh Shea added that MHDO works hard to improve the accessibility and user experience of their data and dashboards. This refresh is a good example. It's important to potentially consider the Board's role in the "now what" part of this process. A press release is an interesting idea, but there needs to be more to it than a notification that the dashboard has been updated. She said something like that is helpful when it includes an actionable item or a conclusion from the data. For example, is the Board saying there is a data element that we are missing or is the Board thinking there is a specific policy that can be attributed to relieving some of the cost increases we are seeing year-over-year? She said it will be interesting to have Board members sit with this information and dashboard and work through it in greater detail to discern whether this is something substantive to say and draw people's attention to.

Lisa Nolan said all of the MHDO resources are great and that the organization does such good work. She said that at the Healthcare Purchaser Alliance they have shared the Compare Maine resource with employers, which can be particularly helpful for them as they approach how to moderate costs. She said as it relates to drug spend under the medical benefit, HPA does have an analytics

department that analyzes about 150,000 lives of their members data. She said they manage to get data on drug spend under the pharmacy benefit and under the medical benefit, which she would be happy to discuss with Karynlee Harrington, if helpful. Lisa Nolan said that last time she looked, drug spend on the pharmacy side across their book was maybe 20 to 21 percent. When you add in the drug spend on the medical side, it gets you to around 25 percent. That is the ballpark estimate for impact for their members.

Karynlee Harrington said she would be interested in touching base to discuss further.

Jennifer Reck asked whether there were any drugs that were on all three of these tabs (costliest, highest year-over-year increases, and most frequently prescribed). It wouldn't necessarily be a new tab, but could be included in a press release. She said Ozempic could be one that spans all three categories, for example. More commonly, there may be drugs that overlap just between the costliest and highest year-over-year tabs. Jennifer Reck said she is also interested in where those drugs might overlap with the Medicare negotiated prices (for drugs that have Medicare negotiated prices available). She said she is curious about potential savings from referencing those drugs.

Karynlee Harrington said that these are great questions and it would be interesting to explore whether there might be a way to provide some of the insight into overlap between lists into the dashboard.

Jim Jones said that he wanted to highlight that with the tableau dashboards, the button in the upper right-hand corner allows users to export all of the data that's underneath the visualizations, including the types of analysis Jennifer Reck made mention to, which would mean looking across all the tabs and identifying common drugs. The dashboard is focused on one set of visualizations and tries to accommodate the most information it can, but there are other ways to go about getting into the details

as well. He said if members are interested in a deeper dive, he would encourage them to download the data and take a look through that as well.

Karynlee Harrington said that one of the things they have reported on for a very long time in their annual transparency report is how we are paying a lot more for generic drugs than what the wholesale acquisition cost (WAC) is. While the WAC changes, what we are paying does not. It goes up. She said in reference to savings, maybe there is an opportunity to pull things out of their current reporting structure and create a separate document that includes key observations. She said Jim Jones made a good point that people are able to download all of the detailed data, but a lot of people are not going to do that. So, she is interested in finding that middle ground here key findings are accessible while those who are interested are still able to drill down into the details.

Sharon Treat said she liked that idea. Before Karynlee Harrington said key observations, she was thinking something along the lines of an FAQ so people are able to better understand how this data might relate to them or decisions by Medicare, for example. Sharon Treat said that in regards to the conversation about exposure, she is assuming that there are links to the MHDO website from other people's websites, but she is wondering how many are out there and if that is something to encourage. While some of this is about the media or general public, a lot of it could be about different organizations that are involved in policy working through this data and being able to find it easily.

Kelsie Snow said that while this may be beyond the scope of what is currently being discussed, she did see that Jardiance is ranked number seven and eight on the highest year-over-year list. At the same time, she is also aware that dapagliflozin, which is the generic for Farxiga, has just come out at a much lower price point. Kelsie Snow said she does not know what discussions there are to identify those types of opportunities because that alone would represent a significant cost savings for people and the payors in particular.

Jim Jones said one of the big challenges for this data is that MHDO receives it retrospectively. HE said if you look at the top of the report you can see the time period. At this point, we are looking back almost a full year, so some of the newer to market drugs are not going to start showing in the reports until this next year, unfortunately. The challenge they have with a lot of new to market drugs is that lag period between dispensing when they are able to get the data and then when they are actually able to present it.

Lisa Nolan said that when those generics start appearing, it is interesting to see what the uptake is once the data starts to reflect availability. Sometimes you see generics come into a space but people are already really tied to the brand drug, which is really expensive. To the extent people are able to be redirected, if it's medically appropriate, to a generic is another area for potential savings. She said that seeing if there is uptake once those generics are available would be interesting.

Noah Nesin asked Lisa Nolan if she was referring to prescribers.

Lisa Nolan said she was referring to everyone, to an extent. She said she tends to approach things from a purchaser perspective, but often you will see that it's partly based on what's in the formulary. Of course, it varies but you'll often see generics out there for specialty drugs but you don't see the needle move at all in correlation to that availability of a cheaper alternative. There are lots of reasons why that could be happening. For example, maybe the formulary hasn't been updated to encourage members through a lower cost sharing structure for that drug, or maybe it can be attributed to prescribing patterns, for example. There are a lot of different reason why it could be happening but getting a sense of potential savings that could be realized through the introduction of a generic would be interesting.

Noah Nesin said that from a prescriber standpoint, a number of things contribute to a slowness in changing to generic. One is a lack of familiarity with the relative efficacy, so there could be an

opportunity for provider education there. He said another reason is uncertainty about insurance coverage. It's not the instance in every case that a generic is a lower tier drug than a brand name. Over the course of the day, he said she thinks providers tend not to want to take the time to investigate that and they simply don't have the time to do it. Noah Nesin said that another reason has to do with electronic health records. To renew a prescription is essentially one click in an electronic health record, but to change it, even to generic intentionally, is several keystrokes that take time that prescribers just don't have. He said those are important practical interventions for improving uptake of generic equivalents when they are available and less costly.

Lisa Nolan said that those points all make sense, especially given the time crunch prescribers are under. She agreed that some of them present an opportunity for practical policy intervention.

Ceilidh Shea said that connects to the Board's conversation at the last PDAB meeting about provider education, the Maine Independent Clinical Information Service (MICIS), and real time prescription benefit tools. She said to add onto previous points about alerting people to the existence and update of the dashboard, there is also the opportunity to couple findings from the dashboard with survey results in Maine of prescription drug affordability that organizations like Consumer for Affordable Health Care have conducted. She said having a staff member dedicated to the PDAB in the near future would also allow for further exploration of how the Board would like to engage, if at all, in getting the word out about MHDO data. Coupling the empirical data with findings about Maine people and their struggle to afford the medications they need could be a powerful way to draw attention to the key findings from the dashboards.

Karynlee Harrington said she has been thinking about this issue for a long time. She said that in looking at some of the reports out there, around six out of ten people take at least one prescription drug. It is becoming a much bigger part of health care spending and MHDO's data just on the pharmacy side alone. She said they

do not have the self-funded ERISA plans, who are exempt from state law that requires payors to submit data. But, in looking at the populations that MHDO does cover, prescription drugs costs are about 26 percent of the total in their claims data. Karynlee Harrington said she has been thinking for a long time about creating something similar to the Compare Maine platform for prescription drugs. She said that for those not familiar, Compare Maine shows, as required by law, the average payments by service provider in the commercial market, though they are starting to pull in some of the MaineCare data. She said that for prescription drugs, they could start with the top 25 most costly, most utilized etc. If there is some overlap between the three categories, let's assume 50 drugs for the purposes of this conversation, if MHDO were to show those drugs, users could select their insurance carrier. Karynlee Harrington used Jardiance as an example. Users would be able to select that drug and then see the difference in average payment for, and this is where it gets complicated, but let's say a 30 day supply in pill form. They could show the different pharmacies and average payment across different payers. This could give people a sense of what the difference is going from one pharmacy to another, which can vary in price.

Kelsie Snow said she really liked the Compare Maine idea. She said there is variation not just by payor but also by individual plan. For example, she had been accepting one payor for quite a while but they had tried to exclude her from some of their individual plans based on employer. She said she did not know what that would look like given it's not only differentiated by payor but also at the more granular individual plan level.

Karynlee Harrington said that they are capturing information about whether or not the plan is an HMO or PPO or point of service or a plan offered on CoverMe. She said, to Kelsie Snow's point, that is part of the complexity of this and why they haven't gone there yet. But, she said she thinks they could probably figure that out with the data they have.

Kelsie Snow said this would be an amazing tool for patients.

Noah Nesin said Kelsie Snow had mentioned his concern about different plans under the same carrier or payor but that it would be a great tool for consumers and prescribers if we can get it in front of them.

Karynlee Harrington said she is retiring in eight years so the group has eight years to figure this out.

Ceilidh Shea asked members if they had anything else to add or ask about the dashboards.

Lisa Nolan said she was looking at the minutes from the last time MHDO presented to the Board and it was not clear whether there was an answer to this or not, but she asked whether it is possible for something like this, to see the prices at affiliated versus non-affiliated pharmacies. She asked if that is something that is discoverable if someone were to start digging down into the data.

Karynlee Harrington said that has not been a data element they have had. She said she believes that is one of the proposed changes they are making in this upcoming rule change. She said it is similar to healthcare setting in a way, because with that element they want to know what is owner by a hospital or a system versus what is independent or non-affiliated.

Kelsie Snow said is we were to use this for prescription drugs, it would be great if there was a way to put the patient's entire medication list into the system. From a patient safety standpoint, one of the things we try to avoid is having patients go to a bunch of different pharmacies. So, if there was a way to get a conglomerate price of the whole med list at one pharmacy or maybe two, that would be great. She said she does worry about the potential for some pretty serious patient safety concerns if they are going all over the place for individual drugs.

Jennifer Kent said she really likes the idea of having a Compare Maine option for pharmacy costs. She asked, though, how often

prices fluctuate. She said it is her understanding that on the pharmacy side, prices by carrier and prescription and pharmacy can change very frequently, so her concern would be whether the information, by the time it is put out publicly, would be dated.

Kelsie Snow said that she sees prices change daily. There is a lot of variation. That is something she monitors very frequently with her wholesalers.

Karynlee Harrington said that is one of the complexities of this. Even with the medical information they put out on Compare Maine, there is a lag. It is meant to be directional, which is not real time and not as useful as if it were a real time tool. That is something that needs to be considered in addition to whether something like this would really help or whether it would cause more confusion. She said with Compare Maine, there are hundreds of thousands of hits for the site since it was launched many years ago and they have received less than a handful of people that have called to raise concerns that what they saw on Compare Maine wasn't what they actually experienced. Part of that may be due to the fact that MHDO has provided caveats on the site that pop up to inform consumers that the information displayed is not indicative of what they will pay. Instead, it is information that's meant to lead to a conversation with a provider in a health plan.

Jennifer Reck said she likes the idea. She said she supports transparency and believes it should be encouraged wherever possible. She said she is trying to get her head around the consumer experience with this because of copays. If a consumer has a fixed copay of 20 dollars that wouldn't necessarily change depending on the pharmacy, even if the plan itself is paying more or less to different pharmacies. She asked if a consumer has a copay that's a percentage of the drugs price, what would the end use case for the consumer look like or how would the consumer use the tool to make sure they were getting the best deal out there given the copays.

Karynlee Harrington said that is something they would have to think about, particularly in weighing whether something like this would be useful. She said she thinks it connects back to educating people about their plans. For example, yes, consumers pay copays, but they also pay premiums. That premium is based on the cost of everything that people are receiving. So, the cost of a drug may only be 20 dollars to that one consumer, but it costs their plan and ultimately that comes back to them in the form of premiums. She said that if there is a lower cost drug that is just as effective, even though they still only have to pay 20 dollars for the cost of that specific drug, it ties back to their premium and it would be better for the plan if that consumer were on a lower cost drug.

Lisa Nolan said it is really difficult to get that message out, which often attempted at open enrollment, for example, but it doesn't seem to stick at that point. She said it is pretty normal for people to not think about what underlying costs might be. To that end, though, HPA has seen some of their members layering, on top of their pharmacy plans, some sort of service that reaches out to let them know there may be a less costly drug, even if it wouldn't make any difference from the consumers cost sharing perspective they are still better informed that there is a generic that would cost the plan less. They then work with the member to get that drug, so it is kind of set up like a concierge service. Lisa Nolan said that was set up because like Karynlee Harrington mentioned, it is very hard to get consumers to react when they are shielded from the true cost. The ideal way to go is to make sure that the higher cost drugs have higher cost sharing associated. If there is a lower cost drug available, they should be on a lower tier in the formulary, although that doesn't always happen and it is sometimes left to the PBM, who isn't necessarily going to be making those kinds of changes.

Kelsie Snow said there is also utility in comparing cash prices. She said that the Board has talked about this before, including the fact that cash prices are essentially made up because they vary so significantly. But, she says not a day goes by where she does not

have the discussion with consumers, telling them they should ask about the pharmacy's cash price because it could very well be cheaper than the insurance copay. She said this often is not an insignificant difference of a couple of dollars. She has seen differences around 100 dollars for a single, pretty cheap generic drug. Kelsie Snow said she thinks there is a lot of utility in a tool like this for prescription drugs because that adds up very quickly and it's not always something people know to investigate or ask about.

Lisa Nolan added that they have seen some purchasers, when looking at PBM contracts, include that the price has to be whatever the price is that's being put out there by the PBM or the cash price, whichever is lower. Some plans have been successful in getting that kind of change included in their contracts, though she is not sure how widespread that is.

Ceilidh Shea asked Board members if there were any other comments specifically related to the dashboard or the Compare Maine idea. She said if not, the group could transition back to a larger conversation about data collection in Maine if people have anything to add. She said the office shared some resources with members prior to the meeting, outlining where Maine stands on data collection and compared Maine to other states.

Jennifer Reck said that because this has a data element, she wanted to flag that there is language in the Maine PDAB statute that says at a minimum, the Board shall assess the following strategies, and then under number two (UPLs and referenced based pricing) including reviewing potential savings for the state employee health plan from implementing referenced based pricing for the first ten negotiated drugs in the Medicare Drug negotiation Program. She said that is something the Board would obviously need MHDO help to do, but that she just wanted to put it on everyone's radar, that one of the strategies the Board is tasked with assessing has a data element requirement.

Ceilidh Shea said that additionally, in the Board's report to the HCIFS committee, including not only a preliminary analysis but some sort of indication of the additional resources needed to conduct that kind of analysis would be helpful, whether that ends up being through MHDO or another vendor. Ceilidh Shea asked Karynlee Harrington if she wanted to share any updates on rulemaking.

Karynlee Harrington said that she did not have an update on rulemaking at this point and that MHDO is still trying to work through some of the comments they received. She said she had a good conversation with one of the top five health plans in the state last week. It was about the issue with formulary designation. She said they understood completely and that they had the information and thought it was important MHDO get it. They just needed to figure out the right structure to share it. She said hopefully she will have more of an update at the next PDAB meeting.

Ceilidh Shea thanked Karynlee Harrington. She asked if Board members had any final items on data collection.

Ceilidh Shea said the last thing on the agenda is planning for the June 22nd meeting, which will focus on UPLs. She said that as members know, so far the structure of meetings has been in pairs, with the first meeting focused on education for a certain topic and the second meeting focused on discussion and exploring positionality in greater depth. She said that given UPLs are such a big topic that Board members have been interested in for a long time, there is the option to dive right in. If members are interested, the office would be happy to provide some education. Then, she said she was thinking of inviting speakers, potentially from Colorado, to tee up the conversation for the second meeting so there is as much time as possible to delve into this topic. She asked members if there were any specific speakers or specific states they would like to hear from.

Jennifer Reck said she would like to bring in state speakers, but because there are such big differences between Colorado and Maryland's work, hearing from both states would be helpful. She said members are aware that NASHP has been convening the states that have been implementing PDABs and UPLs for many years now. She said they have a new director on their team, Johanna Butler, who is really digging in on this. If it were helpful, Johanna could provide a high-level overview of where different states are at in implementing UPLs and any issues they have flagged as they work through that. Jennifer Reck said that additionally, people often have legal concerns during these conversations. NASHP has been working closely with Rachel Sachs, who is a constitutional law expert who has been tracking PDABs and she would likely be available to be a resource for that conversation as well. She said she does not think the Board would need a presentation from her but if people had questions come up, she would be a helpful resource.

Sharon Treat said she liked that idea, which would be to have an overview looking at different states before getting presentation from specific states because you can't really put it into context. Different states are doing it differently. She said she would like to hear from those states, or at least Maryland and Colorado, because it runs so long and also has different models. She said that because legal questions have come up throughout this process, specifically related to the UPL program, it is a great opportunity to have someone join the meeting who can speak to that directly. Sharon Treat said she is grateful to NASHP for making these connections and providing these resources.

Lisa Nolan agreed that it would be helpful to have a legal expert present, especially given a lot of these arguments are heard in spaces like public hearings, where it can be hard to discern the real risk or how concerning these legal problems are. She said if there are other states with PDABs who have opted not to move forward UPLs, a conversation about why would be helpful.

	Ceilidh Shea said she would look into it, though her understanding is that states with UPL authority are either in the beginning stages of working on affordability reviews, building the foundation for those reviews, or are actively pursuing implementation. Lisa Nolan said even context on problems they have run into as they lay the groundwork could be helpful. Jennifer Reck said that perhaps Johanna Butler from NASHP could offer some of those details in her opening presentation. Ceilidh Shea said that she will work on reaching out to speakers from Colorado, Maryland, and NASHP. She said that the July 27th meeting will be focused on positionality and more open-ended discussion in follow up to the June 22 presentations. She reminded the group that there is flexibility in the schedule later in the year should more time be needed on the UPL subject. Jennifer Reck said that she wondered whether it might make more sense to have a longer meeting on June 22 to combine it with the July 27 meeting. She asked whether there were members who were not able to make the July 27 meeting. Jennifer Reck said, given everyone seemed able to make the July 27 meeting, that keeping the schedule as is makes sense. Ceilidh Shea said that is a valid concern. She said that as we get closer to the July 27 meeting, if there are members who have conflicts arise, the Board can consider potentially holding another meeting dedicated to UPL positionality or shift the meeting all together. She said they would plan to keep the schedule the same, for now.	
VII. Open Discussion		
VIII. Adjourn	Sharon Treat made a motion to adjourn. Noah Nesin seconded. The meeting was adjourned.	

Next meeting: June 22nd, 2026

